CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 185	Date: JANUARY 26, 2007
	Change Request 4378

SUBJECT: Updating Financial Reporting Requirements for Workload and Cost Associated With the Return of Demand Bills.

I. SUMMARY OF CHANGES: Instructs contractors to return home health demand bills to the provider, rather than reviewing them when the has not selected the checkbox indicating he or she wants Medicare billed. An exception occurs in state that have specific policies regarding billing for dual-eligibles.

NEW/REVISED MATERIAL
EFFECTIVE DATE: February 26, 2007
IMPLEMENTATION DATE: February 26, 2007

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/3.4.2/Medical Review Denials Notices
R	11/11.1.3.4/Third Party Liability or Demand Bills Workload and Cost (Activity Code 21010)

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 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: 185	Date: January 26, 2007	Change Request: 4378

SUBJECT: Updating Financial Reporting Requirements for Workload and Cost Associated With the Return of Demand Bills.

I. GENERAL INFORMATION

A. Background: This transmittal updates the Program Integrity Manual (PIM) chapter 11, §11.1.3.4 to include reporting requirements for Medical Review workload associated with the return of demand bills (condition code 20) to providers when the beneficiary has not selected a checkbox on the Home Health Advance Beneficiary Notice (HHABN) form which indicates that he or she wants Medicare to be billed for the services. It also provides instruction on processing home health demand bill claims in states which have specific policies regarding billing Medicare for dual-eligible beneficiaries PIM chapter 3, Section 3.4.2- Denials Notices, has also been revised for consistency with these requirements.

B. Policy: Program Integrity Manual chapter 6, section 6.2.2, instructs that, as a result of litigation settlements, intermediaries must perform complex medical review on 100% of the home health demand bills. Program Integrity Manual, chapter 11, section 11.1.3.4, currently instructs that intermediaries shall report the costs associated with the medical review of third party liability and the medical review of demand bills in Activity Code 21010. It also provides instruction regarding reporting of the number of claims reviewed to the appropriate Workload in Activity Code 21010. This CR instructs that an exception to that process is made when the provider submits a demand bill claim, and the beneficiary has not selected a checkbox on the HHABN which indicates that he or she wants Medicare to be billed. In most cases, the Regional Home Health Administrator (RHHI) shall RTP such claims submitted in error, except in the case of dual-eligible beneficiaries where there is a state-specific policy instructing otherwise. In those cases where there is a state-specific policy, the RHHI shall process the demand bill, in accordance with IOM 100-04, chapter 30, §60.5.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4378.1	Contractors shall return demand bills (condition code 20) of type 32X, 33X, and 34X to the provider when the beneficiary has not selected a checkbox on the HHABN which indicates that he or she wants Medicare to be billed, except in states which have specific policies related to billing for dual-eligible beneficiaries.		X							
4378.1.1	Contractors shall follow State-specific policies regarding billing for dual-eligibles, in accordance with IOM 100-04, chapter 30, section 60.5.		X							
4378.2	Contractors shall report cost associated with returning demand bills, when option 2 on the HHABN form is selected, to the provider in the workload section of CAFM II Activity code 21010.		X							
4378.3	Contractors shall report the number of demand bills returned to the provider in the remarks section of CAFM II Activity code 21010.		X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4378.1 4378.1.1 4378.2 4378.3	While CMS does not anticipate that demand bills will be received for bill type 34X, the RHHI shall follow these instructions if demand bills are received for that bill type.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 26, 2007 **Implementation Date:** February 26, 2007 **Pre-Implementation Contact(s):** Kimberly Spalding (kimberly.spalding@cms.hhs.gov) **Post-Implementation Contact(s):** Regional offices	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev.185, 01-26-07)

3.4.2 – *Medical Review* Denials Notices

(Rev.185, Issued: 01-26-07, Effective: 02-26-07, Implementation: 02-26-07)

Contractors must deny claims, in full or in part, under the circumstances listed below. Contractors do not have the option to "Return to Provider" or reject claims under these circumstances. Contractors must deny the claim in full or in part. See *CMS Pub. IOM 100-04, chapter 30, §20.1* for further information on partials denials (known as "down coding").

A. Denial Reasons Used for Reviews Conducted for MR or BI Purposes

Contractors must 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 and national coverage determination, coverage provision in 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. (Contractors shall use this denial reason for all non-responses to ADRs.); and
- Was not billed in compliance with the national and local coding requirements; *or*
- *Does not meet reasonable and necessary criteria specified in an LCD.*

Contractors must give the specific reason for denial. Repeating one of the above bullets is not a specific reason. *An exception to this instruction may occur when a demand bill (condition code 20) is submitted with an administrative error, such as when the beneficiary has not selected the checkbox indicating he or she wants Medicare to be billed on the HHABN (see CMS Pub. IOM 100-08, chapter 11, §11.1.3.4 for instructions regarding appropriate intermediary processes when this situation occurs). In most cases, the contractor shall RTP such claims submitted in error, except in the case of dual-eligible beneficiaries where there is a state-specific policy, as described in IOM 100-04, chapter 30, §60.5 A.*

B. Denial Reasons Used for Reviews Conducted for BI Purposes

Contractors must deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full whenever there is evidence that a service:

- Was not rendered (or was not rendered as billed);

- Was furnished in violation of the self referral prohibition; or

- Was furnished, ordered or prescribed on or after the effective date of exclusion by a provider excluded from the Medicare program and that provider does not meet the exceptions identified below in PIM chapter 4, §4.21.2.6.

Contractors must deny payment whenever there is evidence that an item or service was not furnished, or not furnished as billed even while developing the case for referral to OIG or if the case has been accepted by the OIG. In cases where there is apparent fraud, but the case has been refused by law enforcement, contractors deny the claim(s) and collect the overpayment where there is fraud- - after notifying law enforcement. It is necessary to document each denial thoroughly to sustain denials in the appeals process. Intermediaries must make adjustments in cost reports, as appropriate.

C. Denial Notices

If a claim is denied, in full or in part, the contractor must notify the beneficiary and/or the provider. The contractor shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN) and Remittance Advice.

Beneficiary Notices

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

> "A local medical review policy (LMRP) or local coverage determination (LCD) was used when we made this decision. An LMRP/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 or carrier 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 LMRP/LCD to see whether additional information from your physician would change our decision."

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

> 15.19 - Una Política Local de Revisión Médica (LMRP, por sus siglas en inglés) o una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La Política Local de Revisión Médica y la Determinación de Cobertura Local proveen una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta política está disponible en su intermediario o su empresa de seguros Medicare local al llamar al número que aparece en la sección de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas

establecidas en la Política Local de Revisión Médica y en la Determinación de Cobertura Local para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

Use the above message in every instance of a prepayment denial where *an LCD* was used in reviewing the claim. Use this message, and message 15.20 (now for FISS FI's, 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, routine, or complex review. Do not use this message on denials not *involving LCDs*. For claims reviewed on a postpayment basis, use the above message 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 #(s) and NCD #(s)] were used when we made this decision."(Pub. 100-04, chapter 21). 15.19 must continue to be used in conjunction with the MSN message 15.20, where 15.19 is applicable. Contractors may combine these messages if necessary, but 15.19 must not be deleted.

Provider Notices

Prepay Denial Messages

Because the amount of space is limited, contractors need only provide high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared standard system remittance advice messages are sufficient notices to the provider. However, for routine and complex review, the contractor must retain more detailed information in an accessible location so that upon written or verbal request from the provider, the contractor can explain the specific reason the service was considered non-covered or not correctly coded.

Post Pay Denial Messages

When notifying providers of the results of post pay medical review determinations, the contractor must explain the specific reason each service was considered non-covered or not correctly coded.

Indicate in the Denial Notice Whether Records Were Reviewed

Effective March 1, 2002, for claims where the contractor has sent an ADR letter and no timely response was received, contractors must make a §1862(a)(1) of the Act denial (except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information) and indicate in the provider denial notice, using remittance advice code N102, that the denial was made without reviewing the medical record because the requested records were not received or were not received timely. This information will be useful to the provider in deciding whether to appeal the decision.

For claims where the contractor makes a denial following complex review, contractors may, at their discretion, indicate in the denial notice, using remittance advice code N109 that the denial was made after review of medical records. This includes those claims where the provider submits medical records at the time of claim submission and the contractor selects that claim for review.

D. Audit Trail

For reporting purposes, contractors need to differentiate automated, routine and complex prepayment review of claims. Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied. When downcoding, contractors must retain a record of the HCPCS codes and modifiers that appeared on the original claim as submitted.

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

Contractors must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

- If the contractor requests additional documentation from the provider or other entity (in accordance with PIM chapter 3, section 4.1.2.) for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not received within 45 days, the contractor should issue a reasonable and necessary denial, in full or in part.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, but the evidence of the benefit category requirement is missing, the contractor should issue a benefit category denial.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, which shows evidence that, the benefit category requirement is present but is defective, the contractor should issue a reasonable and necessary denial.

EXAMPLE: A contractor is conducting a review of partial hospitalization (PH) services on a provider who has a problem with failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the contractor finds that there is no signed certification present in the medical record. The contractor must 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 contractor determines that a signed certification is present in the medical

record, but the documentation does not support the physician's certification, the services must be denied under §1862(a)(1)(A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

- If a contractor performs routine review on a surgical procedure and determines that the procedure was cosmetic surgery 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.

11.1.3.4 - Third Party Liability or Demand Bills Workload and Cost (Activity Code 21010)

(Rev.185, Issued: 01-26-07, Effective: 02-26-07, Implementation: 02-26-07)

Intermediaries shall report only the workload and costs associated with the medical review of third party liability claims and the workload and costs associated with the medical review of demand bills. Funding for claims processing and the appeals for third party liability and demand bills must be funded through program management.

Intermediaries shall report the costs associated with the medical review of third party liability *claims* and the medical review of demand bills in Activity Code 21010. *Intermediaries* shall report the total number of claims reviewed, i.e., third party liability claims plus claims for demand bills, in Workload 1 *in CAFM II Activity Code 21010*. Intermediaries shall report the number of claims denied in whole or in part in Workload 2. Intermediaries shall report demand bills (claims) reviewed in Workload 3.

An exception to the preceding instruction may occur when the provider submits a home health demand bill (condition code 20) type 32X, 33X, or 34X, and the beneficiary has not selected the checkbox indicating that he or she wants Medicare to be billed on the Home Health Advance Beneficiary Notice (HHABN). In most cases, the contractor shall return to the provider (RTP) such claims submitted in error, except in the case of dual-eligible beneficiaries where there is a state-specific policy regarding billing Medicare. Contractors and HHAs who serve dual-eligibles shall comply with a state-specific policy on billing for dual-eligible beneficiaries (see CMS Pub. IOM 100-04, chapter 60, §60.5 A. for further instruction on that situation).