CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10184	**Date: June 19, 2020**
	Change Request 11812

SUBJECT: Updates to Chapters 4, 6, and 8 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections within Chapters 4, 6, and 8 in Pub. 100-08

EFFECTIVE DATE: July 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 21, 2020

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	4/4.6/4.6.2/4.6.2.5/UPIC and I-MEDIC Responsibilities
R	4/4.12/4.12.4/Initial Entry and Update Requirements for LE Payment Suspension Requests
R	4/4.12/4.12.9/UCM Helpdesk
R	4/4.18/4.18.1/4.18.1.2/Immediate Advisements to the OIG/OI
R	4/4.31/Vulnerabilities
R	6/6.2/Medical Review of Home Health Services
R	6/6.5/6.5.2/Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions
R	6/6.5/6.5.6/Length-of-Stay Review
R	6/6.5/6.5.9/Circumvention of PPS
R	6/6.6/Referrals to the Quality Improvement Organization (QIO)
R	6/6.7/Medical Review of Inpatient Rehabilitation Facility (IRF) Services
R	6/6.7/6.7.1/Reviewing for Intensive Level of Rehabilitation Therapy Services Requirements
R	8/Table of Contents
R	8/8.3/8.3.3/8.3.3.1/DME Payment Suspensions (MACs and UPICs)
R	8/8.3/8.3.3/8.3.3.2/Non-DME National Payment Suspensions (MACs and UPICs)

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: 10184	Date: June 19, 2020	Change Request: 11812

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EFFECTIVE DATE: July 21, 2020
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I. GENERAL INFORMATION

A. Background: The CMS is making revisions to Chapters 4, 6, and 8 in Pub. 100-08 based on updates to Unified Program Integrity Contractor (UPIC) and Investigations Medicare Drug Integrity Contractor (I-MEDIC) processes and procedures.

B. Policy: The 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11812.1	The I-MEDIC shall further screen the lead, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days once a complaint has been escalated to lead screening.									UPICs
11812.2	The I-MEDIC shall track all complaints received by its complaint screening staff in an internal tracking system.									UPICs
11812.2.1	The I-MEDIC shall track all complaints that that have escalated to a lead status the Unified Case Management (UCM) system.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11812.3	The UPIC shall follow the process outlined in section 8.3.3.1 and section 8.3.3.2, Chapter 8 of Publication (Pub.) 100-08 if the payment suspension is a national payment suspension.									UPICs
11812.4	UCM users shall contact the UCM helpdesk at UCMHelpDesk@cms.hhs.gov or 1-833-FLD-DESK (1-833-353-3375) for UCM issues.									UPICs
11812.5	UCM users shall contact their Contracting Officer's Representative (COR), who will provide the most current information available, in the event of UCM contract changes that affect the helpdesk contact information.									UPICs
11812.6	The UPIC shall request written and/or email confirmation from the Office of Inspector General (OIG) Office of Investigations (OI) acknowledging receipt of an Immediate Advisement (IA) upon submission to the OIG/OI.									UPICs
11812.7	The UPICs shall use the updated Vulnerability Template, as described in section 4.31, Chapter 4 of Pub 100-08.									UPICs
11812.8	The UPICs shall follow the medical review of home health services									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	guidance, as described in section 6.2, Chapter 6 of Pub 100-08.									
11812.9	The UPICs shall follow the requirements associated with conducting patient status reviews of claims for Medicare Part A payment for inpatient hospital admissions, as described in section 6.5.2, Chapter 6 of Pub 100-08.									UPICs
11812.10	The MACs, Supplemental, Medical Review Contractor (SMRC), Recovery Audit Contractors (RAC), and the Comprehensive Error patient Rate Testing (CERT) contractor shall make a referral to the UPIC when it is determined that a beneficiary's stay was unnecessarily long, and potentially represents fraud or abuse.	X		X						CERT, RAC, SMRC
11812.11	The MAC, SMRC, RAC, and the CERT contractor shall make a referral to the UPIC when it is suspected, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing the Prospective Payment System and that action resulted in unnecessary	X		X						CERT, RAC, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services.									
11812.12	The UPICs shall follow the medical review of inpatient rehabilitation facility (IRF) services guidance, as described in section 6.7, Chapter 6 of Pub 100-08									UPICs
11812.13	The UPICs shall verify that the IRF documentation requirements are met in accordance with Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 110.									UPICs
11812.14	The UPICs shall not make absolute claim denials based solely on a threshold of therapy time not being met.									UPICs
11812.15	The UPICs shall use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time.									UPICs
11812.16	The UPICs shall follow the Durable Medical Equipment DME Payment Suspension									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	guidance, as described in section 8.3.3.1, Chapter 8 of Pub 100-08.									
11812.17	The UPICs shall follow the Non-DME National Payment Suspension guidance, as described in section 8.3.3.2, Chapter 8 of Pub 100-08.									UPICs

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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jesse Havens, 410-786-6566 or jesse.havens@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 4 - Program Integrity

Table of Contents

(Rev. 10184; Issued: 06-19-2020)

4.6.2.5 – UPIC and I-MEDIC Responsibilities

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to the UPICs.

When the complaint is received from the MAC screening staff, the UPIC shall further screen the
complaint, resolve the complaint, or make referrals, as needed, to the appropriate entity.

The MAC shall screen and forward the complaints within 45 business days from the date of receipt by the screening staff, or within 30 business days of receiving medical records and/or other documentation, whichever is later, to the UPIC. The UPIC shall send the acknowledgement letter within 15 calendar days of receipt of the complaint referral from the MAC screening staff, unless it can be resolved sooner. The letter shall be sent on UPIC letterhead and shall contain the telephone number of the UPIC analyst handling the case.

If the UPIC staff determines, after screening the complaint, that it is not a potential fraud, waste, and/or abuse issue, but involves other issues (e.g., MR, enrollment, claims processing), the complaint shall be referred back to the MAC area responsible for screening. The MAC screening staff shall track the complaints returned by the UPIC. However, the UPIC shall send an acknowledgement to the complainant, indicating that a referral is being made, if applicable, to the appropriate MAC unit for further action. The UPIC shall track complaints referred by the MAC screening area in the UPIC's internal tracking system. The UPIC shall send the complainant a resolution letter within seven (7) calendar days of resolving the complaint investigation.

This section applies to the I-MEDIC.

When a complaint is received by the I-MEDIC complaint screening staff, an acknowledgement letter shall be sent to the complainant within five (5) calendar days. The I-MEDIC complaint screening staff shall screen, resolve, or if warranted, escalate the complaint to the screening team at the I-MEDIC within 30 calendar days from the date of receipt.

Once a complaint has been escalated *to lead* screening, the I-MEDIC shall further screen the *lead*, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days.

The I-MEDIC shall track *all* complaints received by its complaint screening staff *in an internal tracking system. All complaints that have escalated to a lead status shall be tracked* in the UCM.

The I-MEDIC complaint screening staff shall send the complainant a resolution letter within five (5) calendar days of resolving the complaint investigation.

4.12.4 - Initial Entry and Update Requirements for LE Payment Suspension Requests

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

Law Enforcement Payment Suspension Requests and all applicable documentation shall be entered into the UCM within five (5) calendar days of receipt of the request, unless otherwise directed by the Payment Suspension team manager.

CMS expects the UPICs to make timely updates, generally within two (2) business days of the action, to the UCM throughout the course of a LE Payment Suspension, including timely

monthly reports of any escrow dollars. If the Payment Suspension is a National Payment Suspension, the UPIC shall follow the process outlined in *8.3.3.1 DME Payment Suspensions (MACs and UPICs) and 8.3.3.2 Non-DME National Payment Suspensions (MACs and UPICs)*. The lead UPIC is responsible for entering all documentation into the UCM within five (5) calendar days as well as communicating/coordinating with the non-lead UPICs to make sure their information also is entered timely.

Within seven (7) calendar days of the termination of a LE payment suspension, or if a LE Payment Suspension request is denied or withdrawn, the UPIC shall finalize any remaining actions and close the UCM Payment Suspension (PSP) record.

4.12.9 - UCM Helpdesk

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

For UCM issues, users can contact *the UCM helpdesk at UCMHelpDesk@cms.hhs.gov or 1-833-FLD-DESK (1-833-353-3375). If there are UCM contract changes that affect the helpdesk contact information, users can contact their COR, who will provide the most current information available*.

4.18.1.2 - Immediate Advisements to the OIG/OI

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

The UPIC shall notify the OIG/OI of an immediate advisement as quickly as possible, but not more than four (4) business days after identifying a lead or investigation that meets the following criteria. The UPIC shall maintain internal documentation on these advisements when it receives allegations with one or more of the following characteristics:

- Indications of UPIC or MAC employee fraud
- Allegations of kickbacks or bribes, discounts, rebates, and other reductions in price
- Allegations of a crime committed by a federal or state employee in the execution of their duties
- Indications of fraud by a third-party insurer that is primary to Medicare
- Confirmation of forged documentation during the course of an investigation, include, but is not limited to:
    - identification of forged documents through medical review; and/or
    - attestation from provider confirming forged documentation.
- Allegations and subsequent verification of services not rendered as a result of any of the following:
    - medical review findings;
    - interviews or attestations from a minimum of three (3) beneficiaries indicating that they did not receive services; and/or
    - attestations from referring/ordering providers indicating they did not refer/order a service (e.g., confirmation of no relationship with the beneficiary prior to service, or confirmed impossible day billings).
- Confirmed complaints from current or former employees that indicate the provider in question inappropriately billed Medicare for all or a majority of its services. Confirmation would be required though one of the following:
    - minimum of three (3) beneficiary interviews confirming the inappropriate billing;
    - provider attestation(s) confirming the inappropriate billing; or
    - medical review findings.
- Confirmation of beneficiary recruitment into potentially fraudulent schemes (e.g., telemarketing or solicitation schemes);

- Substantiated identity theft of a provider's Medicare number, a beneficiary's Medicare number, or selling or sharing of beneficiary lists;
- Confirmed indication of patient harm (e.g., through medical review findings or confirmation of issues identified during an onsite visit or interviews with providers or beneficiaries).

IAs should be referred to the OIG/OI only when the above criteria are met, unless prior approval is given by the COR and IAG BFL.

Should local LE have specific parameters or thresholds in place that do not allow them to accept certain IAs, the UPIC shall notify its COR/BFL and request exemption from the applicable IA criteria in that particular jurisdiction.

When IA criteria are met, the UPICs shall perform an initial assessment to identify and document dollars currently pending payment to the provider, and/or if RAP claim payment is pending, if applicable. Should high dollar amounts be identified with either scenario, the UPIC shall notify CMS immediately, but not to exceed two (2) business days from date of identification.

Once the criteria for an IA are met, the UPIC shall notify the OIG/OI via phone or email to determine if a formal IA referral should be sent to the OIG/OI. The UPIC shall document this communication in UCM. The UPIC shall also send notification to its COR and IAG BFL of the potential IA. If the UPIC does not receive a response from the OIG/OI within two (2) business days (5 business days for the I-MEDIC), it shall notify its COR and BFL team and await further instructions. If the OIG/OI confirms that a formal IA should be sent, the UPIC shall provide all available documentation to the OIG/OI within four (4) business days of receiving the response from OIG/OI. Upon submission of the IA to the OIG/OI, the *UPIC* shall request written and/or email confirmation from the OIG/OI acknowledging receipt of the IA. Simultaneously, the UPICI-MEDIC shall notify the CMS identified Strike Force points of contacts, if the notification includes providers/suppliers located within a Strike Force jurisdiction. Additionally, the UPIC shall notify and send a copy of the IA to its COR/BFL and the case coordination team, at CPIMCCNotifications@cms.hhs.gov, the same day the advisement is made to OIG/OI. If the OIG/OI determines that a formal IA is not needed, the UPIC shall advise its COR/BFL and immediately continue its investigation. In instances where an IA is related to a Plan employee whistleblower, the I-MEDIC does not have to notify the case coordination team of the IA nor does the IA have to be discussed at a case coordination meeting. Rather, the I-MEDIC shall close the complaint upon acceptance and/or declination of the IA due to these complaint types being outside of the I-MEDIC's SOW.

In this notification to CMS, the UPIC shall advise if it has any other potential administrative actions it may want to pursue related to the provider(s)/supplier(s). If so, the IA will then be added to the next case coordination meeting agenda for discussion and final approval.

If the IA is related to a provider/supplier that spans multiple jurisdictions, the UPIC shall send a notification to the other UPIC and/or I-MEDIC Program Directors on the same date the formal IA is sent to OIG/OI. The UPIC shall copy its COR/BFL on such communication. Upon receipt of the notification from the primary UPIC, the other UPICs and/or I-MEDIC shall provide confirmation to the primary UPIC and its COR/BFL that the notification has been received, and it is ceasing activity as instructed below. Upon receipt of acceptance or declination of the IA from the OIG/OI, the primary UPIC shall notify the other UPIC and/or I-MEDIC Program Directors of the outcome.

Upon identification and submission of an IA to the OIG/OI, unless otherwise directed, all impacted UPICs and/or I-MEDIC shall cease all investigative and administrative activities,

with the exception of screening activities, data analysis, etc., until the OIG/OI responds with its acceptance or declination of the IA. If the UPIC does not receive an immediate response from the OIG/OI, the UPIC shall contact OIG/OI after two (2) business days from the date of the IA notification and document the communication in the UCM system. If the UPIC does not receive a response from the OIG/OI within five (5) business days from the date of the IA notification, the UPIC shall contact its COR/BFL for further guidance.

If the OIG/OI declines or accepts the IA, the UPIC shall document the decision in UCM and follow the processes described in Chapter 4, § 4.6.4 and § 4.7 of the PIM, unless otherwise directed by CMS.

Additionally, until the necessary updates are made in the UCM, if the UPIC submits an IA based on the updated criteria, it shall select all six (6) IA options on the "External Stakeholders" page of the UCM, and notate the justification of the IA in the Record Summary section of the UCM.

During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to the IA. If the UPIC has questions following the case coordination meeting, the UPIC shall coordinate with its COR and IAG BFL.

4.31 - Vulnerabilities

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to UPICs and SMRCs.

Program vulnerabilities are identified flaws or weaknesses in policy and/or regulatory authority
that increases the likelihood of significant inappropriate payments being made to a broad provider/supplier population. Program vulnerabilities can be identified through a variety of sources such as the Chief Financial Officer's audit, Fraud Alerts, the GAO, the OIG, data driven
studies, and UPIC and Medicare contractor operations.

Program Integrity concerns are issues CPI and/or the UPICs/SMRCs have identified through their own analysis and have the ability to mitigate through existing operations. Examples of PI concerns include, but are not limited to: routine changes and implementation of new billing codes (i.e. ICD-10, HCPCs, CPT codes, etc.) that may lead to questionable billing practices, reports/complaints of a potential fraud schemes that can be addressed in CMS regulations or policy guidance, or identified concerns and significant mitigating changes to enrollment processes.

The UPICs and SMRC shall discuss potential program vulnerabilities with the COR(s) and BFL(s) during the established recurring workload meetings. Program vulnerabilities should be submitted sooner if the UPIC/SMRC believes it requires immediate consideration. The BFL will validate the lead to determine whether the potential issue is a program vulnerability, a PI Concern, or another type of issue that may need to be addressed. Should the BFL need additional information, the UPIC shall submit an overview of the potential program vulnerability, program impact, and proposed action to the COR(s) and BFL(s) via email.

Should the COR(s) and BFL(s) agree that the identified issue is a program vulnerability, the UPIC/SMRC shall submit the proposed program vulnerability to the vulnerability mailbox at CPIVulnerabilityIntake@cms.hhs.gov, using the Vulnerability Template.

Additionally, all program vulnerabilities that are submitted to the mailbox shall be documented in the UPIC/SMRC program vulnerability report. If the UPIC/SMRC believes the proposed program vulnerability has potential Medicaid impact, the UPIC/SMRC shall document this in the submission to the vulnerability mailbox.

Should the COR(s) and BFL(s) determine that the identified issue is a PI concern, the COR(s) and BFL(s) shall advise the UPIC/SMRC to mitigate the concern through its existing operations. Issues not considered to be program vulnerabilities or PI concerns will be addressed on a case by case basis.

Vulnerability Template

Date Submitted:

Submitted by*:*

Name:
Organization:
Phone:
Email:

Vulnerability
Vulnerability *Title*:

Provider Type (if applicable):

Vulnerability Description:

Risk Factors (specific conditions, drivers, and/or actions that likely cause the vulnerability or increase the chances of it occurring):

** Be as specific as possible about what the root cause(s) of the vulnerability may be. This field provides detail that may be used to ultimately help "solve the problem" and mitigate the vulnerability.*

For the below, provide risk assessment point valuation and provide a written justification for each (This is not required but will greatly assist in the vulnerability process).

Likelihood (Likelihood for the identified vulnerability. Provide 1-2 sentences behind the reasoning for selecting this level of likelihood for the vulnerability):

4 -- Almost Certain (>=75% likelihood to occur)
3 -- Likely (>=50% - <75% likelihood to occur)
2 -- Possible (>=25% - <50% likelihood to occur)
1 -- Unlikely (<25% likelihood to occur)

Patient Harm (Provide 1-2 sentences behind the reasoning for selecting this level of likelihood for the vulnerability):

4 -- Life Threatening
3 -- Significant
2 -- Minimal
1 -- No harm

Financial Impact (Provide 1-2 sentences behind the reasoning for selecting this level of financial impact for the vulnerability):

4 -- Greater than $200m (>=$200 million)
3 -- $100m - $200m (>=$100 million <$200 million)
2 -- $10m - $100m (>=$10 million <=$100 million)
1 -- Less than $10m (<$10 million)

Breadth (Provide 1-2 sentences behind the reasoning for selecting this level of breadth for the vulnerability):

4 -- National
3 -- Regional
2 -- Pocketed
1 -- Isolated

Existing Controls (Provide current projects or activities that are underway to address the risk factor):

Suggested Mitigation Activities (Suggestions for action items (i.e. key results) that may help to mitigate the risk factor(s):

Source (i.e. person/organization that first identified it):

FPS Model-Related (Y/N):
* If yes, simultaneously report the information consistent with requirements of the FPS.

Attachments *(If applicable, upload document(s), such as Office of Inspector General reports or relevant data that can provide additional information or context on the vulnerability being reported):*

Medicare Program Integrity Manual

Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

Table of Contents

(Rev. 10184; Issued: 06-19-2020)

6.2 - Medical Review of Home Health Services

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to *Unified Program Integrity Contractors (UPIC),* Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit *Contractors (RAC)* and the Comprehensive Error Rate Testing (CERT) contractor.

6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to *Unified Program Integrity Contractors (UPIC),* Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors and the Comprehensive Error patient Rate Testing (CERT) contractor.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors shall conduct reviews of medical records for inpatient acute IPPS hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as so permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.

A. Determining the Appropriateness of Part A Payment

The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. Medicare contractors shall conduct such reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A; “patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

Per the 2-midnight presumption, Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

Per the 2-midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than 2 midnights. If a stay is not reasonably expected to span 2 or more midnights, Medicare contractors shall assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

- If the procedure is on the Secretary’s list of “inpatient only” procedures (identified through annual regulation);

- If the procedure is a CMS-identified, national exception to the 2-midnight benchmark; or

- If the admission otherwise qualifies for a case-by-case exception to the 2- midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2- midnight expectation. Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The 2-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

I. Reviewing Hospital Claims for Patient Status: The 2-Midnight Benchmark

A. Determine if the stay involved an "Inpatient Only" procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor shall determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an "inpatient only" procedure is performed. "Inpatient only" procedures are so designated per 42
C.F.R. § 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

Medicare contractors shall review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are present, then the Medicare review contractor shall deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.
If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the 2-midnight benchmark.

B. Calculating Time Relative to the 2-Midnight Benchmark

Per the 2-midnight benchmark, Medicare contractors shall assess short stay (i.e., less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews shall assess the information available at the time of the original physician/practitioners' decision. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his or her plan of care, treatment orders, and progress notes. Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms,

current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors shall take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission. This pre- admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the 2-midnight benchmark at the recipient hospital, the Medicare contractors shall take into account the time and treatment provided to the beneficiary at the initial hospital. That is, the start clock for transfers begins when the care begins in the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor shall request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2- midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See Pub. 100-02, Ch. 1, Section 10.2 for additional information regarding the formal order for inpatient admission.)

C. Unforeseen Circumstances Interrupting Reasonable Expectation

The 2-midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors shall, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors shall look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner’s original judgment. An event that interrupts an otherwise reasonable expectation that a beneficiary’s stay will span 2 or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

D. Stays Expected to Span Less than 2 Midnights

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than 2 midnights, the

services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor shall assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

E. Exceptions to the 2-Midnight Rule

1. Medicare's Inpatient-Only List

As discussed above, inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule

If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met. CMS has identified the following national or general exception to the 2-midnight rule:

> Mechanical Ventilation Initiated During Present Visit
>
> CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient–only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule

For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

- The beneficiary history and comorbidities;
- The severity of signs and symptoms;
- Current medical needs; and
- The risk of an adverse event.

Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark, and as such, may be prioritized for medical review.

A. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

Medicare contractors shall utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim

as billed. If the medical record supports that they were not, then utilize ICD-9- CM or ICD-10-CM coding guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review.
When you determine that the beneficiary did not, at the time of admission, have an expected length of stay of 2 or more midnights, or otherwise meet CMS standards for payment of an inpatient admission, but that the beneficiary's condition changed during the stay and Part A payment became appropriate, you shall review the case in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;
- The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and
- The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.
- Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.

When you determine that the beneficiary did not meet the requirements for Part A payment at any time during the admission, deny the claim in full.

6.5.6 - Length-of-Stay Review

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

The contractor shall determine whether the length-of-stay for PPS cost outlier claims and specialty hospital/unit claims, when selected for medical review, is appropriate and medically necessary. Identify cases of potential delayed discharge. For example, the beneficiary was medically stable, and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the safety or health of the beneficiary (see §4110).

If Medicare payment is applicable to only part of the stay, review the covered portion of the stay and enough of the rest of the medical record (if necessary) to answer any specific questions that may arise from review of the covered part of the stay. If a beneficiary became Medicare eligible during a hospital stay, review enough of the medical record prior to the initiation of Medicare benefits to acquire sufficient information to make a determination. Do not perform lengthy reviews of non-covered care. In PPS waived/excluded areas, length-of-stay review is performed for all inpatient admissions that are selected for medical review.

The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers. However, the contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments. Where it is determined that a beneficiary’s stay was unnecessarily long, and potentially represents fraud or abuse, the contractor shall make a referral to the *UPIC*.

6.5.9 - Circumvention of PPS

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

If you suspect, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing PPS (as described in §1886(f)(2) of the Act) and that action resulted in unnecessary admissions,

premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, you shall make a referral to your *UPIC*.

6.6 - Referrals to the Quality Improvement Organization (QIO)

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

The MACs shall only refer Quality of (Health) Care Concerns to the QIOs. A Quality of (Health) Care Concern is defined as "a concern that care provided did not meet a professionally recognized standard of health care." The Contractor shall follow the referral process as agreed upon in the QIO-MAC Joint Operating Agreement. The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, transfer reviews, readmission reviews and, provider-requested higher-weighted DRG reviews.

The Circumvention of PPS will continue to be reported to your *UPIC*. The quality initiatives associated with payment for performance are now the reporting source for Readmission Reviews and Transfer Review data to the QIOs. Non-covered benefits/services are not to be reported to the QIO.

All initial payment determinations and claim adjustments are required to be performed by the MAC.

All MACs are to turn off all automated edits/processes that generate a referral to the QIOs prior to a medical record review of the claim. Referrals to the QIO shall be limited to Quality of Health Care issues as defined above and shall result from a clinician's medical record review of a provider's medical documentation.

If during the medical record review process, "a concern that care provided did not meet a professionally recognized standard of health care," the MAC shall issue a payment determination and/or adjustment for the claim, complete the QIO referral form, and forward the completed referral form and file(s) to the QIO. If the referral form is not complete, the QIO will return the file to the MAC and request that the MAC provide the missing information prior to the QIO performing a review.

A non-covered service and/or procedure shall not be automatically referred to the QIO. The MAC shall make the initial payment determination and/or claim adjustment for a non-covered service or procedure in accordance with the Medicare IOM 100-04, Claims Processing Manual and IOM 100-02, Benefit Policy Manual.

If during the medical record review process, "a concern that care provided did not meet a professionally recognized standard of health care," such as a medically unnecessary procedure, the claim shall be referred to the QIO for quality review after payment determination and/or claim adjustment is made.

The MACs shall not instruct providers, suppliers, or beneficiaries to refer payment issues to the QIO. If the provider or supplier does not agree with the payment and/or claim adjustment decision, the MAC shall communicate their options to follow the current process in IOM 100-08, requesting a reopening or an appeal. If the beneficiary disagrees with the payment decision and makes a request for re-evaluation/redetermination, this will be considered a demand bill and is the responsibility of the MAC.

6.7 - Medical Review of Inpatient Rehabilitation Facility (IRF) Services

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to *Unified Program Integrity Contractors (UPIC),* Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors (RAC) and the Comprehensive Error Rate Testing (CERT) *C*ontractor, as indicated.

6.7.1 – Reviewing for Intensive Level of Rehabilitation Therapy Services Requirements

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

When reviewing IRF claims, the *UPIC,* MAC, SMRC, CERT and RAC shall verify that the IRF documentation requirements are met in accordance with IOM 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 110.

The *UPIC,* MAC, SMRC, CERT and RAC shall not make absolute claim denials based solely on a threshold of therapy time not being met. When the current industry standard of generally 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) per day at least 5 days per week or at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period is not met, the claim shall undergo further review.

The *UPIC,* MAC, SMRC, CERT and RAC shall use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time. The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group and concurrent therapy can be used on a limited basis within the current industry standard of generally 3 hours of therapy per day at least 5 days per week or at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF. However, MAC, SMRC, CERT and RAC shall not deny solely because the situation/rationale that justifies group therapy is not submitted in response to an ADR.

Medicare Program Integrity Manual

Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation

Table of Contents
(Rev. 10184; Issued: 06-19-2020)

Transmittals for Chapter 8

8.3.3.1 - DME Payment Suspensions (MACs and *U*PICs)

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

For national payment suspensions involving durable medical equipment (DME) suppliers that are enrolled in multiple jurisdictions, the following is applicable for DME MACs and *U*PICs:

- When CMS suspends payments to a DME supplier, all payments to the supplier are suspended in all DME jurisdictions if the same Tax Identification Number is used. The information (whether based on fraud or non-fraud) that payments should be suspended in one DME jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.

- The *U*PIC that requests the national payment suspension to CPI shall become the "*L*ead" *UPIC* for the payment suspension if the payment suspension is approved. The *Lead UPIC* is responsible for informing the other *UPICs (non-lead UPICs)* of the payment suspension being initiated and for the coordination of the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities of the national suspension by each of the contractors.

- The *Lead UPIC* is responsible for coordinating and reporting to its CORs and BFLs whether the *non-lead UPICs* are compliant with the payment suspension timeframe and activities.

- All non-lead *UPICs* are responsible for determining an overpayment(s) for its jurisdiction. *Non-lead UPICs* shall take into account the findings of the *Lead UPIC* and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.

For *U*PIC-initiated DME payment suspensions:

- Each *U*PIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective DME MAC jurisdiction and has communicated this to the lead *U*PIC. *If non-lead UPIC determines that medical review would not be appropriate in their jurisdiction for subject provider, non-lead UPIC sh*all *notify and request permission from* their *BFL to opt out of the medical review.*

- *The Lead UPIC shall create both a CSE record, if not already created, to track the investigative activities and a PSP record to track the activities specific to the payment suspension in UCM. The lead UPIC shall check the "lead" checkbox. Non-lead UPICs shall not create a separate PSP and is responsible for timely updating the lead UPIC's PSP with monthly escrow amounts within their jurisdictions, as well as adding any pertinent comments and/or documentation. Non-lead UPICs shall create a CSE and the appropriate administrative action records to track their activities.*

8.3.3.2 – Non-DME National Payment Suspensions (MACs and *U*PICs)

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

For national payment suspensions involving national providers (such as chain hospitals, chain Skilled Nursing Facilities, franchised clinics, laboratories, etc.) that are enrolled in multiple jurisdictions, the following may be applicable for MACs and *U*PICs:

- When CMS suspends payments to a national provider, all payments to the national provider are suspended in all jurisdictions if they share the same Tax Identification Number. The information (whether based on fraud or non-fraud) that payments should

be suspended in one jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.

- The *U*PIC that requests the national payment suspension to CPI shall become the "*L*ead" *UPIC* for the payment suspension. The *L*ead *UPIC* is responsible for informing the other *UPICs (non-lead UPICs)* of the payment suspension being initiated and for the coordination regarding the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities by each of the contractors.

- The *Lead UPIC* is responsible for coordinating and reporting to its CORs and BFLs whether the *non-lead UPICs* are compliant with the payment suspension timeframe and activities.

- *All non-lead UPICs are responsible for determining an overpayment(s) for its jurisdiction. Non-lead UPICs shall take into account the findings of the Lead UPIC and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.*

For *U*PIC-initiated non-DME national payment suspensions:

- Each *U*PIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective MAC jurisdiction and has communicated this to the *L*ead *U*PIC. *If non-lead UPIC determines that medical review would not be appropriate in their jurisdiction for subject provider, non-lead UPIC shall notify and request permission from their BFL to opt out of the medical review.*

- *The Lead UPIC shall create both a CSE record to track the investigative activities and a PSP record to track the activities specific to the payment suspension in UCM. The lead UPIC shall check the "lead" checkbox. Non-lead UPICs shall not create a separate PSP and is responsible for timely updating the lead UPIC's PSP with monthly escrow amounts within their jurisdictions, as well as adding any pertinent comments and/or documentation. Non-lead UPICs shall create a CSE and the appropriate administrative action records to track their activities.*