CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 79 **Date: JULY 9, 2004**

CHANGE REQUEST 3222

I. SUMMARY OF CHANGES: Revises the LMRP MSN message to say LMRP/LCD. Manualizes medical review elements of CR 2081, which lets beneficiaries know when their claim was denied as a result of local policy.

NOTE: For Part B, MSN message 15.20 is not fully implemented (See CR 3089).

MANUALIZATION- EFFECTIVE DATE: February 3, 2003
***IMPLEMENTATION DATE: August 9, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, 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	3/4.2.C/Denial Notices
R	3/5.1.1C/Adding LMRP and NCD ID Numbers to Edits

***III. FUNDING:**
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Local Medical Review Policy/ Local Coverage Determination Medicare Summary Notice (MSN) Message Revision

I. GENERAL INFORMATION

A. Background: Transmittal 63 provided detail on the conversion from local medical review policy (LMRP) to local coverage determinations (LCD). AB-02-155 provided contractors information on what to do if a claim was denied based on an LMRP.

B. Policy: This instruction revises MSN message 15.19 to reflect the current policy conversions from LMRP to LCDs. Furthermore, it manualizes those elements of AB-02-155 that have not been previously manualized. (Reason/Action code N115 has been revised in CR 3227.)

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3222.1	Contractors shall give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of an LMRP/LCD.	Contractors
3222.2	Contractors shall ensure that all denials that result from LMRP/LCDs provide the MSN message 15.19 in addition to 15.20 (upon implementation of this CR for FISS FIs and when fully implemented for MCS/VMS carriers as described in CR 3089) and the current applicable message.	Contractors
3222.3	Contractors shall make these messages available in Spanish where appropriate.	Contractors
3222.4	Contractor shall use message 15.19, and 15.20 (upon implementation of this CR for FISS FIs, and when 15.20 is fully implemented for contractors on the MCS/VMS system carriers as described in CR 3089) on both full and partial	Contractors

	denials, whether the denial was made following automated, routine, or complex review.	
3222.5	Contractor shall not use message 15.19 on denials not involving LMRP/LCDs.	Contractors
3222.6	For claims reviewed on a postpayment basis, contractors shall use the message 15.19 and 15.20 (upon implementation of this CR for FISS FIs, and when 15.20 is fully implemented for contractors on the MCS/VMS system carriers as described in CR 3089)	Contractors
3222.7	If sending a letter, contractors shall include the language exactly as contained in MSN message 15.19 and 15.20.	Contractors

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: February 3, 2003 **Implementation Date:** August 9, 2004 **Pre-Implementation Contact(s):** Dan Schwartz (dschwartz2@cms.hhs.gov) **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

3.4.2 – Denials

(Rev. 79, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

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 Ruling 95-1 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, or LMRP/LCD;
- 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.

Contractors must give the specific reason for denial. Repeating one of the above bullets is not a specific reason.

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 LMRP/LCD. All denials that result from LMRP/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 LMRP/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 LMRP/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 LMRP/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.

3.5.1.1 - Prepayment Edits

(Rev. 79, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services and to select targeted claims for review prior to payment. medical review (MR) edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

Contractors may not install edits that result in the automatic denial of services based solely on the diagnosis of a progressively debilitating disease where treatment may be reasonable and necessary. The appearance of a progressively debilitating disease on a claim or history does not permit automated prepay denials that presume a stage of that disease that negates the effectiveness of treatment. Additionally, when a beneficiary with a progressively debilitating disease experiences an illness or injury unrelated to their progressively debilitating disease, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 Code V43.64 (Hip joint replacement by artificial or mechanical device or prosthesis) as the primary diagnosis, not ICD-9 Code 331.0 (Alzheimer's Disease). Automated denials may only be used when the service, in that circumstance, is never reasonable and necessary. For example, an EMG for Alzheimer's may be auto denied because it will never be reasonable and necessary for that ICD code; but EMG may not be auto denied when the claim shows "focal muscular weakness" -- even though that claim also shows Alzheimer's. Physical therapy may not be auto denied solely because multiple sclerosis appears on the claim, but may be if there is no other justification for the service listed. There are stages of the disease at which, for example, physical therapy for gait training will not be effective, but MR must look into the claims history or examine records to make that determination.

A -- Ability to Target

Contractors must focus edits to suspend only claims with a high probability of being denied on medical review. Focused edits reduce provider burdens and increases the efficiency of medical review activities. Edits should be specific enough to identify only the services that the contractor determines to be questionable based on data analysis. Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type Of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Carrier systems must be able to select claims for prepayment review using different types of comparisons. By January 2001 (unless otherwise specified), FI systems must be able to perform these comparisons as well. At a minimum, those comparisons must include:

- Procedure-to-Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history. Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Procedure to Provider – For a given provider, this permits selective screening of services that need review.

- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period. Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin Bl2 injection is related to pernicious anemia, absence of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.

- Procedure to Specialty Code (Carrier) or TOB (Intermediary) – This permits contractors to screen services provided by a certain specialty or type of bill.

- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;

- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);

- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over $500);

- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and

- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

B -- Evaluation of Prepayment Edits

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits as follows:

- Automated edits must be evaluated annually.

- All routine or complex review edits must be evaluated quarterly.

These evaluations are to determine their effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too brief a time to observe a change. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ESTABLISHED AUTOMATED** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to RO (for PSCs, the GTL, Co-GTL, and SME) and CO staff documentation demonstrating that they consider appeals in their edit evaluation process; and

- Specificity of edits in relation to identified problem(s).

Contractors should note that even an automated edit that results in no denials may be effective so long as the presence of the edit is not preventing the installation of other automated edits.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ALL OTHER** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal,

etc. Contractors must maintain and make available to RO and CO staff documentation demonstrating that they consider appeals in their edit evaluation process.

- Specificity of edits in relation to identified problem(s);

- Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;

- Impact of educational or deterrent effect in relation to review costs; and

- The presence of more costly problems identified in data analysis that needs higher priority than existing edits considering the number of claims/days/charges reviewed in comparison to claims/days/charges denied.

Contractors must test each edit before implementation and determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

C –Adding LMRP/*LCD* and NCD ID Numbers to Edits

By January 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on an LMRP/LCD *or NCD* includes the LMRP/LCD *or NCD* ID number(s) associated with the denial.

By April 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on a *lab negotiated* NCD includes the NCD ID number(s) associated with the denial.

By October 4, 2004, VMS carriers and PSCs must ensure the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

By October 4, 2004, MCS carriers must ensure that the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.