Program Memorandum Carriers

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

Transmittal B-02-032 **Date: MAY 1, 2002**

CHANGE REQUEST 2131

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

Hours for October 2002 release are for standard system maintainer analysis only. No coding is required. There is no impact on carriers until implementation of PCA modules; CMS will issue another PM at that time.

This Change Request (CR) provides additional detail and requirements to support Chapter 3 Sections 1-4 of the Program Integrity Manual (PIM) concerning MR PCA. The PIM instructs all contractors to implement PCA to the extent possible. This Program Memorandum (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 Contractors (DMERC)) 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 full implementation of the PIM Chapter 3, sections 1-4 by the implementation date CMS will provide in a future 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 medical review,
- Suspend claims in the sample for prepayment review,
- Calculate error rates (prepayment and postpayment review), and
- Track providers and records under PCA.

Contractors must ensure that all sections of the PIM Chapter 3, sections 1-4, are fully implemented by the implementation date of this PM. Contractor data centers must insure that the module that this CR 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 CR requires that VIPS modify the VIPS-VMS and DMERC standard systems and that EDS modify the MCS-EDS standard system to allow contractors to

- Draw a representative sample prepayment (utilizing systematic random sampling, i.e., drawing claims at a fixed interval after a random start -- Please 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) or postpayment (using simple random sampling, i.e., draw claims based upon a set of randomly determined identifiers such as randomly numbers that uniquely correspond to Individual Control Numbers (ICNs) in the universe),
- Extract the sample for (1) all claims, (2) specific provider types, (3) specific benefit types and within benefit types by specific Health Care Common Procedure Coding System (HCPCS) , or a combination of provider types and benefit types,

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- 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 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 and an unlimited number of postpayment criteria at any time,

- 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 which type of numbers they use for a sample,

- 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,

- Suspend claims prepayment, possibly using existing software such as SuperOp,

- 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 annotate claim by claim, pay/no pay decisions,

- Track the claims sampled and their disposition after medical review for up to 36 months (Medicare contractors must be able to specify how many months they will track providers),

- Calculate provider specific, benefit type specific, and HCPCS Code level error rates,

- As part of the error rate calculations, calculate estimates of standard errors by provider, benefit type, and HCPCS, and

- Estimate a total dollar value of errors by provider, benefit type and HCPCS Codes along with the standard errors associated with those estimates.

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

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. We wish to select a claim before it goes to development.

The system must include an interactive menu that allows a user to specify pre-pay vs. post-pay claims. The module must identify whether the claims are selected prepayment or postpayment based upon the user's entries in the selection screen.

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 prepayment module and a postpayment module. The CMS encourages use of existing modules such as SuperOp or the Part B Program Integrity module that CR 1397 (Transmittal B-01-66, dated October 31, 2001) requires.

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 select the claim if it meets sample criteria. Therefore, all claims that are correctly submitted will have an equal chance of submission -- a requirement for a representative, unbiased sample.

This CR does not add new pricing files or edits. Coinsurance and deductibles do not need to be considered in complying with this requirement. Linkages or modifications to Pricer, OCE, and OPPS are not required. New EOMBs and MSNs must be generated as a result of this application. Those MSNs and EOMBs must indicate that the contractor has acted upon the claim for PCA purposes. CMS will provide specific messages later. You may include the new messages and other messages generated by the claim in the same notice. PS&R will not be affected.

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. Hours for October 2002 release are for standard system maintainer analysis only. No coding is required. There is no impact on carriers until implementation of PCA; CMS will issue another PM at that time.**

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

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