CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 76 **Date: MAY 28, 2004**

CHANGE REQUEST 3211

I. SUMMARY OF CHANGES: This change request provides clarification to the definition of complex medical review.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 28, 2004
***IMPLEMENTATION DATE: June 28, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/4.5/Types of Prepayment and Postpayment Review

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-8	Transmittal: 76	Date: May 28, 2004	Change Request 3211

SUBJECT: Clarification of Complex Medical Review

I. GENERAL INFORMATION

A. Background: This change request provides clarification to the definition of complex medical review.

B. Policy: N/A

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3211.1	The contractor shall consider complex medical review to involve using clinical judgment by a licensed medical professional to evaluate medical records.	FI, carriers, DMERCs
3211.2	The contractor shall consider medical records to include any additional medical documentation, other than what is included on the face of the claim, that supports the service that is billed.	FI, c arriers, DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A
D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: June 28, 2004 **Implementation Date:** June 28, 2004 **Pre-Implementation Contact(s): Stacy Holdsworth, e-mail address SHoldsworth@cms.hhs.gov** **Post-Implementation Contact(s): Stacy Holdsworth, e-mail address SHoldsworth@cms.hhs.gov**	**These instructions should be implemented within your current operating budget.**

4.5 - Types of Prepayment and Postpayment Review

(Rev. 76, 05-28-04)

Claim review activities are divided into three distinct types of review:

A - Automated Prepayment Review

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See Section 5.1 for further discussion of automated prepayment review.

B - Routine Prepayment/Postpayment Review

Routine prepayment review is limited to rule-based determinations performed by specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be suspended for routine review because an MR determination cannot be automated.

Routine review requires hands-on review of the claim, and/or claims history file and/or internal MR guidelines *but does not require the application of clinical judgment by a licensed medical professional*.

C - Complex Prepayment/Postpayment Review

Complex medical review involves *the application of clinical judgment by a licensed medical professional in order to evaluate medical records. Medical records include any medical documentation, other than what is included on the face of the claim that supports the service that is billed. For items of durable medical equipment that require a Certificate of Medical Necessity (CMN), the CMN is considered part of the face of the claim.* Complex medical review determinations require *a licensed medical professional* to make a *clinical* judgment about whether a service is covered, and is reasonable and necessary.

*C*omplex review for the purpose of making coverage determinations must be *performed* by nurses (RN/LPN) or physicians, unless this task is delegated to other licensed health care professionals. Contractors must ensure that services reviewed by other licensed health care professionals are within their scope of practice and that their MR*/LPET S*trategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e. speech therapy claim, physical therapy claim). Contractors should establish QI processes that verify the accuracy of MR decisions made by licensed health care professionals.

Contractors must maintain a credentials file for each reviewer who performs one or more complex reviews (including consultants, contract staff, subcontractors, and temporary

MR staff). The credentials file must contain at least a copy of the reviewer's professional license.

*During c*omplex *review,* nurse and physician reviewers may call upon other health care professionals (e.g., dieticians, and physician specialists) for advice. Any determination must be documented and include the rationale for the decision. While MR staff must follow *National Coverage Determinations* and *Local Coverage Determinations*, they are expected to use their expertise to make clinical judgments when making medical review determinations. They must take into consideration the clinical condition of the beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations. For example, if a medical record indicates that a beneficiary is a few days post-op for a total hip replacement and femur plating, even though the medical record does not specifically state that the beneficiary requires the special skills of ambulance transportation, MR nurses and physicians must use their clinical knowledge to conclude that ambulance transportation is appropriate under such circumstances.

Complex medical review performed by medical review staff for purposes other than MR (for example, for benefit integrity investigations or for appeals) should be charged for expenditure reporting purposes to the area requiring medical review services.

D - Examples

The following examples are provided to assist contractors in understanding the definitions of automated, routine, and complex review.

EXAMPLE 1: A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will request documentation, suspend for manual review, and auto-deny in 45 days if no documentation is received. For claims where no documentation is received within 45 days, the computer auto-denies the claim without manual intervention. Even though the contractor intended to perform manual review, because they ACTUALLY performed automated review, this review should be counted a AUTOMATED.

EXAMPLE 2: A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For claims where no documentation is received within 45 days, the computer denies the claim. Because the contractor ACTUALLY performed routine manual review, this claim should be counted as ROUTINE review.

EXAMPLE 3: A contractor sets up the system so that for a particular HCPCS/ICD9 combination, the computer will suspend for routine manual review. During routine manual review, the reviewer determines that complex review is needed and initiates a request for additional documentation. For

claims where documentation is received, MR nurses (RN/LPN) or physicians will review the documentation and make a decision regarding the services billed. Because the HIGHEST LEVEL of review the contractor performed was complex manual review, this claim should be counted as COMPLEX review.