CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 933	**Date: January 10, 2020**
	Change Request 10828

Transmittal 907, dated October 4, 2019, is being rescinded and replaced by Transmittal 933 dated, January 10, 2020, to change the effective date to February 3, 2020. All other information remains the same.

SUBJECT: Update to Chapter 3, Section 3.2.3.1 Additional Documentation Requests (ADR) of Publication (Pub) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide updated instructions to the Medicare Administrative Contractors (MACs) and Recovery Auditor Contractors (RACs) requesting additional documentation to perform prepayment and post payment reviews utilizing an Electronic Medical Documentation Request (eMDR) via Electronic Submission of Medical Documentation (esMD).

EFFECTIVE DATE: February 3, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3.2.3 Requesting Additional Documentation During Prepayment and Post payment Review

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: In certain circumstances, the MACs, Comprehensive Error Rate Testing (CERT), RACs, and Unified Program Integrity Contractor (UPICs) 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). The term ADR refers to all documentation requests associated with prepayment review and postpayment review. MACs, CERT, RACs, and UPICs 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.

This CR will update instructions to the MACs and RACs requesting additional documentation to perform prepayment and post payment reviews utilizing an eMDR via esMD.

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

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II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10828.1	Contractors shall have the ability to submit ADRs to registered providers and suppliers via esMD effective February 3, 2020.	X	X	X	X					RAC
10828.2	The contractors shall send an eMDR via esMD to those providers/suppliers that have	X	X	X	X					RAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	registered to receive the request electronically.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Melanie Jones, 410-786-5461 or Melanie.Jones@cms.hhs.gov , Oladimeji Ibraheem, 410-786-5560 or Oladimeji.Ibraheem@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev.933, Issued: 01-10-20)

3.2.3.1 - Additional Documentation Requests (ADR)

(Rev.933; Issued: 01-10-20; Effective: 02- 03- 20; Implementation: 01-06- 20)

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

The MACs, CERT, Recovery Auditors, and *UPICs* 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.

The MACs and the RACs shall also support soliciting documentation from the provider or supplier via Electronic Submission of Medical Documentation (esMD). The contractors shall send an Electronic Medical Documentation Request (eMDR) via esMD to those providers/suppliers that have registered to receive the request electronically. The contractors are encouraged to explore other ways to send eMDRs electronically (For example, using direct exchange, clearinghouses, state Health Information Exchange (HIEs)).

Providers interested in submitting documentation via esMD can find information on the CMS esMD website at http://www.cms.gov/esMD.

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.