CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 505	**Date: February 5, 2014**
	Change Request 8425

SUBJECT: Removing Prohibition

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to allow the contractors to make a decision or take action on claims that are not currently being under review.

EFFECTIVE DATE: March 6, 2014
IMPLEMENTATION DATE: March 6, 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	3/3.2.3/Requesting Additional Documentation During Prepayment and Postpayment 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

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

Attachment - Business Requirements

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EFFECTIVE DATE: March 6, 2014

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I. GENERAL INFORMATION

A. Background: Removing the prohibition on contractors taking action on claims that are not currently being reviewed.

B. Policy: 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	
8425.1	The MAC, Recovery Auditor, and ZPIC should *have the discretion to* deny other *related* claims submitted before or after the claim in question.	X	X	X	X					RA, ZPICs
8425.2	The MACs shall consider related claim denials as routine review as no additional clinical review judgment shall be needed.	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): Jennifer McCormick, 410-786-2852 or Jennifer.McCormick@cms.hhs.gov

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

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 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.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev.505, Issued: 02-05-14, Effective: 03-06-14, Implementation: 03-06-14)

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

A. General

In certain circumstances, the MACs, CERT, Recovery Auditors, and ZPICs 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, Recovery Auditors, and ZPICs 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 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, Recovery Auditor, and ZPIC *have the discretion to* deny other *related* claims submitted before or after the claim in question. *If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Claims may be "related" in the following EXAMPLE situations:*

- *An inpatient claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the physician claim can be determined to be not reasonable and necessary.*
- *A diagnostic test claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the professional component can be determined to be not reasonable and necessary.*

The list of examples is not an exhaustive list and claims may be "related" in other scenarios.

If "related" claims are denied automatically, MACs shall count these denials as automated review. If the "related" claims are denied after human intervention, MACs shall count these denials as routine review.

The MAC, Recovery Auditor, and ZPIC are not required to request additional documentation for the related claims before issuing a denial for the related claims.

B. Authority to Collect Medical Documentation

Contractors are authorized to collect medical documentation by the Social Security Act. Section 1833(e) states "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states "…no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

The OMB Paperwork Reduction Act collection number is 0938-0969. This number shall be on every additional documentation request or any other type of written request for additional documentation for medical review. It can be in the header, footer or body of the document. CMS suggest the information read "OMB #: 0938-0969" or OMB Control #: 0938-0969."