Program Memorandum Carriers

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

Transmittal B-02-078 **Date: NOVEMBER 1, 2002**

CHANGE REQUEST 2433

SUBJECT: Medical Review (MR) Progressive Corrective Action (PCA)--ACTION

Standard systems should not expend more than 1000 hours for the April 2003 release. Standard systems should make as much progress toward meeting requirements of this CR as they can within those limits. Carriers should work with standard systems to develop the PCA module. If necessary, contractors may revise their medical review strategy to allow work on this CR. CMS will issue additional Program Memoranda (PMs) for continued work on PCA.

This PM provides additional detail and requirements to support Chapter 3, §§ 1-4 of the Program Integrity Manual (PIM) concerning MR PCA. The PIM instructs all contractors to implement PCA to the extent possible. This PM requires that contractors (including Program Safeguard Contractors that have assumed carrier or intermediary medical review responsibilities) using the Viable Information Processing System (VIPS) standard systems (i.e., VIPS Medicare System (VMS) and Durable Medical Equipment Regional Contractor (DMERC) system) or the Electronic Data System Medicare Contractor System (EDS-MCS), contractor data centers supporting the VIPS or EDS-MCS standards systems, and VIPS and EDS-MCS standard systems maintainers make changes for implementation of the PIM Chapter 3, §§ 1-4 by the implementation date of this PM. Systems changes include, but are not limited to developing the following functions and including them in the standard systems:

- Select a predetermined percentage OR number of claims for prepayment medical review,
- Suspend claims in the sample for prepayment review, and
- Provide a dataset containing information needed to calculate error rates.

Contractors must ensure that all sections of the PIM, Chapter 3, §§1-4, are fully implemented by the implementation date of this PM. Contractor data centers must insure that the module that this PM requires is ready for Medicare contractors to use by the implementation date. The VIPS and EDS-MCS standard systems maintainers must develop and make available the module described below in time for contractors to begin using the system by the implementation date.

APPROACH TO IMPLEMENTING PCA

This PM requires that VIPS modify the VIPS-VMS and DMERC standard systems and that EDS modify the MCS-EDS standard system to allow contractors to:

- Select a predetermined percentage OR number of claims for prepayment medical review;
- Draw a representative sample prepayment (utilizing systematic random sampling, i.e., drawing claims at a fixed interval after a random start -- Note that drawing a systematic sample prepayment eliminates the need to accumulate all claims in the universe before the sample is drawn. In a systematic sample, claims are drawn "on the fly" at a fixed interval after a random start);
- Extract the sample for (1) all claims or (2) allow users to draw a sample based upon a criteria set containing any three of the 15 criteria below:

1. CPT/HCPCS codes - individual, ranges, and sets of procedure codes that are single and ranged;
2. CPT/HCPCS plus Modifiers – individual or ranges;
3. Modifiers – individual or ranges;
4. ICD-9 codes – individual or ranges;
5. Provider Ids;
6. Provider specialty – individual or ranges;
7. Dates of service;
8. Referring provider ID;
9. Place of service;
10. Type of service;
11. Beneficiary ID;
12. Allowed amount – where this can be done prepayment;
13. Number of services per period of time – where this can be done prepayment;
14. EOMB's /MSNs where this can be done prepayment; and
15. Billed amount.

The system must allow a user to specify between one and seven different individual values and/or ranges of values for each criterion. It must allow a user to exclude no pay bills, i.e., bills submitted to demonstrate that Medicare will not cover services included on the bill. A user must be able to "and" as well as "or" criteria listed above.

- Allow users to exclude from the sample specific providers for a service specific review;
- Sample from either a subset (e.g., a specific service for a specific provider) or a universe of claims (e.g., all claims for a specific provider) or both (e.g., all claims for one provider and only a sample for a specific service for a second provider);
- Draw the sample at a user-specified rate (between 1% – 100%) and (1) sample at that rate for a user-specified period (from one week to 6 months) OR (2) for a user specified maximum number of claims;
- Provide for contractors applying up to 700 prepayment selection criteria sets; and
- Sample by any individual or combination of types of provider number available in the standard system; i.e., billing, rendering, referring, or attending provider number; and allow use of either the provider ID number (PIN) or the unique physician identification number (UPIN) to identify the provider. Medicare contractors must be able to select the type of number they wish to use for a sample.

<u>Suspend claims in the sample for prepayment review</u>

- Suspend claims prepayment, possibly using existing software such as SuperOp [The system does not have to suspend the claim as soon as it is selected. The system may flag the claim and suspend it later in the processing cycle. However, the module must insure that the claim is not paid until PCA review is completed even if the provider resubmits the claim.];
- Interface with the standard system record request module (i.e., the system module that the contractor uses to send a letter to request additional documentation before a claims is paid, e.g., the VMS Additional Documentation System) and identify claim by claim, pay/no pay decisions [The system should bundle PCA documentation requests with those for other edits that result in suspension for additional documentation; that needs to be done to minimize provider burden.], and

- The prepayment module must select a claim before the contractor does any manual review on the claim but after the standard system has initiated automated processing. VIPS has indicated it can

draw the sample after online edits are completed and EDS has indicated it can draw the sample after edits and before audits. That will meet the requirements of this PM. We wish to select a claim before it goes to development.

Provide needed information to track providers

1) Produce statistics that compare the sample universe and the sample on the following: HCPCS, submitted services per day, submitted dollars per day, specialty, and PIN or UPIN.
2) Provide the following information needed to calculate error rates and variances (See Attachment A for definitions of information):
   a) Criteria ID;
   b) Provider ID;
   c) Sum of the HCPCS code fee schedule amounts for submitted HCPCS for the criteria set;
   d) Sum of the allowed amounts for the criteria set;
   e) Number of services submitted for the criteria set;
   f) Number of services denied for the criteria set;
   g) Number of claims in the sample;
   h) Sampling rate;
   i) Sum of the allowed amounts times the error rate times the HCPCS code fee schedule amounts for submitted HCPCS;
   j) Sum of each allowed amount times itself; and
   k) Sum of each submitted HCPCS code fee schedule amount times itself.
3) Provide the following information needed to evaluate Evaluation and Management Code reviews (do only for studies that include an E&M code as one of the criteria in the criteria set and provide one line of information for each different combination of submitted (the code that is the criteria) and allowed HCPCS codes (See Attachment A for definitions of information):
   a) Criteria ID;
   b) Submitted HCPCS code;
   c) Allowed HCPCS code; and
   d) Number of services for which the submitted HCPCS code recoded to the allowed HCPCS code.
4) Provide the following information needed identify claims in the sample (provide a line for each claim in the sample. See Attachment A for definitions of information):
   a) Criteria ID and
   b) ICN of the claim.

The information must be available to users in electronic form at all times as of the close of the previous business day.

The system must perform the functions required above for both probe and regular PCA prepayment review.

Where existing systems duplicate PCA requirements, standard system maintainers should provide for use of the existing systems.

In developing the module, the standard system maintainer should use existing capabilities where possible. Those capabilities might include suspension procedures used with system edits, manual

entry of the results of manual review, and generation of beneficiary and provider notices. Where development would be more efficient, functions may be included in separate modules. For example, the maintainer could develop a service specific and a provider specific module. CMS encourages use of existing modules such as SuperOp.

The system will process only information that is on a claim. If a claim does not have sufficient information to identify it for selection, the system will not be able to select it. The impact of that fact on the representativeness of the sample cannot be determined. However, all claims that do not have sufficient information to allow processing, i.e., a missing provider number, are returned to the submitter for resubmission. Once the claim is correctly resubmitted, the module must include the claims in the universe and select the claim if it meets criteria in the sample criteria set. Therefore, all claims that are correctly submitted will have an equal chance of submission -- a requirement for a representative, unbiased sample.

This PM does not add new pricing files or edits. Coinsurance and deductibles do not need to be considered in complying with this requirement; allowed amount includes coinsurance and deductibles. Linkages or modifications to Pricer, OCE, and OPPS are not required. PS&R will not be affected.

No new EOMBs and MSNs must be generated because of this application; the activities required by this PM do not include claims denials. You will make denials as part of the existing review process and you can use EOMBs and MSNs you use in prepayment review for the reviews done on the samples selected for prepayment PCA. You do not need to include a statement regarding PCA in remittance advice regarding a claim you review for PCA.

Standard systems maintainers must develop the module in time for data centers to install and test the module on or before the implementation date. CMS defines contractor data center implementation of the module as the data center insuring that the module is available and ready for use by each Medicare contractor they serve by the implementation date. Contractors must begin performing all components of PCA by the implementation date.

***Effective* and *implementation date* to be determined for the Part B and DMERC VIPS and MCS standard systems, Part B and DMERC data centers using VIPS and MCS standard systems, and Part B carriers and DMERCs using VIPS and MCS standard systems. Contractors on the HCFA Part B Standard System (HPBSS) will begin implementation of PCA when they transition to the MCS system. CMS will issue additional PMs for continued work on PCA for carriers. We will issue additional PMs to establish effective dates for Part A standard systems and Fiscal Intermediaries. All contractors are required to have implemented PCA to the extent possible without the module required by this PM by October 1, 2000.**

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact John Stewart on (410) 786-1189.

Attachment

ATTACHMENT A
FORMAT FOR THE PCA TRANSFER FILE

ITEM	ITEM	DESCRIPTION	ST	END	LEN	TYPE
	CRITERIA ID (1-700)	An unique ID number corresponding to the criteria set for the study.	1	3	3	Numeric
2a						
2b	PROVIDER ID	A PIN or UPIN used as a criteria for the study. Enter only if Provider ID is one of the criteria for the study. One record should be created for each Provider ID in the study. Right justify	4	23	20	Alpha - numeric
2c	SUM OF RATES FOR SUBMITTED HCPCS	Sum of the Medicare fee schedule amounts for submitted HCPCS codes for the criteria set and provider ID combination, i.e., each combination of items 1, and 2. Calculate to two decimal places and put in the decimal. Do not put in commas or dollar signs.	24	36	13	Numeric
2d	SUM OF LOWER OF RATE FOR ALLOWED HCPCS OR SUBMITTED CHARGE	Sum of the lower of the Medicare fee schedule amount or submitted amounts for allowed HCPCS for the criteria set and provider ID combination, i.e., each combination of items 1 and 2. Calculate to two decimal places and put in the decimal. Do not put in commas or dollar signs	37	49	13	Numeric
2e	SERVICES SUBMITTED	Sum of the number of submitted services in the sample for each criteria set and provider type combination, i.e., each combination of items 1 and 2. Do not put in commas.	50	54	5	Numeric
2f	SERVICES DENIED	Sum of the number of services in the sample denied after PCA review for each criteria set and provider type combination, i.e., each combination of items 1, and 2. Do not put in commas.	55	59	5	Numeric
2h	NUMBER OF CLAIMS IN THE SAMPLE	The number of claims in the sample for each criteria set (item 1). Do not put in commas. This line should be the same for each line of the study.	73	76	4	Numeric
2g	SAMPLING RATE	The sampling rate for each criteria set (item 1), i.e., Number in Universe/Number in sample. Carry out to four decimal places. Field size includes the decimal. Do not put in commas. This number should be the same for each line of the study.	60	72	13	Numeric w decimal point

ATTACHMENT A
FORMAT FOR PCA TRANSFER FILE

2i	SUM OF ALLOWED TIMES SUBMITTED AMOUNTS	Sum of the allowed amount times the HCPCS code fee schedule amounts for submitted HCPCS - Sum of (A*S) where A= the line item amount used for item 4 and S=the line item amount used for item 3. Carry out to four decimal places. Field size includes the decimal. Do not put in commas. This number should be the same for each line of the study.	77	96	20	Numeric
2j	SUM OF ALLOWED DOLLARS SQUARED	Sum of the allowed dollars times itself - Sum of (A*A) where A= the line item amount used for item 4. Carry out to four decimal places. Field size includes the decimal. Do not put in commas. This number should be the same for each line of the study.	97	116	20	Numeric
2k	SUM OF THE SUBMITTED CHARGES SQUARED	Sum of the submitted dollars times itself - Sum of (S*S) where S= the line item amount used for item 3. Carry out to four decimal places. Field size includes the decimal. Do not put in commas. This number should be the same for each line of the study.	117	136	20	Numeric

FORMAT FOR THE E&M CODE FILE

ITEM	ITEM	DESCRIPTION	ST	END	LEN	TYPE
3a	CRITERIA ID (1-700)	An unique ID number corresponding to the criteria set for the study.	1	3	3	Numeric
3b	E AND M CODE FOR SUBMITTED HCPCS CODE (IF E AND M CODES ARE INCLUDED IN THE CRITERIA SET)	Enter only if an E&M Code is one of the criteria for the study. A submitted E&M code used as a criteria for the study. One line is needed for each Submitted - Allowed HCPCS code (E&M) outcome for the study.	4	8	5	Alpha - numeric
3c	E AND M CODE FOR ALLOWED HCPCS CODE (IF E AND M CODES ARE INCLUDED IN THE CRITERIA SET)	Enter only if an E&M Code is one of the criteria for the study. The allowed E&M code determined as part of the PCA study for the code in item 2. One line is needed for each Submitted - Allowed HCPCS code (E&M) outcome for the study	9	13	5	Alpha - numeric
3d	NUMBER OF SERVICES CHANGED	Number of services for each Submitted - Allowed HCPCS code (E&M) outcome for the study.				

ATTACHMENT A
FORMAT FOR THE ICN FILE

ITEM	ITEM	DESCRIPTION	ST	END	LEN	TYPE
4a	CRITERIA ID (1-700)	An unique ID number corresponding to the list of criteria for the study.	1	3	3	Numeric
4b	ICN SELECTED FOR THE SAMPLE	An ICN selected for PCA review by the system. Include a record for each ICN in the sample.	4	20	17	Alpha - numeric