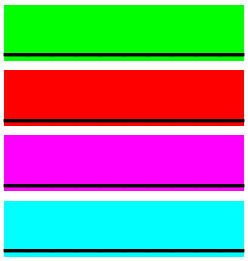

Probe Review – Provider Specific
Probe Review – Service Specific
Prepayment Review
Attestation

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.2.2 - Provider Notice

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MAC and Recovery Auditors, as indicated.

Because the CERT contractors select claims on a random basis, they are not required to notify providers of their intention to begin a review. The ZPICs are also not required to notify providers before beginning a review.

A. Notice of Provider-Specific Review

When MAC data analysis indicates that a provider-specific potential error exists that cannot be confirmed without requesting and reviewing documentation associated with the claim, the MAC shall review a sample of representative claims. Before deploying significant medical review resources to examine claims identified as potential problems through data analysis, MACs shall take the interim step of selecting a small "probe" sample of generally 20-40 potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures that medical review activities are targeted at identified problem areas. The MACs shall ensure that such a sample is large enough to provide confidence in the result, but small enough to limit administrative burden. The CMS encourages the MACs to conduct error validation reviews on a prepayment basis in order to help prevent improper payments. MACs shall select providers for error validation reviews in the following instances, at a minimum:

- The MAC has identified questionable billing practices (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis;

- The MAC receives alerts from other MACs, Quality Improvement Organizations (QIOs), CERT, Recovery Auditors, OIG/GAO, or internal/external components that warrant review;

- The MAC receives complaints; or,

- The MAC validates the items bulleted in§ 3.2.1.

Provider-specific error validation reviews are undertaken when one or a relatively small number of providers seem to be experiencing the same problem with billing. The MACs shall document their reasons for selecting the provider for the error validation review. In all cases, they shall clearly document the issues noted and cite the applicable law, published national coverage determination, or local coverage determination.

For provider-specific problems, the MAC shall notify providers in writing that a probe sample review is being conducted. MACs have the discretion to use a letter similar to the letters in Exhibit 7 of the PIM when notifying providers of the probe review and requesting documentation. MACs have the discretion to advise providers of the probe sample at the same time that medical documentation or other documentation is requested.

Generally, MACs shall subject a provider to no more than one probe review at any time; however, MACs have the discretion to conduct multiple probes for very large billers as long as they will not constitute undue administrative burden.

MACs

The MACs shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice. MACs shall indicate whether the review will occur on a prepayment or postpayment basis. This notification may be issued via certified letter with return receipt requested. MACs shall notify providers of the specific reason for selection. If the basis for selection is comparative data, MACs shall provide the data on how the provider varies significantly from other providers in the same specialty, jurisdiction, or locality. Graphic presentations help to communicate the perceived problem more clearly.

Recovery Auditors

The Recovery Auditors are required to post a description of all approved new issues to the Recovery Auditor's Web site before correspondence is sent to the provider. After posting, the Recovery Auditor should issue an additional documentation request (ADR) to the provider, if warranted.

B. Notice of Service-Specific Review

This section applies to MACs and Recovery Auditors, as indicated.

Service-specific reviews are undertaken when the same or similar problematic process is noted to be widespread and affecting one type of service (e.g., providing tube feedings to home health beneficiaries across three (3) States).

MACs

The MACs shall provide notification prior to beginning a service-specific review by either posting a review description on its Web site, or by sending individual written notices, such as an ADR, to the affected providers. MACs have the discretion to issue the notice separately or include it in the ADR.

When MAC data analysis confirms that an improper payment can be prevented through service-specific complex review, the MAC shall install service-specific complex review edits as soon as feasible under their MR Strategy. The MAC is not required to conduct an error validation review prior to installing these edits.

Recovery Auditors

Before beginning widespread service-specific reviews, Recovery Auditors shall notify the provider community that the Recovery Auditor intends to initiate review of certain items/services through a posting on the Recovery Auditor Web site describing the item/service that will be reviewed. Additionally, for complex reviews, the Recovery Auditors shall send ADRs to providers that clearly articulate the items or services under review and indicate the appropriate documentation to be submitted.

3.2.3 - Requesting Additional Documentation During Prepayment and Postpayment Review

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.

A. General

In certain circumstances, the MACs, CERT, Recovery Auditors, and ZPICs may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an additional documentation request (ADR). MACs, CERT, Recovery Auditors, and ZPICs have the discretion to collect documentation related to the beneficiary's condition before and after a service in order to get a more complete picture of the beneficiary's clinical condition. The MAC, Recovery Auditor, and ZPIC shall not deny other claims submitted before or after the claim in question unless appropriate

consideration is given to the actual additional claims and associated documentation. The CERT contractor shall solicit documentation in those circumstances in accordance with its Statement of Work (SOW).

The term "additional documentation" refers to medical documentation and other documents such as supplier/lab/ambulance notes and includes:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.

- Supplier/lab/ambulance notes include all documents that are submitted by suppliers, labs, and ambulance companies in support of the claim (e.g., Certificates of Medical Necessity, supplier records of a home assessment for a power wheelchair).

- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

NOTE: Reviewers shall consider documentation in accordance with other sections of this manual

B. Authority to Collect Medical Documentation

Contractors are authorized to collect medical documentation by the Social Security Act. Section 1833(e) states "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states "…no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

3.2.3.1 - Additional Documentation Requests (ADR)

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, Recovery Auditors, CERT and ZPICs, as indicated.

The MACs, CERT, Recovery Auditors, and ZPICs shall specify in the ADR only those individual pieces of documentation needed to make a determination. When reviewing documentation, the reviewer shall give appropriate consideration to all documentation that is provided in accordance with other sections of this manual.

A. Outcome Assessment Information Set (OASIS)

Medicare's Home Health PPS Rate Update for CY 2010 final rule, published in the November 10, 2009 Federal Register, includes a provision to require the submission of the OASIS as a condition of payment, that is codified in regulations 42 CFR§484.210(e). Beginning January 1, 2010, home health agencies (HHAs) are required to submit an OASIS as a condition for payment. The MACs shall deny the claim if providers do not meet this regulatory requirement. The assessment must be patient specific, accurate and reflect the current health status of the patient. This status includes certain OASIS elements used for calculation of payment. These include documentation of clinical needs, functional status, and service utilization.

B. Plan of Care (POC)

Comprehensive care planning is essential to good patient care under the Medicare program. In fact, it is specifically written into the coverage and/or certification requirements for a number of healthcare settings. For purposes of the Part A benefit for home health, inpatient rehabilitation facility and hospice, the Social Security Act describes criteria and standards used for covering these services. This includes establishing an individualized POC.

The POC identifies treatment goals and coordination of services to meet patient needs as set forth in CFR §418.200 requirement for coverage. The POC must be established by a physician(s). However, in the case of a hospice, in addition to the physician, an interdisciplinary group shall establish a POC.

Section 1814(a)(2)(C), Part B 1835(a)(2)(A) of the Act, and CFR §409.43 state that a POC established by a treating physician must contain all pertinent information, such as, the patient history, initial status, treatment goals, procedures/services duration, and progress notes.

CFR§ 412.622 requires an individualized POC by a rehabilitation physician that meets the requirements listed in the regulation. MACs shall deny the claim as not meeting statutory requirements under the Social Security Act when the provider of services fails to comply with the POC requirements.

Pursuant to 42 CFR §489.21, a provider of services shall not charge a beneficiary for services that have been denied for the reasons stated above.

3.2.3.2 - Time - Frames for Submission

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, Recovery Auditors, CERT, and ZPICs, as indicated.

A. Prepayment Review Time Frames

When requesting documentation for prepayment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 30 calendar days of the request. The reviewer has the discretion to grant extensions to providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 45.

B. Postpayment Review Time Frames

When requesting documentation for postpayment review, the Recovery Auditor shall notify providers that the requested documents are to be submitted within 45 calendar days of the request. MACs, CERT and ZPICs shall notify providers that requested documents are to be submitted within 30 calendar days of the request. MACs, CERT, and ZPICs have the discretion to grant extensions to providers who need more time to comply with the request. The number of submission extensions and the number of days for each extension is solely within the discretion of the MACs, CERT and ZPICs. Recovery Auditors shall follow the time requirements outlined in their SOW.

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, Recovery Auditors, CERT and ZPICs, as indicated.

Unless otherwise specified, the MAC, Recovery Auditor and ZPIC shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, Recovery Auditor and ZPIC.

The MAC, ZPIC and Recovery Auditor have the discretion to send a separate ADR to third-party entities involved in the beneficiary's care. They shall not solicit documentation from a third party unless they first or simultaneously solicit the same information from the billing provider or supplier. The following requirements also apply:

- The MACs, ZPICs and Recovery Auditors shall notify the third party and the billing provider or supplier that they have 30 calendar days to respond for a prepayment review or 45 calendar days for a postpayment review for MACs and Recovery Auditors and 30 calendar days for ZPICs.

- For prepayment review, the MACs and ZPICs shall pend the claim for 45 calendar days. This 45 day time period may run concurrently as the 45 days that the billing provider or supplier has to respond to the ADR letter;

- The MACs and ZPICs have the discretion to issue as many reminder notices as they deem appropriate to the third party via email, letter or phone call prior to the 30th or 45th calendar day , as discussed above;

- When information is requested from both the billing provider or supplier and a third party and a response is received from one or both that fails to support the medical necessity of the service, the MACs and ZPICs shall deny the claim, in full or in part, using the appropriate denial code. Contractors shall count these denials as complex review.

- Contractors shall include language in the denial notice reminding providers that beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub. IOM 100-04, chapter 30.

- Refer to§3.2.3.7 for ADR to ordering providers for lab services.

3.2.3.4 - Additional Documentation Request Required and Optional Elements

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, Recovery Auditors, CERT, and ZPICs, as indicated.

- The MAC shall use discretion to ensure that the amount of medical documentation requested does not negatively impact the provider's ability to provide care.

- The Recovery Auditors shall issue ADRs in accordance with limits established by their Contract Officer Technical representative (COTR) for each calendar year.

- The MACs, CERT ,and Recovery Auditors, shall request records related to the claim(s) being reviewed and have the discretion to collect documentation related to the beneficiary's condition before and after a service, but shall not request documentation dating from more than 12 months prior to the Date of Service unless an exception exists.

- The MACs, Recovery Auditors, and ZPICs have the discretion to issue as many reminder notices as they deem appropriate. Reminder notices can be issued via email or letter.

- The CERT shall issue reminder notices in accordance with its SOW.

- MACs, Recovery Auditors, and ZPICs shall not target their ADRs to providers based solely on the provider's electronic health record status or chosen method of submitting records.

3.2.3.5 - Acceptable Submission Methods

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, Recovery Auditors, CERT, and ZPICs, as indicated.

Reviewers shall be clear in their ADR letters about what documentation submission methods they will accept from a provider or HIH. The table below indicates for each contractor type whether it shall or has the discretion to include in their ADRs various documentation submission options.

	MAC MR Units	CERT	Recovery Auditors
Paper	**Shall give provider the option**	**Shall give provider the option**	**Shall give provider the option**
Fax	**Have the discretion to give provider the option**	**Shall give provider the option**	**Shall give provider the option**
CD/DVD	**Have the discretion to give provider the option**	**Shall give provider the option**	**Shall give provider the option**
Electronic Submission of Medical Documentation (esMD)	**Have the discretion to give provider the option**	**Will have the discretion to give provider the option**	**Have the discretion to give provider the option**

Table 1: Acceptable submission methods for providers/HIHs when responding to ADRs from MACs, CERT, and Recovery Auditors.

A. Paper

The MACs, CERT, and Recovery Auditors are encouraged to state in the ADRs that paper medical documentation can be mailed by any means including US Postal Service, FedEx, UPS, or certified mail. To facilitate delivery of documentation, CERT and Recovery Auditors should provide a physical mailing address instead of a P.O. Box. MACs are encouraged to use physical mailing addresses.

B. Fax

If the MACs, CERT, or Recovery Auditors have the capability to offer fax confirmation, they are encouraged to send such confirmations with every successfully received fax.

C. Imaged Medical Documentation File(s) Sent on CD/DVD

The MACs or CERT that accept this form of documentation submission from providers/HIHs shall state in the ADR that imaged medical documentation files on CD/DVD are permitted to be mailed by any means. Recovery Auditor ADRs shall provide a Web site link or phone number that provides information regarding the requirements for submitting imaged documentation on CD or DVD.

D. Medical Documentation Sent via Electronic Submission of Medical Documentation (esMD) Transmission

Electronic Submission of Medical Documentation (esMD) is a system that will allow providers/HIHs to submit medical documentation over secure electronic means. Information about the esMD system can be found at www.cms.gov/esMD.

All MACs, CERT and Recovery Auditors are encouraged to post a statement to their Web sites indicating whether they do or do not accept esMD transactions along with a link to a Web site about how a provider HIH can submit medical documentation via the esMD mechanism.

MACs, and CERT that accept this form of documentation submission from providers/HIHs are encouraged to state in their ADRs how providers can get more information about submitting medical documentation via the esMD mechanism.

3.2.3.6 - Reimbursing Providers and HIHs for Additional Documentation

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to Recovery Auditors, MACs, CERT, and ZPICs, as indicated.

- The MACs, CERT and ZPICs are not required to pay for medical documentation for either prepayment or postpayment review.

- The Recovery Auditors performing postpayment review of hospital inpatient prospective payment system (PPS) and long term care facilities are required to pay the providers for photocopying and submitting hard copy documents sent via mail. Recovery Auditors shall follow the payment rate methodology established in 42 CFR§476.78.

- The Recovery Auditors shall pay the same per-page rate established in 42 CFR§476.78 for the submission of imaged or electronic documentation sent via the esMD mechanism or on CD/DVD.

- The Recovery Auditors that accept esMD transactions shall pay a transaction fee of $2.00/case in lieu of postage.

- The Recovery Auditors performing postpayment review of any other provider types are not required to pay providers for photocopying and submitting documentation.

- The Recovery Auditors shall issue photocopying payments on at least a monthly basis and shall issue all photocopying payments within 45 calendar days of receiving the documentation.

- The Recovery Auditors shall honor all requests from providers to issue photocopying payments to HIHs. Recovery Auditors should gather from the provider all necessary information, such as, the HIH's name, phone number and bank routing number, etc.

3.2.3.7 - Special Provisions for Lab Additional Documentation Requests

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs, CERT, Recovery Auditors, and ZPICs, as indicated.

Use ICD-9 until such time as ICD-10 is in effect. Further instructions will be issued regarding claims containing ICD-9 codes with dates of service prior to the ICD-10 implementation that are submitted after ICD-10 is in effect.

When the MACs, CERT, Recovery Auditors and ZPICs send an ADR for a lab service, the following documentation shall be requested from the billing lab:

- The order for the service billed (including sufficient information to allow the reviewer to identify and contact the ordering provider);
- Verification of accurate processing of the order and submission of the claim; and
- Diagnostic or other medical information supplied to the lab by the ordering provider, including any ICD-9 codes or narratives.

The contractor shall deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or send an ADR to the ordering provider in order to determine medical necessity. The contractor shall review information from the lab and find it insufficient before the ordering provider is contacted. The contractor shall send an ADR to the ordering provider that shall include sufficient information to identify the claim in question.

If the documentation received does not demonstrate that the service was reasonable and necessary, the contractor shall deny the claim. These denials count as complex reviews. Contractor denial notices shall remind providers that beneficiaries cannot be held liable for these denials unless they have received proper liability notification before services were rendered, as detailed in CMS Pub. IOM 100-04, chapter 30.

The MACs, CERT and Recovery Auditors shall implement these requirements to the extent possible without shared systems changes.

3.3.2.4 - Signature Requirements

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section is applicable for MACs, CERT, and ZPICs. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN, etc) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

NOTE: Conditions of participation (COP) are not conditions of payment.

If MAC and CERT reviewers find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation that contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

B. Signature Log

Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

C. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

"I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]__ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Although this format is acceptable, the CMS currently neither requires nor instructs providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers. However, since no form for signature attestation has been approved by the

Office of Management and Budget (OMB), the contractors should not give the providers any standard format on which to submit the attestation. Once the OMB has assigned an OMB Paperwork Reduction Act number to this attestation form, its use will be mandatory.

Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.

D. Signature Guidelines

The guidelines below will assist in determining whether to consider the signature requirements met:

- In the situations where the guidelines indicate **"signature requirements met,"** the reviewer shall consider the entry.

- In situations where the guidelines indicate **"contact billing provider and ask a non-standardized follow up question,"** the reviewer shall contact the person or organization that billed the claim and ask if the billing entity would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins on the date of the telephone contact with the provider or on the date the request letter is received by the provider. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry.

- In cases where a reviewer has requested a signature attestation or log, the time for completing the review is extended by 15 days. This extension starts upon receipt of the signature attestation or log.

- The MACs, CERT and ZPICs shall document all contacts with the provider and/or other efforts to authenticate the signature.

  Note: The MACs, CERT and ZPICs shall **NOT** contact the **biller when the claim should be denied for reasons unrelated** to the signature requirement.

	Signature Requirement	Contact billing provider and ask a

		Met	non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name Example :  John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity **o**f the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a signature log, or an attestation statement Example: 		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the		X

	page		
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

E. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

F. Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber and dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve beneficiary safety and quality of care.

A "qualified" e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing).

1. E-Prescribing for Part B Medications (Other than Controlled Substances)

The MAC, CERT and ZPIC reviewers shall accept as a valid order any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system. For Medicare Part B medical review purposes, a qualified e-prescribing system is one that meets all 42 CFR §423.160 requirements. When Part B medications have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

2. E-Prescribing for Part B Controlled Substance Medications

Historically, the Drug Enforcement Agency (DEA) has not permitted the prescribing of controlled substance medications through e-prescribing systems. Therefore, when reviewing claims for controlled substance medications, MAC, CERT and ZPIC reviewers shall only accept hardcopy pen and ink signatures as evidence of a medication order.

However, the DEA is in the process of establishing requirements for electronic prescriptions for controlled substances. Refer to 21 CFR§§1300, 1304, 1306 and 1311 for further information.

3. E-Prescribing for Medications Incident to DME

The MAC, CERT and ZPIC reviewers shall accept as valid any e-prescribed order for medications incident to Durable Medical Equipment (DME), other than controlled substances. For the purpose of conducting Medicare medical review of medications incident to DME, a qualified e-prescribing system is one that meets all §42 CFR 423.160 requirements. When medications incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Refer to PIM chapter 5 for further details regarding additional signature requirements for DMEPOS.

H. Signature Dating Requirements

For medical review purposes, if the relevant regulation, NCD, LCD and other CMS manuals are silent on whether the signature must be dated, the MACs, CERT and ZPICs shall ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Example: The claim selected for review is for a hospital visit on October 4. The ADR response is one page from the hospital medical record containing three (3) entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer should conclude that the physician visit was conducted on October 4.

I. Additional Documentation Request Language Regarding Signatures

The CERT contractor shall use language in its ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document. For example, a hospital discharge summary in the physician's office files may be unsigned, whereas the version of the discharge summary in the hospital files should be signed and dated. MACs are encouraged to use such language in their letters. In addition, MACs, CERT and ZPICs have the discretion to add language to their ADRs stating that the provider is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer finds a note with a missing or illegible signature, the ADR may inform the provider that it should submit a signature log or signature attestation as part of the ADR response.

The following is sample language that reviewers may choose to use in certain ADRs:

> "Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.
>
> The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.
>
> If you question the legibility of your signature, you may submit an attestation statement in your ADR response.
>
> If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated."

J. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the ZPIC for development. If MAC, Recovery Auditor or CERT reviewers identify a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate ZPIC for further development.

3.7.1 - Progressive Corrective Action (PCA)

(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)

This section applies to MACs.

The MACs shall ensure that actions imposed upon Medicare providers or suppliers for failure to meet Medicare rules, regulations and other requirements are appropriate given the level of non-compliance.

When an error has been validated through MR, the corrective action imposed by the MACs should match the severity of the error. PCA is a means of evaluating the relative risk of the error and assigning appropriate corrective actions. The principles of PCA are:

- It is data-driven. Errors are validated by prepayment and postpayment claims review. (See below).

- Hypotheses and edits are tested prior to implementation to determine facility, utility, and return on investment.

- Workloads are targeted, specific, and prioritized.
- Money is collected when errors are validated.
- Referrals for potential fraud are made when necessary.
- Provider feedback and education are mandatory.
- Medical review resources should be used efficiently.

For each provider data identifies as being at risk, the potential error is validated with prepayment or postpayment review of generally 20-40 potentially erroneous claims. Payments are either denied or recouped. Any underpayments by Medicare will be netted out during the financial reconciliation process. Corrective actions are then implemented based on whether the error represents a minor, moderate, or major concern.

For potentially risky services, errors are validated by prepayment and postpayment review of generally up to 100 potential problem claims for that service from a representative sample of providers. Service-specific errors may require more widespread education for providers and may require the implementation of service-specific prepayment edits.

An example of a minor concern would be a provider with a low error rate and no pattern of errors who has made a relatively minor error with low financial impact. Education and collection of the overpayment may be sufficient corrective actions.

For moderate concerns, where a provider with a low error rate has made an error with substantial financial impact, some level of prepayment review should be considered. The prepayment review should be tracked and adjusted or eliminated according to the provider's response.

A major concern would be a provider with a high error rate who has made a high-dollar error with no mitigating circumstances, indicating the need for stringent administrative action. A high level prepayment review should be considered along with possible payment suspension and referral to the ZPICs.

Exhibit 7 - Sample Letter for On-Site Reviews

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME: CONTRACTOR NAME:

PROVIDER ADDRESS: CONTRACTOR ADDRESS:

OPENING

Dear _____:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review we have determined that you have been overpaid. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that your facility utilized _____ services at a rate of 50 percent more than that of your peer group.

HOW THE OVERPAYMENT WAS DETERMINED

A random sample of _____ claims processed from 01/01/98 to 06/30/98 was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Our review found that some services you submitted were not reasonable and necessary as required by the Medicare statute or did not meet other Medicare coverage requirements.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable or necessary, and/or you did not follow correct procedures or use care in billing or receiving payment.

The attachment identifies the specific claims that have been determined to be fully or partially non-covered, the specific reasons for denial, an explanation of why you are responsible for the incorrect payment and the amount of the overpayment.

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by _____ and no interest charge will be assessed. Make the check payable to Medicare Part A and send it with a copy of this letter to:

Intermediary's Address

IF YOU DO NOT REFUND WITHIN 30 DAYS:

If you repay the overpayment within 30 days, you will not have to pay any interest charge.

However, if you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time.

On _____ we will automatically begin to recoup the overpayment amount against your pending claims. Recouped payments will be applied to the accrued interest first and then to the principal. If you believe that recoupment should not be put into effect, submit a Statement within 15 days of the date of this letter to the above address, giving the reason(s) why you feel this action should not be taken. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

For copies of the applicable laws and regulations, please contact us at the address shown in our letterhead, to the attention of the _____ Department.

APPEAL RIGHTS:

If you disagree with the overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for a redetermination to:

Address to which redetermination request should be sent

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following national Medicare guidelines in submitting claims for necessary and reasonable _____ services. In addition, you have not followed the Provider Bulletins and letters sent to you regarding local medical review policies and specific problems that we have identified with your billing practices. Your

future claims for _____ will be suspended for prepayment review until you correct your billing.

If you have any questions regarding this matter, please contact _____ at _____.

Thank you in advance for your prompt attention to this matter.

Sincerely,

7.1 - Attachment to Letter for Provider Site Reviews - (Rev. 3, 11-22-00)

Following is a list of the claims denied as a result of the review:

- Beneficiary Name: John Smith
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/08/97 - 12/08/97
- Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/97
- Reason for Denial: MRI's are not considered reasonable and medically necessary for the diagnosis of xxxx.
- Why the Provider is Responsible: We believe you knew or should have known that the services were not reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1997, outlined Local Medical Review Policy which indicated that MRI's were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
- Overpayment: $900.00
- Beneficiary Name: Mary Smith
- HI Claim Number: 000-00-0000B
- Service Dates: 10/01/97 - 10/31/97
- Services Denied and Dates: Physical therapy evaluation and re-evaluation on 10/03/97 and 10/26/97.
- Reason for Denial: The two physical therapy visits are not reasonable and medically necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation.

- Why you are Responsible: In a letter dated 07/30/97 you were notified that such therapy evaluation and re-evaluation were not considered reasonable and necessary. Therefore, you are responsible for the overpayment.
- Overpayment: $ 200.00
- Beneficiary Name: Tom Jones
- HI Claim Number: 000-00-0000A
- Service Dates: 12/10/97 - 12/31/97
- Services Denied and Dates: 10 physical therapy visits from 12/10/97 - 12/31/97
- Reason for Denial: No plan of care signed by a physician.
- Why you are responsible: We find you responsible for the overpayment because regulations at 42 CFR, and manual instructions at §xxxx, clearly require a plan of care signed by a physician for therapy visits.
- Overpayment: $1,200.00

7.2 - Exhibit-Sample Letter--Request For Medical Records - (Rev.)

The intermediary uses the following letter to request necessary medical records from the provider.

DATE:

PROVIDER NAME: **INTERMEDIARY NAME:**
PROVIDER ADDRESS: **INTERMEDIARY ADDRESS:**
PROVIDER NUMBER:
OPENING:

Dear XXXXX:

You have been selected for a comprehensive medical review (CMR) of your billing for Medicare services pursuant to CMS's statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that you may be billing inappropriately for services.

We have selected a random sample of ___ claims for services provided during the period _____ through _____. (See attached listing.) For each of these claims, we are requesting the following information:

[The following list is for illustrative purposes. MR should request any documentation that will permit them to conduct a thorough review of the claims submitted with regard to coverage, eligibility, medical reasonableness and necessity, limitation on liability determinations (§1879), without fault determinations (§1870), etc.]

- Form HCFA-485;
- Form HCFA-486, or equivalent information, if applicable;
- Form HCFA-487, or equivalent information, if applicable;
- Flow sheets or treatment sheets, if used;
- Narrative or progress notes, if used;
- Supplemental order, if applicable;
- Itemized breakdown of supplies, if supplies are billed;
- Lab values, if applicable;
- Copy of the UB-92 for each bill;
- Lab reports for any B12 injections;
- Lab or x-ray reports for any calcimar injection;
- Other _____

The above information should be mailed to the following address within 30 days from the date of this letter:

Intermediary Name, Address, and Contact Person

Our medical review staff will review the documentation you submit for each of the claims to determine if the services billed are reasonable and necessary and meet all other requirements for Medicare coverage. Along with our claims payment determination, we will make a limitation on liability decision for services that are subject to the provisions of §1879 of the Social Security Act (the Act), and a determination in accordance with §1870 of the Act (whether you are without fault for any overpayments).

We will project the overpayments identified in the sample to the universe of claims processed during the time frame described above. We will adjust the projected overpayment to reflect any previously denied claims which are payable, denied claims for which you were found not liable under §1879 of the Act, and denied claims for which you were found to be without fault under §1870 of the Act.

Following our review, we will inform you in writing of our findings. We will provide you with a listing of the claims that were reviewed and our determinations with regard to those claims (i.e., full or partial denials and payable claims), the specific reasons for

denial, identification of denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, the amount of the overpayment or underpayment, and interest accrual on unpaid balances. We will provide you with an explanation of your right to submit a rebuttal statement under 42 CFR 405.370-375 if we determine that you have been overpaid, and your options for repaying any overpayments, or our refund of any underpayments. We will provide you with an explanation of how any overpayment was determined, including the sampling methodology used to project the amount of the overpayment. We will also provide you with a full explanation of your appeal rights, including appeal of the sampling methodology used to determine the overpayment, estimation of the overpayment, coverage decisions, limitation on liability decisions under §1879 of the Act, and our determination as to whether you are without fault under §1870 of the Act.

If you have any questions concerning this request, you may contact me at (telephone number). Your cooperation is appreciated.

Sincerely,

Enclosure: Listing of Sample Claims Requiring Medical Documentation

7.3 - Exhibit: Part A Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME: INTERMEDIARY NAME:
PROVIDER ADDRESS: INTERMEDIARY ADDRESS:
PROVIDER NUMBER:

OPENING:
Dear XXXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.750 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

TOTAL OVERPAYMENTS

(List the aggregate overpayments)

Be advised that this overpayment amount is based on your interim payment rate in effect at the time the review was done. Further adjustments may be made when your cost report is settled.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct

procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of the specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclose a list of the specific claims from the sample that have been found not to be covered. See the example within this exhibit.)

The sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclosed an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by (insert date, 15 days from date of letter). However, you may request an extended repayment schedule in accordance with 42 CFR 401.607(c). Please contact (name of contact person at the FI/RHHI) on (phone number of contact person) to discuss repayment options for the full amount of the overpayment determined by the projection of errors found on the ___claim sample.

INTEREST

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time. Medicare charges interest on its outstanding Part A debts in accordance with §1815(d) of the Act and 42 CFR 405.378.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

As provided in regulations at 42 CFR 401.607(a) and 405.370-375, on (insert date provided in above paragraph captioned, "What You Should Do"), we will automatically begin to recoup the overpayment amount against your pending and future claims. If you do not repay the debt within 30 days, we will apply your payments, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act, we may refer your debt to the Department of Treasury for offset against any monies payable to you by the Federal Government.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

FI Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within fifteen days whether the facts justify continuation, modification, or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2) of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

If you choose not to submit a rebuttal Statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do "). Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.704, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date you receive this letter (unless you can show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual § _____ for further details.)

If you have any questions regarding this matter, please contact _____ at _____. (Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.3.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the Results, and Request Repayment of Overpayments
(Rev.)

The following is a list of claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A

2. Service Dates: 12/01/96 - 01/15/97

3. Services Denied and Dates: 45 Inpatient SNF Days, 12/1/96 - 1/15/97

4. Reason for Denial: The therapy services rendered were not medically reasonable and necessary because they were for overall fitness and general well being and did not require the skills of a qualified physical therapist (§1879 denial). (Provide details that led you to the conclusion that the services were non-skilled.)

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. We believe you knew or should have known that the services were not medically reasonable and necessary because of the educational contacts made in July 1996 and October 1996 regarding Medicare coverage of therapy services. In these contacts numerous similar examples were cited as noncovered. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: $2,000.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number:000-00-0000 B

2. Service Dates: 01/01/97 - 01/31/97

3. Services Denied and Dates: 31 Inpatient SNF Days, 01/01/97 - 01/31/97

4. Reason for Denial: There was no skilled care furnished on a daily basis. Skilled therapy services were furnished 2-3 times a week, although therapy is available in your facility on a daily basis.

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not

without fault in accordance with §1870 of the Social Security Act. The Medicare coverage guidelines in the SNF manual clearly state the requirement for daily skilled services. You were also notified in educational contacts in July 1997 and October 1997 of similar cases. Therefore, you are responsible for the overpayment.

6. Overpayment: $200.00

7.4 - Exhibit: Part B Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

SAMPLE LETTER--MEDICARE PART B

DATE:

PROVIDER NAME: INTERMEDIARY NAME:
PROVIDER ADDRESS: INTERMEDIARY ADDRESS:
PROVIDER NUMBER:

OPENING:
Dear XXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.841 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials

of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclosed a list of the specific claims and an explanation of fault for each. See the example within this exhibit.)

An explanation of the sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclose an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

_____Address

IF YOU DO NOT REFUND IN 30 DAYS

In accordance with 42 CFR 405.378, simple interest at the rate of _____ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the rate of _____.

We must request that you refund this amount in full. If you are unable to make refund of the amount at this time, advise this office immediately so that we may determine if you are eligible for an extended repayment schedule. (See enclosure for details.) Any extended repayment schedule (where one is approved) would run from the date of this letter.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT
If payment in full is not received by (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is received.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

Carrier Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within 15 days whether the facts justify continuation, modification or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2) of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.803, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date of this letter (unless you show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and overpayment recovery. (See 42 CFR 405.801, et seq. and 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual Section _____ for further details.)

IF YOU HAVE FILED A BANKRUPTCY PETITION

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If you have any questions regarding this matter, please contact _____ at _____. (Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.4.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev.)

The following is a list of the claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A

2. Service Dates: 12/08/96 - 12/08/96

3. Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/96

4. Reason for Denial: MRIs are not considered medically reasonable and necessary for the diagnosis of xxxx (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. You knew or should have known that the services were not medically reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1996, outlined Local Medical Review Policy which indicated that MRIs were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: $900.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number: 000-00-0000 B

2. Service Dates: 01/01/97 - 01/31/97

3. Services Denied and Dates: Physical Therapy evaluation and re-evaluation on 01/03/97 and 01/26/97

4. Reason for Denial: The two Physical Therapy visits are not medically reasonable and necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. In a letter dated 10/30/96, you were notified that such therapy evaluation and re-evaluation were not considered medically reasonable and necessary. Therefore, you are responsible for the overpayment.

6. Overpayment: $200.00