CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 512	**Date: April 18, 2014**
	Change Request 8716

SUBJECT: Revision to the Program Integrity Manual, Chapter 3, section 3.3

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update the Program Integrity Manual, Chapter 3, section 3.3.

EFFECTIVE DATE: May 19, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 19, 2014

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	3/3.3/ Policies and Guidelines Applied During Review

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not 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

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to update Chapter 3 of the Medicare Program Integrity Manual.

B. Policy: The purpose of this change request (CR) is to update Chapter 3 of the Medicare Program Integrity Manual.

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	
8716.1	The primary authority for all coverage provisions and subsequent policies is the Social Security Act. In general, MACs, CERT, Recovery Auditors, SMRCs, and ZPICs shall apply the provisions of the Act according to the following hierarchy of documents in effect at the time the item(s) or service(s) was provided to make medical review decisions: • Social Security Act • Code of Federal Regulations • CMS' Rulings • National Coverage Determination (NCDs) • Coverage provisions in Interpretive Manuals or Internet Only Manuals (IOM) which includes Medical Review Guidance in the Medicare Program Integrity Manual • CMS coding policies • Technical Direction Letters (TDLs)*	X	X	X	X					CERT, RA, RACs, SMRC, ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The relevant MAC's Local Coverage Determination (LCDs) • The relevant MAC's local articles • AHA Coding Clinics. *TDLs that contain MR guidance may provide an exception to this hierarchy.									

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): Pamela Villanyi, 410-786-1522 or pamela.villanyi@cms.hhs.gov (Marissa Malcolm marissa.malcolm@cms.hhs.gov 410-786-0119)

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.

3.3 Policies and Guidelines Applied During Review
(Rev.512, Issued: 04-18-14, Effective: 05-19-14, Implementation: 05-19-14)

This section applies to MACs, CERT, Recovery Auditors, *Supplemental Medical Review Contractors (SMRCs)* and ZPICs, as indicated.

A. Statutes, Regulations, the CMS' Rulings, National Coverage Determinations, Coverage Provisions in Interpretive Medicare Manuals, and Local Coverage Determinations

The primary authority for all coverage provisions and subsequent policies is the Social Security Act. *In general,* MACs, CERT, Recovery Auditors, *SMRCs,* and ZPICs shall apply the provisions of the Act *according to the following hierarchy of documents in effect at the time the item(s) or service(s) was provided to make medical review decisions:*

Social Security Act
Code of Federal Regulations
CMS' Rulings
National Coverage Determination (NCDs)
Coverage provisions in Interpretive Manuals or Internet Only Manuals (IOM) which includes Medical Review Guidance in the Medicare Program Integrity Manual
CMS coding policies
*Technical Direction Letters (TDLs)**
The relevant MAC's Local Coverage Determination (LCDs)
The relevant MAC's local articles
AHA Coding Clinics.

**TDLs that contain MR guidance may provide an exception to this hierarchy.*

B. Coding Guidelines

The MACs, CERT, Recovery Auditors, and ZPICs shall apply coding guidelines to services selected for review. All contractors shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, ICD-9, HCPCS and CMS policy or guideline requirements, LCDs, or MAC articles.

C. Internal Medical Review Guidelines

The MAC, CERT, Recovery Auditor, and ZPIC staffs have the discretion to develop detailed written review guidelines to guide staff during claim reviews. Internal MR guidelines shall specify the information to be reviewed by reviewers and the appropriate resulting determination. Recovery Auditors are required to develop written review guidelines in accordance with their SOW. The MACs, CERT, Recovery Auditors, and ZPICs shall make their internal MR guidelines available to their staff, as needed. Internal MR Guidelines shall not create or change the CMS policy.