CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

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CHANGE REQUEST 2873

I. SUMMARY OF CHANGES: Changing the use of remittance advice code N109 from mandatory to contractor's discretion.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 10, 2003
***IMPLEMENTATION DATE: October 10, 2003**

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 3/ Section 4.2.C/ Denial Notices

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

4.2 - Denials –

(Rev. 49, 09-26-03)

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 "downcoding").

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

Contractors must deny payment on claims either partially (e.g., by downcoding, 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;
- 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 downcoding 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 3, §11.2.6.

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 -- 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.

- **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 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 a 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.

- **Postpay Denial Messages**
  When notifying providers of the results of postpay medical review determinations, the contractor must explain the specific reason each service was considered noncovered 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 Part A providers cannot appeal benefit category and statutory exclusion denials, and 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.