CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 100 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3644

SUBJECT: Review of Documentation During Medical Review

I. SUMMARY OF CHANGES: Updates chapter 3, section 4.1.2, and chapter 5, section 2, of the Program Integrity Manual, to clarify that contractors shall review and consider all documentation provided when performing medical review to determine if an item or service is medically reasonable and necessary**.**

NEW/REVISED MATERIAL - EFFECTIVE DATE*: February 1, 2005
IMPLEMENTATION DATE: February 22, 2005

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. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/4.1.2/Additional Documentation Requests (ADR) During Prepayment or Postpayment MR
R	5/2/Documentation in the Patient's Medical Records

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

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

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 100	Date: January 21, 2005	Change Request 3644

SUBJECT: Review of Documentation During Medical Review

I. GENERAL INFORMATION

A. Background: Contractors review medical record documentation to determine if services billed are reasonable and necessary, coded correctly and actually provided. This documentation includes physician chart note as well as other non-contemporaneously created documents.

B. Policy: When reviewing documentation during medical review contractors shall give appropriate consideration to all documentation that is provided.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3644.1	Contractors shall review and give appropriate consideration to all documentation collected during medical review and shall make a determination as to whether a service is medically reasonable and necessary based on the totality of that documentation.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3644.1	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 1, 2005 **Implementation Date:** February 22, 2005 **Pre-Implementation Contact(s):** John Warren (410) 786-3633 **Post-Implementation Contact(s):** John Warren (410) 786-3633	**Medicare contractors shall implement these instructions within their current operating budgets.**

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3.4.1.2 - Additional Documentation Requests (ADR) During Prepayment or Postpayment MR

(Rev. 100, Issued: 01-21-05, Effective: 02-01-05, Implementation: 02-22-05)

When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an additional documentation request (ADR). *Contractors must request records related to the claim(s) being reviewed.*

Contractors must specify in the ADR the specific pieces of documentation needed (and ONLY those pieces needed) to make a coverage or coding determination.

When reviewing documentation during medical review, contractors shall review and give appropriate consideration to all documentation that is provided. Documentation provided for pre- or post-payment medical review must support the medical necessity of the item(s) or service(s) provided.

The treating physician or another clinician or provider may create this documentation. This documentation may take the form of PT/OT evaluations, physician letters, other written physician evaluations, or other documents intended to record relevant information about a patient's clinical condition and treatment(s).

The date that an individual document was created, or the creator of a document is not the sole deciding factor in determining if the documentation supports the services billed.

In instances where documentation is not supported by contemporaneous information in physician progress notes, physician progress notes shall be the determining factor. In instances where documentation is provided in lieu of contemporaneous physician progress notes, contractors shall determine if the documentation is sufficient to justify coverage. If it is not, the claim shall be denied.

A. Development of Non-Lab Claims for Additional Documentation

If, during pre- or postpay review, a contractor chooses to send an ADR regarding a non-lab targeted service, they must solicit the documentation from the **billing provider** and may solicit documentation from other entities (**third parties**) involved in the beneficiary's care. If a contractor chooses to solicit documentation from a third party, they may send the third party ADR simultaneously with the billing provider ADR. Contractors must send ADRs in accordance with the following requirements:

BILLING PROVIDER ADRs

- Contractors who choose to request additional documentation must solicit such information from the billing provider and must notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the timeframe upon request. The contractor must pend the claim for 45 days. Contractors may cc a third party.
- Contractors have the discretion to issue no more than 2 "reminder" notices via letter or phone call prior to the 45th day.
- If information is automatically requested only from the billing provider and no response is received within 45 days after the date of the request (or extension), the contractor must deny the service as not reasonable and necessary (except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information). This would count as automated review.
- If information is requested **only** from the **billing provider** and the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part, using the appropriate denial code (see section 4.2). This would count as a complex review.

THIRD PARTY ADRs

A contractor may NOT solicit documentation from a **third party** unless the contractor first or simultaneously solicits the same information from the **billing provider**. Beneficiaries are not third parties.

When a contractor solicits documentation from a third party:

- The contractor must notify the third party that they have 30 days to respond and copy the billing provider. Contractors have the discretion to grant extensions of the timeframe upon request.
- For prepay review, the contractor must pend the claim for 45 days. This 45 day time period may run concurrent with the 45 day time period for the billing provider ADR letter;
- Contractors have the discretion to issue no more than 2 "reminder" notices via email, letter or phone call prior to the 45th day;
- If information is requested from **both** the billing provider and a third party and no response is received from either within 45 days after the date of the request (or extension), the contractor must deny the claim, in full or in part, as *not* reasonable and necessary. This would count as automated review.
- If information requested from **both** the billing provider and a third party and a response is received from one or both, but the information fails to support the coverage or coding of the claim, the contractor must deny the claim, in full or in part, using appropriate denial code (see section 3.4.2).

B. Development of Lab Claims for Additional Documentation

Effective November 25, 2002, contractors shall develop lab claims in accordance with the following requirement:

- If, during pre- or postpay review, a contractor chooses to send an ADR regarding a targeted lab service, they must solicit the documentation from the billing provider, and under certain circumstances, must also solicit documentation from the ordering provider.

Contractors must send ADRs in accordance with the following requirements:

Billing Provider ADRs

- Contractors who choose to request additional documentation must solicit such information from the **billing provider** and must notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the time frame upon request. For prepay review, the contractor must pend the claim for 45 days. **Contractors may solicit billing providers only for the following information**:
    - Documentation of the order for the service billed (including information sufficient to allow the contractor to identify and contact the ordering provider);
    - Documentation showing accurate processing for the order and submission of the claim; and
    - Diagnostic or other medical information supplied to the billing provider by the ordering provider, including any ICD-9 codes or narratives supplied.
- Contractors have the discretion to issue no more than 2 "reminder" notices via letter, e-mail, or phone call prior to the 45th day;
- If no response is received from the billing provider within 45 days after the date of the request (or extension), the contractor must deny the service as not reasonable and necessary. This would count as automated review;
- If a response is received that demonstrates that the service is not covered or correctly coded, the contractor must deny. *This would count as complex review;*
- If the information requested from the **billing provider** is received, does not demonstrate noncoverage or incorrect coding of the claim, but fails to support the coverage or coding of the claim in full or in part, the contractor must:
    - Deny the claim if a benefit category, statutory exclusion, or coding issue is in question, or;
    - Develop to the ordering provider in accordance with the requirements listed below if a reasonable and necessary issue is in question.

Ordering Provider ADRs

A contractor may NOT solicit documentation from the ordering provider unless the contractor:

1) Solicits information from the **billing provider,**

2) Finds the ADR response from the billing provider insufficient or not provided, and

3) The issue in question is one of medical necessity. Contractors may implement these requirements to the extent possible without shared systems changes.

When a contractor solicits documentation from the ordering provider the contractor must provide to the ordering provider information sufficient to identify the claim being reviewed.

- The contractor must solicit from the ordering provider those parts of the medical record that are relevant to the specific claim(s) being reviewed. The contractor must notify the ordering provider that they have 30 days to respond and copy the billing provider. Contractors have the discretion to grant extensions of the time frame upon request.
- For prepay review, the contractor must pend the claim for 45 days.
- Contractors have the discretion to issue no more than 2 "reminder" notices via email, letter or phone call prior to the 45th day.
- If information is requested from the ordering provider and no response is received within 45 days after the date of the request (or extension), the contractor must deny the claim, in full or in part, as not reasonable and necessary. This would count as automated review.
- If the information requested from the ordering provider is received, but the information fails to support the coverage or coding of the claim, the contractor must deny the claim, in full or in part, using appropriate denial code (see section 3.4.2). This would count as a complex review.

C. Psychotherapy Notes

*Psychotherapy notes are defined in 45 CFR §164.501as "notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record." The definition of psychotherapy notes expressly **excludes** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date. Physically integrating information excluded*

from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall a contractor request a provider to submit notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the denial of a claim.

If the medical record includes any of the information excluded from the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting the information required to support that the claim is reasonable and necessary. Contractors must review the claim using all supporting documentation submitted by the provider. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

5.2 – Documentation in the Patient's Medical Record

(Rev. 100, Issued: 01-21-05, Effective: 02-01-05, Implementation: 02-22-05)

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN, it is recommended that a copy of the completed CMN be kept in the patient's record. However, neither a physician's order nor a CMN nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

See PIM chapter 3, section 3.4.1.2, for additional instructions regarding the review of documentation during pre- and post-payment review.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DMERC or DMERC PSC. However, the DMERC or DMERC PSC may request this information in selected cases. If the DMERC or DMERC PSC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.