CMS Medicare Manual System
Pub. 100-8 Program Integrity

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

Transmittal 45 **Date: JULY 25, 2003**

CHANGE REQUEST 2693

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7	7		

Red italicized font identifies new/revised material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 1, 2003
IMPLEMENTATION DATE: August 8, 2003

Medicare contractors only: these instructions should be implemented within your current operating budget.

Chapter 7, Section 7 – FMR Activity Report – revises the requirement that FMR activity reports and bulletins should be sent to central office. FMR reports should only be sent to regional offices.

7 - FMR Activity Report - (Rev.45, 07-25-03)

Intermediaries must complete the report semi-annually. (See Exhibit 2.) The reporting periods must cover the first two quarters of the FY (i.e., November thru April) and the last two quarters (i.e., May thru October) of the FY. Within 45 days of the end of the reporting periods, i.e., by May 15 for the first reporting period and by November 14 for the second reporting period, *they submit the report to the RO.*

Report the following elements:

- Date report was prepared;
- Contact name and telephone number;
- Period covered by the report;
- FMR criteria (specific revenue code, HCPCS code, provider, etc.) being reviewed;
- Reason for selection. Show the specific reason the FMR edit was selected (e.g., the providers rank in the top 5 percent in utilization of MRIs, referral from fraud unit, utilization aberrancy, or new technology);
- Date established (the date the edit was initially established);
- Actions taken. Intermediaries show the actions taken to resolve problems, e.g., educational efforts, fraud referrals, development of LMRP (attach copy); and
- Effectiveness. Intermediaries show the following:
    - Number of bills medically reviewed;
    - Percent of bills partially or fully denied;
    - Average or actual charges, days, or visits reviewed under criteria;
    - Average or actual charges, days, or visits denied;
    - Percent of increase or decrease of days/visits/charges denied from previous period if edit has been in place during a prior period;
    - Approximate charges billed in prior period versus current period to show cost avoided as a result of provider practice change;
    - The cost benefit ratio (CBR) which is based on the average unit cost for review per bill type and savings as computed on the RBS. The CBR is required if you are using denials as the reason for continuing the edit;
    - Other measurable result or reason the edit is being continued. If an edit is discontinued or modified and one of the above results are not applicable, give the reason for discontinuation or modification; or
    - Estimated or potential overpayment for referrals to fraud.

- Reasons for denials. Intermediaries list reasons claims are denied under this edit; and
- Status. Intermediaries show continued, discontinued, or modified status, as applicable. If the edit was modified prior to the reporting period, the FMR criteria described must reflect the modified edit. If the modification occurs during the reporting period, they identify the changes.

A - Summary Sheet

Intermediaries must provide the following information on a cover sheet to the report:

- Number of edits reviewed this period;
- Number of edits modified or discontinued this period; and
- Number of edits reviewed in effect for 12 months or more.

They show the edit number on the report and indicate any actions taken by the intermediary or the providers as a result of the problem being identified.

EXAMPLES: Edits 1, 5, and 6 - conducted provider education meetings.

Edit 6 - provider changed billing practice.

Edit SNF 2 - generated provider bulletin, no change in billing practices to date.

When applicable, intermediaries include on the cover sheet any of the following information:

- New hardware or software development that the intermediary found particularly effective in conducting data analysis. Include any commercial products reviewed and believe would be of benefit;
- Any new patterns, trends, or problem identifications found to be significant. This includes any referrals to the fraud unit;
- Any new coverage issues that require clarification or development of national policy; and
- Any new FMR issues that need to be brought to the attention of other intermediaries, carriers, the QIOs, ROs, and/or CO.