CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 485	**Date: August 21, 2013**
	Change Request 8079

Transmittal 446, dated December 28, 2012, is being rescinded and replaced by Transmittal 485 to include the manual information from CR 7330, Transmittal 396, dated November 2, 2011, which was erroneously omitted. All other information remains the same.

SUBJECT: Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification

I. SUMMARY OF CHANGES: The purpose of this CR is to instuct PSCs and ZPICs to notify providers when a PSC or ZPIC places them on prepayment or postpayment review.

EFFECTIVE DATE: January 29, 2013
IMPLEMENTATION DATE: January 29, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2.2/Provider Notification
R	3/3.3.1.1/Complex Medical Review
R	3/Exhibits Table of Contents
N	3/Exhibit 45-ZPIC Prepayment and Postpayment Notification

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 485	Date: August 21, 2013	Change Request: 8079

Transmittal 446, dated December 28, 2012, is being rescinded and replaced by Transmittal 485 to include the manual information from CR 7330, Transmittal 396, dated November 2, 2011, which was erroneously omitted. All other information remains the same.

SUBJECT: Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification

EFFECTIVE DATE: January 29, 2013
IMPLEMENTATION DATE: January 29, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to require PSCs and ZPICs to send prepayment and postpayment notification letters to providers. This CR also establishes a timeframe for PSCs and ZPICs to make and document the review determination and notify the MAC of the determination.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8079.1	The PSCs and ZPICs shall notify the selected providers prior to beginning a provider-specific review by sending an individual written notice. The PSCs and ZPICs shall indicate whether the review will occur on a prepayment or postpayment basis.											PSCs and ZPICs
8079.2	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.											PSCs and ZPICs
8079.3	The PSCs and ZPICs shall provide notification prior to beginning a service-specific review by sending individual written notices to the affected providers.											PSCs and ZPICs

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	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.											
8079.4	The PSCs and ZPICs shall maintain a copy of the letter and the date it was mailed.											PSCs and ZPICs
8079.5	When a PSC or ZPIC receives all documentation requested for prepayment review within 45 calendar days, the PSC or ZPIC shall make and document the review determination and notify the MAC of its determination within 60 calendar days of receiving all requested documentation.											PSCs and ZPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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): Kimberly Downin, 410-786-0188 or kimberly.downin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

3.2.2 - Provider Notice

(Rev. 485, Issued: 08-21-13, Effective: 01-29-13, Implementation: 01-29-13)

This section applies to MAC*s*, Recovery Auditors, *and ZPICs,* 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, Recovery Auditors, 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 the same problem 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 should, at their discretion, 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.

Recovery Auditors

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

Zone Program Integrity Contractors

The Zone Program Integrity Contractors shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. ZPICs shall indicate whether the review will occur on a prepayment or postpayment basis. ZPICs 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 and Recovery Auditors, 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

The MACs shall provide notification prior to beginning a service-specific review by either posting a review description on its Web site, or by sending individual written notices, such as an ADR, to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR. 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.

When MAC data analysis confirms that an improper payment can be prevented through service-specific complex review, the MAC shall install service-specific complex review edits as soon as feasible under their MR Strategy. The MAC is not required to conduct an error validation review prior to installing these edits.

Recovery Auditors

Before beginning widespread service-specific reviews, Recovery Auditors shall notify the provider community that the Recovery Auditor intends to initiate review of certain items/services through a posting on the Recovery Auditor Web site describing the item/service that will be reviewed. Additionally, for complex reviews, the

Recovery Auditors 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

The ZPICs 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 shall maintain a copy of the letter and the date it was mailed. Refer to Exhibit 45 for the letter to be sent.

3.3.1.1 - Complex Medical Review

(Rev. 485, Issued: 08-21-13, Effective: 01-29-13, Implementation: 01-29-13)

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

A. Credentials of Reviewers

The MACs, CERT, and ZPICs shall ensure that complex 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. Recovery Auditors shall ensure that the credentials of their reviewers are consistent with the requirements in the Recovery Auditor SOW.

During a complex 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 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). Recovery Auditors shall follow guidance related to calling upon other healthcare professionals as outlined in the Recovery auditor SOW.

The CERT and Recovery Auditors shall ensure that complex reviews for the purpose of making coding determinations are performed by certified coders. MACs are encouraged to make coding determinations by using certified coders. ZPICs have the discretion to make coding determinations using certified coders.

B. Credential Files

The MACs, CERT, Recovery Auditors, and ZPICs shall maintain a credentials file for each reviewer (including consultants, contract staff, subcontractors, and temporary staff) who performs complex reviews. The credentials file shall contain at least a copy of the reviewer's active professional license.

C. Quality Improvement (QI) Process

The MACs, CERT, and ZPICs shall establish a Quality Improvement (QI) process that verifies the accuracy of MR decisions made by licensed health care professionals. This includes contractor-developed annual training on clinical review judgment and inter-rater reliability assessments.

D. Advanced Beneficiary Notice (ABN)

The MACs, CERT, Recovery Auditors and ZPICs shall request as part of the ADR, during a complex medical record review, a copy of any mandatory ABNs, as defined in IOM 100-04, Medicare Claims Processing Manual Chapter 30 §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 IOM 100-04 Medicare Claims Processing Manual chapter 30 § 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 § 1879 of the Social Security Act.

E. MAC Funding Issues

The MAC complex medical 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 complex 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 manual 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.

F. Review Timeliness Requirement

<u>For Prepayment Reviews</u>

When a MAC receives requested documentation for prepayment review within 45 calendar days, the MAC shall do the following within 60 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).

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

For prepayment reviews, the MAC shall count day one as the date each new medical record is received in the mailroom. Each new medical record received would have an independent 60-day review time period associated with it.

<u>For Postpayment Reviews</u>

The MAC or Recovery Auditor shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation, provided the documentation is received within 45 calendar days of the date of the ADR.

The MAC has the option to either:

- Begin counting the 60 days at the receipt of each medical record in the mailroom. Each new medical record would have an independent 60 day time period associated with it; or

- Wait until all requested medical documentation is received in the mailroom. The date on which the last of the requested medical documentation is received would represent the beginning of the 60 day time period.

G. Auto Denial of Claim Line Item(s) Submitted with a GZ Modifier

Effective for dates of service on and after July 1, 2011, all MACs, PSCs and ZPICs shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with the GZ modifier. The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review. See Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1. under paragraph F “GZ Modifier” for codes and the MSN to be used when automatically denying claim line(s) items submitted with a GZ modifier.

Medicare Program Integrity Manual
Exhibits

Table of Contents
(Rev. 485, Issued: 08-21-13)

Exhibit 45 – ZPIC Prepayment and Postpayment Notification Letter
(Rev. 485, Issued: 08-21-13, Effective: 01-29-13, Implementation: 01-29-13)

DATE:
PROVIDER NAME:
PROVIDER ADDRESS:
PROVIER NUMBER:

PSC/ZPIC NAME/ZONE:
PSC/ZPIC CONTACT/PHONE NUMBER:
PSC/ZPIC ADDRESS:

Dear Provider Name:

As a Medicare contractor, the Program Safeguard Contractor (PSC) and the Zone Program Integrity Contractor (ZPIC) is required by the Centers for Medicare & Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment. Specifically, as a (indicate PSC or ZPIC), (write PSC or ZPIC Name) is required to investigate situations of potential fraud, waste, and abuse.

Your claims have been selected for a comprehensive medical review of your billing for Medicare services pursuant to CMS' statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that there may be aberrancies in your billing.

We have selected claims for services provided during the period _____ through _____. You will subsequently receive a request for medical records, which will explain the specific documentation that is being requested. If you have any questions regarding the letter requesting medical records/documentation, please contact (PSC/ZPIC Contact's Name) at (Phone Number of PSC/ZPIC Contact).

Thank you for your prompt response to the request for medical records/documentation.