CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 663	**Date: July 15, 2016**
	Change Request 9690

SUBJECT: Denial Codes for Missing or Insufficient Documentation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the codes that are to be used when a claim is denied due to missing or insufficient documentation.

EFFECTIVE DATE: August 16, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 16, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2/3.2.3/3.2.3.8 - No Response or Insufficient Response to Additional Documentation
R	3/3.2/3.2.3/3.2.3.9 - Reopening Claims with Additional Information or Denied Due to Late or No Submission of Requested Information
R	3/3.6/3.6.4 - Notifying the Provider
R	7/7.2/7.2.2/7.2.2.5 - Prepay Complex Provider Specific Review
R	7/7.2/7.2.2/7.2.2.6 - Prepay Complex Service Specific Review
R	7/7.2/7.2.2/7.2.2.12 - Postpay Complex Provider Specific Review
R	7/7./7.2.2/7.2.2.13 - Postpay Complex Service Specific Review

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 663	Date: July 15, 2016	Change Request: 9690

SUBJECT: Denial Codes for Missing or Insufficient Documentation

EFFECTIVE DATE: August 16, 2016
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I. GENERAL INFORMATION

A. Background: When a contractor denies a claim, they must use appropriate codes to explain why the claim was denied. This CR will provide the appropriate codes to use when a claim is denied due to missing or insufficient documentation.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9690.1	When denying a claim due to no receipt of requested documentation, contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.	X	X	X	X					RA, RRB-SMAC, ZPICs
9690.2	Contractors medical review departments shall reopen a claim that has been appealed and the claim was denied using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a "medical necessity" by the payer and	X	X	X	X					RRB-SMAC, ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	Contractors have the discretion to indicate in the denial notice that the denial was made after the review of submitted documentation during a complex medical review by using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC): 50; these are non-covered services because this is not deemed a "medical necessity" by the payer.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, 410-786-7480 or debbie.skinner@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

This section applies to MACs, Recovery Auditors, and ZPICs, as indicated.

A. Additional Documentation Requests

If information is requested from both the billing provider or supplier and a third party and no response is received from either within 45 calendar days for MACs and Recovery Auditors or 30 calendar days for ZPICs after the date of the request (or within a reasonable time following an extension), the MACs, Recovery Auditors and ZPICs shall deny the claim, in full or in part, as not reasonable and necessary. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.*

Contractors shall count these denials as automated review or manual review depending on the method of development. For claims that had a PWK modifier, and the unsolicited documentation was reviewed, the review shall be counted as complex review.

B. No Response

During prepayment review, if no response is received within 45 calendar days after the date of the ADR, the MACs, and ZPICs shall deny the claim.

During postpayment review, if no response is received within 45 calendar days after the date of the ADR (or extension), the MACs and Recovery Auditors shall deny the claim as not reasonable and necessary and count these denials as non-complex reviews. ZPICs shall deny the claim as not meeting reasonable and necessary criteria if no response is received within 30 calendar days. Recovery Auditors shall report these denials as "No Response Denials." Recovery Auditors shall not count these as complex or non-complex reviews. Ambulance claims may be denied based on §1861(s) (7) of the Act.

C. Insufficient Response

If the MAC, CERT, Recovery Auditor, or ZPIC requests additional documentation to verify compliance with a benefit category requirement, and the submitted documentation lacks evidence that the benefit category requirements were met, the reviewer shall issue a benefit category denial. If the submitted documentation includes defective information (the documentation does not support the physician's certification), the reviewer shall deny the claim as not meeting the reasonable and necessary criteria.

3.2.3.9 - Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

If the MACs and CERT receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim. MACs and CERT who choose to reopen shall notify the provider or supplier of their intent to reopen, make a MR determination on the lines previously denied due to failure to submit requested documentation, and do one of the following, within 60 calendar days of receiving

documentation in the mailroom. Processing claims with additional information follows these general provisions:

- For claims originally selected for postpayment review, the reviewer shall issue a new letter containing the revised denial reason and the information required by PIM chapter 3 §3.6.4;

- For claims originally selected for prepayment review, the MAC shall enter the revised MR determination into the shared system, generating a new Medicare Summary Notice (MSN) and remittance advice with the new denial reason and appeals information;

- The workload, costs, and savings associated with this activity shall be allocated to the appropriate MR activity (e.g., postpayment complex);

In cases where the MAC or ZPIC denied a claim and the denial is appealed, the appeals entity will send the claim to the contractor's MR department for reopening in accordance with CMS Pub. IOM 100-04, chapter 34, § 10.3. *The claim sent back to the contractor's MR department must have been denied using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.* The MR department of the contractor (AC, MAC, PSC, or ZPIC) who initiated the prepayment edit shall be responsible for conducting the reopening.

- The MACs and CERT who choose not to reopen claims when documentation is received past the deadline shall retain the information (hardcopy or electronic) in a location where it can be easily accessed.

If the Recovery Auditor receives requested documentation from a supplier after a denial has been issued they shall not reopen the claim.

- If a Recovery Auditor receives documentation after the submission deadline, but before they have issued a demand letter, the Recovery Auditor shall review and consider the late documentation when making a claim determination;

- If the Recovery Auditor receives a late response to a documentation request after they have issued a demand letter, the Recovery Auditor shall retain the documentation so that it is available for review during the appeal process

3.6.4 - Notifying the Provider

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

This section applies to, MACs, Recovery Auditors, and ZPICs, as indicated.

A. General

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider even if no overpayment determination is made. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the Recovery Auditors shall issue a Review Results Letter for complex audits as outlined in their SOW requirements. ZPICs shall comply with the requirements listed below when issuing Review Results Letters.

Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;
- Reason for conducting the review or good cause for reopening;
- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;
- The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded and if others were payable;
- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;
- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;
- Total underpayment amounts;
- Total overpayment amounts that the provider or supplier is responsible for;
- Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault;
- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days (not applicable to Recovery Auditors or ZPICs);
- The provider's or supplier's right to request an extended repayment schedule (not applicable to Recovery Auditors or ZPICs);
- The MACs and ZPICs shall include limitation of liability and appeals information in the provider notices;
- The MACs shall include appeals information in the provider notices;

- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and,

- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re-review in 6 months).

If a claim is denied through prepayment review, the MACs and ZPICs are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and Recovery Auditor shall notify the provider by issuing a notification letter to meet this requirement. The ZPIC shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for complex review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

C. Recovery Auditors

For overpayments detected through **complex** review, the Recovery Auditor shall send a review results letter as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For overpayments detected through **non-complex** review, the Recovery Auditor shall notify the provider as indicated in the Recovery auditor SOW and will communicate sufficient information to the MAC so that the MAC can send a Remittance Advice to the provider.

For underpayments, the Recovery Auditor shall notify the provider as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and pay back the underpayment.

D. ZPICs

For overpayments detected through **complex** review, and after coordination between the ZPIC and OIG, the ZPIC shall send a review results letter (the MAC sends the demand letter). In addition, the ZPIC shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The ZPIC shall use discretion on whether to send the review results letter.

E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC or ZPIC had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, that the denial was made without reviewing the documentation because the requested documentation was not received or was not received within the allowable time frame (§1862(a) (1) of the Act). This information will be useful to the provider in deciding whether to appeal the decision. *When denying the claims, contractors shall use Group Code: CO -*

Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

For claims where the reviewer makes a denial following complex review, the reviewer has the discretion to indicate in the denial notice, using *Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer* that the denial was made after review of submitted documentation. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.

Medicare Program Integrity Manual
Chapter 7 - MR Reports

7.2.2.5 - Prepay Complex Provider Specific Review

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. If the requested documentation is not received, the review is not considered complex. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service*. For the purpose of calculating and reporting MR workload, cost and savings, contractors shall count these denials as automated review or manual review depending on the method of development.

7.2.2.6 - Prepay Complex Service Specific Review

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific prepay medical review of claims requires that a medical review determination be made before claim payment directed at a certain service. It includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.* For the purpose of calculating and reporting MR workload, cost and savings, contractors shall count these denials as automated review or manual review depending on the method of development.

7.2.2.12 - Postpay Complex Provider Specific Review

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Provider specific postpay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment directed at an individual provider. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service*. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay complex review and is not to be counted as a probe review.

7.2.2.13 - Postpay Complex Service Specific Review

(Rev.663, Issued: 07-15-16, Effective: 08-16-16, Implementation: 08-16-16)

Complex medical review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific postpay medical review of claims requires that a benefit category review, statutory exclusion review, and/or reasonable and necessary review be made after claim payment

directed at a certain service. This includes requests for, collection and evaluation of medical records or any other documentation. The review is as a result of vulnerabilities determined by data analysis and identified in the Medical Review strategy. If the requested documentation is not received, it is not considered a complex review. The failure of the provider to submit documentation shall result in a denial. *Contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service*. For the purpose of calculating and reporting MR workload, cost and savings, this is postpay complex review and is not to be counted as a probe review.