CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 721	**Date: June 9, 2017**
	Change Request 9809

SUBJECT: Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to instruct contractors to not perform routine reviews including documentation compliance reviews and that there are now the following three types of reviews: 1) Medical records review-formerly "complex review"; 2) Automated review; and 3) Non-medical record review.

EFFECTIVE DATE: July 11, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 11, 2017

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/Table of Contents
R	3/3.2/Overview of Prepayment and Postpayment Reviews
R	3/3.2/3.2.2/Provider Notice
R	3/3.2/3.2.3/Requesting Additional Documentation During Prepayment and Postpayment Review
R	3/3.2/3.2.3.3/Third-party Additional Documentation Request
R	3/3.2/3.2.3.7/Special Provisions for Lab Additional Documentation Requests
R	3/3.2/3.2.3.8/No Response or Insufficient Response to Additional Documentation Requests
R	3/3.2/3.2.3.9/Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information
R	3/3.2/3.2.4/Use of Claims History Information in Claim Payment Determinations
R	3/3.3/3.3.1/Types of Review: Medical Record Review, Non-Medical Record Review, and Automated Review
R	3/3.3/3.3.1.1/Complex Medical Review
R	3/3.3/3.3.1.2/Non-Complex Review
R	3/3.3/3.3.1.3/Automated Review
R	3/3.4/3.4.1/Electronic and Paper Claims
R	3/3.4/3.4.1.4/Prepayment Review of Claims Involving Utilization Parameters
R	3/3.4/3.4.2/Prepayment Medical Record Review Edits
R	3/3.5/Postpayment Medical Record Review of Claims
R	3/3.5/3.5.1/Re-opening Claims
R	3/3.5/3.5.2/Case Selection
R	3/3.5/3.5.3/CMS Mandated Edits
R	3/3.5/3.5.4/Tracking Medicare Contractors' Postpayment Reviews
R	3/3.6/3.6.2.5/Denial Types
R	3/3.6/3.6.3/Beneficiary Notification
R	3/3.6/3.6.4/Notifying the Provider

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.7/Corrective Actions
R	3/3.7/3.7.3/3.7.3.1/Evaluation of Prepayment Edits
R	4/4.34/Suppression and/or Exclusion – Examples
R	6/6.1/6.1.5/Workload
R	6/6.2/6.2.7/Medical Review of Home Health Demand Bills
R	6/6.6/Referrals to the Quality Improvement Organization (QIO)
R	7/Table of Contents
R	7/7.1/7.1.2/7.1.2.6/7.1.2.6.1/7.1.2.6.1.1/Workload Reporting Tables
R	7/7.2/Medical Review Definitions
R	7/7.2/7.2.2/Definition
R	7/7.2/7.2.2/7.2.2.1/Automated Medical Review
R	7/7.2/7.2.2/7.2.2.2/Non-Medical Record Review
R	7/7.2.2.1/Automated Medical Review
R	7/7.2.2.2/Non-Medical Record Review
R	7/7.2/7.2.2/7.2.2.5/Prepay Provider Specific Medical Record Review
R	7/7.2/7.2.2/7.2.2.6/Prepay Service Specific Medical Record Review
R	7/7.2/7.2.2/7.2.2.7/Prepay Provider Specific Probe Medical Record Review
R	7/7.2/7.2.2/7.2.2.8/Prepay Service Specific Probe Medical Record Review
R	7/7.2/7.2.2/7.2.2.10/Postpay Provider Specific Probe Medical Record Review
R	7/7.2/7.2.2/7.2.2.11/Postpay Service Specific Probe Medical Record Review
R	7/7.2/7.2.2/7.2.2.12/Postpay Provider Specific Medical Record Review
R	7/7.2/7.2.2/7.2.2.13/Postpay Service Specific Medical Record Review

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/7.2/7.2.4/Monthly Reporting of Medical Review Savings
R	7/7.3/7.3.2/7.3.2.5/7.3.2.5.1/7.3.2.5.1.1/Workload Reporting Tables

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: 721	Date: June 9, 2017	Change Request: 9809

SUBJECT: Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews

EFFECTIVE DATE: July 11, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 11, 2017

I. GENERAL INFORMATION

A. Background: Previously, contractors were allowed to do routine reviews including documentation compliance reviews. This CR will instruct contractors to not perform routine reviews including documentation compliance reviews and that there are now the following three types of reviews: 1) Medical records review-formerly "complex review"; 2) Automated reviews; and 3) Non-medical record review.

The medical record review and automated review definitions remain unchanged. Non-medical record review occurs when a claim determination is made without clinical review of medical documentation (i.e., denial of related claims, no receipt of documentation in response to an additional document request (ADR) where such a denial cannot be automated).

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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9809.1	Contractors shall not perform routine reviews including documentation compliance	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reviews.									
9809.2	MACs shall adjust their improper payment review strategy and medical review workloads as necessary to accommodate this change request as no additional funding will be provided.	X	X	X	X					
9809.3	MACs shall describe any necessary workload changes in detail, including the rationale for these changes to their Contracting Officer's Representative and medical review Business Function Lead.	X	X	X	X					
9809.4	Contractors shall perform medical record reviews (this	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	includes reopenings).									
9809.5	Contractors shall only perform non-medical record reviews for denials of related claims and/or no receipt of documentation in response to an ADR where such denials cannot be automated.	X	X	X	X					
9809.6	Contractors shall revise their reporting to reflect the three categories (medical record review, automated review, and non-medical record review) accurately.	X	X	X	X					
9809.6.1	Until such time as reporting templates are updated the	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractors shall report medical record reviews in the complex review field and the non-medical record reviews in the routine review field.									
9809.6.2	Contractors shall report medical record reviews and non-medical record reviews in the new fields beginning from the implementation date until the end of the month. All subsequent reports shall be for the full month.	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): Linda O'Hara, 410-786-8347 or linda.ohara@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

Table of Contents

(Rev. 721; Issued: 06-09-17)

Transmittals for Chapter 3

3.3.1 - Types of Review: *Medical Record Review, Non-Medical Record Review and Automated Review*

3.3.1.1 - *Medical Record Review*

3.3.1.2 - Non-Medical Record Review

3.3.1.3 – *Automated Reviews*

3.4.2 - Prepayment *Medical Record Review* Edits

3.5 - Postpayment *Medical Record* Review of Claims

3.2 – Overview of Prepayment and Postpayment Reviews

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, CERT, *RACs*, *SMRCs,* and ZPICs*/Unified Program Integrity Contractors (UPICs)*, as indicated.

A. Prepayment and Postpayment Review

Prepayment review occurs when a reviewer makes a claim determination before claim payment has been made. Prepayment review always results in an "initial determination"

Postpayment review occurs when a reviewer makes a claim determination after the claim has been paid. Postpayment review results in either no change to the initial determination or a "revised determination" indicating that an overpayment or underpayment has occurred.

B. Prepayment Edit Capabilities

Prepayment edits shall be able to key on a beneficiary's Health Insurance Claim Number (HICN), National Provider Identifier (NPI) and specialty code, service dates, and diagnosis or procedure code(s) (i.e., Healthcare Common Procedure Coding System [HCPCS] and/or International Classification of Diseases diagnoses codes), Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

The MAC systems shall be able to select claims for prepayment review using different types of comparisons. At a minimum, those comparisons shall include:

- Procedure to Procedure -permits contractor systems to screen multiple services at the claim level and in history.

- Procedure to Provider - permits selective screening of services that need review for a given provider.

- Frequency to Time- permits contractors to screen for a certain number of services provided within a given time period.

- Diagnosis to Procedure- permits contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin B12 injection is related to pernicious anemia, absent of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.
- Procedure to Specialty Code or TOB- permits contractors to screen services provided by a certain specialty or TOB.

- Procedure to Place of Service- permits selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional MAC system comparisons shall include, but are not limited to the following:

- Diagnoses alone or in combination with related factors.

- Revenue linked to the health care common procedure coding system (HCPCS).
- Charges related to utilization, especially when the service or procedure has an established dollar or number limit.

- Length of stay or number of visits, especially when the service or procedure violates time or number limits.

- Specific providers alone or in combination with other parameters.

The MR edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician or claims analyst can review the claim and associated documentation (including documentation requested after the claim is submitted) in order to make determinations about coverage and payment under Section 1862(a) (1) (A) of the Act. Namely, the claim is for a service or device that is medically reasonable and necessary to diagnose or treat an injury or improve the functioning of a malformed body member. All non-automated review work resulting from MR edits shall:

- Involve activities defined under the MIP at §1893(b)(1) of the Act;

- Be articulated in the MAC's medical review strategy;

- Be designed in such a way as to reduce the MAC's CERT error rate or prevent the MAC's CERT error rate from increasing, or;

Prevent improper payments identified by the *RACs*.

3.2.2 - Provider Notice

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

Because the CERT contractors select claims on a random basis, they are not required to notify providers of their intention to begin a review.

Providers may submit unsolicited documentation to the MAC when submitting a claim. Providers are to list the PWK 02 Report Transmission Code (PWK (paperwork) modifier) on the claim when submitting this documentation. MACs should inform the providers that they are NOT required to submit unsolicited documentation (and the corresponding PWK modifier) and that the absence or presence of PWK modifier does not mean that their claim will be reviewed. MACs should, at their discretion, consider posting to their website or sending letters to

providers informing them of what additional documentation is needed to make a determination on the claim.

A. Notice of Provider-Specific Review

When MAC data analysis indicates that a provider-specific potential error exists that cannot be confirmed without requesting and reviewing documentation associated with the claim, the MAC shall review a sample of representative claims. Before deploying significant medical review resources to examine claims identified as potential problems through data analysis, MACs shall take the interim step of selecting a small "probe" sample of generally 20-40 potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures that medical review activities are targeted at identified problem areas. The MACs shall ensure that such a sample is large enough to provide confidence in the result, but small enough to limit administrative burden. The CMS encourages the MACs to conduct error validation reviews on a prepayment basis in order to help prevent improper payments. MACs shall select providers for error validation reviews in the following instances, at a minimum:

- The MAC has identified questionable billing practices (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis;

- The MAC receives alerts from other MACs, Quality Improvement Organizations (QIOs), CERT*, RACs*, OIG/GAO, or internal/external components that warrant review;

- The MAC receives complaints; or,

- The MAC validates the items bulleted in §3.2.1.

Provider-specific error validation reviews are undertaken when one or a relatively small number of providers seem to be experiencing similar/recurrent problems with billing. The MACs shall document their reasons for selecting the provider for the error validation review. In all cases, they shall clearly document the issues noted and cite the applicable law, published national coverage determination, or local coverage determination.

For provider-specific problems, the MAC shall notify providers in writing that a probe sample review is being conducted. MACs shall consider sending letters to providers informing them of what additional documentation is needed to make a determination on the claim. MACs have the discretion to use a letter similar to the letters in Exhibit 7 of the PIM when notifying providers of the probe review and requesting documentation. MACs have the discretion to advise providers of the probe sample at the same time that medical documentation or other documentation is requested.

Generally, MACs shall subject a provider to no more than one probe review at any time; however, MACs have the discretion to conduct multiple probes for very large billers as long as they will not constitute undue administrative burden.

MACs

The MACs shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. MACs shall indicate whether the review will occur on a prepayment or postpayment basis. This notification may be issued via certified letter with return receipt requested. MACs shall notify providers of the specific reason for selection. If the basis for selection is comparative data, MACs shall provide the data on how the provider varies significantly from other providers in the same specialty, jurisdiction, or locality. Graphic presentations help to communicate the perceived problem more clearly.

*RAC*s

The *RACs* are required to post a description of all approved new issues to the *RAC*'s Web site before correspondence is sent to the provider. After posting, the *RAC* should issue an additional documentation request (ADR) to the provider, if warranted.

Zone Program Integrity Contractors *(ZPICs)/Unified Program Integrity Contractor (UPIC)*

The ZPICs*/UPICs* shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. ZPICs*/UPICs* shall indicate whether the review will occur on a prepayment or postpayment basis. ZPICs*/UPICss* shall maintain a copy of the letter and the date it was mailed. This notification shall be mailed the same day that the edit request is forwarded to the MAC. Refer to Exhibit 45 for the letter to be sent.

B. Notice of Service-Specific Review

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

Service-specific reviews are undertaken when the same or similar problematic process is noted to be widespread and affecting one type of service (e.g., providing tube feedings to home health beneficiaries across three (3) states).

MACs

Web site postings

The MACs shall provide notification prior to beginning a service-specific review by posting a review description on their Web site. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination on their Web site. MACs shall keep the Web site current by posting active reviews. MACs should, at their discretion, create an archive for old review topics that are no longer under active review. Active review is defined as the time period during which ADRs are sent, determinations are made and findings are communicated to the providers. MACs should categorize the active review topics by provider type.

Individual written notices

MACs have the discretion to also notify providers about a service-specific review by sending individual notices to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR. MACs should, at their discretion, state what additional documentation is needed from providers to make a claim determination in the written notices.

RACs

Before beginning widespread service-specific reviews, *RACs* shall notify the provider community that the *RAC* intends to initiate review of certain items/services through a posting on the *RAC* Web site describing the item/service that will be reviewed. Additionally, for *medical record reviews*, the *RACs* shall send ADRs to providers that clearly articulate the items or services under review and indicate the appropriate documentation to be submitted.

Zone Program Integrity Contractors *(ZPIC/UPICs)/Unified Program Integrity Contractors (UPICs)*

The ZPICs*/UPICs* shall provide notification prior to beginning a service-specific review by sending individual written notices to the affected providers. This notification shall be mailed the same day that the edit request is forwarded to the MAC. The ZPICs*/UPICs* shall maintain a copy of the letter and the date it was mailed. Refer to Exhibit 45 for the letter to be sent.

SMRC

The SMRC shall operate/maintain a public Web site that displays what types of issues are under review. For each area, the SMRC shall include a link to the relevant OIG/GAO or other reports available. In addition to the Web site, the SMRC shall notify providers about a service-specific review by sending an ADR. The SMRC shall state what additional documentation is needed from providers to make a claim determination in the ADR.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

A. General

In certain circumstances, the MACs, CERT, *RACs,* and ZPICs*/UPICs* may not be able to make a determination on a 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, the reviewer shall solicit documentation from the provider or supplier by issuing an additional documentation request (ADR). The term ADR refers to all documentation requests associated with prepayment review and postpayment review. MACs, CERT, *RACs*, and ZPICs*/UPICs* have the discretion to collect documentation

related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. The MAC, *RAC,* and ZPIC*/UPIC* shall not deny other claims submitted before or after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation. The CERT contractor shall solicit documentation in those circumstances in accordance with its Statement of Work (SOW).

The term "additional documentation" refers to medical documentation and other documents such as supplier/lab/ambulance notes and includes:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.

- Supplier/lab/ambulance notes include all documents that are submitted by suppliers, labs, and ambulance companies in support of the claim (e.g., Certificates of Medical Necessity, supplier records of a home assessment for a power wheelchair).

- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

NOTE: Reviewers shall consider documentation in accordance with other sections of this manual.

The MAC and ZPIC*/UPIC* have the discretion to deny other "related" claims submitted before or after the claim in question, subject to CMS approval as described below. If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Approved examples of "related" claims that may be denied as "related" are in the following situations:

- When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.

- Reserved for future approved "related" claim review situations. The MAC shall report to their BFL and COR prior to initiating denial of "related" claims situations.

The MAC and ZPIC*/UPIC* shall await CMS approval prior to initiating requested "related" claim(s) review. Upon CMS approval, the MAC shall post the intent to conduct "related" claim review(s) to their Web site within 1 month prior to initiation of the approved "related" claim review(s). The MAC shall inform CMS of the implementation date of the "related" claim(s) review 1 month prior to the implementation date.

If “related” claims are denied automatically, MACs shall count these denials as automated review. If the “related” claims are denied after manual intervention, MACs shall count these denials as *non-medical record review*.

The *RAC* shall utilize the review approval process as outlined in their SOW when performing reviews of “related” claims.

The MAC, *RAC*, and ZPIC*/UPIC* are not required to request additional documentation for the “related” claims before issuing a denial for the “related” claims.

Contactors shall process appeals of the “related” claim(s) separately.

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

Unless otherwise specified, the MAC, *RAC* and ZPIC*/UPIC* shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, *RAC* and ZPIC*/UPIC*.

The CERT reviewer shall request medical record documentation from the referring provider as submitted/identified by National Provider Identifier/Unique Physician Identification Number on the claim when such information is not sent in by the billing supplier/provider initially and after a request for additional documentation fails to produce medical documentation necessary to support the service billed and supported by the Local and National Coverage Determinations.

The MAC, ZPIC*/UPIC* and *RAC* have the discretion to send a separate ADR to third-party entities involved in the beneficiary’s care. They shall not solicit documentation from a third party unless they first or simultaneously solicit the same information from the billing provider or supplier. The following requirements also apply:

- The MACs, ZPICs*/UPICs* and *RAC*s shall notify the third party and the billing provider or supplier that they have 30 calendar days to respond for a prepayment review or 45 calendar days for a postpayment review for MACs and RACs and 30 calendar days *for* ZPICs*/UPICs*.

- For prepayment review, the MACs and ZPICs*/UPICs* shall pend the claim for 45 calendar days. This 45 day time period may run concurrently as the 45 days that the billing provider or supplier has to respond to the ADR letter;

- The MACs and ZPICs*/UPICs* have the discretion to issue as many reminder notices as they deem appropriate to the third party via email, letter or phone call prior to the 30th or 45th calendar day, as discussed above;

- When information is requested from both the billing provider or supplier and a third party and a response is received from one or both that fails to support the medical necessity of the service, the MACs and ZPICs*/UPICs* shall deny the claim, in full or in part, using the appropriate denial code. Contractors shall count these denials as *medical record reviews*.

- Contractors shall include language in the denial notice reminding providers that beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub.100-04, Medicare Claims Processing Manual, chapter 30.

- Refer to§3.2.3.7 for ADR to ordering providers for lab services.

3.2.3.7 - Special Provisions for Lab Additional Documentation Requests

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

ICD-10-CM is used for diagnoses on inpatient discharges and for other services provided upon implementation of ICD-10. ICD-9-CM is used for discharges and other services before that implementation.

When the MACs, CERT, *RACs*, and ZPICs*/UPICs* send an ADR for a lab service, the following documentation shall be requested from the billing lab:

- The order for the service billed (including sufficient information to allow the reviewer to identify and contact the ordering provider);

- Verification of accurate processing of the order and submission of the claim; and

- Diagnostic or other medical information supplied to the lab by the ordering provider, including any diagnosis codes or narratives.

The contractor shall deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or send an ADR to the ordering provider in order to determine medical necessity. The contractor shall review information from the lab and find it insufficient before the ordering provider is contacted. The contractor shall send an ADR to the ordering provider that shall include sufficient information to identify the claim in question.

If the documentation received does not demonstrate that the service was reasonable and necessary, the contractor shall deny the claim. These denials count as *medical record review*s. Contractor denial notices shall remind providers that beneficiaries cannot be held liable for these denials unless they have received proper liability notification before services were rendered, as detailed in CMS Pub. IOM 100-04, chapter 30.

3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, *RACs*, *CERT,* and ZPICs*/UPICs*, 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 *RACs* or 30 calendar days for ZPICs*/UPICs* after the date of the request (or within a reasonable time following an extension), the MACs, *RACs* and ZPICs*/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.

Contractors 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 45 calendar days after the date of the ADR, the MACs, and ZPICs*/UPICs* 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 shall deny the claim as not reasonable and necessary and count these denials as non-*medical record reviews*. ZPIC*/UPICs* shall deny the claim as not meeting reasonable and necessary criteria if no response is received within 30 calendar days. *RACs* shall count these as complex or non-complex reviews.

C. Insufficient Response

If the MAC, CERT, *RAC*, or ZPIC*/UPIC* 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. 721, Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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 *medical record review*);

In cases where the MAC or ZPIC*/UPIC* 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*/UPIC*) 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 *RAC* receives requested documentation from a supplier after a denial has been issued they shall not reopen the claim.

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

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

3.2.4 - Use of Claims History Information in Claim Payment Determinations

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

A. Contractors to Which This Section Applies

This section applies to ACs, MACs, CERT and *RACs*.

B. General

In general, AC, MAC, CERT and *RAC* reviewers shall not use claims history information to make a payment determination on a claim. However, this policy does not prevent contractors from using claims history for other purposes such as data mining.

The AC, MAC, CERT and *RAC* reviewers shall use claims history information as a supplement to the medical record only in the following circumstances when making *medical record review* determinations about payment on a claim.

1. AC, MAC, CERT and *RAC* reviewers have the discretion to use beneficiary payment history to identify other providers, other than the billing entity, who may have documentation to support payment of a claim. AC, MAC, CERT and *RAC* reviewers have the discretion to contact identified providers for supporting documentation.

Example: A diabetic beneficiary may have an order from a family practitioner but is also seeing an endocrinologist. The documentation from the family practitioner does not support the level of diabetic testing, but medical records from the endocrinologist do support the level of testing.

2. AC, MAC, CERT and *RAC* reviewers have the discretion to use claims history information to document an event, such as a surgical procedure, that supports the need for a service or item billed in limited circumstances. In some cases, this event occurs a number of years prior to the date of service on the claim being reviewed, making it difficult to collect medical record documentation. If repeated attempts to collect medical record of the event are unsuccessful, contractors have the discretion to consider claims history information as documentation of the event. Contractors shall document their repeated attempts to collect the medical record if they chose to consider claims history information as documentation of the event. Claims history information shall be used only to validate specific events; not as a substitute for the medical record.

Example: A beneficiary is eligible for immunosuppressant drugs only if they received an organ transplant. Patients generally remain on these life-saving drugs for the rest of their life so it is possible for the transplant to have occurred many years prior to the date of service being reviewed. If there was no record of the transplant in the medical documentation provided by the ordering physician, the contractor may use claims history to validate the transplant occurred.

3. AC, MAC, CERT and *RAC* reviewers shall use claims history information to verify that the frequency or quantity of supplies provided to a beneficiary do not exceed policy guidelines.

4. AC, MAC, CERT and *RAC* reviewers shall use claims history information to make a determination of the quantity of items to be covered based on policy guidelines. Information obtained on a claim being reviewed may be applied to a prior paid claim to make a determination of how long the quantity of items provided/billed on the paid claim should last. If a new quantity of items is billed prior to the projected end date of the previously paid claim (based on policy guidelines), the new quantity should be denied.

Example: Twice per day testing of blood sugars is ordered for a non-insulin treated beneficiary with diabetes. A 3 month quantity of supplies (for twice per day testing) is provided on July 1 and is paid without review. Another 3 month quantity of supplies is provided on 10/1. That claim is developed and reviewed and a determination is made that the medically necessary frequency of testing is once per day. Therefore, the 10/1 claim should be denied because the quantity of supplies paid for on 7/1 was sufficient to last beyond 10/1 if testing was done once per day.

5. AC, MAC, CERT and *RAC* reviewers shall use claims history information to identify duplication and overutilization of services.

3.3.1 - Types of Review: *Medical Record Review, Non-Medical Record Review, and Automated Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

A. General

Most of the claim review activities completed for the purpose of identifying inappropriate billing and avoiding improper payments are divided into *three* distinct types: *Medical Record Review, Non-Medical Record Review, and Automated Review.*

The chart below indicates which contractors perform which types of review:

	Prepayment			Postpayment	
Contractor Type	*Medical Record Review*	*Non-Medical Record Review*	*Automated Reviews*	*Medical Record Review*	*Non-Medical Record review*
MACs	Yes	Yes	*Yes*	Yes	Yes
CERT	No	No	*No*	Yes	*No*
RACs	No	No	*No*	Yes	*No*
SMRC	*No*	*No*	*No*	*Yes*	*Yes*
ZPIC/UPIC	*Yes*	*No*	*No*	*Yes*	*Yes*

3.3.1.1 -Medical *Record* Review
(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, CERT, *RACs*, Supplemental Medical Review Contractor(s) and ZPICs*/UPICs*, as indicated.

A. ***Definition***

Medical record review involves requesting, receiving, and reviewing medical documentation associated with a claim.

Medical record review, for the purpose of determining medical necessity, requires a licensed medical professional to use clinical review judgment to evaluate medical record documentation.

B. ***Clinical Review Judgment***

Clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient and,

2. The application of this clinical picture to the review criteria is to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. MAC, CERT, RAC, and ZPIC/UPIC clinical review staff shall use clinical review judgment when making medical record review determinations about a claim.

Clinical review judgment does not replace poor or inadequate medical records. Clinical review judgment by definition is not a process that MACs, CERT, RACs and ZPICs/UPICs/UPICs can use to override, supersede or disregard a policy requirement. Policies include laws, regulations, the CMS' rulings, manual instructions, MAC policy articles attached to an LCD or listed in the Medicare Coverage Database, national coverage decisions, and local coverage determinations.

C. Credentials of Reviewers

The MACs, CERT, and ZPIC/UPICs/UPICs shall ensure that *medical record reviews* for the purpose of making coverage determinations are performed by licensed nurses (RNs and LPNs) or physicians, unless this task is delegated to other licensed health care professionals. *RAC*s and the *SMRC* shall ensure that the credentials of their reviewers are consistent with the requirements in their respective SOWs.

During a *medical record review*, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians or physician specialists) for advice. The MACs, CERT, and ZPICs/*UPICs* shall ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e., speech therapy claim, physical therapy). *RAC*s and the

SMRC shall follow guidance related to calling upon other healthcare professionals as outlined in their respective SOWs.

RACs shall ensure that *a licensed medical professional will perform medical record reviews* for the purpose of *determining medical necessity, using their clinical review judgment to evaluate medical record documentation. Certified coders will perform* coding determinations. CERT and MACs are encouraged to make coding determinations by using certified coders. ZPIC/UPICs/UPICs have the discretion to make coding determinations using certified coders.

D. Credential Files

The MACs, CERT, *RAC*s, and ZPIC*/UPICs* shall maintain a credentials file for each reviewer (including consultants, contract staff, subcontractors, and temporary staff) who performs *medical record reviews*. The credentials file shall contain at least a copy of the reviewer's active professional license.

***E*. Quality Improvement (QI) Process**

The MACs, CERT, *RAC*s, and *SMRCs* shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. The MACs, CERT, *RAC*s, and *SMRCs* shall attend the annual medical review training conference as directed by the CMS and/or their SOW. The MACs, CERT, *RAC*s, and *SMRCs* shall include inter-rater reliability assessments in their QI process and shall report these results as directed by CMS.

***F*. Advanced Beneficiary Notice (ABN)**

The MACs, CERT, *RAC*s, ZPICs*/UPICs*, and *SMRCs* shall request as part of the ADR, during a *medical record review*, a copy of any mandatory ABNs, as defined in Pub. 100-04, Medicare Claims Processing Manual Chapter 30 section 50.3.1. If the claim is determined not to be reasonable and necessary, the contractor will perform a face validity assessment of the ABN in accordance with the instructions stated in Pub. 100-04 Medicare Claims Processing Manual chapter 30 section 50.6.3.

The Face Validity assessments do not include contacting beneficiaries or providers to ensure the accuracy or authenticity of the information. Face Validity assessments will assist in ensuring that liability is assigned in accordance with the Limitations of Liability Provisions of section 1879 of the Social Security Act.

***G*. MAC Funding Issues**

The MAC-medical *record* review work performed by medical review staff for purposes other than MR (e.g., appeals) shall be charged, for expenditure reporting purposes, to the area requiring medical review services.

All *medical record review* work performed by MACs shall:

- Involve activities defined under the Medicare Integrity Program (MIP) at Section 1893(b)(1) of the Act;

- Be articulated in its medical review strategy; and,

- Be designed in such a way as to reduce its Comprehensive Error Rate Testing (CERT) error rate or prevent the contractor's error rate from increasing.

The MACs shall be mindful that edits suspending a claim for *medical* review to check for issues other than inappropriate billing (i.e. completeness of claims, conditions of participation, quality of care) are not medical review edits as defined under Section 1893(b)(1) of the Act and cannot be funded by MIP. Therefore, edits resulting in work other than that defined in Section1893 (b) (1) shall be charged to the appropriate Program Management activity cost center. *Activities associated with claims processing edits shall not be charged to MIP.*

H. Review Timeliness Requirements

Prepayment Review Requirements for MACs

When a MAC receives requested documentation for prepayment review within 45 calendar days of the date of the ADR, the MAC shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination and 2) enter the decision into the Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), or the VIPS Medicare System (VMS). The 30 calendar day timeframe applies to prepayment *non-medical record review*s and prepayment *medical record review*s. The 30 calendar day timeframe does not apply to prepayment reviews of Third Party Liability claims. The MACs shall make and enter a review determination for Third Party Liability claims within 60 calendar days.

Counting the 30 Calendar Day Timeframe

The MACs and RACs shall count day one as the date each new medical record is received in the mailroom. The MACs and RACs shall give each new medical record received an independent 30 day review time period.

Prepayment Review Requirements for ZPICs/UPICs

When a ZPIC/UPIC receives all documentation requested for prepayment review within 45 calendar days of the date of the ADR, the ZPIC/UPIC shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation.

Postpayment Review Requirements for MACs

The MAC shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation.

For claims associated with any referrals to the ZPIC*/UPIC* for program integrity investigation, MACs shall stop counting the 60-day time period on the date the

referral is made. The 60-day time period will be restarted on the date the MAC received requested input from the ZPIC/*UPIC* or is notified by the ZPIC/*UPIC* that the referral has been declined.

For claims sent to MR for reopening by the contractor appeals department, in accordance with Pub. 100-04, chapter 34, §10.3, begin counting the 60 days from the time the medical records are received in the MR department.

Postpayment Review Requirements for *RAC*s

When a *RAC* receives requested documentation for review within 45 calendar days of the date of the ADR, the *RAC* shall do the following within 30 calendar days of receiving the requested documentation: 1) make and document the review determination, and 2) communicate the results to the provider.

State Laws that Affect Prepayment Review Timeliness Requirements

The MACs shall adhere to state laws that require an evidentiary hearing for the beneficiary before any denials are processed. The MAC shall review the claim within 30 days, allow the time required for the evidentiary hearing, and then continue with the processing of the claim on the next business day.

3.3.1.2 - Non-*Medical Record* Review

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, *SMRC*, and ZPICs/*UPICs*, as indicated.

A. Definition

Non-medical record reviews uses manual intervention, but only to the extent a reviewer can make a determination based on information on a claim. It does not require clinical judgment in review of medical record documentation. Contractors shall only perform a non-medical record review for denials of related claims and/or no receipt of ADR documentation where such denials cannot be automated.

3.3.1.3 - *Automated Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

A. Definition

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no manual intervention.

CERT refers to all reviews where no documentation was requested as "T-claim review." T-claims are a particular category of claim reviewed by CERT. T-claims are claims that were automatically denied by the MAC.

B. Basis for Automated Reviews

The MAC, RAC, CERT, SMRC, and ZPIC/UPIC shall ensure that automated prepayment and postpayment denials are based on clear policy that serves as the

basis for denial; or a Medically Unlikely Edit (MUE); or occurs when no timely response is received to an ADR.

When a clear policy exists (or in the case of a MUE), MACs, RACs, SMRC, and ZPICs/UPICs have the discretion to automatically deny the services without stopping the claim for manual review, even if documentation is attached or simultaneously submitted. Reviewers shall still make a determination based on the liability limitations of §1879 of the Act. The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, coding guideline, LCD or MAC article that specifies the circumstances under which a service will always be considered non-covered, incorrectly coded, or improperly billed.

A MUE is a unit of service (UOS) edit for a Healthcare Common Procedure Coding system (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. The MUE program provides a method to report medically reasonable and necessary UOS in excess of a MUE.

Automated edits can be used for apparent typographical errors (e.g., 10,000 blood cultures for the same beneficiary on the same day).

MACs shall implement automated prepayment review whenever appropriate.

The RACs refer to all reviews where no documentation was requested as "automated review."

3.4.1 - Electronic and Paper Claims

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The Administrative Simplification Compliance Act (ASCA, Section 3 of Pub. L, 107-105, 42 CFR 424.32) requires that all Medicare claims be submitted electronically using the ASC X12 837 institutional or professional claim formats with few exceptions. MACs shall not require providers to submit paper claims when they are targeted for prepayment medical *record* review. The MACs shall allow providers that qualify for an ASCA mandatory electronic billing exception to submit paper claims when they are targeted for prepayment review (See IOM Pub.100-04, chapter 24, §90 for exceptions).

3.4.1.4 - Prepayment Review of Claims Involving Utilization Parameters

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

A. For Non-lab Claims

The MACs shall implement prepayment edits that will prevent payment to providers who have a pattern of billing for items or services that are not covered, incorrectly coded or inappropriately billed. The MACs shall respond quickly when they identify providers who seem to have egregious overutilization of a non-lab item or service and who bill for egregious amounts. The identification of, and response to these providers shall be within the context of the MAC's MR Strategy and prioritization of review targets.

B. Utilization Denials

The MACs have the discretion to establish edits to automatically deny services when overutilization of a non-lab service is identified and clear policy serves as the basis for denial.

The MACs shall establish *medical record review* edits and make individual claim determinations when overutilization of a non-lab service is identified and there is not clear policy to serve as the basis for denial.

The MACs shall establish *medical record review* edits that do not involve utilization parameters and make individual claim determinations when overutilization of a lab service is identified and there is no clear policy to serve as the basis for denial. For example, if the problem is limited to a few laboratory providers, the MAC could develop a provider-specific prepayment edit to suspend payment for all of the lab services in question from the problem providers. If the problem is widespread, the MAC could develop a service-specific edit to suspend payment for all of the lab services in question or all of the services in question for a particular diagnosis or revenue code. Based on data analysis within each MAC jurisdiction, the MACs shall focus the edit by provider, diagnosis, procedure code, or in any other way except by use of a utilization parameter.

3.4.2 – Prepayment *Medical Record* Review Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall focus prepayment *medical record review* edits to suspend only claims with a high probability of aberrant billing practices. Focused edits reduce provider burdens and increase the efficiency of MR activities. The MACs shall ensure that edits are specific enough to identify only the services that they determine to be questionable based on data analysis. MACs are encouraged to ensure that most MR edits are located in the table driven portion of the system and are not hard coded. It is important to have the flexibility to modify MR edits based on workload demands and changes in provider behavior.

The MACs have the discretion to establish prepayment *medical record review* edits that are either service-specific or provider-specific. Provider-specific edits can suspend all claims from a particular provider or focus on selected service(s), place of service, or other parameters.

3.5 – Postpayment *Medical Record* Review of Claims

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The MACs shall initiate targeted provider-specific or *service-specific* postpayment *medical record* review only when there is the likelihood of a sustained or high level of payment error. *RAC*s, ZPICs*/UPICs*, *and SMRC* shall perform postpay review of claims as outlined in their SOW.

3.5.1 - Re-opening Claims

(Rev721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, CERT, *RAC*s, *SMRC* and ZPICs*/UPICs*, as indicated.

The MACs, CERT, *RAC*s, *SMRC,* and ZPICs*/UPICs* shall adhere to the rules found in CFR 405.980 through 986 when conducting automated or postpayment *medical record* reviews. High error rate and/or potential overutilization, identified by data analysis, are reasons to perform postpayment review and represent sufficient cause to reopen claims in accordance with 42 CFR 405.986. See Pub. 100-04, chapter 34 for more information on good cause for reopening.

3.5.2 - Case Selection

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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

Case review and development provisions:

The MACs and the SMRC shall not perform postpayment review of unassigned claims. A claim submitted for a service or supply by a provider who has not accepted the Medicare fee schedule is an unassigned claim.

- The MACs, SMRC, and ZPICs*/UPICs* have the discretion to select cases for postpayment review on a claim-by-claim basis or use statistical sampling for overpayment estimation.
    - When MACs, SMRC, and ZPICs*/UPICs* conduct claim-by-claim postpayment review, they shall only collect or refund the actual overpayment or underpayment amount.
    - When MACs, SMRC, and ZPICs*/UPICs* conduct statistical sampling for overpayment estimation as specified in PIM chapter 8, they shall extrapolate the sampling results to the known universe of similar claims when calculating the projected overpayment or underpayment amount.
- The MACs, *RAC*s, SMRC, and ZPICs*/UPICs* have the discretion to conduct the postpayment review *onsite* at the provider or supplier’s location.

- MAC staff shall review their provider tracking system, *using RAC Data Warehouse (RACDW) data,* and consult with the ZPICs*/UPICs* to ensure non-duplication during the process of selecting providers for postpayment review.

- *To prevent duplicate claim reviews, the MACs, SMRC, and RACs shall use the RACDW to identify, and exclude from review, claims that were previously reviewed, or that are under current review, by another contractor.*

- CERT shall duplicate another contractor's review, when appropriate, if those claims are chosen as part of a statistically valid random sample to measure the improper payment rate.

- This instruction does not prevent the ZPICs*/UPIC* from reviewing a claim that has been reviewed by another contractor in order to support their case development or other administrative action.

- When the MACs, CERT, *RAC*s, SMRC and ZPICs*/UPICs* choose to send the provider an ADR for a postpayment review, they shall do so in accordance with PIM chapter 3, §3.2.3.2. The contractors may grant an extension of the submission timeframes at their discretion or in accordance with their SOWs.

- The MACs, CERT, *RAC*s, SMRC and ZPICs*/UPICs* make coverage, coding, and/or other determinations when re-adjudicating claims.

- The MACs, CERT, *RAC*s, SMRC and ZPICs*/UPICs* shall document all incorrectly paid, denied, or under-coded (e.g., billed using a procedure/supply or other code that is lower than what is supported by medical documentation) items or services.

- Services newly denied as a result of re-adjudication shall be reported as positive values.

- Services that were denied, but are reinstated as a result of re-adjudication shall be reported as negative values.

- The MACs, CERT, *RAC*s, SMRC and ZPICs*/UPICs* shall document the rationale for denial and include the basis for revisions in each case (important for provider appeals). MACs, CERT, and ZPICs*/UPICs* should include copies of the NCD, coverage provisions from interpretive manuals, or LCD and any applicable references needed to support individual case determinations. *RAC*s and the SMRC shall include detailed rationale as outlined in their SOWs.

- The MACs have the discretion to deny payment without the review of the claim with a medically unlikely service edit.

3.5.3 – CMS Mandated Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

In past years, CMS created mandated edits that suspend certain claims for *medical review* coverage and coding review. However, more recently, CMS has given the contractors the discretion to prioritize workload to effectively lower the error rate. CMS is now in the process of removing such mandated coverage and coding review edits from CWF, pricer, grouper, fee schedules, etc.

Contractors may override CMS mandated edits that suspend for *medical review* coverage and coding review without performing review if one or more of the following conditions apply:

1. The contractor does not have MR responsibility for the claim, or

2. The contractor's data analysis/priority setting/ MR strategy does not indicate this service is a problem in their jurisdiction, or

3. It is not a *skilled nursing facility* (excluding swing beds) or *a home health* demand bill (these demand bills must be reviewed).

3.5.4 - Tracking Medicare Contractors' Postpayment Reviews

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medicare Administrative Contractors (MACs) shall input all postpayment *medical record review*s into the *RAC* Data Warehouse. All claims chosen for review by the MAC where an additional documentation request letter was issued to the provider after payment was made shall be included. MACs shall include all reviews, even those that did not result in an improper payment.

Claims may be manually uploaded into the data warehouse or submitted by flat file. The MACs shall use the attached file layout for claims uploaded to the *RAC* Data Warehouse. Claims shall be submitted to the *RAC* Data Warehouse by the 20th day of every month for the previous month.

The SMRC shall upload claims into the RAC Data warehouse according to their statement of work. SMRC and MAC staff who need access to the Data Warehouse shall contact RAC@cms.hhs.gov.

In the following Data Warehouse template, the contractors should count "medical record reviews" in the description labeled "Complex Review".

Header Layout

Field Name	Locatio n	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	4	Value: 004
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	188	188
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified
Filler	47	1	AN-1		Space fill
MAC Jurisdiction	48	1	AN-1	F	A-N

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C

Claim Type	2	2	1-A	R	NCH MQA Record Identification Code 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = Carrier 7 = Durable Medical Equipment
Out-of-Jurisdiction Flag	3	3	1-A	S	Use "Z" for claims from out-of-jurisdiction providers. All other cases, use space.
State Code	4	5	2-A	R	State Codes: ME, CA
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.
Workload ID	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim For Claim Type 1 through 5 - length must be equal to or greater than 14. For Claim Type 6 - length must be 15. For Claim Type 7 - length must be 14.
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5.
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.

Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Original Claim Paid Amount	76	84	9.2-N	R	Amount of original payment made from Medicare fund ex: 999999.99
Original Claim Paid Date	85	92	8-N	R	Date claim was paid YYYYMMDD
Date of Service Start	93	100	8-N	R	Date service started/performed YYYYMMDD
Date of Service End	101	108	8-N	R	Date service ended YYYYMMDD
Provider Type	109	110	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice 5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC)

					14 = Other
CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files
Review Type	113	114	2-AN	R	Automated Review-AR Complex Review-CR Semi-Automated Review-SA
Review Status	115	116	2-AN	S	Valid Values: UP = Underpayment Reimbursed in Full; OP = Overpayment Paid in Full; AP = Appealed Claim; RC = Review Concluded without identification of improper payment; CR = Debt Resolved by Contractor. Example: MAC notifies RAC that provider has declared bankruptcy or has disappeared. PR = Debt Resolved by Provider. Example: Provider supplies new evidence in discussion period; RAC agrees and reverses improper payment finding. TR = Terminated by CMS. Example: Claim was excluded while under review. ER = Closed due to error in record (can be reloaded as new corrected record) RE = Reopen claim(to activate a closed claim)

Adjustment ID	117	139	23-AN	R*	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim
Date Code A	140	141	2-AN	R*	Type of date: 01-Initial selection of record for audit 02-Request for medical records 03-Received medical records from provider 04-Results letter sent to provider (complex review) 05-Demand letter sent. 06-Claim closed 07-No findings letter sent. * Date Code 01 is always required.
Date A	142	149	8-N	R	Date format YYYYMMDD
Date Code B	150	151	2-AN	S	Type of date:
Date B	152	159	8-N	S	Date format YYYYMMDD

Date Code C	160	161	2-AN	S	Type of date:
Date C	162	169	8-N	S	Date format YYYYMMDD
Date Code D	170	171	2-AN	S	Type of date:
Date D	172	179	8-N	S	Date format YYYYMMDD
Demand Letter Amount	180	188	9.2-N	R*	ex: 999999.99 * Submit negative amounts for underpayments

3.6.2.5 - Denial Types

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, CERT, *RAC*s, and ZPICs*/UPICs*, as indicated.

A. Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

The MACs, CERT, *RAC*s, and ZPICs*/UPICs* shall be cognizant that the denial type may affect the financial liability of beneficiaries. They shall ensure that benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. They shall ensure that statutory exclusion denials take precedence over reasonable and necessary denials. MACs, CERT, and ZPICs*/UPICs* shall use the guidelines listed below in selecting the appropriate denial reason. *RAC*s shall follow denial reason guidance outlined in their SOW.

- If additional documentation was requested from the provider or other entity for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not received within 45 calendar days or a reasonable time thereafter, the MACS, CERT, and ZPICs*/UPICs* shall issue a reasonable and necessary denial, in full or in part.

- If additional documentation was requested because compliance with a benefit category requirement is questioned and the documentation received fails to support compliance with the benefit category, the MACs, CERT, and ZPICs*/UPICs* shall issue a benefit category denial.

- If additional documentation was requested because compliance with a benefit category requirement is questioned and the received documentation shows evidence that the benefit category requirement is present but is defective, the MACs, and ZPICs*/UPICs* shall issue a reasonable and necessary denial.

EXAMPLE 1: A MAC is conducting a review of partial hospitalization (PH) claims from a provider who has a pattern of failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the MAC finds that there is no signed certification present in the medical record. The MAC shall deny all PH services for this beneficiary under §1835(a) (2) (F) of the Act (a benefit category denial). However, in the second medical record, the MAC determines that a signed certification is present in the medical record, but the documentation does not support the physician's certification, the services shall be denied under §1862(a) (1) (A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

Example 2: The MAC performs a *medical record review* on a surgical procedure claim and determines that the procedure was cosmetic in nature and was not reasonable and necessary; the denial reason would be that the service is statutorily excluded since statutory exclusion denials take precedence over reasonable and necessary denials.

The MACs, CERT, *RAC*s, and ZPICs*/UPICs* shall deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full, and provide the specific reason for the denial whenever there is evidence that a service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act, NCD, or coverage provision in an interpretive manual;

- Is statutorily excluded by other than §1862(a)(1) of the Act;

- Is not reasonable and necessary as defined under §1862(a) (1) of the Act. MACs, CERT, *RAC*s, and ZPICs*/UPICs* shall use this denial reason for all non-responses to documentation requests;

- Was not billed in compliance with the national and local coding, payment or billing requirements; and/or

- Was not delivered or provided to the beneficiary, or not provided as billed.

The denial explanation needs to be more specific than merely repeating one of the above bullets. The general exception to the need for a full denial explanation is in the event of a clerical error, for example, the billing entity transposes two digits in the HICN on a claim. The claim is quickly returned, usually electronically, to the provider for correction. In the case of dual-eligible beneficiaries where there is a State-specific policy, see CMS IOM Pub. 100-04, chapter 30, §60.5 A for a detailed explanation of handling administrative denials.

3.6.3 - Beneficiary Notification

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs, CERT, *RAC*s, and ZPICs*/UPICs*, as indicated.

A. General

If a claim is denied through prepayment or postpayment review, the MAC shall notify the beneficiary consistent with the requirements in PIM chapter 3, §3.6.2.3. The MAC shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN). The CERT, *RAC*s, and ZPICs*/UPICs* are not required to issue beneficiary notices for claims they deny. Instead, CERT, *RAC*s, and ZPICs*/UPICs* shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate beneficiary notice.

The MACs are required to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of a LCD. All denials that result from LCDs shall provide the MSN message 15.19 in addition to the current applicable message. Message 15.19 states (IOM Pub. 100-04, chapter 21):

> "A local coverage determination (LCD) was used when we made this decision. A LCD provides a guide to assist in determining whether a particular item or

service is covered by Medicare. A copy of this policy is available from your local intermediary, carrier or (Medicare Administrative Contractor) by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LCD to see whether additional information from your physician would change our decision."

The MACs shall make these messages available in Spanish where appropriate. The 15.19 portion of the MSN message states:

> Una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La LCD es una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta póliza está disponible en su intermediario, local o en su empresa de seguros Medicare, o en su Contratista Administrative de Medicare, al llamar al número que aparece en la información de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la LCD para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

The MACs shall use the above message in every instance of a prepayment denial where a LCD was used in reviewing the claim. Use this message, and message 15.20 (now for FISS MACs, and when 15.20 is fully implemented for contractors on the MCS/VMS systems) on both full and partial denials, whether the denial was made following automated, *non-medical review,* or *medical record review*. MACs shall not use this message on denials not involving LCDs. For claims reviewed on a postpayment basis, include the language exactly as contained in the MSN message above if sending the beneficiary a new MSN. If sending a letter, include the language exactly as contained in the MSN message above. Message 15.20 currently states:

> "The following policies [insert LCD ID# and NCD#] were used when we made this decision."(Pub.100-04, chapter 21).

The MACs shall continue to use 15.19 in conjunction with the MSN message 15.20, where 15.19 is applicable. MACs should, at their discretion, combine these messages if necessary, but 15.19 shall not be deleted.

In the case where the results of claims sampling are extrapolated to the universe, only those beneficiaries in the sample need to be notified. In *RAC* cases, the *RAC* and MAC Joint Operating Agreement (JOA) shall specify what information the *RAC* will supply to allow the MAC to notify the beneficiary when re-adjudication results in a change to the initial determination.

3.6.4 - Notifying the Provider

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to, MACs, *RAC*s, and ZPICs*/UPICs*, 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 *RAC*s shall issue a Review Results Letter for *all* audits as outlined in their SOW requirements. ZPICs*/UPICs* 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 *RAC*s or ZPICs*/UPICs*);
- The provider's or supplier's right to request an extended repayment schedule (not applicable to *RAC*s or ZPICs*/UPICs*);

- The MACs and ZPICs*/UPICs* 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*/UPICs* 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 *RAC* shall notify the provider by issuing a notification letter to meet this requirement. The ZPIC/UPIC 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 *medical record 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. *RAC*s

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

For underpayments, the *RAC* shall notify the provider as indicated in the *RAC* SOW. In addition, the *RAC* 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*/UPICs*

For overpayments detected through *medical record review*, and after coordination between the ZPIC*/UPIC* and OIG, the ZPIC*/UPIC* shall send a review results letter (the MAC sends the demand letter). In addition, the ZPIC*/UPIC* 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*/UPIC* 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*/UPIC* 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 *medical record 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.

3.7 - Corrective Actions

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall take corrective actions they deem necessary based upon their findings during or after a review. These actions may include payment suspension, imposition of civil money penalties, institution of prepayment or postpayment review, additional edits, etc.

Providers/suppliers who show a pattern of failing to comply with requests for additional supporting documentation for any claims submitted to CMS may be subject to medical *record* review for all claims. This paragraph applies to both providers and suppliers and to instances in which CMS or its contractors request documentation directly from these entities to support services billed on the claim. This paragraph does not change or diminish the provider's or supplier's responsibility to provide required documentation. For purposes of this paragraph, a pattern is two or more ADRs that have gone unanswered.

3.7.3.1 - Evaluation of Prepayment Edits

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to MACs.

The MACs shall develop prepayment edits based on the findings of data analysis, followed by identification and prioritization of identified problems. The MACs shall evaluate all service-specific and provider-specific prepayment edits as follows:

- Automated edits shall be evaluated annually, and
- *Non-medical record* review or *medical record review* edits shall be evaluated quarterly.

The edit evaluations are to determine their effectiveness on the provider or service area while assessing the effect of the edit tasks on workload. The MACs shall consider an edit to be effective when it has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. The MACs shall revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, for instance, a measurable impact is expected, or a quarter is too brief a time period to observe a change. The MACs shall analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. The MACs should replace existing effective edits to address problems that are potentially more costly, if appropriate.

4.34 - Suppression and/or Exclusion – Examples

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

This section applies to ZPICs*/UPICs* and RA*C*s, as indicated.

- Suppressions of providers/suppliers that the ZPIC*/UPIC* has referred to law enforcement and are the subject of a law enforcement investigation should remain effective until the provider's/supplier's case is returned with a declination for prosecution from law enforcement and without a request for ZPIC*/UPIC* administrative action. The suppression may be entered using one of the following methods:

  - Suppression at the provider/supplier and/or geographic level requires the user to supply detailed justification for each request; in addition to provider name/type, start/end dates, and other fields as specified in the RA*C* Data Warehouse User's Guide. ZPICs*/UPICs* shall routinely monitor accepted suppression records to ensure that the suppressions remain relevant/appropriate and that they are ultimately released in a timely manner.

  - Suppression at the procedure code level for individual providers/suppliers may be done without providing justification, due to the narrower scope of the suppression. Suppressions at this level still require the user to supply a DRG, ICD-9/10 procedure or HCPCS code, provider/supplier identifiers, start and end dates, and any additional information as defined in the RA*C* Data Warehouse User's Guide.

Note: The RA*C*s can review claims paid as early as 10/1/2007, which is before NPI submission became mandatory. Therefore, ZPICs*/UPICs* are strongly encouraged to enter suppressions on both NPIs and legacy provider/supplier numbers for suppressions that cover the period of October 2007 through May 2008.

Suppression/Exclusion for postpayment review where extrapolation may or may not be performed – In the event that the ZPIC*/UPIC* is unable to determine at the time of review whether any overpayments that are identified will be extrapolated to the parent claim universe, the ZPIC*/UPIC* shall enter a suppression on the relevant provider/supplier ID and service code(s). If the ZPIC*/UPIC* does ultimately assess an extrapolated overpayment, the ZPIC*/UPIC* shall release the suppression and exclude the entire universe. If the overpayment is computed based only on the sampled claims (i.e., the overpayment is not projected to the entire universe), the ZPIC*/UPIC* shall release the suppression and exclude only the sample claims that were actually reviewed.

Exclusion for prepayment edits or clinically unlikely edits (CUEs) – Claims that have been subjected to automated edits only are still eligible for RA*C* review and should generally not be excluded. Claims that have subsequently undergone *medical record* review do require exclusion.

Exclusion for prepayment review – In those instances in which a provider/supplier is under investigation and is subject to 100% prepayment review, a suppression will not be necessary because the RA*C*s do not receive claim data in real time. However, all individual claims that were reviewed shall be excluded (this requirement applies whether the provider/supplier was on 100% prepayment review, or a lesser fraction of that provider's/supplier's claims were being reviewed).

For access to the RA*C* Data Warehouse, contact the system administrators at rac@cms.hhs.gov. Current suppression/exclusion file layouts and the user's guide are available from the help desk staff or by download from the system itself.

The ZPICs*/UPICs* shall have a JOA with the RA*C*s. Refer to PIM Exhibit 44 for the JOA between the ZPICs*/UPICs* and the RA*C*s. The ZPICs*/UPICs* shall include in the JOA quarterly meetings with the RA*C* in their zone, at a minimum, to discuss trends in possible fraudulent billing. If ZPICs*/UPICs* or RA*C*s have any recommendations for modifying the JOA, they shall provide these modifications to their respective CORs.

6.1.5 - Workload

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

All Medicare contractors must review some level of SNF PPS bills based on data analysis. These are *medical record reviews* and should be reviewed by professionals, i.e., at a minimum, by LPNs. Workload projections are to be addressed through the annual Budget Performance Requirements process.

6.2.7 - Medical Review of Home Health Demand Bills

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

As a result of litigation settlements, A/B MACs (A) must perform *medical record reviews* on 100% of the home health demand bills.

6.6 - Referrals to the Quality Improvement Organization (QIO)

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

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 ZPIC*/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.

Medicare Program Integrity Manual
Chapter 7 - MR Reports

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7.1.2.6.1.1 – Workload Reporting Tables

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The following tables shall be included in the IPRS:

Medical Review Program Workload A/B MAC and HHH MAC

Statement of Work (SOW)	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance
C.5.12.1.6	Defending MR Decisions at ALJ Hearings				
C.5.12.2.1	Automated Medical Review				
C.5.12.2.2	*Non-Medical Record* Review				
C.5.12.2.3	Demand Bill Claims Review				
C.5.12.2.4	Medical *Record* Review Reopening				
C.5.12.2.5	Prepay Provider Specific *Medical Record* Review				
C.5.12.2.6	Prepay Service Specific *Medical Record* Review				
C.5.12.2.7	Prepay Probe Provider Specific *Medical Record Review*				
C.5.12.2.8	Prepay Probe Service Specific *Medical Record Review*				
C.5.12.2.10	Postpay Probe Provider Specific *Medical Record Review*				
C.5.12.2.11	Postpay Probe Service Specific *Medical Record Review*				

Statement of Work (SOW)	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance
C.5.12.2.12	Postpay Provider Specific *Medical Record Review*				
C.5.12.2.13	Postpay Service Specific *Medical Record Review*				
C.5.12.2.17	Externally Directed Reviews				
C.5.12.2.18	Provider compliance Group Directed Reviews				
C.5.12.2.20	One on One Education				

Medical Review Program Workload DME MAC

SOW	MR Activity	Projected workload for this Period of Performance
4.7.1	Automated Medical Review	
4.7.2	*Non-Medical Record Review*	
4.7.3	Demand Bill Claims Review	
4.7.4	Medical *Record* Review Reopening	
4.7.5	Prepay Provider Specific *Medical Record Review*	
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4.12	Defending MR decisions at ALJ Hearings	

7.2.2 – Definitions

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The reporting process will require data that can be classified under three different categories of activity measures: Workload, Cost, and Savings. The Medical Review definitions shall apply to all Medical Review activities and shall not be deviated from or interpreted differently than stated below. The consistency in the application of these definitions will provide validity to the data reported that is required to assess the effectiveness of the CMS Medical Review and Education Program being administered by the Contractor(s)

MEDICAL REVIEW

The review of claims and associated medical documentation that occurs when review staff:

1. Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims, or

2. Investigate complaints to determine whether a corrective action was effective (e.g., an MR activity such as provider notification letter), or identify situations that require prepayment edits or the development of a local coverage determination (LCD).

The *medical review* process requires the application of clinical judgment either as part of a review, in writing policies, or in the development of guidelines and processing instructions. For local *medical review* edits, input must be from the Contractor Medical Review clinicians/staff. For national edits, input from the Contractor medical/clinical staff is not necessary. The *medical review can* be performed either before or after the claim has been paid. Generally, a line cannot result in *medical review* workload or savings if it is not referred to *medical review*. A line that potentially involves both *medical review* and claims processing work should suspend to a claims processing reviewer, and that reviewer should refer the line to *medical review* only if the claims processing reviewer cannot make a decision based on guidelines available to that reviewer.

Do NOT consider the review as *medical review* if it requires:

1. Pricing Only, or
2. Coding Only, or
3. Pricing and Coding only.

Consider the review as *medical review* if:

1. Pricing is based on medical *record* review determination. or
2. Coding is based on medical *record* review determination, or
3. Coding and Pricing are based on medical *record* review determination.

If an automated claims processing edit has already made a decision to pay, and the claim only suspends for pricing, consider the review automated claims processing and do not count it for *medical review* workload or costs.

7.2.2.1 - Automated Medical Review

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

A medical review is considered automated when a payment decision is made at the system level, using available electronic information, with no *manual* intervention. It must be based on guidelines for which the contractor's Medical Review area has developed some or all of the logic for review of specific billing and coverage criteria based on vulnerabilities identified by the Contractor's Medical Review area. This process is done completely through the Medical Review Contractors' technology developed in response to medical review data analysis.

7.2.2.2 - *Non-Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Non-medical record reviews uses manual intervention, but only to the extent a reviewer can make a determination based on information on a claim. It does not require clinical judgment in review of medical record documentation. Contractors shall only perform a non-medical record review for denials of related claims and/or no receipt of ADR documentation where such denials cannot be automated.

7.2.2.5 - Prepay Provider Specific *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record 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 *medical record 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, contractors shall count these denials as automated reviews or *non-medical record reviews* depending on the method of development.

7.2.2.6 - Prepay Service Specific Medical *Record* Review

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record 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 *non-medical record* review depending on *whether the denial is automated or requires manual intervention.*

7.2.2.7 - Prepay Provider Specific Probe *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay probe *medical record reviews* are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical *record* review. In the case of a possible provider specific problem, contractors should generally use a sample of 20 -40 claims submitted by that individual provider.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs*/UPICs*, RACs, or others as appropriate.

7.2.2.8 - Prepay Service Specific Probe *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Prepay service specific probe *medical record reviews* are done to verify that the program vulnerability identified through data analysis actually exists and will require education and possible targeted medical review. For Prepay review in the case of a possible systemic problem, the contractor shall include a random or stratified sample of generally 100 claims submitted from across all providers or suppliers that bill the particular item or service in question.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub.100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs*/UPICs*, RACs or others as appropriate.

7.2.2.10 - Postpay Provider Specific Probe *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay provider specific probe *medical record* reviews are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For postpay review of an individual provider in the case of a possible provider specific problem, contractors shall include in the probe sample a random or stratified sample of generally 20 -40 claims from that provider with dates of service from the period under review.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs*/UPICs*, RACs or others as appropriate.

7.2.2.11 - Postpay Service Specific Probe *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Postpay service specific probe *medical record reviews* are done to verify that the program vulnerabilities identified through data analysis actually exist and will require education and/or further medical review. For Postpay review in the case of a possible service/systemic problem, the contractor should generally include a random or stratified sample of 100 claims with dates of service from the period under review from across all providers or suppliers that bill the particular item or service in question.

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with, IOM Pub. 100-08 Chapter 3. Once a problem has been verified, the Contractor shall implement the necessary PCA. This includes providing the initial notification of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE, ZPICs*/UPICs*, RACs or others as appropriate.

7.2.2.12 - Postpay Provider Specific *Medical Record Review*

(Rev. 721, Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Provider specific postpay medical *record* 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 *medical record review* and is not to be counted as a probe review.

7.2.2.13 - Postpay Service Specific *Medical Record Review*

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

Medical record review requires a licensed medical professional to use clinical review judgment to evaluate medical records. Service specific postpay medical *record* 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 *medical record 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 *medical record review* and is not to be counted as a probe review.

7.2.4 - Monthly Reporting of Medical Review Savings

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

The Contractor shall utilize the definitions in their statement of work (SOW) to report those savings resulting from medical review. The report shall be submitted by the 20th day of each calendar month and submitted as a deliverable via the CMS ART portal. The activities and metrics to be reported for calculating Medical Review Savings are detailed in the spreadsheet below. The template, developed by the Provider Compliance Group, includes the formulas required to calculate MR savings and shall not be altered or deviated from.

Medical Review Savings Report Template Sample next page.

Monthly Medical Review Reporting for Prepay & Postpay Review Activity-Contractor/MAC #															
ACTIVITY	METRIC	SEPT 2016	OCT 2016	NOV 2016	DEC 2016	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUN 2017	JUL 2017	AUG 2017	SEPT 2017	TOTAL 2017
Automated MR	# Claims														0
Automated MR	# Claims Denied														0
Automated MR	$'s Denied														$0
Automated MR	$'s Reversed														$0
Automated MR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Medical Record Review	# Claims														0
Non-Medical Record Review	# Claims Denied														0
Non-Medical Record Review	$'s Denied														$0
Non-Medical Record Review	$'s Reversed														$0
Non-Medical Record Review	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Demand Bill Claims MR	# Claims														0
Demand Bill Claims MR	# Claims Denied														0
Demand Bill Claims MR	$'s Denied														$0
Demand Bill Claims MR	$'s Reversed														$0
Demand Bill Claims MR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Provider MRR	# Claims														0
Prepay Provider MRR	# Claims Denied														0
Prepay Provider MRR	$'s Denied														$0
Prepay Provider MRR	$'s Reversed														$0
Prepay Provider MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Service MRR	# Claims														0
Prepay Service MRR	# Claims Denied														0
Prepay Service MRR	$'s Denied														$0
Prepay Service MRR	$'s Reversed														$0
Prepay Service MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepay Probe MRR	# Claims														0
Prepay Probe MRR	# Claims Denied														0
Prepay Probe MRR	$'s Denied														$0
Prepay Probe MRR	$'s Reversed														$0
Prepay Probe MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Probe MRR	# Claims														0
Postpay Probe MRR	# Claims Denied														0
Postpay Probe MRR	$'s Denied														$0
Postpay Probe MRR	$'s Reversed														$0
Postpay Probe MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Provider MRR	# Claims														0
Postpay Provider MRR	# Claims Denied														0
Postpay Provider MRR	$'s Denied														$0
Postpay Provider MRR	$'s Reversed														$0
Postpay Provider MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postpay Service MRR	# Claims														0
Postpay Service MRR	# Claims Denied														0
Postpay Service MRR	$'s Denied														$0
Postpay Service MRR	$'s Reversed														$0
Postpay Service MRR	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	# Claims	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	# Claims Denied	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	$'s Denied	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$'s Reversed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	$'s Saved	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

(Medical Record Review (MRR))

7.3.2.5.1.1 - Workload Reporting Tables

(Rev. 721; Issued: 06-09-17; Effective: 07-11-17; Implementation: 07-11-17)

SAR/Medical Review Program Workload A/B MAC and HHH MAC

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
C.5.12.1.6	Defending MR					

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
	Decisions at ALJ Hearings					
C.5.12.2.1	Automated Medical Review					
C.5.12.2.2	*Non-Medical Record* Review					
C.5.12.2.3	Demand Bill Claims Review					
C.5.12.2.4	Medical Review Reopening					
C.5.12.2.5	Prepay Provider Specific *Medical Record Review*					
C.5.12.2.6	Prepay Service Specific *Medical Record Review*					
C.5.12.2.7	Prepay Probe Provider Specific *Medical Record Review*					
C.5.12.2.8	Prepay Probe Service Specific *Medical Record Review*					

SOW	MR Activity	Part A Projected Workload for this Period of Performance	Part B Projected Workload for this Period of Performance	Home Health Projected Workload for this Period of Performance	Hospice Projected Workload for this Period of Performance	Modifications/ Changes since the previous IPRS
C5.12.2.10	Postpay Probe Provider Specific *Medical Record Review*					
C.5.12.2.11	Postpay Probe Service Specific *Medical Record Review*					
C.5.12.2.12	Postpay Provider Specific *Medical Record Review*					
C.5.12.2.13	Postpay Service Specific *Medical Record Review*					
C.5.12.2.17	Externally Directed Reviews					
C.5.12.2.18	Provider Complian ce Group Directed Reviews					
C.5.12.2.20	One on One Education					

SAR/Medical Review Program Workload DME MAC

SOW	MR Activity	DME Workload for this Period of Performance	DME Budget for this Period of Performance	Modifications/ Changes Since the Previous IPRS
4.7.1	Automated Medical Review			
4.7.2	*Non-Medical Record* Review			
4.7.3	Demand Bill Claims Review			
4.7.4	Medical Review Reopening			
4.7.5	Prepay *Medical Record Review* Provider Specific			
4.7.6	Prepay *Medical Record Review* Service Specific			
4.7.7	Prepay *Medical Record Review* Probe Review Provider Specific			
4.7.8	Prepay *Medical Record Review* Probe Review Service Specific			
4.7.10	Postpay *Medical Record Review* Probe Review Provider Specific			
4.7.11	Postpay *Medical Record Review* Probe Review Service Specific			
4.7.12	Postpay *Medical Record Review* Provider Specific			
4.7.13	Postpay *Medical Record Review* Service Specific			
4.7.17	Externally Directed Reviews			
4.7.18	Provider Compliance Group Directed Reviews			

SOW	MR Activity	DME Workload for this Period of Performance	DME Budget for this Period of Performance	Modifications/ Changes Since the Previous IPRS
4.7.22	One on One Education			
4.12	Defending MR Decisions at ALJ Hearings			