CMS Manual System

Pub. 100-04 Claims Processing

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

Transmittal 629 **Date: JULY 29, 2005**

CHANGE REQUEST 3699

SUBJECT: Certificate of Medical Necessity Claim Edits Workload Reporting

SUMMARY OF CHANGES: ViPS shall design the system to allow the DMERCs the flexibility to report CMN edits as MR workload or claims processing workload.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2006
IMPLEMENTATION DATE: January 3, 2006

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: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	20/230/DMERC Systems

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. 100-04	Transmittal: 629	Date: July 29, 2005	Change Request 3699

SUBJECT: Certificate of Medical Necessity (CMN) Claim Edits Workload Reporting

I. GENERAL INFORMATION

A. Background: There is hard-coded VMS logic linked to two CMN edits that trigger PIMR Medical Review (MR) workload and claim data reporting. Additional claims edits are linked to the CMNs that are set to reduce or deny payment and can be set up to cause additional workload and claim data to report on subsequently processed claims. These claim edits are not specific to individual CMNs and cannot be specified for only certain CMNs. The associated PIMR reporting is also not CMN specific. Action codes are designated as either PIMR or non-PIMR. If a PIMR edit results in a denial and the denial is not a PIMR action code, an error record is produced. If a non-PIMR edit results in a denial with a PIMR action code, a claim error occurs, requiring manual intervention by the claim approver. Existing CMN records that are set up to deny payment include the action code with which denial should be made. The MR has determined that CMN edits do not always meet the CMS definition of a MR edit, therefore claims processing is likely to take over some of the workload generated by the CMN editing. In order for this to happen, we must be able to prevent the data from this editing being captured for MR workload.

B. Policy: The CMS Division of Medical Review, determined that the contractors' Medical Review (MR) staff conduct review for claims processing edits and inappropriately charge this work to the MR functional line. The amount of MR resources this workload consumes varies significantly among contractors. For this reason, some contractors have managed to transition this workload out of MR to the appropriate functional area, while others have not. For those contractors who were unable to accomplish this task prior to the FY 05 Budget Request and Strategy submission, CMS will allow full implementation of this transition to occur over the 2005 fiscal year. In addition, as stated in the Medicare Program Integrity Manual, Pub. 100-8, Chapter 3, all edits that suspend claims for complex review shall be evaluated quarterly. This process will enable the contractor to identify which edits truly need to be transitioned to claims processing, which edits are ineffective and should be retired, and which edits should be developed for progressive corrective action in MR.

CMS has instructed the DMERCs to perform edit reviews to determine which existing edits meet the requirements of the 2005 Budget and Performance Requirement to limit MR routine or complex review to those areas identified as problems in their MR/LPET Strategies.

The purpose of this Change Request is to require ViPS to give DMERCs the flexibility to report CMN edits as medical review or claims processing workload.

C. Provider Education: None.

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	
3699.1	ViPS shall allow the DMERCs the flexibility to report CMN edits as claims processing or medical review workload.				X			X		

III. 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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Stacy Holdsworth for Policy, x63530; Joanne Spalding for Operations x63352. **Post-Implementation Contact(s):** Appropriate Regional Office Project Officer	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

Medicare Claims Processing Manual

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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(Rev. 629, 07-29-05)

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230 – DMERC Systems

(Rev. 29, Issued: 07-29-05; Effective: 01-03-06; Implementation: 01-01-06)

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