CR 2916 Q&As

Q1. Could you explain what is intended by the requirements statement, "There could be multiple LMRPs ID numbers and/or multiple NCD numbers associated with each edit."? Our thought is that multiple LMRPs could be tied to a single edit or audit. Our proposed approach is that we will be able to flag the edit/audit with an LMRP number, flag individual procedure codes within an audit with an LMRP number, and be able to flag services meeting the criteria within the expert system with an LMRP number. Using this approach, depending upon the complexity of the edit/audit, an edit or audit could have virtually an unlimited number of LMRP/NCD numbers associated.

A1. Some contractors have reported to us that 2 or more policies could be associated with a single edit. The shared system must accommodate this need.

Q2. Does CMS believe that there will be the need to report multiple LMRPs on a single service? We do not believe this is necessary, since a service is truly denied for only one reason. Does CMS agree that on LMRP at the claim level and one LMRP for each detail is the correct approach?

A2. See A1.

Q3. If multiple LMRPs are to be applied to a single service, how many should be accommodated? In MCS, only one edit/audit is responsible for a service denial.

A3. For estimation purposes, the maintainers should assume that a single line item denial may be due to up to 4 policies (e.g., one LMRP and three NCDs, or four LMRPs, etc.).

Q4. Currently the provider SPR is a CMS specified format. The CMS will need to provide direction as to how this LMRP/NCD number is to be displayed on the SPR as the current remark code field is not large enough to accommodate a length of 11.

A4. The CMS will not specify how the work is to be done. The solution chosen by the maintainer must meet the requirements listed in the CR and meet the needs of all the users of that system. The proposed solution described by one of the maintainers on the 9/23 conference call seemed to both meet the CR requirements and meet the carriers' needs.

Q5. Will the remark codes at both header (claim level) and detail?

A5. For each item/service denied based on an LMRP or NCD, the beneficiary needs to know which LMRPs/NCDs caused the denial.

Q6. Will a glossary description on the SPR be required to indicate the title of the LMRP/NCD associated with this number?

A6. CMS/Program Integrity staff does not understand the question. This question should be raised verbally during one of the conference calls.

Q7. Does provider education need to be done to ensure the providers understand the new use of the remark code?

A7. CMS agrees.

Q8. Why are NCD's now being included in this CR?

A8. The lawsuit that generated the requirement for a generic LMRP message to appear on the beneficiaries MSN was limited to LMRPs. Thus, in order to satisfy the terms of the settlement agreement, we limited the first CR to only the items required by the settlement. Although not required by the settlement, we are now taking additional steps that we believe make sense to make beneficiaries aware of the reasons behind the denials they receive from Medicare.

Q9. NCD's are a big concern. How do we search and get the correct information to the beneficiaries when the CIM is not user friendly for our Customer Service Reps to use?

A9. All LMRPs and NCDs are now available in the Medicare Coverage Database (http://www.cms.hhs.gov/mcd).

Q10. Also, how do we do this if the section of the CIM is not yet manualized and the information is not in the CIM?

A10. Contractors should not be implementing NCD edits prior to the NCD being published.

Q11. Will the CIM database be incorporated into NGD for ease of use for CSRs?

A11. Yes.

Q12. We have LMRP's, which contain NCD guidelines, and there is a concern that we will not point to the correct LMRP or NCD. How will the system be automated to know which one to use when?

A12. Each contractor must know the reason behind each denial. Contractors probably have various ways of keeping track of this information. When the basis for the denial is an LMRP, the contractor will add the LMRP number to the edit. When the basis for the denial is an NCD, the contractor will add the NCD number to the edit. When the basis for the denial is both an LMRP and an NCD, the contractor will add both the LMRP and NCD numbers to the edit. When the edit results in a denial, the system will automatically pull the policy numbers listed by the contractor and insert those numbers into the MSN message. To the extent possible, contractors should consider separating NCDs from LMRPs.

Q13. How will the standard systems accommodate this request to auto-fill this information? Empire feels this will require a separate edit/audit for each LMRP and/or NCD and a separate denial message for each edit/audit. This is a huge volume of work not to mention a possible expansion of the number of edits/audits and denial messages to accommodate this request.

A13. Each contractor must know the reason behind each denial. CMS realizes that this CR will require work on the part of each contractor. For this reason, CMS released this CR months in advance to allow contractors sufficient time to complete this work.

Q14. The Call Center is concerned how copies of the NCDs will be available to them to send to the beneficiaries.

A14. Call Center staff should make use of the Medicare Coverage Database at www.cms.hhs.gov/mcd. Call center staff may refer callers to this site or may print from this site and mail to callers.

Q15. In the MCS system we have MCM instructions, which can become part of the LMRP. These are denied via the procedure code file and do not hit an edit or audit. For example, a code that is a status B on the MPFSDB will bundle and deny via the procedure code file not due to an edit/audit. How do these fit into this process, would an edit/audit have to be created?

A15. If the basis for the denial is the MPFSDB, then the basis for the denial is not an LMRP or NCD. No LMRP or NCD number needs to appear on the MSN in situations where the claim is denied based on a rule other than an LMRP or NCD.

Q16. When a telephone representative would receive a call for a copy of the LMRP, the number that would print on the MSN would not be the same as our internal LMRP numbers which would cause a great deal of confusion for the phone reps and the inquirer. The beneficiaries would not be able to go to our Web site and find the LMRP that is reference on their MSN.

A16. This is one of the primary reasons the Medicare Coverage Database (www.cms.hhs.gov/mcd) was created.

Q17. Currently we send out a copy of our LMRP from our system, not through the database. We would have to implement a process to go out to the database to print a copy of an LMRP or NCD to send out to the inquirer. Do you have any suggestions on making this an easy process for carriers?

A17. We encourage users to submit User Change Requests to their shared systems. Contractors are also welcome to send language to Julie Day (Jday@cms.hhs.gov) as CMS could include this requirement in a future CR.

Q18. Notice this is for beneficiary only. Wouldn't it be beneficial to do beneficiary and provider at the same time?

A18. The current Remit Advice format is incapable of accommodating "fill in the blank" or customizable messages. We first must change the record layout to allow this. Then in a few years, we can make the systems changes to allow these types of messages to be communicated to providers.

Q19. The LMRP and NCD's must be "auto-filled" into the new MSN message that is being required to print when claims finalize. This cannot be a manual process. Will the edit file be expanded to include a new field to identify the policy numbers?

A19. CMS/PI defers to the shared system maintainers to answer this one.

Q20. This CR only references suspense editing screens, the majority of HGSA claims go through and are auto-denied. Will MCS be able to pull the appropriate NCD or LMRP ID number from this auto-denial to the appropriate detail line level (not feasible as carriers maintain their own SCF/SCC files and have different edit/audit numbers associated with denials as well as different coverage for Local Policies)? This will cause major concerns and costs (FTE) to carriers especially if all claims would have to be suspended and reviewed so that the appropriate LMRP or NCD (if applicable) can be applied.

A20. All LMRP and NCD denials – whether automated denials or manual denials – must generate a message to the beneficiary informing them of the policy number associated with their denial. The share system must be developed in such a way to allow this to occur.

Q21. Additional costs to the carriers in order to ensure that qualified staff/personnel who are needed to make decisions especially from a Medical Review perspective are identifying the appropriate LMRP or NCD when claims are appealed from the back-end departments.

A21. Contractors should adjust their MR strategies as needed to perform this work.

Q22. Edits don't always carry to the MSG/AUD field if the claims go through auditing as well. Would the MCS system retain all of the edits and audits that the claim hits (which it does not display today) and then fill them into the MSN message? It would be hard to make a determination as to what caused the claim denial if it goes through both the edit and audit file and determine what ultimately caused the detail line of service to deny. What if the edit covers several policies? Are we going to list the policies? In order to make a true determination when a claim has denied for an NCD or an LMRP, edits and audits are not all viewable on the history audit trail. When claims would be denied, claim dumps would be necessary to accurately reflect all edits and audits to make a determination as to what actually caused the claim to deny.

A22. Contractors and shared systems must make whatever changes are necessary to properly notify beneficiaries of the reason behind the denials.

Q23. The MCS system is already up to two lines of information to be keyed (D1 and D2) for one reported line of service. The MCS system will require extensive system changes to allow a 11-digit field to be created and will impact all aspects of claims processing in addition to the internal file changes that will impact all carriers to ensure that we are in compliance with the mandated instructions in CR 2916. Again additional costs to the carriers to perform data entry, analysis, and testing which probably will require temporary personnel to be hired to assist with file maintenance and testing. If MCS opts for the detail claim fields, we would have to create a new third line to accommodate this request.

A23. Contractors should adjust their MR strategies as needed to perform this work.

Q24. The CR states that the beneficiaries will be notified of the specific LMRP and/or number(s). What about the provider?

A24. No provider notification is required in this CR. In a few years, CMS hopes to inform providers of the LMRP/NCD behind the denials. In the interim (and especially for services with a high error rate), contractors are encouraged to send providers “Denial Summary Letters” that let the provider know how many of their claims were denied based on which LMRP/NCD in the past month, quarter or year.

Q25. MCS user files will need to be expanded to accommodate new edits/audits/messages.

A25. Shared systems will need to make all changes necessary to implement this CR.

Q26. Will the Medicare Coverage Database interface with the MCS system?

A26. CMS/PI is not aware of any shared system request to interface with the Medicare Coverage Database.

Q27. The Medicare Coverage Database is only updated every two weeks. There is a possibility that a claim would deny for a new policy, the beneficiary would receive their MSN and the MCD would not be updated.

A27. In the near future, CMS will begin weekly updates to the Medicare Coverage Database.

Q28. Testing would be impossible to complete for new LMRP's that are implemented by carriers as the number is not assigned to the LMRP or NCD until they are added to the CMS database and this is added when carriers actually implement the revision. If adding new policies, testing could only occur in production and could cause incorrect or invalid information to be displayed.

A28. The Medicare Coverage Database will soon contain an application that will allow contractors to enter draft LMRPs. The CMS will work with the database contractor to accommodate this need in the draft LMRP database.

Q29. MCS normally doesn't release any system changes they make until one month prior to implementation. With this CR which will impact all areas of the MCS system, there would not be sufficient time to even complete minimal testing and PLOG's are always numerous when CR's are implemented that will span across all areas of the MCS system.

A29. The CR has been revised to indicate that carriers will have until July to complete the data entry of the LMRP/NCD numbers into each edit.

Q30. It states that the LMRP number or the CIM section will have to be reported when denying claims. What would be done or reported if a claim was denied due to a MCM section - not a CIM section? Would anything be cited? An example would be for colorectal cancer screening or epotein alfa audits. The CR only talks about informing with the LMRP number or the CIM section number.

A30. This CR applies only to denials that result from LMRPs or NCDs. This is due in part to the upcoming BIPA 522 regulation that will allow beneficiaries to appeal LMRPs and NCDs. Denials based on coverage provisions in interpretive manuals (such as the MCM) or documents other than LMRPs and NCDs do not require this special beneficiary notification.

Q31. The identifier you're using for LMRPs seems more synonymous with our CAG numbers we assign to each NCD. Would we not want to use them, as opposed to section numbers in the manual?

A31. The LMRP ID numbers are generated from the Medicare Coverage Database (www.cms.hhs.gov/mcd). Each of these numbers begins with the letter L followed by an up to 11 digit number. We don't believe these LMRP numbers will be confused with the NCD numbers which do not contain Ls and do not contain dashes.

Q32. In requirement number 2 you state that "Between now and April 1, 2004, VMS carriers must revise their suspense editing screens to specify the LMRP ID number(s) and/or NCD number(s) associated with that edit." How can the carriers have their suspense edit screens updated within the next 6 months when VIPS Medicare System (VMS) will not have the suspense edit screen updated to accept the Local Medical Review Policy (LMRP) identification number(s) and/or the National Coverage Determination (NCD) number(s) until April 1, 2004? Can the carrier requirement be extended until October 1, 2004?

A32. We have extended the due date for completing this work until July 1, 2004. Between now and April 1, 2004, carriers can review their edits to determine which edit is associated with which LMRP or NCD. Then between April 1, 2004, and July 1, 2004 carriers can begin entering the ID#s into the edits themselves.

Q33. This transmittal states that there is a January 1st requirement. We thought this had been rescinded until a later date due to the requirements we are working on now.

A33. See A 32.

Q34. If multiple LMRP/NCD codes must be accepted, can a maximum number of LMRP/NCD codes be established?

A 34. We have established a maximum number of policies that can be associated with a single line item denial as 4.

Q35. How many digits/characters is an NCD code and can it be variable? What is it's format?

A35. See section B: Policy for an explanation of the NCD format.

Q36. Can the claim line store only the last LMRP/NCD code that forced the final decision for that claim line or do all need to be stored?

A36. All (up to 4) policies on which the denial is based must be listed.

Q37. If applying multiple LMRP/NCD codes to an edit, can a hierarchy be established for the LMRP/NCD codes?

A37. Shared systems and carriers have the option to establish a hierarchy of codes so long as the requirement to notify the beneficiary of all policies (up to 4) that caused their denial is met.

Q38. Are the NCDs only associated with the black box or can an NCD be associated with other edits set up by the carriers?

A38. Carriers can set up NCD edits.

Q39. The April 1, 2004 date in requirement 2, when combined with requirement 1b, seems incorrect. The carriers will not be able to enter the LMRP/NCD numbers into their screens until after the changes in requirement 1b are implemented. The earliest the carriers can enter the LMRP/NCD numbers is during the April release weekend. We don't believe it will be possible for carriers to do this during the release weekend. Please clarify.

A39. See answer # 32.

Q 40. When a claim is denied for medical review reasons (medical review denial) and that denial is not related to a specific NCD or LMRP, is CR2916 not applicable? For example(s):

(1) An E&M visit is downcoded to a lower E&M. While there are denied dollars for medical review, there is no specific NCD and/or LMRP related to the denial.

(2) A service is denied due to no and/or insufficient documentation to support the billed service(s).

(3) The NCD and/or LMRP requires supporting documentation and none is provided (whether developed or not). Does this type of denial apply to the requirement "specify the LMRP ID number(s) and/or NCD number(s) of each LMRP and/or NCD associated with that edit"?

A40. CR 2916 only applies to denials resulting from an LMRP or NCD.

(1) No NCD exists for E&M services so the denial cannot be based on an NCD. If a carrier has no LMRP for E&M services, then the denial is not based on an LMRP. In these cases, CR2916 would not apply. If the carrier had an LMRP for E&M services to reiterate the AMA E&M guidelines and the requirements described in that LMRP were not met, then CR2916 would apply. If the carrier had an article for E&M services to reiterate the AMA E&M guidelines and the requirements described in that article were not met, then CR2916 would not apply. CR 2916 applies only to denials resulting from an LMRP or NCD.

(2a) A contractor receives no documentation in response to an Additional Documentation Request (ADR). The contractor denies the claim due to the providers' failure to respond. CR 2916 does not apply.

(2b) A contractor has an LMRP for a given service and in order to determine if the requirements of the policy are met chooses to send an ADR. The provider sends a response but the response fails to demonstrate that the LMRP requirements are met. Because the denial is based on the LMRP, CR 2916 applies.

(2c) A contractor has no LMRP for a given service but chooses to review it on an individual consideration basis so the contractor sends an ADR letter. The provider sends a response but the response fails to demonstrate that the service was reasonable and necessary based on individual consideration. Because the denial is not based on an LMRP, CR 2916 does not apply.

(3a) NCDs and LMRPs should not require supporting documentation to be provided at the time of claims submission as this is a violation of the Paperwork Reduction Act (PRA). Contractors should contact staff in CMS' Division of Medical Review for further questions about the PRA.

(3b) The NCD and/or LMRP requires supporting documentation and none is provided when the contractor sends an ADR letter. Because the denial is based on the LMRP, CR 2916 applies.