



Clinical Review Judgment – JA6954

Note: This Job Aid was revised to include an additional reference to Chapter 3 of the *Medicare Program Integrity Manual* on page 2.

Related CR Release Date: May 14, 2010

Date Job Aid Revised: June 23, 2010

Effective Date: April 23, 2010

Implementation Date: June 15, 2010

Key Words	MM6954 CR6954, R338PI, Clinical, Review, Judgment
Contractors Affected	<ul style="list-style-type: none"> • Medicare Carriers • Fiscal Intermediaries (FIs) • Part A/B Medicare Administrative Contractors (A/B MACs) • Regional Home Health Intermediaries (RHHIs) • Durable Medical Equipment MACs (DME MACs)
Provider Types Affected	All physicians, providers, and suppliers who bill Medicare carriers, FIs, RHHIs, A/Bs MACs, or DME MACs for services provided to Medicare beneficiaries are affected.

Change Request (CR) 6954 was release to:

- Add Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language, regarding clinical review judgments; and
- Require that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Provider Needs to Know...	<ul style="list-style-type: none"> • This clinical review judgment involves the following steps: <ul style="list-style-type: none"> • Step 1. The synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and • Step 2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.
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Note: Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede, or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid Services (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).

Background Medicare claim review contractors (carriers, FIs (called affiliated contractors, or ACs), MACs, the Comprehensive Error Rate Testing contractor, and Recovery Audit Contractors), along with Program Safeguard Contractors and Zone Program Integrity Contractors, are tasked with measuring, detecting, and correcting improper payments in the Fee-for-Service Medicare Program.

Operational Impact N/A

Reference Materials The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6954.pdf> on the CMS website. The official instruction (CR6954) regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R338PI.pdf> on the CMS website. The updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 14 (Clinical Review Judgment) is an attachment to that CR6954. The original Chapter 3, which contains more information on the CMS medical review processes, may be reviewed at <http://www.cms.gov/manuals/downloads/pim83c03.pdf> on the CMS website.
