CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 802	**Date: June 22, 2018**
	Change Request 10640

SUBJECT: Use of Accessible and Applicable Claims History During Medical Review

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to clarify the role of accesible claims/billing history during the course of medical review.

EFFECTIVE DATE: July 24, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 24, 2018
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	3/3.2/3.2.4/Use of Claims History Information in Claim Payment Determinations
R	3/3.3/3.3.2.1/Documents on Which to Base a Determination

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: Medical review contractors are instructed to review any information necessary to make a prepayment and/or postpayment claim determination. In certain circumstances, it may be appropriate for medical reviewers to use relevant and accessible claims history to assist in making medical record review determinations. While claims history may provide an alternate source of information, it may not be used to override, supersede or disregard existing policy requirements. This CR reiterates and clarifies existing instruction.

B. Policy: This CR does not involve any regulatory, legislative or statutory changes.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10640.1	Medical review contractors shall, in certain circumstances, use relevant and accessible claims history to assist in making medical record review determinations.	X	X	X	X					CERT, RACs, SMRC, UPICs
10640.2	Contractors shall, as appropriate to a given claim decision and their scope of review, follow the instructions provided in chapter 3, sections 3.3.2.1 and 3.2.4 of Pub. 100-08, to determine the applicability of claims history to Medicare payment decisions.	X	X	X	X					CERT, RACs, SMRC, UPICs
10640.3	Contractors shall not use claims history to override, supersede, or disregard existing policy requirements.	X	X	X	X					CERT, RACs, SMRC, UPICs

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): Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov , Marissa Petto, Marissa.Petto@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

3.2.4 - Use of Claims History Information in Claim Payment Determinations

(Rev. 802; Issued: 06-22-18; Effective: 07-24-18; Implementation: 07-24-18)

A. Contractors to Which This Section Applies

This section applies to MACs, CERT*, SMRC,* and RACs.

B. General

In certain circumstances it may be appropriate for medical reviewers to use relevant and accessible claims history to assist in making medical record review determinations. Examples of when this may be used for payment purposes, include, but are not limited to:

1. *R*eviewers have the discretion to use beneficiary payment history to identify other providers, other than the billing entity, who may have documentation to support payment of a claim. MAC, CERT and RAC reviewers have the discretion to contact identified providers for supporting documentation. Example: A diabetic beneficiary may have an order from a family practitioner but is also seeing an endocrinologist. The documentation from the family practitioner does not support the level of diabetic testing, but medical records from the endocrinologist do support the level of testing.

2. *R*eviewers have the discretion to use claims history information to document an event, such as a surgical procedure, that supports the need for a service or item billed in limited circumstances. In some cases, this event occurs a number of years prior to the date of service on the claim being reviewed, making it difficult to collect medical record documentation. If repeated attempts to collect medical record of the event are unsuccessful, contractors have the discretion to consider claims history information as documentation of the event. Contractors shall document their repeated attempts to collect the medical record if they chose to consider claims history information as documentation of the event. Example: A beneficiary is eligible for immunosuppressant drugs only if they received an organ transplant. Patients generally remain on these life-saving drugs for the rest of their life so it is possible for the transplant to have occurred many years prior to the date of service being reviewed. If there was no record of the transplant in the medical documentation provided by the ordering physician, the contractor may use claims history to validate the transplant occurred.

3. *R*eviewers shall use claims history information to verify that the frequency or quantity of supplies provided to a beneficiary do not exceed policy guidelines.

4. *R*eviewers shall use claims history information to identify duplication and overutilization of services.

3.3.2.1 - Documents on Which to Base a Determination

(Rev. 802; Issued: 06-22-18; Effective: 07-24-18; Implementation: 07-24-18)

This section applies to MACs, CERT, *RACs*, *SMRC* and *U*PICs, as indicated.

The MACs, CERT, *RACs*, *SMRC,* and *U*PICs shall review any information necessary to make a prepayment and/or postpayment claim determination, unless otherwise directed in this manual. This includes reviewing any documentation submitted with the claim and any other documentation subsequently requested from the provider or other entity when necessary. *In certain circumstances it may be appropriate for medical r*eviewers to consider *relevant and accessible* billing history or other information obtained from the Common Working File (in limited circumstances), outcome assessment and information set (OASIS), or the minimum data set (MDS), among others. For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met.