CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 338	Date: May 14, 2010
	Change Request 6954

SUBJECT: Clinical Review Judgment (CRJ)

I. SUMMARY OF CHANGES: This change request adds language regarding CRJ. The new language directs the contractors to use CRJ while performing complex reviews. CRJ is not to be used to assume facts not in evidence in the medical record, nor can CRJ supercede any policy or regulation.

EFFECTIVE DATE: APRIL 23, 2010
IMPLEMENTATION DATE: June 15, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/3.14/Clinical Review Judgment (CRJ)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 338	Date: May 14, 2010	Change Request: 6954

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I. GENERAL INFORMATION

A. Background: Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the comprehensive error rate testing (CERT) contractor, program safeguard contractors (PSCs), zone program integrity contactors (ZPICs) and recovery audit contractors (RACs)) are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

The proposed language clarifies existing language regarding clinical review judgments found in Pub. 100-08, PIM, chapter 3.

B. Policy: Clarifies and updates various sections of the PIM.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6954.1	The AC, MAC, CERT, RAC, PSC and ZPIC clinical review staff shall use clinical review judgment when making complex review determinations about a claim.	X	X	X	X	X					ZPICs, PSCs, CERT, RACs
6954.2	Clinical review judgment by definition is not a process that ACs, MACs, CERT, RACs, PSCs and ZPICs can use to override, supersede or disregard a policy requirement.	X	X	X	X	X					ZPICs, PSCs, CERT, RACs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6954.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly	X	X	X	X	X					ZPICs PSCs

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

V. CONTACTS

Pre-Implementation Contact(s): Anne Jones, anne.jones2@cms.hhs.gov
Post-Implementation Contact(s): Jesse Polansky, MD jesse.polansky@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev. 338, 05-14-10)

3.14 – Clinical Review Judgment (CRJ)

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(Rev. 338, Issued: 05-14-10, Effective: 04-23-10, Implementation: 06-15-10)

A. Contractors to Which This Section Applies

This section applies to ACs, MACs, CERT, RACs, PSCs, and ZPICs, as indicated below.

B. General

The CRJ involves two steps: (1) the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient, and (2) the application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met. AC, MAC, CERT, RAC, PSC, and ZPIC clinical review staff shall use CRJ when making complex review determinations about a claim.

The CRJ does not replace poor or inadequate medical records. CRJ by definition is not a process that ACs, MACs, CERT, RACs, PSCs and ZPICs can use to override, supersede or disregard a policy requirement. Policies include laws, regulations, CMS rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations.