CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 72 **Date: APRIL 16, 2004**

CHANGE REQUEST 3088

I. SUMMARY OF CHANGES: Adding medically unbelievable service(s) to the requirements on which an automated review must be based.

NEW/REVISED MATERIAL - EFFECTIVE DATE: March 1, 2004
***IMPLEMENTATION DATE: May 1, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/5.1/ Automated Prepayment Review

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT:

I. GENERAL INFORMATION

A. Background:

When a clear policy exists or in the case of a medically unbelievable service(s) contractors may automatically deny the services without stopping the claim for routine or complex review, even if documentation is attached.

B. Policy:

None.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3088.1	Contractors should automatically deny a claim if there is a medically unbelievable error.	Contractors

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

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: March 1, 2004 **Implementation Date:** May 1, 2004 **Pre-Implementation Contact(s):** Debbie Skinner (410) 786-7480, Dskinner2@cms.hhs.gov **Post-Implementation Contact(s):** Debbie Skinner	**These instructions should be implemented within your current operating budget**

5.1 - Automated Prepayment Review - (Rev. 72, 04-1604)

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. When appropriately implemented, automated review increases efficiency and consistency of decisions. Contractors must implement automated prepayment review whenever appropriate.

Automated review must:

1. Have **clear policy** that serves as the basis for denial; *or*
2. Be based on *a medically unbelievable service(s)*; or
3. Occur when **no timely response** is received in response to an ADR letter.

When a clear policy (see PIM Chapter 3, Section *3.*4.1.1) exists or in the case of *a medically unbelievable service(s)*, contractors may automatically deny the services without stopping the claim for routine or complex review, **even if documentation is attached**. Reviewers must still make a §1879 of the Act limitation on liability determination, which may require routine review. If additional documentation has been requested for a claim and the information has not been received within 45 days, the denial can be counted as an automated review if there was no human intervention. If human intervention occurs, the denials are counted as routine review.

NOTE: The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded.