CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 44 | **Date JULY 25, 2003**

CHANGE REQUEST 2592

I. SUMMARY OF CHANGES: This transmittal requires contractors to undertake certain activities required to move all LMRPs from www.LMRP.net to the new Medicare coverage database on www.cms.hhs.gov. This transmittal includes the LMRP requirements of transmittal AB-02-098 (CR 2238).

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2003

IMPLEMENTATION DATE: October 1, 2003

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

II. REVISIONS:

Chapter	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
13	**4 -** When to Develop New/Revised LMRP		
	5.1 - Coverage Provisions in LMRPs		
	6 - Contractor Medical Director (CMD)		
	7 - LMRP Development Process		
	7.4.4 - Final LMRP Web Site Requirements		
Exhibits	**Table of Contents**		**6.1 –**LMRP Submission/Requirements
	6 – LMRP Format		

III. FUNDING: Included in the 2003 BPR. Contractors should adjust their MR strategies as needed to accomplish these activities.

IV. ATTACHMENTS:

X Business Requirements Document
X Manual Instruction
__ Confidential Requirements
__ One Time Special Notification

Business Requirements

Pub. 100-08	Transmittal: 44	Date: 07-25-03	Change Request 2592

I. GENERAL INFORMATION

A. Background: In an effort to ensure that all beneficiaries and providers have easy access to Medicare's local coverage, coding and Medical Review related billing rules, CMS has developed the Medicare Coverage Database. The database currently houses all contractors' Local Medical Review Policies (LMRPs).

B. Policy: This transmittal describes the requirements contractors must follow when entering LMRPs to the Medicare coverage on (www.cms.hhs.gov/coverage.) This transmittal includes the LMRP requirements of the transmittal AB-02-098 (CR 2238). A separate transmittal will be issued at a later time that will manualize the articles/FAQ requirements from PM AB-02-098 (CR 2238).

C. Provider Education: No provider education is needed.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
Ch 13, Sec 6, Requirement #1	Contractors must cease emailing final LMRPs to Julie Berkey.	All contractors and PSCs with LMRP responsibilities
Ch 13, Sec 6 Requirement #2	Contractors must keep the Medicare coverage database up to date by adding new LMRPs, editing existing LMRPs, and archiving retired LMRPs.	All contractors and PSCs with LMRP responsibilities
Ch 13, Sec 6 Requirement #3	Contractors must use the required Exhibit 6 format for all LMRPs	All contractors and PSCs with LMRP responsibilities
Ch 13, Sec 4, Requirement #4	The existing requirement for contractors to update LMRPs within 120 days of publication of HCPCS and ICD-9-CM changes is being extended until the database conversion is completed (5/1/03).	All contractors and PSCs with LMRP responsibilities
Ch 13, Sec 7.4.4 Requirement #5	Requires contractors to develop a mechanism for ensuring the accuracy of the information entered into the Medicare Coverage Database.	All contractors and PSCs with LMRP responsibilities

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change
Chapter 13, Section 4, When To Develop New/Revised LMRP	Changes www.lmrp.net to Medicare Coverage Database**.** Encourages contractors to retire LMRPs that are no longer used for prepay, postpay, or educational purposes.
Chapter 13, Section 5.1, Coverage Provisions in LMRPs	Deletes the reference to the Program Safeguard Contractor Statement Of Work.
Chapter 13, Section 7, LMRP Development Process	Changes www.lmrp.net to Medicare Coverage Database.
Chapter 13, Section 7.4.4, Final LMRP Web Site Requirements	Changes www.lmrp.net to Medicare Coverage Database. Explains when the Medicare Coverage Database will become available and what the Database will contain.
Exhibit 6, LMRP Format	Revised to match the Medicare Coverage Database requirements.
Exhibit 6.1, LMRP Submission/Requirements	Deleted.

V. CMS Contacts

Pre-Implementation: Casey Hinson (410) 786-9513 or Melanie Combs (410) 786-7683

Post-Implementation: Casey Hinson (410) 786-9513 or Melanie Combs (410) 786-7683

Medicare Program Integrity Manual

Chapter 13 - Local Medical Review Policy

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4 - When To Develop New/Revised LMRP - (Rev. 44, 07-25-03)

The use of a LMRP helps avoid situations in which claims are paid or denied without a provider having a full understanding of the basis for payment and denial.

A -- Contractors MUST Develop New/Revised LMRP

Contractors must develop LMRPs when they have identified a service that is never covered under certain circumstances and wish to establish automated review in the absence of an NCD or coverage provision in an interpretive manual that supports automated review.

B -- Contractors MAY Develop New/Revised LMRP

Contractors may develop LMRPs when any of the following occur:

- *A* validated **widespread problem** demonstrates a significant risk to the Medicare trust funds (identified or potentially high dollar and/or high volume services); See Chapter 3,§ 2A, Error Validation Review, for an explanation of the problem validation process. Multi-state contractors may develop uniform LMRP across all its jurisdictions even if data analysis indicates that the problem exists only in one state.

- *A* LMRP is needed to assure **beneficiary access** to care.

- *A* contractor has assumed the LMRP development **workload of another contractor** and is undertaking an initiative to create uniform LMRPs across its multiple jurisdictions; or is a **multi-state contractor** undertaking an initiative to create uniform LMRP across its jurisdiction; or

- ***F*requent denials** are issued (following routine or complex review) or frequent denials are anticipated.

C -- Contractors Must REVIEW LMRP

Although the LMRPs that appear on the contractor's website are the "official" LMRPs for legal purposes, contractors must ensure that the LMRPs appearing on the contractor's LMRP website and the LMRPs appearing in the Medicare Coverage Database are identical. Contractors are encouraged to make use of the Medicare Coverage Database "Export to HTML" feature to assist in this effort.

Within 90 Days

Contractors must review and appropriately revise affected LMRP within 90 days of the publication of program instruction (e.g., Program Memorandum, manual change, etc.) containing:

- *A* new or revised NCD*;*
- *A* new or revised coverage provision in *an* interpretive manual*; or*
- *A* change to national payment policy*.*

Within 120 Days

The Medicare Coverage Database will notify contractors of each LMRP that is affected by an update (major or minor) to a HCPCS code or ICD-9-CM code.

Major changes include the deletion of a code listed in an LMRP. The database will not automatically make any LMRP revisions based on major changes.

Minor changes include wording changes to a HCPCS or ICD-9-CM code descriptor or the addition of a new code that falls within the range of codes listed in a contractor's LMRP. For each minor change, the Medicare Coverage Database will incorporate the change into a revised LMRP which will be placed in "to be reviewed" status.

Contractors must review and *approve and/or* appropriately revise affected LMRP within 120 days of *the date of this notification. Contractors must revise the effective date, revision number, and the revision history on all revisions due to major HCPCS and ICD-9-CM changes. Contractors need not revise the effective date, revision number and revision history on revisions due to minor HCPCS changes. Contractors must ensure that corresponding changes are made to the LMRPs appearing on the contractor's LMRP websites.*

NOTE: The Medicare Coverage Database will only alert contractors to the existence of new codes if the new code falls within a code range listed in the LMRP.

Annually

Effective October 2001, to ensure that all LMRPs remain accurate and up-to-date at all times, at least annually, contractors must review and appropriately revise LMRPs based upon CMS NCD, coverage provisions in interpretive manuals, national payment policies

and national coding policies. If an LMRP has been rendered useless by a *new/revised* national policy, *the LMRP* must be retired. This process must include a review of the *LMRPs in the Medicare Coverage Database* and on the contractor's website.

Contractors should consider retiring LMRPs that are no longer being used for prepay review, post pay review or educational purposes. For example, contractors should consider retiring LMRPs for outdated technology with no claims volume.

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5.1 - Coverage Provisions in LMRPs - (Rev. 44, 07-25-03)

A service may be covered by a contractor if it meets all of the following conditions:

- It is one of the benefit categories described in title XVIII of The Act;
- It is not excluded by title XVIII of The Act other than 1862(a)(1); and
- It is reasonable and necessary under 1862(a)(1) of *T*he Act.

A - Benefit Category

In order to be covered under Medicare, a service must be one of the benefits described in title XVIII of the Act and it must meet the definition of that benefit category listed in CMS's Manual, e.g., (See MIM, §3101ff).

B - Statutory Exclusions on Grounds Other Than Section 1862(a)(1)

In order to be covered under Medicare, a service must not be excluded by title XVIII of the Act, **other than** by §1862(a)(1). Such exclusions include, but are not limited to, routine physical checkups, immunizations, cosmetic surgery, hearing aids, eyeglasses, routine foot care for certain patients, and most dental care.

C - Reasonable and Necessary

In order to be covered under Medicare, a service must be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LMRP for the service is considered reasonable and necessary under 1862(a)(1). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and

- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and/or furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative.

There are several exceptions to the requirement that a service be reasonable and necessary for diagnosis or treatment of illness or injury. The exceptions appear in the full text of §1862(a)(1) and include but are not limited to:

- Pneumococcal, influenza and hepatitis B vaccines are covered if they are reasonable and necessary for the prevention of illness;
- Hospice care is covered if it is reasonable and necessary for the palliation or management of terminal illness;
- Screening mammography is covered if it is within frequency limits and meets quality standards;
- Screening pap smears and screening pelvic exam are covered if they are within frequency limits;
- Prostate cancer screening tests are covered if within frequency limits;
- Colorectal cancer screening tests are covered if within frequency limits; and
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an interlobular lens.

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6 - LMRP Format - (Rev. 44, 07-25-03)

All contractor LMRPs must be listed in the Medicare Coverage Database. Any newly developed policies after February 1, 2001 must use the standard format listed in Exhibit 6.

All LMRPs must be *posted on the contractor's website* in HyperText Markup Language (HTML). *The Medicare Coverage Database will have a feature that will allow a contractor to "export to HTML" a file of a recently entered LMRP.* Contractors may alter the appearance of the HTML file to meet their own website needs, e.g., change the background color.

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7 - LMRP Development Process - (Rev. 44, 07-25-03)

When a new or revised LMRP is needed, contractors do the following:

- Contact the CMD facilitation contractor, other contractors, the local carrier or intermediary, the DMERC (if applicable), *the Medicare Coverage Database* or QIOs (formerly PROs) to inquire if a policy which addresses the issue in question already exists;
- Adopt or adapt an existing LMRP, if possible; or
- Develop a policy if no policy exists or an existing policy cannot be adapted to the specific situation.

The process for developing the LMRP includes developing a draft LMRP based on review of medical literature and the contractor's understanding of local practice.

A -- Multi-State Contractors

A contractor with LMRP jurisdiction for 2 or more states is strongly encouraged to develop uniform LMRP across all its jurisdictions. However, carriers must continue to maintain and utilize CACs in accordance with §*8* below.

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7.4.4 - Final LMRP Web Site Requirements - (Rev. 44, 07-25-03)

A -- Final LMRP on the Contractor Web Site

Contractors must post all final LMRPs on their Web Site. Every contractor website must contain all final LMRPs for that contractor. The number of *active* LMRPs *in the Medicare Coverage Database* should equal the number of final LMRPs on the contractor Web Site.

Contractors who are an intermediary and a carrier within the same corporation must have separate Web pages for the LMRPs. Contractors must notify all providers via a bulletin

article of the contractor LMRP Web address. *If a c*ontractor *becomes aware of a provider without web access, the contractor* must advise providers without access to the Web *by sending them a* bulletin *advising them* to request a hard copy of the LMRP.

B -- Final LMRPs *in the Medicare Coverage Database*

The public can access the Medicare Coverage Database at **www.cms.hhs.gov/coverage**.

Contractors must update *the Medicare Coverage Database* when they issue a new or revised LMRP *or retire an existing LMRP.* Contractors must *enter* new final LMRPs *in*to *the Medicare Coverage Database* no later than 2 business days after the start of the notice period. *Contractors must enter revisions to final LMRPs into the Medicare Coverage Database no later than 2 business days after the revision is published on the contractor's website. PSCs tasked with developing new/revised LMRPs are responsible for maintaining all LMRPs in the Medicare Coverage Database.*

Contractors must ensure that no draft LMRPs appear *in the Medicare Coverage Database*.

Contractors must develop a mechanism for ensuring the accuracy of the information entered into the Medicare Coverage Database. This mechanism must include, at a minimum, a process by which data that is entered into the database is reviewed and verified for accuracy within 2 days of appearing to the public on the web.

Medicare Program Integrity Manual

Exhibits

Table of Contents
(Rev. 44, 07-25-03)

1 - Definitions
3 - Description of CAC Members
- 3.1 - Physicians
- 3.2 - Clinical Laboratory Representative
- 3.3 - Beneficiaries
- 3.4 - Other Organizations

4 - Reliable Information
5 - Background Information for Contractor Staff When IRP is Questioned
- 5.1 - Reward Eligibility Notification Letter
- 5.2 - Reward Claim Form
- 5.3 - How to Use the IRP Tracking System
- 5.4 - Section I: Pending Case List Screen
- 5.5 - Section II: Pending Case List by Contractor Screen
- 5.6 - Section III: New Case
- 5.7 - Section IV: Closed Case List
- 5.8 - Section V: Closed Case List by Contractor
- 5.9 - Section VI: Report Menu

6 – Exhibit 6 – LMRP Format
7 - Sample Letter for On-Site SVRS Reviews
- 7.1 - Attachment to Letter for Provider Site SVRS Reviews
- 7.2 - Intermediary SVRS Review Procedures Using Statistical Sampling for Overpayment Estimation (Type 2)
- 7.3 - Select SVRS Period To Be Reviewed and Composition of Universe
- 7.4 - Select Sample
- 7.4.1 - Select Sample Design
- 7.4.2 - Select Sample Size and Claims to Include
- 7.4.3 - Document Universe and Frame
- 7.4.4 - Actions After Provider and Sample Have Been Selected
- 7.4.4.1 - File Compilation and Provider Notification of the Review
- 7.5 - Exhibit-Sample Letter--Request For Medical Records
- 7.6 - Exhibit: Part A Sample Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments
- 7.6.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments
- 7.7 - Exhibit: Part B Sample Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments
- 7.7.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the SVRS Results, and Request Repayment of Overpayments

8 - Recovery of Overpayment and Corrective Actions
9 - Projection Methodologies and Instructions for Reviews of Home Health Agencies
10 - Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs)
11 - Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS)
12 - Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs)
13 - Postpayment CMR Summary Report Format Example
14 - Contractor Denials 1862(a)(1) of the Act
    14.1 - Section 1879 of the Act Determination - Limitation of Liability
    14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment
    14.3 - Section 1842(l) of the Act Determination - Refunds to Beneficiary
    14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews
15 - Consent Settlement Documents
16 - Model Suspension of Payment Letters
    16.1 - OIG/OI Case Referral Fact Sheet Format
    16.2 - OIG/OI Case Summary Format
17 - Medicare Fraud Unit Managers
18 - Medicare Fraud Information Specialist (MFIS)
19 - Durable Medical Equipment Regional Carrier Program Integrity Coordinators (PICs)
20 - Durable Medical Equipment Regional Carrier Jurisdictions
21 - Regional Home Health Intermediaries/Jurisdictions
22 - Office of Inspector General, Office of Investigations Field Offices
23 - PIM Acronyms
24 - CMS Forms 700 and 701
25 - Form Letter for DOJ Requests
26 - DOJ Report (Excel Spreadsheet)
27 - National Medicare Fraud Alert
28 - Restricted Medicare Fraud Alert
29 - Description of Items Contained on Form CMS-485
30 - Treatment Codes
31 - Form CMS-485, Home Health Certification and Plan of Care

Exhibit 6 - LMRP Format (Rev. 44, 07-25-03)

Contractors must ensure that all new LMRPs are written in the following format. *Contractors must also ensure that all LMRPs revised after 5/1/2003 are written in the following format. C*ontractors are encouraged to format all revised policies as follows.

Contractors may *display on their websites* column and headings instead of using the table format as shown below but the LMRP content must include all the same information.

The column "Mandatory During Conversion" indicates whether the field is required for conversion from www.LMRP.net to the Medicare Coverage Database.

The column "Mandatory After Conversion" indicates whether the field is required for all new and revised LMRPs after 5/1/2003.

Field Name	***Mandatory During Conversion? (7/24/2002 – 5/1/2003)***	***Mandatory After Conversion? (5/1/2003 - Forward)***	***Field Description***	***Type of Field***
Contractor Name	*Mandatory*	*Mandatory*	*The name of the Contractor.*	*Picklist (Select one)*
Contractor Number	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*The unique identifier assigned to a Contractor by CMS.*	*Automatic Fill-in*
Contractor Type	*Mandatory*	*Mandatory*	*The type of contractor responsible for the policy.*	*Picklist (Select one)*
LMRP Database ID Number	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*A unique identification number assigned to an LMRP by the LMRP Data Entry System.*	*Automatic Fill-in*
LMRP Version Number	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*A unique identification number assigned to an LMRP, each time it is edited, by the LMRP Data Entry System*	*Automatic Fill-in Integer beginning with an "L"*
LMRP Title	*Mandatory*	*Mandatory*	*A* one-line description of the topic or subject matter of the policy.	*Text*
Contractor's Policy Number	*Optional*	*Optional*	*The* unique policy identifier *designated by the policy author to an LMRP.*	*Text*
AMA CPT Copyright Statement	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*The* copyright statement in each LMRP: "CPT codes, descriptions and other data only are copyright 200*2* American Medical Association (or such other dat*e* of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."	*Automatic Fill-in*

Field Name	*Mandatory During Conversion? (7/24/2002 – 5/1/2003)*	*Mandatory After Conversion? (5/1/2003 - Forward)*	*Field Description*	*Type of Field*
CMS National Coverage Policy	*Optional*	*Optional*	*The* associated CMS National Coverage Determination or Coverage Provision in an Interpretive Manual. A description if a National Coverage Determination or Provision is being expanded, *adds* greater clarification and/or codes.	*Memo*
Primary Geographic Jurisdiction	*Mandatory*	*Mandatory*	*The* geographical area *[i.e., state(s)]* to which the *policy* appl*ies.*	*Picklist (Select one or more)*
Secondary Geographic Jurisdiction	*Optional*	*Mandatory (for FIs and RHHIs who have a secondary geographic jurisdiction)*	*The* secondary geographic *area [i.e., state(s)]* for those facilities *(primarily for chain organizations)* that nominate a FI or RHHI to process their claims.	*Picklist (Select one or more)*
Oversight Region	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*T*he *CMS* region that *has* oversight *responsibility for a CMS* contractor's *LMRP development process even though that contractor may operate in more than one CMS region.*	*Automatic Fill-in*
CMS Consortium	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*T*he consortium *associated with the Oversight Region.*	*Automatic Fill-in*
DMERC Region LMRP Covers	*Mandatory (System will auto-fill)*	*Mandatory (System will auto-fill)*	*T*he region that *the DMERC* policy covers.	*Automatic Fill-in*
Original Policy Effective Date	*Mandatory*	*Mandatory*	*T*he date *the policy originally went into* effect. *Also includes optional descriptive text indicating what the effective date refers to.*	*Date (mm/dd/yyyy)*
Entire Policy Ending Date	*Optional*	*Mandatory (System will auto-fill)*	The date the *entire* policy *is no longer in effect (i.e., policy retired).*	*Automatic Fill-in*

Field Name	*Mandatory During Conversion? (7/24/2002 – 5/1/2003)*	*Mandatory After Conversion? (5/1/2003 - Forward)*	*Field Description*	*Type of Field*
Revision Effective Date	*Optional*	*Mandatory* for revised policies	*T*he date *on* which a revision *of the policy went into effect* or became effective*. Also includes optional descriptive text indicating what the effective date refers to: -for services performed on or after this date -for claims received on or after this date.*	*Date (mm/dd/yyyy)*
Revision Ending Date	*Optional*	*Mandatory (System will auto-fill)*	*The date on which a revision of the policy is no longer effective (i.e., subsequent Revision Effective Date entered or policy retired).*	*Automatic Fill-in*
LMRP Abstract	*Mandatory*	*Mandatory*	*Prior to 2/1/03:* Characterize or define the service and explain how it operates or is performed. Use this filed to enhance the policy subject. *All new/revised LMRPs entered into the database after 2/1/03: Enter here a brief explanation of the LMRP.*	*Memo*
Indications and Limitations of Coverage and/or Medical Necessity	*Optional*	*Mandatory*	*T*he general indications for which a service is covered and/or considered reasonable and necessary. Also, the limitations such as least costly alternative reductions.	*Memo*
CPT/HCPCS Section	*Optional*	*Mandatory*	*T*he CPT/HCPCS section *(Heading Levels 1 and 2) that applies to* the policy*.*	*Memo*
Benefit Category	*Mandatory*	*Mandatory*	*The benefit category that applies to the policy.*	*Picklist (Select one or more)*
Coverage Topic	*Mandatory*	*Mandatory*	*The coverage topics (from the 82 topics that are currently listed in the www.medicare.gov Your Medicare Coverage Database)*	*Picklist (Select one or more)*

Field Name	*Mandatory During Conversion? (7/24/2002 – 5/1/2003)*	*Mandatory After Conversion? (5/1/2003 - Forward)*	*Field Description*	*Type of Field*
			that apply to the policy.	
Type of Bill Code	*Mandatory (for FIs and RHHIs)*	*Mandatory (for FIs and RHHIs)*	*T*he related type of bill codes for the service. Type of Bill Code *applies only* to FIs and RHHIs.	*Picklist (Select one or more)*
Revenue Codes	*Mandatory (for FIs and RHHIs)*	*Mandatory (for FIs and RHHIs)*	*T*he related revenue code *(Version I)* for the service.	*Code List (Enter one or more)*
CPT/HCPCS Codes	*Mandatory (for FIs, Carriers, and DMERCs)*	*Mandatory (for FIs, Carriers, and DMERCs)*	*T*he related *CPT/*HCPCS codes and any appropriate modifiers for the service. *Contractors may list NOC codes in this field.*	*Code List (Enter one or more)*
Does the "CPT 30% Rule" apply?	*Mandatory*	*Mandatory*	*The short descriptor should be displayed for a CPT code if more than 30% of the CPT section codes are used in the LMRP. Otherwise, the long CPT descriptors should be displayed. Possible options for this field include Yes, No, and Undefined.*	*Radio button (Y/N/ Undefined)*
Not Otherwise Classified (NOC)	*Optional*	*Optional*	*T*he NOC code and the classified codes associated with the text. *This field will be eliminated in the future. Contractors should list NOC codes in the "CPT/HCPCS Codes" field instead.*	*Code List (Enter one or more)*
ICD-9-CM Codes that Support Medical Necessity	*Mandatory (for FIs, Carriers, and RHHIs)*	*Mandatory (for FIs, Carriers, and RHHIs)*	The ICD-9-CM codes for which the service is general covered, and/or considered medically necessary. A policy can be associated with one or many diagnosis codes.	*Code List (Enter one or more; may enter ranges)*
Diagnoses that Support Medical Necessity	*Optional*	*Optional*	In the absence of ICD-9-CM codes, the medical diagnoses that supports the medical necessity for the service.	*Memo*
ICD-9-CM Codes that DO NOT	*Optional*	*Optional*	*T*he ICD-9-CM codes that do not support the medical necessity of the service.	*Code List (Enter one or more; may*

Field Name	*Mandatory During Conversion? (7/24/2002 – 5/1/2003)*	*Mandatory After Conversion? (5/1/2003 - Forward)*	*Field Description*	*Type of Field*
Support Medical Necessity				*enter ranges)*
Diagnoses that DO NOT Support Medical Necessity	*Optional*	*Optional*	In the absence of ICD-9-CM codes, the medical diagnoses that do not support medical necessity of the service.	*Memo*
Reasons for Denials	*Optional*	*Mandatory*	The specific situations under which a service will **always** be denied. Also, list the reasons for denial such as investigational, cosmetic, routine screening, dental, program exclusion, otherwise not covered, or never reasonable and necessary.	*Memo*
Noncovered ICD-9-CM Codes	*Optional*	*Optional*	*T*he ICD-9-CM codes that are never covered.	*Code List (Enter one or more; may enter ranges)*
Noncovered Diagnos*e*s	*Optional*	*Optional*	*T*he medical diagnoses that are not covered.	*Memo*
Coding Guidelines	*Optional*	*Optional*	*T*he relationships between codes. *D*efine how services are billed. Include information about the units of service, place of service, HCPCS modifiers, etc. An example of an appropriate coding technique is "use CPT xxxxx to bill this service rather than yyyyy."	*Memo*
Documentation Requirements	*Optional*	*Optional*	Specific information from the medical records or other pertinent information that would be required to justify the service.	*Memo*
Appendices	*Optional*	*Optional*	*A text narrative of appendices for the LMRP that is searchable. Future enhancements will allow*	*Memo*

Field Name	*Mandatory During Conversion? (7/24/2002 – 5/1/2003)*	*Mandatory After Conversion? (5/1/2003 - Forward)*	*Field Description*	*Type of Field*
			attachment of forms, graphics, and tables.	
Footnotes	*Optional*	*Optional*	*This field contains the footnotes for the LMRP.*	*Memo*
Utilization Guidelines	*Optional*	*Optional*	*T*he information concerning the typical or expected utilization for the service.	*Memo*
Other Comments	*Optional*	*Optional*	*Other* information not included in other field*s*.	*Memo*
Sources of Information and Basis for Decision	*Optional*	*Mandatory for new policies*	*T*he information sources, pertinent references (other than national policy) and other clinical or scientific evidence reviewed in the development of this policy. Cite, for example: Agency for Health Care Policy and Research (AHCPR) guidelines, position papers released by specialty societies or other sources used during the development of this policy. Also, include the basis for *the* coverage decision and references that may apply.	*Memo*
Advisory Committee *Meeting* Notes	*Optional*	*Optional*	*T*he meeting date on which the policy was discussed with the advisory committee *and/or any notes from the meeting.*	*Memo*
Start Date of Comment Period	*Optional*	*Optional*	*T*he date th*is version of the* LMRP was released for comment.	*Date (mm/dd/yyyy)*
End Date of Comment Period	*Optional*	*Optional*	*T*he date the comment period ended.	*Date (mm/dd/yyyy)*
Start Date of Notice Period	*Optional*	*Mandatory*	*T*he date the medical community was notified *of* th*is version of the* LMRP.	*Date (mm/dd/yyyy)*
Revision History	*Optional*	*Mandatory (for revisions)*	*T*he revision number *(unique identifier created by a*	*Memo*

Field Name	***Mandatory During Conversion? (7/24/2002 – 5/1/2003)***	***Mandatory After Conversion? (5/1/2003 - Forward)***	***Field Description***	***Type of Field***
Number			*Contractor).*	
Revision History *Explanation*	*Optional*	*Mandatory (for revisions)*	*A*n explanation of the revisions made to the policy.	*Memo*
Disclaimer Specialty Name	*Optional*	*Optional*	*The system will auto-fill the following text when the LMRP is viewed or printed*: "This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with representatives from [fill in appropriate specialty name]."	*Memo*
Notes	*Optional*	*Not Applicable after the Transition*	*This field is for Fu Associates data entry users to enter questions that they had while entering the LMRP so that contractors can focus on these areas in their review process. Data entry users will also have the capability to include codes that were not accepted in previous field because they are invalid.*	*Memo*

Please note that not all fields that appear in the Coverage Database Data Entry System will appear in the Medicare Coverage Database "front end" search results.