# CMS Medicare Manual System
# Pub. 100-8 Program Integrity

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

**Transmittal 35** **Date: NOVEMBER 29, 2002**

**CHANGE REQUEST 2418**

| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
|---|---|---|---|
| 3 | 4.5 | | |

*Red italicized font identifies new material.*

**NEW/REVISED MATERIAL - EFFECTIVE DATE: Jan 1, 2003**
**IMPLEMENTATION DATE: Jan 1, 2003**

**Medicare contractors only: these instructions should be implemented within your current operating budget.**

**Chapter 3, §4.5 – Types of Prepayment and Postpayment Review** -- clarifies the circumstances under which contractors may use health care professionals other than a physician or nurse (RN/LPN) during the review of claims.

## *4.5 - Types of Prepayment and Postpayment Review - (Rev. 35, 11-25-02)*

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 a*n *MR* determination cannot *be* automated.

Routine review requires hands-on review of the claim and/or any attachment submitted by the provider (other than medical records) and/or claims history file and/or internal MR guidelines.

**C -- Complex Prepayment/Postpayment Review**

Complex *medical* review *involves evaluating* medical records or any other documentation *by a licensed medical professional. Complex medical review determinations require the reviewer to make a judgment about whether a service is covered and is reasonable and necessary.*

*MR-directed and BI-directed complex review (i.e., review that involves any evaluation of medical records) for the purpose of making coverage determinations must be conducted 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 strategy supports the need for their specialized expertise in the adjudication of particular claim type (i.e. speech therapy claim, physical therapy claim, etc). 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.

*Complex nurse and physician reviewers* may call upon other health care professionals (e.g., dieticians, and physician specialists) for advice. Any determination *made* by *complex MR staff* must be documented and include the rationale for the decision. While *complex MR staff must* follow NCD and LMRPs, 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, *complex 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.
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> ***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.
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> ***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.