Program Memorandum Intermediaries

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

Transmittal A-03-010 **Date: FEBRUARY 14, 2003**

CHANGE REQUEST 2434

SUBJECT: Manual Medical Review Indicator for the Comprehensive Error Rate Testing (CERT) Program

I - GENERAL INFORMATION:

A. Background:

This Program Memorandum (PM) provides instructions for automating the manual medical review indicator for the CERT Program.

CMS requires that contractors:

> *"Provide the CERT contractor with the Sample Claims Resolution file, claims history replica file, and provider address file within 5 working days of a CERT request.*
>
> Within 5 working days of a CERT request, provide for every claim listed in the *sampled claims transaction file* that has undergone payment adjudication (i.e., denial, reduction, return, or payment approval) all *sampled claims resolution files, all claims history replica files,* and a single *provider address file*. Note that more than one *sampled claims resolution file* and c*laims history replica file* may be provided under circumstances where the claim control number has changed since its original assignment and claim activity has occurred. Standard systems are expected to provide a look up list, where necessary, to associate the last claim control number submitted to the CERT contractor from the standard system with new claim control numbers assigned to the claim subsequent to that submission. If there are claims adjustments that have not been adjudicated when the sample claims transaction file is received, those adjustments do not need to be included in a sample claims resolution file."

Included in the requirements for the sampled claims resolution file is a requirement to report the manual medical review indicator for each line on the sampled claim. We have defined this item as follows:

"Data Element: **Complex Manual Medical Review Indicator**
Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services

were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance, if relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'Y' or 'N' or blank

Remarks: Set to 'Y' if service was subjected to complex manual medical review, 'N' if the service was subjected to routine manual medical review, and leave it blank if the service was subjected to automated review.

Requirement: Not required"

Interface Identification

The CMS originally determined that the complex manual medical review indicator could be entered manually by contractor staff. Since that time, we have determined that the indicator could be more accurately and efficiently obtained if, whenever possible, the standard system entered the indicator automatically based upon information already in standard system files or processes. That change in requirements should reduce the contractor workload requirements that result from the collection of the manual medical review indicator.

B. Policy:

Contactors must supply the CERT contractor with the sample claims resolution file within 5 working days of a CERT request. Included in the sampled claims resolution file is a requirement to report the manual medical review indicator for each line on the sampled claim. The contractor must enter the necessary data to allow the standard processing intermediary shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review."

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1	In time for contractors to begin reporting the manual medical review indicator for each line on the sampled claim by July 1, 2003, Standard System Maintainers are responsible for developing standard system modifications that automatically place the appropriate manual medical review indicator in the existing manual medical review indicator field on each line of a claim in the sample claims resolution file.	Standard System Main-tainers
2	By July 1, 2003, Contractor Data Centers are responsible for implementing, operating, and maintaining the standard system modifications that automatically place the appropriate manual medical review indicator on each line in the sample claims resolution file.	Contractor Data Centers

3	By July 1, 2003, contractors must insure that standard system maintainers correctly implement standard system modifications that automatically place the appropriate manual medical review indicator on each line in the sample claims resolution file.	Contractor Staff
4	If manual review is not performed on the line the manual medical review indicator must be blank.	All (i.e., standard system maintainers, contractor data centers, and contractor staff)
5	If manual review is performed on a line, the manual medical review indicator must be either a "Y" or an "N."	All
6	The manual medical review indicator must be "Y" for all lines for which the Medicare contractor has received medical records. When the contractor asks for medical records but the provider does not send every one of the notes that the contractor requested, put a "Y" for the lines corresponding to missing notes.	All
7	Contractor staff must manually enter information needed to decide if medical records were obtained for lines where that information cannot be obtained from the system claims processing modules.	Contractor Staff

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Req. #	Instructions

B. Design Considerations:

X-Ref Req. #	Recommendation for Medicare System Requirements
1	Data entered or generated for the Program Integrity Management Reporting (PIMR) system Activity Type may be used to determine the correct manual medical review indicator.
1	Information from automated correspondence systems that are used to make additional documentation requests (ADRs - e.g., the UR Screen on APASS) may be used to determine the correct manual medical review indicator.
1	Modules that automatically deny overdue ADRs may be used to determine the correct manual medical review indicator.

C. Interfaces:

See Section B: Design Considerations, for potential interfaces.

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

IV. Attachment(s): None

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