CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 104

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: FEBRUARY 11, 2005

Change Request 3622

SUBJECT: Requirement that Medicare Carrier System (MCS) Not Allow the Re-review of Previously Denied Claims

I. SUMMARY OF CHANGES: This change request requires that MCS stop the re-review of denials as required by the Medicare Program Integrity Manual (PIM). Medicare Program Integrity Manual (Rev. 36, 12-27-02), Chapter 11 - Fiscal Administration, Section 1.3 - Prepay Review for MR Purposes (Rev. 22, 03-05-02), requires the review of a claim for MR purposes is only counted as medically reviewed once no matter how many times the same claim is reviewed during claims processing. MCS users will be exempt from this requirement until July 5, 2005. Effective July 5, 2005, the MCS system shall be revised to deny as duplicate a newly submitted claim against a claim that has been denied, medically reviewed, or where documentation was requested but not received. The PIM, section 11.1.3, is revised to reflect the effective and implementation dates of this change.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : July 05, 2005
IMPLEMENTATION DATE : July 05, 2005

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:
R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / SubSection / Title
R	11/11.1.3/ CAFM II Reporting for MR Activities

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 104	Date: February 11, 2005	Change Request 3622

SUBJECT: Requirement that Medicare Carrier System (MCS) Not Allow the Re-review of Previously Denied Claims

I. GENERAL INFORMATION

A. Background: This change request (CR) requires that MCS develop a module that will not allow the re-review of medical review (MR) denials as required by the Medicare Program Integrity Manual (PIM), chapter 11, section 1.3.

Medicare Program Integrity Manual (Rev. 36, 12-27-02), Chapter 11 - Fiscal Administration, Section 1.3 - CAFM II Reporting for MR Activities (Rev. 22, 03-05-02): requires "The review of a line for MR purposes is only counted as medically reviewed once no matter how many times the same line is reviewed during claims processing, MCS users will be exempt from this requirement until July 5, 2005. Effective July 5, 2005, the MCS system maintainer shall revise the MCS system to deny as duplicate a newly submitted line against a line that has the contractor or MCS system has denied for MR reasons or medically reviewed, or where the contractor requested documentation but the contractor did not receive the requested documentation."

CR 3271 was rescinded and replaced by CR 3622.

B. Policy: Medicare Program Integrity Manual (Rev. 36, 12-27-02), Chapter 11 - Fiscal Administration, Section 1.3 - Prepay Review for MR Purposes (Rev. 22, 03-05-02): requires that contractors deny as duplicate a newly submitted line that duplicates a line that a contractor has:

(a) Already denied for MR reasons,
(b) Medically reviewed, or
(c) contractor requested but did not receive documentation."

C. Provider Education: Contractors shall notify providers that the providers may not resubmit claim lines denied after MR or that are undergoing MR. Contractors shall also notify providers that, if a provider resubmits a line denied as a result of MR, the provider may not appeal the denial decision on the resubmitted line.

II. BUSINESS REQUIREMENTS

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3622.1	The MCS maintainer shall develop a module that will allow contractors to begin by July 5, 2005, to automatically deny duplicates of lines denied after MR review. Duplicates of denied lines are defined as newly submitted lines that duplicate a line that a contractor has already denied for MR reasons, medically reviewed, or for which the contractor requested but did not receive documentation. Duplicate means that both the original and resubmitted line have the same beneficiary, service, service dates, and provider (billing and/or rendering). The module shall process the claim as early in the processing cycle as practical.						X			
3622.2	By July 5, 2005, contractor data centers shall implement, operate, and maintain the shared system module specified in requirement 3622.1 and provided by shared system maintainers.			X						
3622.3	By July 5, 2005, contractors shall insure that their data centers have correctly implemented and are operating the module developed by the shared system to meet requirement 3622.1 of this CR.			X						
3622.4	Providers may not appeal duplicate denials unless the provider documents that the service was not a duplicate because it was performed more often than indicated in the original line.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3622.5	By July 5, 2005, contractors shall begin using a "Duplicate non-paid" denial message. Where possible, the message shall allow the insertion of a claim number. The message should read: **"We denied this service because it is a duplicate of a service denied on a previous claim. This denial is not appealable unless the provider can document that the service was not a duplicate because it was performed more often than indicated in the original line."**			X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: NA

X-Ref Requirement #	Instructions

B. Design Considerations: NA

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: NA

F. Testing Considerations: NA

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 5, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** John Stewart (410) 786-1189 jstewart@cms.hhs.gov **Post-Implementation Contact(s):** John Stewart (410) 786-1189 jstewart@cms.hhs.gov	**Medicare contractors shall implement these instructions within their current operating budgets.**

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11.1.3 – CAFM II Reporting for MR Activities

(Rev. 104, Issued: 02-11-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors shall report all costs associated with the medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions. All costs associated with collecting the overpayment shall be allocated to the appropriate overpayment collection CAFM II activity code.

To be counted as medical review workload, all claims reviewed by medical review shall be identified in the MR/LPET strategy and be the result of a MR edit. If resources allow, a MR clinician may be shared with another functional area, such as claims processing or appeals, as long as only the percentage of the clinician's time spent on MR activities is identified in the strategy and accounted for in the appropriate functional budget area.

The review of a claim for MR purposes is only counted as medically reviewed once no matter how many times the same claim is reviewed during claims processing. MCS users will be exempt from this requirement until *July 5, 2005. Effective July 5, 2005 the MCS system shall be revised to automatically deny duplicates of denied lines. Duplicates of denied lines are defined as newly submitted lines that duplicate a line that a contractor has (a) already denied, (b) medically reviewed, or (c) for which the contractor requested but did not received documentation. Denial of duplicate lines shall not be appealable unless the provider documents that the service was not a duplicate because it was performed more often than indicated in the original line. Use a "Duplicate non-paid" denial message whenever this denial is made.*