CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10197	**Date: June 26, 2020**
	Change Request 11730

SUBJECT: Publication (Pub.) 100-08 Chapter 3 Updates to Section 3.2.3.2 (Timeframes for Submission) and Section 3.2.3.8 (No Response or Insufficient Response to Additional Documentation Requests (ADRs))

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify our authority to request and require documentation, upon request, to determine the appropriateness of claims for payment.

EFFECTIVE DATE: July 27, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 27, 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	3/3.2/3.2.3.2/Timeframes for Submission
R	3/3.2/3.2.3.8/No Response or Insufficient Response to Additional Documentation Requests

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

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I. GENERAL INFORMATION

A. Background: In certain circumstances, the MACs, Comprehensive Error Rate Testing (CERT) Contractor, Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractor (RAC), Unified Program Integrity Contractors and other contractors may not be able to make a determination on a prepayment or post-payment claim they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, contractors may require providers or suppliers to furnish medical and related supporting documentation in order to determine the amounts due for payment. CMS and its contractors require that sufficient documentation and information be furnished to support that selected claims meet applicable coverage, coding, and billing requirements for payment

During the medical review process, Medicare contractors may reach out to the provider or supplier and request documentation to support payment of the selected claims. Such documentation is reviewed to determine the appropriateness of a claim for payment based on its compliance with our coverage, coding, and billing requirements. Medicare contractors request documentation be provided in specified timeframes once a request for additional documentation is sent to the provider or supplier. In cases where no supporting documentation is received to conduct a medical review, the claim shall be denied. This change request clarifies our authority for to request and require documentation, upon request, to determine the appropriateness of claims for payment.

B. Policy: Sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Social Security Act (the Act).

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	
11730.1	In circumstances where contractors are not able to	X	X	X	X					CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	make a determination on prepayment or post-payment claims they have chosen for review based upon the information on the claim, contractors shall solicit documentation from the provider or supplier by issuing an ADR.									
11730.2	Contractors shall require providers and suppliers to furnish sufficient documentation and information to support that the selected claim meets applicable coverage, coding, and billing requirements for payment.	X	X	X	X					CERT, RAC, SMRC, UPICs
11730.3	When requesting documentation for prepayment review or postpayment review, contractors shall notify providers when they expect documentation	X	X	X	X					CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to be received and cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act exclusively when referring to the authority for requiring submission of documentation. Note- This relates to contractor authored correspondence, and does not implicate systems changes.									
11730.3.1	Contractors should grant extensions to providers who need more time to comply with post-payment review requests.	X	X	X	X					CERT, RAC, SMRC, UPICs
11730.4	Contractors shall deny claims on prepayment review or postpayment review, for no response, when the provider/supplier fails to provide requested documentation to corroborate payment within	X	X	X	X					CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the expected timeframe (and potential postpayment extension).									
11730.5	Contractors shall cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act, exclusively, when issuing claim denials due to no response on prepayment review or postpayment review. Note- This relates to contractor authored correspondence, and does not implicate systems changes	X	X	X	X					RAC, SMRC, UPICs
11730.6	MACs shall count no response denials as automated review or non-medical record review depending whether the denial is automated or requires manual intervention.	X	X	X	X					

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): Jennifer Phillips, 410-786-1062 or jennifer.phillips@cms.hhs.gov , Olufemi Shodeke, olufemi.shodeke@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

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(Rev. 10197; Issued: 06-26-20)

3.2.3.2 - Time - Frames for Submission

(Rev. 10197; Issued: 06-26-20; Effective: 07-27-20; Implementation: 07-27-20)

This section applies to MACs, RACs, CERT, *SMRC,* and *UPICs*, as indicated.

In certain circumstances, the MACs, CERT, SMRC, RACs, UPICs and other contractors may not be able to make a determination on prepayment or post-payment claims they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an ADR.

Contractors are authorized to collect medical documentation by the Social Security Act (the Act).

Section 1815(a) of the Act states that "...no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

Section 1833(e) of the Act states that "[n]o payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

In addition, Contractors are required to ensure that payment is limited to those items and services that are reasonable and necessary.

Section 1862(a)(1)(A) of the Act states that "[n]otwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services— which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Contractors are required, when authoring correspondence related to ADRs, to cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act exclusively when referring to the authority for requiring submission of documentation.

A. Prepayment Review Time Frames

When requesting documentation for prepayment review, the MAC*s* and *UPICs* shall notify providers *when they expect documentation to be received.* The reviewer should not grant extensions to providers who need more time to comply with the request. Reviewers shall deny claims *when* the requested documentation *to support payment is not received by the expected timeframe*.

B. Post-payment Review Time Frames

When requesting documentation for post-payment review, the MAC*s*, CERT, *SMRC, UPICs and* RAC*s* shall notify providers *when they expect documentation to be received*. MACs, CERT, *SMRC,* UPICs *and RACs* have the discretion to grant extensions to providers who need more time to comply with the request.

The MACs, CERT, SMRC, UPICs and RACs shall deny claims when the requested documentation to support payment is not received by the expected timeframe (including any applicable extensions).

C. For esMD submissions

The esMD review contractor shall use the Enterprise File Transfer (EFT) system receipt date as the date the documentation was received. If the EFT receipt date is outside of the contractor's normal business hours, the following business day shall be used as the receipt date. Contractors shall pull for esMD files at least every 4 hours (business hours) daily; including a mandatory pulling between the hours of 6-7pm EST daily. If unforeseeable circumstances occur, in which contractors are not technically capable of retrieving documentation in a timely manner due to issues outside of their control, contractors are to notify the esMD Team and can use the date documentation was available to be retrieved once issues have been resolved in the EFT system.

3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests

(Rev. 10197; Issued: 06-26-20; Effective: 07-27-20; Implementation: 07-27-20)

This section applies to MACs, RACs, CERT, *SMRC,* and UPICs, as indicated.

A. Additional Documentation Requests

The reviewer authority to request that documentation be submitted, to support claims payment, is outlined in Section 3.2.3.2 of this chapter.

If information is requested from both the billing provider or supplier and*/or* a third party and no response is received within *the expected timeframes (or within a reasonable time following an extension)*, the MACs, RACs, *SMRC,* and *UPICs* 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.

MACs shall count these denials as automated review or non-medical record review depending whether the denial is automated or requires manual intervention. For claims that had a PWK modifier, and the unsolicited documentation was reviewed, the review shall be counted as medical record review.

B. No Response

During prepayment review, if no response is received within *the expected timeframes*, the MACs and UPICs shall deny the claim.

During post-payment review, if no response is received within *the expected timeframes* (or extension), the MACs*, RACs, UPICs and SMRC* shall deny the claim as not reasonable and necessary. *These contractors shall cite sections 1815(a), 1833(e), and 1862(a)(1)(A) of the Act exclusively when referring to the authority for requiring submission of documentation, when denying claims for no response within the expected timeframes.* The MACs shall count these denials as non-medical record reviews.

C. Insufficient Response

If the MAC, CERT, RAC, UPIC *or SMRC* 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.