CMS Medicare Manual System
Pub. 100-8 Program Integrity

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

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CHANGE REQUEST 2681

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
3	5.1.1		

Red italicized font identifies new material.

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

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

Chapter 3, Section 5.1.1, Prepayment Edits - Deletes "in the early stages" in the instructions to contractors not to install edits that result in the automatic denial of services based solely on the diagnosis of progressively debilitating disease where treatment may be reasonable and necessary. Examples are added. Instructs contractors to evaluate automated edits annually and all routine and complex edits quarterly.

5.1.1 – Prepayment Edits - (Rev.46, 07-25-03)

Prepayment edits are designed by contractor staff and put in place to prevent payment for noncovered 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 autodenied because it will never be reasonable and necessary for that ICD code; but EMG may not be autodenied when the claim shows "focal muscular weakness" -- even though that claim also shows Alzheimer's. Physical therapy may not be autodenied 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. *E*dits 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 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.