

Medicare Program Integrity Manual

Exhibits

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Exhibit 1 - Definitions

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A

Abuse

Billing Medicare for services that are not covered or are not correctly coded.

Affiliated Contractor (AC)

A Medicare carrier, Fiscal Intermediary (FI), or other contractor such as a Durable Medical Equipment Medicare Administrative Contractor (DME MAC), which shares some or all of the Program Safeguard Contractor's (PSC's) jurisdiction; Affiliated Contractors perform non-PSC Medicare functions such as claims processing.

B-C

Carrier

The Carrier is an entity that has entered into a contract with CMS to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). DME MACs are those carriers that CMS has designated to process DME, prosthetic, orthotic and supply claims.

Case

A case exists when the PSC, ZPIC or Medicare contractor BI unit has referred a fraud allegation to law enforcement, including but not limited to, documented allegations that: a provider, beneficiary, supplier, or other subject has a) engaged in a pattern of improper billing, b) submitted improper claims with actual knowledge of their truth or falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

Contractor

Contractor includes all intermediaries, carriers, DME MAC, RHHIs, MACs, ZPICs, and PSCs.

Centers for Medicare & Medicaid Services (CMS)

CMS administers the Medicare program. CMS' responsibilities include management of AC and Medicare contractor claims payment, managing PSC, ZPIC, AC, and Medicare contractor fiscal audit and/or overpayment prevention and recovery, and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. CMS was formerly known as the Health Care Financing Administration (HCFA).

Closed Case

A FID case shall be closed when no further action will be required of the PSC, ZPIC, or Medicare contractor BI unit by the law enforcement agency(ies) working the case and when the law enforcement agency(ies) has ended all its activity on the case. Note that even after the case is closed, there may still be administrative actions that the PSC, ZPIC, or Medicare contractor BI unit will take.

D-E

Department of Justice (DOJ)

Attorneys from DOJ and United States Attorney's Offices have criminal and civil authority to prosecute those providers who de-fraud the Medicare program.

Demand Bill or Demand Claim

A demand bill or demand claim is a complete, processable claim that must be submitted promptly to Medicare by the physician, supplier or provider at the timely request of the beneficiary, the beneficiary's representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary's subrogee. A demand bill or demand claim is requested usually, but not necessarily, pursuant to notification of the beneficiary (or representative or subrogee) of the fact that the physician, supplier or provider expects Medicare to deny payment of the claim. When the beneficiary (or representative or subrogee) selects an option on an advance beneficiary notice that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill or claim must be submitted.

F

Federal Bureau of Investigation (FBI)

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding, the FBI has direct access to contractor data and other records to the same extent as OIG.

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

G-H

I

Intermediary

The intermediary is a public or private agency or organization that has entered into an agreement with CMS to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional home health intermediaries (RHHIs) are those FIs that CMS has designated to process Medicare claims received from home health and hospice providers.

J-K-L

Local Coverage Determinations (LCDs)

The *LCDs* are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

M

Medicare Contractor (Benefit Integrity)

Medicare contractors include all intermediaries and carriers that have not transitioned their benefit integrity work to a PSC.

Medicare Contractor (Medical Review)

Medicare contractors include intermediaries, carriers and MACs.

Misrepresented

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

N

Noncovered (Not Covered)

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

O

Office of Audit Services (OAS)

The OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

Office of Counsel to the Inspector General (OCIG)

The OCIG is responsible for coordinating activities that result in the negotiation and imposition of Civil Monetary Penalties (CMPs), assessments, and other program exclusions. It works with the Office of Investigations (OIG), Office of Audit Services (OAS), CMS, and other organizations in the development of health care fraud and exclusions cases.

Office of Inspector General (OIG)

The OIG investigates suspected fraud or abuse and performs audits and inspections of CMS programs. In carrying out its responsibilities, OIG may request information or assistance from CMS, its PSCs, its ZPICs (Zone Program Integrity Contractors), Medicare contractors, and QIOs. OIG has access to CMS's files, records, and data as well as those of CMS's contractors. OIG investigates fraud, develops cases, and has the authority to take action against individual health care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor, AC, Medicare contractor, and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. OIG/OI investigates allegations of fraud or abuse whether committed by PSCs, ZPICs, ACs, Medicare contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

The OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCIG for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any State health care programs as defined under §1128(h) of the Social Security Act (the Act);or
- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

Offset

The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

P

Program Safeguard Contractor (PSC)

The PSC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract. They are being replaced with Zone Program Integrity Contractors (ZPICs)

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DME MACs, and RHHs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization (QIO)

The Peer Review Improvement Act of 1982 established the utilization and quality control peer review organization (PRO) program. The PRO name has changed to quality improvement organization. CMS contracts with independent physician organizations in each state to administer the QIO program. Their purpose is to ensure that the provisions of the Peer Review Improvement Act of 1982 are met. Under their contracts with CMS, QIOs are required to perform quality of care reviews of the medical services provided to Medicare beneficiaries in settings including, but not limited to: physician offices, acute care hospitals, specialty hospitals (for example psychiatric and rehabilitation hospitals), and ambulatory surgical centers. In the inpatient setting, QIOs also perform provider-requested higher-weighted DRG reviews for acute inpatient prospective payment system (IPPS) hospitals and long-term care hospital (LTCH) claims.

Recoupment

The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Reliable Information

Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists, for example, that claims are or were false or were submitted for non-covered or miscoded services. Reliable information of fraud exists if the following elements are found:

- The allegation is made by a credible person or source. The source is knowledgeable and in a position to know. The source experienced or learned of the alleged act first hand, i.e., saw it, heard it, read it. The source is more credible if the source has nothing to gain by not being truthful. The source is competent; e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source;
- The information is material. The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable (e.g., instructions handwritten by the provider delineating how to falsify claim forms).
- The act alleged is not likely the result of an accident or honest mistake. For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;

- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

S

Services

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPH or SNF facilities. (42CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

Suspension of Payment

Suspension of payment is defined in the regulation 42CFR 405.370 as "the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists." In other words, ACs or Medicare contractors have received processed and approved claims for a provider's items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

T-U-V-W-X

Exhibit 2 – Reserved for Future Use

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Exhibit 3 - Description of CAC Members

(Rev.106, Issued: 03-04-05, Effective: 02-01-05, Implementation: 04-04-05)

3.1 - Physicians

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Medicare defines physicians as:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Chiropractors;
- Doctors of podiatry or surgical chiropody; and
- Doctors of optometry.

Do not include other practitioners on this committee.

Carriers select committee representatives from names recommended by State medical societies and specialty societies. If the CMD is concerned because of identified utilization/MR problems with an individual who has been recommended as a committee representative, the CMD should discuss the recommendation with the nominating body. They must maintain confidentiality of the specifics of the situation in any discussion.

If there is no organized specialty society for a particular specialty, the CMD should work with the State medical society to determine how the specialty is to be represented. Encourage each State medical society and specialty society to nominate representatives to the CAC.

If there are multiple specialty societies representing a specialty, select only one representative. Encourage specialty societies to work together to determine how a representative is selected and how that representative communicates with each society.

The CMDs who become committee members or are appointed or elected as officers in any state or national medical society or other professional organization must provide written notice of membership, election, or appointment to CO and RO, as well as to the CAC within 3 months of the membership, election, or appointment effective date. This notice can be provided as part of the CAC minutes if the CMD chooses to give CAC notice via the CAC meeting forum, provided that the CAC meeting is held within the 3-month notice period.

Attempt to include, as members of your CAC, physician representatives from each of the following groups:

- State medical and osteopathic societies (president or designee);

- National Medical Association (representative of either the local or State chapter or its equivalent, if one exists); and

- Medicare Medicare Advantage organizations. In order to enhance the consistency of decision making between Medicare Medicare Advantage plans and traditional fee-for-service, Medicare Medicare Advantage organizations shall also have representation on the CAC. The number of Medicare Advantage representatives on the CAC should be based on the Medicare penetration (enrollment) rates for that State; one representative for those States with penetration rates of less than 5 percent and two representatives for those States with penetration rates of 5 percent or higher. The State HMO association should periodically submit nominees for membership on the CAC.

- Physician representatives for each of the following: 1) Chiropractic; 2) Maxillofacial/Oral surgery; 3) Optometry; and 4) Podiatry.

Include one physician representative of each of the following clinical specialties and sub-specialties:

- Allergy;
- Anesthesia;
- Cardiology;
- Cardiovascular/Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Family Practice;
- Gastroenterology;
- Gerontology
- General Surgery;
- Hematology;
- Internal Medicine;
- Infectious Disease;
- Interventional Pain Management;
- Medical Oncology;
- Nephrology;
- Neurology;
- Neurosurgery;
- Nuclear Medicine;
- Obstetrics/Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;

- Pathology;
- Pediatrics;
- Peripheral Vascular Surgery;
- Physical Medicine and Rehabilitation;
- Plastic and Reconstructive Surgery;
- Psychiatry;
- Pulmonary Medicine;
- Radiation Oncology;
- Radiology;
- Rheumatology; and
- Urology

The CMD must work with the societies to ensure that committee members are representative of the entire service area and represent a variety of practice settings.

3.2 - Clinical Laboratory Representative - (Rev. 3, 11-22-00)

In addition to the representatives for physician clinical specialties, include an individual to represent clinical laboratories. This individual may also be a physician. Consider recommendations from national and local organizations that represent independent clinical laboratories in making this selection.

3.3 - Beneficiaries - (Rev. 3, 11-22-00)

Include two representatives of the beneficiary community:

- One based on recommendations made by an association(s) representing issues of the elderly (e.g., coalitions for the elderly, senior citizen centers), and
- One based on recommendations made by an association(s) representing the disabled.

One role of the beneficiary representatives is to communicate with other beneficiary groups that have an interest in LMRP.

3.4 - Other Organizations - (Rev. 3, 11-22-00)

Carriers invite the following to be members:

- A representative from the State Hospital Association;
- QIO medical director;
- Intermediary medical director;
- Medicaid medical director (or designee); and

- A representative of an association representing administrative practices, such as the American Group Practice Association or the Medical Group Management Association.

Welcome congressional staff to attend as observers. Send notice to them of the agenda and dates. Invite representatives of the RO to attend and participate.

Exhibit 4 - Reliable Information - (Rev. 3, 11-22-00)

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

Exhibit 5 - Background Information When IRP is Questioned - (Rev. 3, 11-22-00)

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 allows the federal government to pay a reward to individuals who report evidence of suspected fraud and abuse against the Medicare program. Implementing regulations, issued on June 8, 1998, were effective on July 8, 1998 and provide that a complainant may be rewarded up to 10 percent of the amount recovered, but not more than \$1,000. Not everyone is eligible for the reward, though. To be eligible for a reward:

- The information you give has to lead to a recovery of at least \$100;
- The suspected fraud must be acts or omissions that are grounds for the government to impose sanctions provided under certain provisions of the law;
- There isn't another reward that you qualify for under another government program;

- You must not have participated in the sanctionable offense with respect to which payment is being made;
- If the person or organization is already under investigation; and
- You are not an immediate family member or an employee of the Department of Health and Human Services, its contractors or subcontractors, the Social Security Administration, the Office of the Inspector General, a State Medicaid agency, the Department of Justice, the FBI, or any other federal, State, or local law enforcement agency at the time he or she came into possession, or divulged information leading to a recovery of Medicare funds.

You'll receive a letter from us acknowledging that we have received your complaint. Some investigations take a long time to complete, and may take several months or years to resolve. You'll be notified by letter of your eligibility to receive a reward after the Medicare funds have been recovered. If you do receive a reward for this information you may be expected to pay any applicable state and federal taxes.

5.1 - Reward Eligibility Notification Letter - (Rev. 3, 11-22-00)

Dear _____:

You are eligible for a reward as part of the Medicare Incentive Reward Program for telling us about Medicare fraud and abuse.

To claim your reward, please fill out the enclosed form and return it to [contractor information] in the enclosed envelope. You have **one year** from the date of this letter to claim your reward.

In the case of death or incapacitation of the person reporting the potential fraud, a legal representative of that person may claim the reward on his or her behalf when evidence is submitted to justify the claim.

If it is later found that you received the reward caused by your misrepresentation of the facts, all monies paid to you must be returned to Medicare. If you have questions, please contact [contractor information].

Sincerely,

[Contractor Information]

Enclosures

5.2 - Reward Claim Form - (Rev. 3, 11-22-00)

[To be completed by contractor.]

Provider/Supplier Name

Case Number

REWARD CLAIM FORM

Date

Dear [Contractor Information]:

I am claiming the reward for providing information about Medicare fraud by filling out this form as it applies to me. My signature verifies that I am a proper recipient of the incentive reward or that I am the legal representative of the proper recipient of the reward. I also understand that the reward must be repaid by the recipient if it is later determined that the reward should not have been received.

CLAIMANT INFORMATION

Name _____

Street Address _____

City, State, Zip code _____

Telephone Number _____

Claimant (or Representative) Signature _____

REPRESENTATIVE INFORMATION

If the intended recipient of the reward has become incapacitated or has died, his or her executor, administrator, or other legal representative may collect the reward on the individual's behalf or for the individual's estate. In addition to submitting this letter, please also submit certified copies of letters testamentary, letters of administration, or other similar evidence to show your authority to claim the reward. In the space provided below, please submit your name and the mailing address where the check should be sent if that address differs from the information stated above.

Name _____

Street Address _____

City, State, Zip code _____

Telephone Number _____

5.3 - How to Use the IRP Tracking System - (Rev. 3, 11-22-00)

Selected IRP screen exhibits may be viewed from the PIM whenever "**Click here to view the selected screen**" is indicated in bold.

After you log on to the Winframe, you will see the IRP Tracking group icon. Double click on that icon, then double click on the IRP Tracking to run the application. The first screen IRP Menu will appear.

Click here to view an exhibit of the IRP Menu screen.

A. Screen Use

From the IRP menu screen, click on the item you would like to select. Reference §§5.4 through 5.9 below for explicit instructions on how to use every menu option of the IRP system.

B. Options

1. Pending Case List - This function allows you to view all of the pending cases in the system. See §5.4 below for details on this option.

2. Pending List By Contractor - This function allows you to view all of the pending cases that are listed by each contractor ID number. See §5.5 below for details on this option.

3. New Case - This function allows you to enter a new case into the system. See §5.6 below for details on this option.

4. Closed Case List - This function allows you to view all of the closed cases in the system. See §5.7 below for details on this option.

5. Closed Case List By Contractor - This function allows you to view all of the closed cases that are listed by each contractor's ID number. See §5.8 below for details on this option.

6. Report Menu - This function allows you to open the report menu that contains all available predefined reports.

5.4 - Section I: Pending Case List Screen - (Rev. 3, 11-22-00)

Click [here](#) to view an exhibit of the Pending Case List Screen.

View Case- After you select a case number, you can double click on the view case button on the bottom of the screen to view the case detail screen of the case selected. From the case detail screen you may:

1. View Comments

You may enter/edit contractor comments or view CMS comments. DO NOT EDIT CMS COMMENTS. You may save comments or save/close form.

2. Edit Case

You may select view/edit comments and enter/edit contractor comments or view CMS comments. DO NOT EDIT CMS COMMENTS. You may save comments or save/close form. You may also select enter/edit provider to access the provider detail screen. From the provider detail screen you may click on 1) add new provider; 2) delete provider; 3) edit provider; or 4) enter/edit an allegation against a provider. To edit the provider appearing on the screen, click on the edit provider button. You may click on next provider or previous provider to find the one that you want to edit. To enter/edit an allegation, click on the allegation button to get to the view allegations screen. Select the case desired and you may add or delete an allegation or cancel this function.

3. View Report

Click on the view report to get to the case report menu. You may now view the details of the selected case.

5.5 - Section II: Pending Case List by Contractor Screen - (Rev. 3, 11-22-00)

You may perform the same functions as in §5.4 (§I) above: Pending Case List. However, information will be provided specific to the contractor ID number entered.

5.6 - Section III: New Case - (Rev. 3, 11-22-00)

Click [here](#) to view an exhibit of the New Case Screen.

Click on the new case button to get the new case screen. You must enter a FID number at this time to enter new case information. You can move from one data field to another by either using the Tab key or the mouse to move the cursor to that data field. After entering all available information, you must remember to click on the enter provider information to access the provider detail screen and click on the enter complainant information to access the complainant detail

screen. You may also edit the provider information or complainant information using this same approach. If the provider number is not entered at this time, the system will not allow you to save this provider information. The case number and complainant's first, middle initial and last name must be entered to allow you to save the complainants information.

1. Provider Detail - Enter provider information. Click the “enter allegation” button to get to the “view allegations” screen. At this point, you may add an allegation, delete an allegation, or cancel the screen. An allegation is added by typing in an allegation code next to the provider number and then clicking on "OK". You may exit the screen by clicking on the ok-save edits button.

2. Complainant Detail - Enter complainant information, and then close screen.

5.7 - Section IV: Closed Case List - Rev.)

Click [here](#) to view an exhibit of the Closed Case List Screen.

You may perform the same functions as in §5.4 (I) above, however, pending case list information will be provided only for closed cases.

5.8 - Section V: Closed Case List by Contractor - (Rev. 3, 11-22-00)

You may perform the same functions as in §5.5 (§II) above: Pending case list by contractor however, information will be provided for closed cases specific to the contractor ID number entered.

5.9 - Section VI: Report Menu - (Rev. 3, 11-22-00)

Click [here](#) to view an exhibit of the Report Menu Screen.

Click [here](#) to view an exhibit of the IRP Cases List Screen.

Click [here](#) to view an exhibit of the View Case Detail Screen.

Click [here](#) to view an exhibit of the Edit Case Detail Screen.

Click [here](#) to view an exhibit of the Comments Screen.

Click [here](#) to view an exhibit of the Provider Detail Screen.

Click [here](#) to view an exhibit of the Provider Edit Detail Screen.

Click [here](#) to view an exhibit of the View Allegations Screen.

Click [here](#) to view an exhibit of the View Edit Allegations Screen.

Click [here](#) to view an exhibit of the View Complainant Detail Screen.

Click [here](#) to view an exhibit of the Case Report Screen.

The report menu provides a variety of management reports in brief format and detailed format. Click on the report menu from the main IRP menu. Select the type of report desired from the following list:

A. Brief List

- All Cases;
- Pending Cases;
- Closed Cases;
- Rewarded Cases;
- Recovery From Ten Thousand Up; and
- Notified But Not Rewarded

B. Detail List

- All Cases

C. List By Contractor

- All Cases- Brief; and
- All Cases- Detailed

Exhibit 6 - LMRP Format (Rev. 44, 07-25-03)

Contractors must ensure that all new LMRPs are written in the following format. Contractors must also ensure that all LMRPs revised after 5/1/2003 are written in the following format. Contractors are encouraged to format all revised policies as follows. Contractors may display on their websites column and headings instead of using the table format as shown below but the LMRP content must include all the same information.

The column “Mandatory During Conversion” indicates whether the field is required for conversion from www.LMRP.net to the Medicare Coverage Database.

The column “Mandatory After Conversion” indicates whether the field is required for all new and revised LMRPs after 5/1/2003.

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
Contractor Name	Mandatory	Mandatory	The name of the Contractor.	Picklist (Select one)
Contractor Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The unique identifier assigned to a Contractor by CMS.	Automatic Fill-in
Contractor Type	Mandatory	Mandatory	The type of contractor responsible for the policy.	Picklist (Select one)
LMRP Database ID Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	A unique identification number assigned to an LMRP by the LMRP Data Entry System.	Automatic Fill-in
LMRP Version Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	A unique identification number assigned to an LMRP, each time it is edited, by the LMRP Data Entry System	Automatic Fill-in Integer beginning with an "L"
LMRP Title	Mandatory	Mandatory	A one-line description of the topic or subject matter of the policy.	Text
Contractor's Policy Number	Optional	Optional	The unique policy identifier designated by the policy author to an LMRP.	Text
AMA CPT Copyright Statement	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The copyright statement in each LMRP: "CPT codes, descriptions and other data only are copyright 2002 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."	Automatic Fill-in
CMS National Coverage Policy	Optional	Optional	The associated CMS National Coverage Determination or Coverage Provision in an Interpretive Manual. A description if a National Coverage Determination or Provision is being expanded, adds greater clarification and/or codes.	Memo
Primary Geographic	Mandatory	Mandatory	The geographical area [i.e., state(s)]	Picklist (Select one or

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
Jurisdiction			to which the policy applies.	more)
Secondary Geographic Jurisdiction	Optional	Mandatory (for FIs and RHHIs who have a secondary geographic jurisdiction)	The secondary geographic area [i.e., state(s)] for those facilities (primarily for chain organizations) that nominate a FI or RHHI to process their claims.	Picklist (Select one or more)
Oversight Region	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The CMS region that has oversight responsibility for a CMS contractor's LMRP development process even though that contractor may operate in more than one CMS region.	Automatic Fill-in
CMS Consortium	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The consortium associated with the Oversight Region.	Automatic Fill-in
DMERC Region LMRP Covers	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The region that the DMERC policy covers.	Automatic Fill-in
Original Policy Effective Date	Mandatory	Mandatory	The date the policy originally went into effect. Also includes optional descriptive text indicating what the effective date refers to.	Date (mm/dd/yyyy)
Entire Policy Ending Date	Optional	Mandatory (System will auto-fill)	The date the entire policy is no longer in effect (i.e., policy retired).	Automatic Fill-in
Revision Effective Date	Optional	Mandatory for revised policies	The date on which a revision of the policy went into effect or became effective. Also includes optional descriptive text indicating what the effective date refers to: -for services performed on or after this date -for claims received on or after this date.	Date (mm/dd/yyyy)
Revision Ending Date	Optional	Mandatory (System will auto-fill)	The date on which a revision of the policy is no longer effective (i.e., subsequent Revision Effective Date entered or policy retired).	Automatic Fill-in

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
LMRP Abstract	Mandatory	Mandatory	Prior to 2/1/03: Characterize or define the service and explain how it operates or is performed. Use this filed to enhance the policy subject. All new/revised LMRPs entered into the database after 2/1/03: Enter here a brief explanation of the LMRP.	Memo
Indications and Limitations of Coverage and/or Medical Necessity	Optional	Mandatory	The general indications for which a service is covered and/or considered reasonable and necessary. Also, the limitations such as least costly alternative reductions.	Memo
CPT/HCPCS Section	Optional	Mandatory	The CPT/HCPCS section (Heading Levels 1 and 2) that applies to the policy.	Memo
Benefit Category	Mandatory	Mandatory	The benefit category that applies to the policy.	Picklist (Select one or more)
Coverage Topic	Mandatory	Mandatory	The coverage topics (from the 82 topics that are currently listed in the www.medicare.gov Your Medicare Coverage Database) that apply to the policy.	Picklist (Select one or more)
Type of Bill Code	Mandatory (for FIs and RHHIs)	Mandatory (for FIs and RHHIs)	The related type of bill codes for the service. Type of Bill Code applies only to FIs and RHHIs.	Picklist (Select one or more)
Revenue Codes	Mandatory (for FIs and RHHIs)	Mandatory (for FIs and RHHIs)	The related revenue code (Version I) for the service.	Code List (Enter one or more)
CPT/HCPCS Codes	Mandatory (for FIs, Carriers, and DMERCs)	Mandatory (for FIs, Carriers, and DMERCs)	The related CPT/HCPCS codes and any appropriate modifiers for the service. Contractors may list NOC codes in this field.	Code List (Enter one or more)
Does the “CPT 30% Rule” apply?	Mandatory	Mandatory	The short descriptor should be displayed for a CPT code if more than 30% of the CPT section codes are used in the LMRP. Otherwise, the	Radio button (Y/N/ Undefined)

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			long CPT descriptors should be displayed. Possible options for this field include Yes, No, and Undefined.	
Not Otherwise Classified (NOC)	Optional	Optional	The NOC code and the classified codes associated with the text. This field will be eliminated in the future. Contractors should list NOC codes in the “CPT/HCPCS Codes” field instead.	Code List (Enter one or more)
ICD-9-CM Codes that Support Medical Necessity	Mandatory (for FIs, Carriers, and RHHIs)	Mandatory (for FIs, Carriers, and RHHIs)	The ICD-9-CM codes for which the service is general covered, and/or considered medically necessary. A policy can be associated with one or many diagnosis codes.	Code List (Enter one or more; may enter ranges)
Diagnoses that Support Medical Necessity	Optional	Optional	In the absence of ICD-9-CM codes, the medical diagnoses that supports the medical necessity for the service.	Memo
ICD-9-CM Codes that DO NOT Support Medical Necessity	Optional	Optional	The ICD-9-CM codes that do not support the medical necessity of the service.	Code List (Enter one or more; may enter ranges)
Diagnoses that DO NOT Support Medical Necessity	Optional	Optional	In the absence of ICD-9-CM codes, the medical diagnoses that do not support medical necessity of the service.	Memo
Reasons for Denials	Optional	Mandatory	The specific situations under which a service will always be denied. Also, list the reasons for denial such as investigational, cosmetic, routine screening, dental, program exclusion, otherwise not covered, or never reasonable and necessary.	Memo
Noncovered ICD-9-CM Codes	Optional	Optional	The ICD-9-CM codes that are never covered.	Code List (Enter one or more; may enter

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
				ranges)
Noncovered Diagnoses	Optional	Optional	The medical diagnoses that are not covered.	Memo
Coding Guidelines	Optional	Optional	The relationships between codes. Define how services are billed. Include information about the units of service, place of service, HCPCS modifiers, etc. An example of an appropriate coding technique is "use CPT xxxxx to bill this service rather than yyyy."	Memo
Documentation Requirements	Optional	Optional	Specific information from the medical records or other pertinent information that would be required to justify the service.	Memo
Appendices	Optional	Optional	A text narrative of appendices for the LMRP that is searchable. Future enhancements will allow attachment of forms, graphics, and tables.	Memo
Footnotes	Optional	Optional	This field contains the footnotes for the LMRP.	Memo
Utilization Guidelines	Optional	Optional	The information concerning the typical or expected utilization for the service.	Memo
Other Comments	Optional	Optional	Other information not included in other fields.	Memo
Sources of Information and Basis for Decision	Optional	Mandatory for new policies	The information sources, pertinent references (other than national policy) and other clinical or scientific evidence reviewed in the development of this policy. Cite, for example: Agency for Health Care Policy and Research (AHCPR) guidelines, position papers released by specialty societies or other sources used during the development of this policy. Also, include the basis for the coverage decision and references that	Memo

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			may apply.	
Advisory Committee Meeting Notes	Optional	Optional	The meeting date on which the policy was discussed with the advisory committee and/or any notes from the meeting.	Memo
Start Date of Comment Period	Optional	Optional	The date this version of the LMRP was released for comment.	Date (mm/dd/yyyy)
End Date of Comment Period	Optional	Optional	The date the comment period ended.	Date (mm/dd/yyyy)
Start Date of Notice Period	Optional	Mandatory	The date the medical community was notified of this version of the LMRP.	Date (mm/dd/yyyy)
Revision History Number	Optional	Mandatory (for revisions)	The revision number (unique identifier created by a Contractor).	Memo
Revision History Explanation	Optional	Mandatory (for revisions)	An explanation of the revisions made to the policy.	Memo
Disclaimer Specialty Name	Optional	Optional	The system will auto-fill the following text when the LMRP is viewed or printed: "This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with representatives from [fill in appropriate specialty name]."	Memo
Notes	Optional	Not Applicable after the Transition	This field is for Fu Associates data entry users to enter questions that they had while entering the LMRP so that contractors can focus on these areas in their review process. Data entry users will also have the capability to include codes that were not accepted in previous field because they are invalid.	Memo

Note that not all fields that appear in the Coverage Database Data Entry System will appear in the Medicare Coverage Database “front end” search results.

EXHIBITS

Exhibit 6.1 - Local Coverage Determination (LCD) Format

(Rev.)

Exhibit 7 - Sample Letter for On-Site Reviews

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME: CONTRACTOR NAME:

PROVIDER CONTRACTOR ADDRESS:
ADDRESS:

OPENING

Dear _____:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review we have determined that you have been overpaid. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that your facility utilized _____ services at a rate of 50 percent more than that of your peer group.

HOW THE OVERPAYMENT WAS DETERMINED

A random sample of _____ claims processed from 01/01/98 to 06/30/98 was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Our review found that some services you submitted were not reasonable and necessary as required by the Medicare statute or did not meet other Medicare coverage requirements.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable or necessary, and/or you did not follow correct procedures or use care in billing or receiving payment.

The attachment identifies the specific claims that have been determined to be fully or partially non-covered, the specific reasons for denial, an explanation of why you are responsible for the incorrect payment and the amount of the overpayment.

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by _____ and no interest charge will be assessed. Make the check payable to Medicare Part A and send it with a copy of this letter to:

Intermediary's Address

IF YOU DO NOT REFUND WITHIN 30 DAYS:

If you repay the overpayment within 30 days, you will not have to pay any interest charge.

However, if you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time.

On _____ we will automatically begin to recoup the overpayment amount against your pending claims. Recouped payments will be applied to the accrued interest first and then to the principal. If you believe that recoupment should not be put into effect, submit a Statement within 15 days of the date of this letter to the above address, giving the reason(s) why you feel this action should not be taken. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

For copies of the applicable laws and regulations, please contact us at the address shown in our letterhead, to the attention of the _____ Department.

APPEAL RIGHTS:

If you disagree with the overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for a redetermination to:

Address to which redetermination request should be sent

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following national Medicare guidelines in submitting claims for necessary and reasonable _____ services. In addition, you have not followed the Provider Bulletins and letters sent to you regarding local medical review policies and specific problems that we have identified with your billing practices. Your future claims for _____ will be suspended for prepayment review until you correct your billing.

If you have any questions regarding this matter, please contact _____ at _____.

Thank you in advance for your prompt attention to this matter.

Sincerely,

7.1 - Attachment to Letter for Provider Site Reviews - (Rev. 3, 11-22-00)

Following is a list of the claims denied as a result of the review:

- Beneficiary Name: John Smith
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/08/97 - 12/08/97
- Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/97
- Reason for Denial: MRI's are not considered reasonable and medically necessary for the diagnosis of xxxx.
- Why the Provider is Responsible: We believe you knew or should have known that the services were not reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1997, outlined Local Medical Review Policy which indicated that MRI's were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
- Overpayment: \$900.00
- Beneficiary Name: Mary Smith
- HI Claim Number: 000-00-0000B
- Service Dates: 10/01/97 - 10/31/97
- Services Denied and Dates: Physical therapy evaluation and re-evaluation on 10/03/97 and 10/26/97.
- Reason for Denial: The two physical therapy visits are not reasonable and medically necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation.

- Why you are Responsible: In a letter dated 07/30/97 you were notified that such therapy evaluation and re-evaluation were not considered reasonable and necessary. Therefore, you are responsible for the overpayment.
- Overpayment: \$ 200.00
- Beneficiary Name: Tom Jones
- HI Claim Number: 000-00-0000A
- Service Dates: 12/10/97 - 12/31/97
- Services Denied and Dates: 10 physical therapy visits from 12/10/97 - 12/31/97
- Reason for Denial: No plan of care signed by a physician.
- Why you are responsible: We find you responsible for the overpayment because regulations at 42 CFR, and manual instructions at §xxxx, clearly require a plan of care signed by a physician for therapy visits.
- Overpayment: \$1,200.00

7.2 - Exhibit-Sample Letter--Request For Medical Records - (Rev.)

The intermediary uses the following letter to request necessary medical records from the provider.

DATE:

PROVIDER NAME:

INTERMEDIARY NAME:

PROVIDER ADDRESS:

INTERMEDIARY ADDRESS:

PROVIDER NUMBER:

OPENING:

Dear XXXXX:

You have been selected for a comprehensive medical review (CMR) of your billing for Medicare services pursuant to CMS's statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that you may be billing inappropriately for services.

We have selected a random sample of ____ claims for services provided during the period _____ through _____. (See attached listing.) For each of these claims, we are requesting the following information:

[The following list is for illustrative purposes. MR should request any documentation that will permit them to conduct a thorough review of the claims submitted with regard to coverage, eligibility, medical reasonableness and necessity, limitation on liability determinations (§1879), without fault determinations (§1870), etc.]

- Form HCFA-485;
- Form HCFA-486, or equivalent information, if applicable;
- Form HCFA-487, or equivalent information, if applicable;
- Flow sheets or treatment sheets, if used;
- Narrative or progress notes, if used;
- Supplemental order, if applicable;
- Itemized breakdown of supplies, if supplies are billed;
- Lab values, if applicable;
- Copy of the UB-92 for each bill;
- Lab reports for any B12 injections;
- Lab or x-ray reports for any calcimar injection;
- Other _____

The above information should be mailed to the following address within 30 days from the date of this letter:

Intermediary Name, Address, and Contact Person

Our medical review staff will review the documentation you submit for each of the claims to determine if the services billed are reasonable and necessary and meet all other requirements for Medicare coverage. Along with our claims payment determination, we will make a limitation on liability decision for services that are subject to the provisions of §1879 of the Social Security Act (the Act), and a determination in accordance with §1870 of the Act (whether you are without fault for any overpayments).

We will project the overpayments identified in the sample to the universe of claims processed during the time frame described above. We will adjust the projected overpayment to reflect any previously denied claims which are payable, denied claims for which you were found not liable under §1879 of the Act, and denied claims for which you were found to be without fault under §1870 of the Act.

Following our review, we will inform you in writing of our findings. We will provide you with a listing of the claims that were reviewed and our determinations with regard to those claims (i.e., full or partial denials and payable claims), the specific reasons for denial, identification of

denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, the amount of the overpayment or underpayment, and interest accrual on unpaid balances. We will provide you with an explanation of your right to submit a rebuttal statement under 42 CFR 405.370-375 if we determine that you have been overpaid, and your options for repaying any overpayments, or our refund of any underpayments. We will provide you with an explanation of how any overpayment was determined, including the sampling methodology used to project the amount of the overpayment. We will also provide you with a full explanation of your appeal rights, including appeal of the sampling methodology used to determine the overpayment, estimation of the overpayment, coverage decisions, limitation on liability decisions under §1879 of the Act, and our determination as to whether you are without fault under §1870 of the Act.

If you have any questions concerning this request, you may contact me at (telephone number). Your cooperation is appreciated.

Sincerely,

Enclosure: Listing of Sample Claims Requiring Medical Documentation

7.3 - Exhibit: Part A Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME:

INTERMEDIARY NAME:

PROVIDER ADDRESS:

INTERMEDIARY ADDRESS:

PROVIDER NUMBER:

OPENING:

Dear XXXXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.750 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

TOTAL OVERPAYMENTS

(List the aggregate overpayments)

Be advised that this overpayment amount is based on your interim payment rate in effect at the time the review was done. Further adjustments may be made when your cost report is settled.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of the specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the

overpayment is attached. (Enclose a list of the specific claims from the sample that have been found not to be covered. See the example within this exhibit.)

The sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclosed an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by (insert date, 15 days from date of letter). However, you may request an extended repayment schedule in accordance with 42 CFR 401.607(c). Please contact (name of contact person at the FI/RHHI) on (phone number of contact person) to discuss repayment options for the full amount of the overpayment determined by the projection of errors found on the ___claim sample.

INTEREST

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time. Medicare charges interest on its outstanding Part A debts in accordance with §1815(d) of the Act and 42 CFR 405.378.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

As provided in regulations at 42 CFR 401.607(a) and 405.370-375, on (insert date provided in above paragraph captioned, "What You Should Do"), we will automatically begin to recoup the overpayment amount against your pending and future claims. If you do not repay the debt within 30 days, we will apply your payments, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act, we may refer your debt to the Department of Treasury for offset against any monies payable to you by the Federal Government.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

FI Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within fifteen days whether the facts justify continuation, modification, or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2)

of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

If you choose not to submit a rebuttal Statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do "). Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.704, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date you receive this letter (unless you can show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual § _____ for further details.)

If you have any questions regarding this matter, please contact _____ at _____.
(Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.3.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the Results, and Request Repayment of Overpayments (Rev.)

The following is a list of claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A
2. Service Dates: 12/01/96 - 01/15/97
3. Services Denied and Dates: 45 Inpatient SNF Days, 12/1/96 - 1/15/97

4. Reason for Denial: The therapy services rendered were not medically reasonable and necessary because they were for overall fitness and general well being and did not require the skills of a qualified physical therapist (§1879 denial). (Provide details that led you to the conclusion that the services were non-skilled.)

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. We believe you knew or should have known that the services were not medically reasonable and necessary because of the educational contacts made in July 1996 and October 1996 regarding Medicare coverage of therapy services. In these contacts numerous similar examples were cited as noncovered. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: \$2,000.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number:000-00-0000 B
2. Service Dates: 01/01/97 - 01/31/97
3. Services Denied and Dates: 31 Inpatient SNF Days, 01/01/97 - 01/31/97

4. Reason for Denial: There was no skilled care furnished on a daily basis. Skilled therapy services were furnished 2-3 times a week, although therapy is available in your facility on a daily basis.

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. The Medicare coverage guidelines in the SNF manual clearly state the requirement for daily skilled services. You were also notified in educational contacts in July 1997 and October 1997 of similar cases. Therefore, you are responsible for the overpayment.

6. Overpayment: \$200.00

7.4 - Exhibit: Part B Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

SAMPLE LETTER--MEDICARE PART B

DATE:

PROVIDER NAME:

INTERMEDIARY NAME:

PROVIDER ADDRESS:

INTERMEDIARY ADDRESS:

PROVIDER NUMBER:

OPENING:

Dear XXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.841 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclosed a list of the specific claims and an explanation of fault for each. See the example within this exhibit.)

An explanation of the sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclose an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

_____Address

IF YOU DO NOT REFUND IN 30 DAYS

In accordance with 42 CFR 405.378, simple interest at the rate of _____ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the rate of _____.

We must request that you refund this amount in full. If you are unable to make refund of the amount at this time, advise this office immediately so that we may determine if you are eligible for an extended repayment schedule. (See enclosure for details.) Any extended repayment schedule (where one is approved) would run from the date of this letter.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

If payment in full is not received by (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is received.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

Carrier Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within 15 days whether the facts justify continuation, modification or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2) of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.803, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date of this letter (unless you show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and overpayment recovery. (See 42 CFR 405.801, et seq. and 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual Section _____ for further details.)

IF YOU HAVE FILED A BANKRUPTCY PETITION

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If you have any questions regarding this matter, please contact _____ at _____.
(Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.4.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the Results, and Request Repayment of Overpayments
(Rev.)

The following is a list of the claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A
2. Service Dates: 12/08/96 - 12/08/96
3. Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/96
4. Reason for Denial: MRIs are not considered medically reasonable and necessary for the diagnosis of xxxx (§1879 denial).
5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. You knew or should have known that the services were not medically reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1996, outlined Local Medical Review Policy which indicated that MRIs were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
6. Overpayment: \$900.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number: 000-00-0000 B

2. Service Dates: 01/01/97 - 01/31/97

3. Services Denied and Dates: Physical Therapy evaluation and re-evaluation on 01/03/97 and 01/26/97

4. Reason for Denial: The two Physical Therapy visits are not medically reasonable and necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. In a letter dated 10/30/96, you were notified that such therapy evaluation and re-evaluation were not considered medically reasonable and necessary. Therefore, you are responsible for the overpayment.

6. Overpayment: \$200.00

Exhibit 8 – Reserved for Future Use

Exhibit 9 - Projection Methodologies and Instructions for Reviews of Home Health Agencies for Claims Not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Reimbursement Methods for Home Health Agencies (HHAs)

Based on the findings from the statistical sampling for overpayment estimation, the Fiscal Intermediary (FI)/Regional Home Health Intermediary (RHHI) will project by discipline to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by discipline (e.g., skilled nursing, physical therapy) for a specified time frame within a single cost reporting period. They determine the reimbursement method for the service(s) reviewed as shown below to ascertain the appropriate projection methodology to be used.

The HHAs are reimbursed as follows:

- Discipline: Patient Services--Reimbursed By Cost Per Visit
- Skilled Nursing;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;
- Medical Social Services; and
- Home Health Aide Service
- Other Patient Services - Reimbursed By Lower of Costs or Charges
- Cost of Medical Supplies;
- Cost of Drugs

Note that the reimbursement methodology for HHA's was changed by the BBA for cost report periods beginning on or after October 1, 1997.

B. Procedures for Disciplines 1 through 6, which are reimbursed by cost per visit:

The following procedures apply to disciplines 1 through 6, which are reimbursed by cost per visit:

- The sample may be chosen from a frame including claims with a particular or many disciplines;
- For each discipline, MR determines the total number of visits and number of visits denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, § 3.10.1.5 – Consultation with a Statistical Expert; Chapter 3, §3.10.1.6 – Use of Other Sampling Methodologies; and Chapter 3, §3.10.5.1 – The Point Estimate on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert.
- Multiply the proportion obtained above by the total number of Medicare visits in the frame. This will determine the projected total number of visits to be denied for the period and the adjusted Medicare visits;
- If the adjustment occurs prior to the submission of the cost report, the projected denied visits will be multiplied by the provider's interim payment rate per visit to determine the overpayment amount by discipline subject to collection. The FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options;

- Upon submission of the cost report, total visits on the cost report will not change. The cost per visit computation will remain the same. Only the Medicare visits and the total cost of Medicare services will be reduced. The charges that are applicable to these adjusted costs must also be determined. Both of these adjusted totals are needed to settle the cost report. For cost report periods beginning prior to 10/1/97, HHA cost reports are settled on the lesser of reasonable cost or customary charges. Under the BBA, for cost report periods beginning on or after 10/1/97, the methodology for settling HHA cost reports has changed. Medical Review staff must complete worksheets 1-7 and notify Audit and Reimbursement staff of all necessary adjustments so that the amount can properly be reflected in the cost report.

Worksheets 1 through 7 may be accessed by clicking on the links below:

[Worksheet 1: Home Health Agency \(HHA\) Calculation of Medical Review Audit Adjustment, Form HHA/Audit-1](#)

[Worksheet 2: Home Health Agency \(HHA\) Calculation of Charges Applicable to Adjusted/Denied Visits, Form HHA/Audit-2](#)

[Worksheet 3: Home Health Agency \(HHA\) Medical Review Sampling Results, Form HHA/MR-1, page 1](#)

[Worksheet 4: Home Health Agency \(HHA\) Medical Review Sampling Results, Form HHA/MR-1, page 2](#)

[Worksheet 5: Home Health Agency \(HHA\) Medical Review Sampling Results, Form HHA/MR-1, page 3](#)

[Worksheet 6: Home Health Agency \(HHA\) Summary of Results Medical Review Sampling - Form HHA/MR-2](#)

[Worksheet 7: Home Health Agency \(HHA\) Summary of Results of Medical Review - Form HHA/MR-3](#)

C. Procedures for Other Patient Services

The following procedures apply to other patient services:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a

ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;

- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If the adjustment occurs prior to the submission of the cost report, the FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, as in the case for disciplines 1 through 6, medical review staff must complete worksheets 1 - 7 identified in §5.3.7B above, and provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

D. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with HHAs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections on denied HHA services must be made for each discipline and revenue center, as instructed above;
- When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs;
- Information from the completed Worksheets 1 - 7 identified in §5.3.7B above, must be routed to the FI/RHHI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs; and

- Upon completion of the review, furnish the audit and reimbursement staff with the information listed in PIM Chapter 3 §5.3.1.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered for cost based services based on the denied services, units and charges, and the provider's allowed costs;
- Use the information on denied services to ensure accurate settlement of the cost report and/or any adjustments to interim rates that may be necessary as a result of MR findings. Audit adjustments will be made to PS&R statistics on the cost report to decrease Medicare visits, increase other visits (total visits remain unchanged) and to adjust Medicare charges, as necessary; and
- In the event that a cost report has been settled, determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 10 - Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs) for Claims not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on SNF Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center, to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

Ancillary Service Cost Centers reimbursed by Lower of Costs or Charges are:

- Radiology;
- Laboratory;
- IV Therapy;
- Oxygen Therapy;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;

- Electrocardiology;
- Medical Supplies;
- Drugs Charged; and
- Other

NOTE: Effective July 1, 1998, SNF services will be reimbursed in accordance with the provisions in the BBA.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, Sections 3.10.1.5, 3.10.1.6, and 3.10.5.1 on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, Medical Review staff will complete Worksheets 8 - 17, and provide the Audit and Reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 8 through 17 may be viewed by double clicking on the name (link) below:

[Worksheet 8: Skilled Nursing Facility \(SNF\) Calculation of Medical Review Audit Adjustment - Form SNF/MR-1, page 1](#)

[Worksheet 9: Skilled Nursing Facility \(SNF\) Medical Review Sampling Results - Form SNF/MR-1, page 1](#)

Worksheet 10: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 2

Worksheet 11: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 3

Worksheet 12: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 4

Worksheet 13: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 5

Worksheet 14: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 6

Worksheet 15: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 7

Worksheet 16: Skilled Nursing Facility (SNF) Summary of Results of Medical Review Sampling - Form SNF/MR-2

Worksheet 17: Skilled Nursing Facility (SNF) Summary of Results of Medical Review - Form SNF/MR-3

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with SNFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied SNF services must be made by each individual ancillary cost center, as instructed above;
- Denied charges must be segregated between Part A and Part B as the SNF Medicare cost report is set up to apportion costs and make separate settlements for Part A and Part B;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 8 - 17 (PIM chapter 3, §5.3.8 above), must be routed to the FI's audit and reimbursement staff. In addition to the actual and

projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and

- Upon completion of the review, MR furnishes the audit and reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. It is expected that, in most cases, cost reports will not have been settled or even filed.

Exhibit 11 - Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS) for Claims Not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on CORF Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period. When making this determination, the following should be used:

- Ancillary Service Cost Centers that are reimbursed by reasonable costs are:
- Skilled Nursing Care;
- Physical Therapy;
- Speech Pathology;
- Occupational Therapy;
- Respiratory Therapy;
- Medical Social Services;
- Psychological Services;
- Prosthetic and Orthotic Devices;
- Drugs and Biologicals;

- Supplies Charged to Patients;
- DME - Sold; and
- DME - Rented.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, Sections 3.10.1.5, 3.10.1.6, and 3.10.5.1 on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the costs report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete Worksheets 24 - 30, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 24 through 30 may be viewed by double clicking on the name (link) below:

[Worksheet 24: Comprehensive Outpatient Rehabilitation Facility \(CORF\) Calculation of Medical Review Audit Adjustment - Form CORF/Audit-1](#)

[Worksheet 25: Comprehensive Outpatient Rehabilitation Facility \(CORF\) Medical Review Sampling Results - Form CORF/MR-1, page 1](#)

[Worksheet 26: Comprehensive Outpatient Rehabilitation Facility \(CORF\) Medical Review Sampling Results - Form CORF/MR-1, page 2](#)

Worksheet 27: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 3

Worksheet 28: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 4

Worksheet 29: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review Sampling - Form CORF/MR-2

Worksheet 30: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review - Form CORF/MR-3

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CORFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied CORF services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 24 - 30 in PIM chapter 3, §5.3.9A, must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, furnish the Audit and Reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual cost report overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 12 - Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs) for Claims not Paid Under PPS - (Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on CMHC Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount. Determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

When making this determination, the following should be used:

Ancillary service cost centers that are reimbursed by lower of costs or charges are:

- Drugs and Biologicals
- Occupational Therapy
- Individualized Activity Therapy
- Psychiatric/Psychological Services
- Individual Therapy
- Group Therapy
- Family Counseling
- Diagnostic Services
- Patient Training and Education

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in [Chapter 3, Sections 14.1.5, 14.1.6, and 14.5.1] on alternative scientific

methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;

- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete worksheets 18 - 23, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 18 through 23 may be viewed by double clicking on the name (link) below:

[Worksheet 18: Community Mental Health Clinic \(CMHC\) Calculation of Medical Review Audit Adjustment - Form CMHC/Audit-1](#)

[Worksheet 19: Community Mental Health Clinic \(CMHC\) Medical Review Sampling Results - Form CMHC/Audit-1, page 1](#)

[Worksheet 20: Community Mental Health Clinic \(CMHC\) Medical Review Sampling Results - Form CMHC/Audit-1, page 2](#)

[Worksheet 21: Community Mental Health Clinic \(CMHC\) Medical Review Sampling Results - Form CMHC/Audit-1, page 3](#)

[Worksheet 22: Community Mental Health Clinic \(CMHC\) Summary of Results of Medical Review Sampling - Form CMHC/MR-2](#)

[Worksheet 23: Community Mental Health Clinic \(CMHC\) Summary of Results of Medical Review - Form CMHC/MR-3](#)

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CMHCs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied CMHC services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs; and
- Information from the completed worksheets 18 - 23 in PIM chapter 3, §5.3.10A must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts).

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 13 - Postpayment CMR Summary Report Format Example
(Rev. 3, 11-22-00)

Identification Section

Provider	Provider Number
Address	ID No. (SSN or EIN)
If Group, Number of Providers Involved	
See attached for names and individual earnings	
Specialty	Sub-specialty
Repeat providers (years)	

Payment and Utilization Section

Payments: Year	Assigned \$	Unassigned \$
Total Number of Beneficiaries:		
Average Number of Services Per Beneficiary:		
Average Payment Per Beneficiary		
Provider on Prepayment Review:		
For Which Services/procedures:		

For What Period:

Carrier Review Conducted Section

Reason Provider Selected for Comprehensive Medical Review:		
Areas on which Comprehensive Medical Review efforts were concentrated:		
See attached for all procedures for which provider exceeded established norms.		
Material Reviewed		
Claims Sampling Method:		
Number of Beneficiaries:	Number of Months per Beneficiary:	
Computer Printouts (Specify):		
Medical Records (Specify):		
Other Records (Specify):		
Did Medical Staff Review Cases?		If so, what percent?
Contacts Made	Number of Cases Reviewed	Reason
Provider		
SNF		
Hospital		
Beneficiary		

Documentation of §1879 of the Act Determinations Section

List the evidence and rationale indicating that the provider knew or should have known that the services were not medically reasonable and necessary.

Documentation of §1870 of the Act Determinations Section

List the evidence and rationale indicating that the provider was "at fault" in causing the overpayment and that the provider is liable for the overpayment (i.e., recovery of overpayment will not be waived).

Exhibit 13.1 - Excluded Providers - (Rev. 3, 11-22-00)

A. Notice to Beneficiaries

To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services furnished by _____ on _____. Effective _____, _____ was excluded from receiving payment for items and services furnished to Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services furnished by _____ if rendered more than 20 days from the date of this notice."

B. Notice to Others

The Medicare Patient and Program Protection Act of 1987 provides that payment is denied for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act. It also provides that payment cannot be denied until the supplier of the items and services has been notified of the exclusion.

If claims are submitted by a laboratory or a DME company for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act, contractors:

- Pay the first claim submitted by the supplier and immediately give notice of the exclusion; and
- Do not pay the supplier for items or services ordered or prescribed by an excluded provider if such items or services were ordered or prescribed more than 20 days after the date of notice to the supplier, or after the effective date of the exclusion, whichever is later.

To ensure that the notice to the supplier indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services ordered or prescribed by _____ on _____. Effective _____, _____ was excluded from receiving payment for items or services ordered or prescribed for Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services ordered or prescribed by _____ if ordered or prescribed more than 20 days from the date of this notice."

Exhibit 14 - Contractor Denials 1862(a)(1) of the Act - (Rev. 3, 11-22-00)

The determinations which follow a §1862(a)(1) denial may require a decision if the beneficiary or provider knew or could have known that a service would not be covered by Medicare because it would be considered medically unnecessary. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. The beneficiary is liable if it is determined the beneficiary knew, or could reasonably have been expected to know (e.g. utilization review notice from a SNF) that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability (i.e., makes payment to a provider even though a non-covered

service is involved) if neither the beneficiary nor the provider knew, or could reasonably be expected to have known, that the services were not covered. Waiver of liability exists when both the beneficiary and the provider did not and could not reasonably have been expected to know that payment would not be made for services.

To find that a beneficiary knew or should have known that a service would not be covered, written notice from the provider is required or evidence that the beneficiary had received a prior denial for the same or similar services. To find that a provider had knowledge that a service would not be covered, actual or constructive notice is acceptable (e.g., carrier bulletin with final LMRP and effective date). Sufficient notice includes:

- Previous denials for the same service;
- Publication by the contractor in a newsletter or other communication to the provider community that a service is considered not reasonable and necessary or constitutes custodial care;
- Knowledge based on experience; and
- Local standards of practice.

14.1 - Section 1879 of the Act Determination- Limitation of Liability - (Rev. 3, 11-22-00)

Section 1879 provides relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision also applies to denials of home health services beginning July 1, 1987 and ending September 30, 1989, where the beneficiary is not homebound or does not or did not need skilled nursing care on an intermittent basis. The provision applies to all carrier determinations on all assigned claims when claims are denied (prepay or postpay) under §1862(a)(1) of the Act. Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary.

A §1879 determination regarding knowledge is part of the framework for determining whether an actual or potential overpayment exists. If a contractor determines that program payment was proper because neither the beneficiary nor the provider knew or should have known that the service was not reasonable and necessary, no overpayment exists. However, if the contractor determines that either the beneficiary or the provider knew or should have known that a service was not medically reasonable and necessary, an overpayment exists. Contractors must consider waiver of recovery of the overpayment under §1870 of the Act.

A. Documentation of §1879 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary/provider (i.e.,

demand letters) should include all §1879 determinations as to knowledge of noncoverage, both favorable and unfavorable. Document the §1879 determination in the CMR summary report.

B. Section 1879 of the Act Determinations and Overpayments

An overpayment would be \$0 (zero) for postpayment denials for assigned claims and claims submitted to an intermediary from a participating provider because a determination was made that neither the beneficiary nor the provider knew or should have known the services were not covered. Program payment was appropriate. However, if the beneficiary is found to be liable under §1879 of the Act, an overpayment to the beneficiary exists and the contractor must make an §1870 determination.

14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment

(Rev. 3, 11-22-00)

Once the contractor has concluded that an overpayment exists (i.e., postpayment review, including §1879 of the Act waiver determinations is complete), it makes a §1870 determination regarding waiver of recovery of the overpayment from the provider. Carriers make this determination for all claims where the provider took assignment. Section 1870, waiver of recovery, is not applicable for the provider on non-assigned postpayment §1862(a)(1) of the Act denied claims because the overpayment is a beneficiary overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims under §1862(a)(1) (A) of the Act denied for not being reasonable and necessary. Section 1870 is the framework for determining whether overpayment recovery is waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived, the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. Section 1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim and this is the basis for the overpayment.

If §1879 of the Act is applicable, the §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was a lack of knowledge by both the beneficiary and the provider.

A. Documentation of §1870 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or provider

(i.e., demand letters) should include all §1870 refund determinations. Also, document the §1870 determination in the CMR summary report.

B. Section 1870 of the Act Determinations and Overpayments

Where waiver of recovery from the provider is appropriate under §1870, the contractor must show an overpayment amount, but also indicate that recovery is being waived.

C. Section 1870 of the Act Determinations and Extrapolations

If recovery of an overpayment from the provider for one or more claims is waived under §1870 (i.e., the provider was without fault), the amount waived must be included when extrapolating in order to get a true projected overpayment as to exactly how much recovery is being waived. Contractors should subtract the projected waived amount from the projected overpayment amount to get the amount the provider must repay.

14.3 - Section 1842(l) of the Act Determination - Refunds to Beneficiary (Rev. 3, 11-22-00)

For §1862(a)(1) of the Act denials on non-assigned claims involving **physician or supplier** services, carriers must make a determination under §1842(l) regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for postpayment denials.

Carriers make a §1842(l) physician or supplier refund determination if the reviewer concludes that the services were not reasonable and necessary. For physician or supplier claims where assignment was not taken, a §1842(l) refund determination must be made. Carriers must make a determination for each claim that is denied as not reasonable and necessary.

A physician or supplier cannot be considered overpaid if payment was not made to the physician for the claim. A physician or supplier who takes assignment on a claim-by-claim basis may be audited and the sample may include some non-assigned claims. Consideration of a refund on the non-assigned claims denied based on §1862(a)(1)(A) of the Act is appropriate, but a finding that a refund is appropriate does not create a Medicare overpayment.

A. Documentation of §1842(l) of the Act Determination

The carrier must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or physician, or supplier (i.e., demand letters) should include all §1842(l) refund determinations. Document §1842(l) determinations in the CMR summary report.

B. Section 1842(l) of the Act Determination With Respect to Overpayments

A physician refund obligation under §1842(l) is not a determination of a program overpayment. If the refund obligation arises in connection with a postpayment denial, any overpayment would be a beneficiary overpayment.

Exhibit 14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews

(Rev. 17, 12-12-01)

The Medicare law contains two provisions that affect the determination and the recovery of overpayments. One is §1879 of the Act, which deals with limitation on liability for services determined to be noncovered because they are, for example, custodial or are not reasonable and necessary under Medicare law, or, for home health services, the patient is not confined to home or the skilled nursing services are not intermittent. If the denial involves items or services to which the provisions of §1879 (limitation on liability) apply, MR makes a determination in accordance with instructions in MIM §3431, MCM §7300 and CMS Ruling 95-1.

The other law affecting the determination and the recovery of overpayments is §1870 of the Act, which provides a framework within which liability for overpayments is determined and recovery of overpayments is pursued. If the denial of a claim involves items or services to which the provisions of §1879 (limitation on liability) do not apply, or if an overpayment results from a §1879 determination that either the beneficiary or the provider is liable, contractors make a determination as to whether the provider was without fault for the overpayment under the provisions of §1870 in accordance with MIM §3431 and MCM §7300.

Exhibit 15 - Consent Settlement Documents - (Rev. 3, 11-22-00)

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires several letters to be sent to providers or suppliers regarding consent settlement. Contractors shall send to the provider or supplier a request for additional information letter, a consent settlement offer letter, and a no action letter if an overpayment was not found or if an overpayment was found, a letter requesting the moneys owed.

A. First Letter in the Consent Settlement Process: Opportunity to Submit Additional Information Before Consent Settlement Offer Notification

Before a consent settlement is offered, contractors must communicate in writing to the provider or supplier that they have the opportunity to submit additional information. This document shall:

- Explain there may be an overpayment due to an initial evaluation of the records;
- Highlight the nature of the problems in the provider's or supplier's billing and practice patterns identified as a result of the preliminary audit;
- Give steps the provider or supplier can take to address the problems; and
- Identify the forty-five (45) day time frame to furnish this additional information.

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842 of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

Based on our preliminary evaluation of your medical records on _____, (Fill in date) we have found an indication of a potential overpayment. The purpose of this letter is to describe the nature of the problems identified in our evaluation, the steps that you should take to address these problems, and give you the time frame to furnish additional information concerning the medical records for the claims being reviewed.

During our initial evaluation, we have ascertained the following issues,
(List the problems found.)

To resolve these issues and to determine that there is an overpayment, the following are the steps you may take:
(List action that can be taken to resolve the problems.)

You have forty-five (45) days from the receipt of this letter, ____ to submit any additional information concerning the medical records for the claims being reviewed in this evaluation. Send this information to _____. If you have any questions, please contact me at _____.

B. Second Letter in the Consent Settlement Process: Consent Settlement Offer

Consent settlement documents must closely conform to the content of the model language provided below. The consent settlement documents shall explain:

- The responsibility of CMS in conducting audits of providers or suppliers to ensure that Medicare Part B claims have been billed and paid appropriately;
- The date of the initial request for records prior to conducting the audit;
- The steps involved in the audit process;

- The problems in the provider's or supplier's billing and practice patterns identified as a result of the audit;
- To notify the provider or supplier of the potential overpayment calculated as a result of the audit; and
- Two options available to the provider or supplier.

NOTE: The Consent Settlement Documents shall include information regarding statistical sampling for overpayment estimation. Refer to §3.10 of the Program Integrity Manual (PIM) for instructions for the use of statistical sampling for overpayment estimation.

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842(a)(1)(C) of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

On _____, [**Fill-in date of initial request for records prior to conducting audit.**] you received a notification letter stating that you had the opportunity to submit additional information to us after our preliminary evaluation of your records indicated a potential overpayment. On _____, [**Fill-in date of initial request for records prior to conducting audit.**] you also received our request for records to conduct an audit of your practice. The purpose of this letter and attachments is to describe the steps involved in the audit process, to highlight problems in your billing and practice patterns identified as a result of our audit, to notify you of the potential overpayment calculated as a result of our audit, and to outline two options available to you.

Our normal full-scale audit process entails the review of records using statistical sampling for overpayment estimation. However, in the interest of economy and expediency for both you and the Medicare program, as a first step, we elected to perform a limited audit. We reviewed claims and medical records for services rendered to beneficiaries over a period of time, from _____ to _____. While _____ beneficiaries were randomly selected

for our sample from a larger universe of beneficiaries for whom you provided services, it is not done based on our instructions for conducting statistical sampling for overpayment estimation.

You were chosen for an audit because _____ **[Fill-in the reason for the audit. The reason may be exceeding peer norms or a call from a beneficiary. For example, if the provider exceeded peer norms the contractor might want to use the following language: "You were chosen for an audit because our records indicate you exceeded the average utilization rates of your peers by _____% for the same time period. Your specialty is listed as _____. The peer group consisted of _____ who billed for the same procedure(s)."]** We selected the _____ beneficiaries by identifying the procedure codes where your billing exceeded the norm for your peers. Included in the universe are only those beneficiaries for whom you rendered and billed at least one of these procedure codes that was paid by Medicare during the review period. From this universe of beneficiaries, a computer is used to randomly select the beneficiaries to be included in the sample. All claims for the procedure codes at issue that were rendered to the sampled beneficiaries and paid within the _____ time period were audited. **[This sentence may be modified depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is stated, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.]** The list of sampled beneficiaries, dates of service, and procedure codes is contained in the attachment to this letter.

The beneficiaries included in our audit resulted in claims being paid by Medicare between _____. **[See note in preceding paragraph. Similar rewording may be required here.]** These claims and their corresponding medical records were audited, resulting in a potential overpayment of \$_____ including an actual overpayment of \$_____ for the _____ beneficiaries. Item 3 under "Audit Results" explains how we calculated the potential overpayment. Please review the attached documents containing the audit results and options along with an explanation of the Extended Repayment Plan.

We must have your response to this letter within sixty (60) days from the date of this letter, _____. If we do not receive a response from you by _____, statistical sampling for overpayment estimation will be chosen for you by default (see attached discussion of audit results). Be advised that by signing this letter your legal options may be affected. Please also be advised that repayment of the overpayment specified herein in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. You may wish to have legal counsel review this letter before signing it. If you have any questions, please contact me –

at _____.

Sincerely,

Attachments

C. Consent Settlement Attachment 1 Audit Results

IDENTIFYING INFORMATION

List the following information in the heading of the attachment:

- Date;
- Provider Name;
- Provider Address; and
- Provider Number.

SCOPE OF AUDIT

This audit covers services that were paid by Medicare from _____ to _____. **[Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is currently stated, all claims would have to have been acutally paid within the time period. Whichever method is used, you must be consistent.]**

The audit revealed the following problems in your billing and practice patterns:

ISSUES/DETERMINATIONS

A physician reviewer, specializing in _____ **[You are required to have a medical specialist involved in the review of the sample claims that are not based on application of clearly articulated existing MR policy. Fill-in the specialty here.]** was consulted during the audit process. The following claims and submitted records of determinations were used in the review.

[This area lists the problem areas noted above, such as exceeding peer norms and medical necessity/documentation concerns. Additionally, each of the sampled beneficiaries, dates of services, procedure codes, and the Medical Director's determination on each denied service is noted here. Attach newsletters discussing medical policy and documentation requirements for the problem areas found during the audit.]

[This is also the area where you explain the §1879 and §1870 determinations, perhaps using, in part, the following language:

For §1879: "Based on available information, we believe you knew or should have known that..."

For§1870: "We have made the determination that you were not "without fault" in causing the overpayment. Therefore, we are not waiving your obligation to repay. We cannot find you without fault because..."

Rationale for the §1879 and/or §1870 findings might include all or part of the following language:]

"The management of a medical or supplier practice that includes a large number of Medicare beneficiaries must understand the conditions governing which services will be covered and payable under Part B of the Medicare Program. Pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of carrier newsletter], from a meeting you attended on date, and from your peers in the medical community ."

Carriers need to make specific findings for §1879 and §1870. The rationale for finding provider knowledge or fault with regard to a particular claim may not be the same as for another claim. This may be so even for multiple denials for a particular code since MN is a unique and individualized determination. These individual findings are especially important if #167;1879 and/or §1870 determinations are partially favorable. In such cases, specify which of the sample claims are affected, why, and how much this reduces the actual and total potential overpayment amounts (see §1879) or reduces the amount of the actual and total potential overpayments which must be refunded (see §1870).

Because §1879 and 1870 determinations are difficult concepts, it is important to explain to physicians exactly why they are being held responsible under these provisions. Your explanation must go beyond conclusory statements and/or findings.]

CALCULATIONS

A copy of our calculation worksheet is enclosed for your information. To calculate the potential projected overpayment amount for each denied procedure code, the following formula was used:

[In this section, insert a complete explanation of the methodology used to calculate the overpayment and the projected overpayment for each denied procedure code. The explanation must include the formula used when the audited services were down coded rather than denied and when only one example of a procedure code was audited.]

Procedure Code Denied	Denied	Down-	Down-	Potential
Services	Services	coded	coded	Overpayment
#Sample	#Universe	Services	Services	
		#Sample	#Universe	

[This table lists procedure codes, the number of services in the sample and in the universe that were denied or down-coded, and the resulting potential overpayment amount.]

The actual overpayment amount is \$_____. The sum of all potential projected procedure code overpayments, including the actual overpayment amount, is \$_____.

OPTIONS

You must now select one of the two options explained below. Our normal audit process entails the routine use of Option One. However, we are now making another option available to you as a consent settlement.

If you fail to notify us of your selected option, Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation) will automatically be selected for you by default. Be aware that when statistical sampling for overpayment estimation is selected for audit, records for all of the services at issue must be available for review.

Please send in your response to the options listed below within sixty (60) days from the date of this letter, _____ .

Regardless of the option selected, beneficiaries **may not** be billed for any of the overpayment amount.

Option One Election to Proceed to Statistical Sampling for Overpayment Estimation

If we do not hear from you within sixty (60) days from the date of this letter, _____, we will proceed with Option One by default. [This is the second step in the audit process if you have been offered a consent settlement on a potential overpayment but do not accept the offer.] This step utilizes statistical sampling for overpayment estimation for the same universe or time period. Your right to appeal to a Hearing Officer, an administrative law judge or to the court remains if you should choose this option. Also, any rights available to you under §1870 and/or 1879 of the Social Security Act remain.

Be aware that this option, either by your selection or by default, means that you are required to submit medical documentation for all of the services at issue in the statistical sampling for overpayment estimation [(just as you would have had to do if we had not first offered you the opportunity for a consent settlement on a potential overpayment).] You should also be aware that this option, whether selected by you or by default, withdraws the option of a consent settlement, as described in Option Two.

If you elect (or accept by default) Option One, it is important that you understand the following information concerning our actions and your responsibilities with regard to the actual overpayments found for the claims involved in the limited audit:

The potential projected overpayment referred to in this correspondence is based on a sample of _____ beneficiaries. We audited claims and medical documentation for the _____ beneficiaries in the sample to arrive at an actual overpayment for these claims. The actual overpayment amount was then projected to the universe of procedure codes to develop the potential projected overpayment. (See above for the actual overpayment amount and the potential projected overpayment amount.)

Option Two involves repayment of the potential projected overpayment, which includes the actual overpayment amount. Choosing Option One does not eliminate your obligation to repay the actual overpayment. Recoupment of the actual overpayment identified for the claims in the limited audit will be pursued individually, but their recovery will be credited against any projected overpayment for the universe to which the claims belong. Your obligation to repay the overpayment for these claims will begin on the date of the official notification of overpayment. You will be notified of your appeal rights on these claims at this same time.

Option Two Acceptance of Consent Settlement Offer

You agree to repay the potential projected overpayment, after providing additional medical documentation relevant to the ____ beneficiaries involved in our sample which was in existence at the time the services were rendered.

Review of this information will result in one of three decisions:

- All services in contention could be determined to be appropriate and allowed as originally processed, and the question of any potential overpayment would be eliminated; or
- A portion of the services in question could be determined to be appropriate and allowed as originally processed, and the amount of the potential overpayment would decrease accordingly; or
- The audit results could remain the same and the potential projected overpayment would remain at \$_____.

You may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination.

If you select Option Two, you agree to refund the revised potential overpayment amount, if any, which will not exceed the dollar amount calculated in Item 3 of this attachment and printed above.

The revised potential overpayment amount will not exceed the capped amount.

By selecting this option, regarding repayment, you agree that there was a problem in your billing as identified by the carrier, you intend to correct this problem in future billings, and you understand how we reached the potential overpayment, i.e., you understand the sampling methodology used and the methodology to project the potential overpayment. Because you agree that there was a problem and agree to make changes in your practice to resolve this problem, you waive your right to appeal the sampled individual overpayments, the potential overpayment resulting from the projection and the sampling procedures. The appeal rights you are waiving include a hearing before a Hearing Officer, Administrative Law Judge, or in the Courts. You also waive any rights you have under §1870 and/or 1879 of the Social Security Act. (Please see Items 6 and 7 in this attachment for a discussion of these rights.)

Election of Option Two means that, in the absence of potential fraud, we will not audit your claims for any procedure codes projected in our audit during the audit time frame again. In the event of fraud and/or if you fail to correct the identified problems, we reserve the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

ASSESSMENT OF INTEREST

We wish to make you aware, should you elect Option Two, that interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final potential overpayment, if any. Should you choose Option One, interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final overpayment determination. We must assess interest as provided in 42 CFR §405.376. Interest will accrue on the unpaid balance for each thirty (30) day period (or portion thereof) that repayment is delayed. The current interest rate is _____ %.

LIMITATION OF LIABILITY

Section 1879 of the Social Security Act (42 USC §1395pp, 42 CFR §411.406) permits Medicare payment to be made to providers on assigned claims for certain services otherwise not covered because they were not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or were custodial services if neither the beneficiary nor the provider knew, or could reasonably be expected to know, that the services were not medically necessary or were for custodial care. Services affected are those disallowed as not reasonable or necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member and those disallowed as custodial services.

WAIVER OF OBLIGATION TO REPAY UNDER §1870 OF THE SOCIAL SECURITY ACT

Section 1870 of the Social Security Act (42 USC §1395gg, 42 CFR §405.704(b)(14)) permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. This determination is made after §1879 is considered. If it is determined that you or the beneficiary knew or should have known that the service was not medically necessary and reasonable or constituted custodial care as described under the provisions of §1879, we address §1870 and determine whether you were "without fault" with respect to causing the overpayment.

GENERAL

We wish to ensure that you are aware of regulations and provisions of the law relating to continuation of the problems discussed herein. They include exclusion from the Medicare Program in accordance with §1128(b) of the Social Security Act (42 USC §1320a-7), civil monetary penalties or other actions in accordance with §1128A of the Social Security Act (42 USC 1320a-7a), and/or, if appropriate, withholding payment under 42 CFR 405.370.

Your decision regarding this matter must be in writing and received by this office within sixty (60) days from the date of this letter. If your decision is not received by the above-mentioned date, Option One, Election to Proceed to statistical sampling for overpayment estimation, will be selected for you by default.

We have enclosed two copies each of the two option forms for your convenience. Select one of the options, complete and sign both forms corresponding to that option, and send them to my personal attention at the address shown below.

The provider must personally sign the forms. A signature stamp, or the signature of a staff member or attorney is not acceptable. After receipt of the two identical option forms with authorized signatures, we will sign both forms and return one to you.

Name:

Title:

Address:

Telephone number:

D. Consent Settlement Attachment 2: Option One - Election To Proceed To Statistical Sampling For Overpayment Estimation

Option One - Election to Proceed to Statistical Sampling for Overpayment Estimation

I, _____:

- have read the results of the audit findings in the letter dated _____.
- elect to proceed to your full-scale audit process, involving use of statistical sampling for overpayment estimation for the same universe of procedure codes and time period as the limited audit, as explained in the letter. I understand the full-scale audit process is the normal audit process, and that the limited audit was offered to me only in the interest of economy and expediency. Upon selection of Option One, I understand that the offer of a consent settlement as stated in Option Two is withdrawn.
- understand that I and/or my office staff will be required to submit medical documentation for all services at issue in the statistical sampling for overpayment estimation, upon request by the carrier.
- understand that all applicable appeals rights, including any right to a hearing officer hearing, an administrative law judge hearing, or court review are available to me. I also retain any rights available under §1879 and/or 1870 of the Social Security Act, as appropriate.
- understand that the claims from the above-referenced limited audit will not be selected for inclusion in the statistical sampling for overpayment estimation; the statistical sampling for overpayment estimation will be a new and independent audit.
- understand that the overpayment identified for claims in the limited audit will be pursued on an individual basis, and that this overpayment will be subtracted from any overpayment resulting from the statistical sampling for overpayment estimation; that I will be provided with appeal rights regarding the overpayment amount on the claims in the limited audit at a later date; and that any interest on the overpayment amount on the claims in the limited audit will be calculated from the date of this later notice with appeal rights.

- understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.

Provider signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Carrier Representative Signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

E. Consent Settlement Attachment 3 Option Two - Acceptance of Consent Settlement Offer

I, _____:

- have read the results of the audit findings in the letter dated_____.
- understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding a redetermined amount of up to \$_____to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.
- have enclosed additional documentation for you to review for the purpose of redetermining the potential overpayment. I understand that I may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination. I understand the redetermined potential overpayment, if any, will not exceed the amount shown above.
- understand that if the redetermined settlement amount is not refunded to Medicare within thirty (30) days from the date of the redetermined potential overpayment notice, the unpaid balance is subject to offset. I may apply for an extended repayment plan and, if approved, may make payments over an approved period of time.

- understand that interest on the amount accrues from the date of the final potential overpayment determination, but that this interest will be waived if repayment is made within thirty (30) days from the date of the final potential overpayment determination.
- understand that claims paid to me from _____ to _____ will not be audited in the future. [**Reword this statement to reflect services dates if service dates were used in the audit to select claims instead of dates of payment.**] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.
- understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.

I, _____, agree by settling this:

- that my right to appeal, which includes a Medicare Part B hearing officer hearing, administrative law judge hearing, or any court appeals regarding this matter, is waived. I also understand any rights available to me under §1879 and/or 1870 of the Social Security Act are waived.

I, _____, do/do not (circle one) wish to request a meeting at this time to discuss the additional documentation I have submitted.

Provider signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Carrier Representative Signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

F. Consent Settlement Attachment 4: Extended Repayment Plan (ERP)

It has been determined by an audit that there is a potential overpayment amount due to Medicare. It is expected that you will remit the entire amount in one payment within thirty (30) days of the date of the final potential overpayment determination if you select Consent Agreement Option Two (Acceptance of Consent Settlement Offer), or, if you select Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation), the date of the final overpayment determination. However, if you are unable to repay the amount within that time, we are authorized to consider repayment in installments based on validated financial hardship.

[Installments are based on the amount of the overpayment as stated in Financial Management, Chapter 4, §§20, 30.] Installments can range from 2-6 months based on the amount of overpayment. Be aware that if repayment is not made within thirty (30) days, interest will be due. If you select Consent Agreement Option Two, interest accrues from the date of the final potential overpayment determination, or if you elect Option One, interest accrues from the date of the final overpayment determination (See 42 CFR 405.378.). Interest will be waived if repayment is made within thirty (30) days of the applicable date cited above for the option chosen. The current rate of interest is _____ percent. If you wish to claim financial hardship, contact _____ to obtain the financial statement of debtor form (CMS-379). This form must be completed and returned with your request for approval of an installment schedule. If compliance with the above is not acceptable to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.

If repayment of the amount due, in a lump sum or on an approved installment plan, is not forthcoming, the Centers for Medicare & Medicaid Services may, at its option; forward the case to the Department of Justice or the Internal Revenue Service (IRS) for enforced collection.

G (1). Third Letter in the Consent Settlement Process: No Action if an Overpayment Was Not Established

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on _____, (Fill in date) we have not found an indication of an overpayment. No additional action on your part, is deemed necessary.

If you have any questions, please contact me at_____.

Sincerely,

G (2). Third Letter in the Consent Settlement Process: Request for Money Owed if Overpayment was Established

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on_____,_ (Fill in date) we have found an indication of an overpayment and the option of a (state if provider elected the statistical sampling for overpayment estimation or accepted the consent settlement offer) was selected. You owe ___(state the amount of money owed).

If you have any questions, please contact me at_____.

Sincerely,

Exhibit 16 - Model Suspension of Payment Letters - (Rev. 3, 11-22-00)

A. Notice Concurrent with Effective Date of Suspension: Failure to furnish information; suspected fraud or misrepresentation; or harm to Trust Funds.

[DATE]

[NAME AND ADDRESS OF PROVIDER]

RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you that your Medicare payments have been [SPECIFY: fully or partially] suspended as of the date of this letter pursuant to CMS regulatory authority found at 42 CFR 405.371(a). This suspension of your Medicare payments may last up to 180 days from the date of this letter and may be extended under certain circumstances. (See 42 CFR 405.372(d).) The Centers for Medicare & Medicaid Services (CMS), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. CMS's decision to suspend payments is not appealable per 42 CFR 405.375(c).

The suspension of your Medicare payments is based on the following: [LIST THE SPECIFIC SOURCE AND NATURE OF THE RELIABLE INFORMATION ON WHICH THE SUSPENSION DECISION IS BASED, EXCEPT FOR FRAUD OR MISREPRESENTATION. FOR FRAUD OR MISREPRESENTATION, THE RO, OR FOR PSCs, THE GTL, CO-GTL, AND SME, WILL PROVIDE DIRECTION ON THE CONTENT OF THE NOTICE.]

During the suspension period, we will review additional evidence to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. (See 42 CFR 405.372(c).) We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to process during the suspension period and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, payment will not be made as long as suspension is in effect. Suspended funds will be used to recoup any determined overpayment.

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing within fifteen (15) days addressing why the suspension should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]

[TITLE]

[AGENCY]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

Upon receipt of your rebuttal statement and any supporting evidence, it will be determined within fifteen (15) days whether the facts justify termination of the suspension per 42 CFR 405.375(a). We will send you separate written notice of the determination to either continue or terminate the suspension. (See 42 CFR 405.375(b)(2).) This separate notice will contain specific findings on the conditions by which your suspension is continued or terminated, as well as an explanatory statement of the determination.

If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

B. Notice Prior to Suspension:

[DATE]

[NAME AND ADDRESS OF PROVIDER]

RE: Notice of Suspension of Medicare Payments to [PROVIDER]

Dear [PROVIDER]:

The purpose of this letter is to notify you of our intent to [SPECIFY: fully or partially] suspend your Medicare payments pursuant to 42 CFR 405.371(a). The suspension of your Medicare payments will take effect fifteen (15) days from the date of this letter [OR SPECIFY DATE]. The suspension of your Medicare payments may last up to 180 days from the effective date of the suspension and may be extended under certain circumstances. (See 42 CFR 405.372(d).)

The Centers for Medicare & Medicaid Services (CMS), through its Regional Office in [REGIONAL OFFICE CITY], is responsible for the decision to suspend your Medicare payments. CMS's decision to suspend payments is not appealable per 42 CFR 405.375(c). We will apply suspended funds to recoup any determined overpayment.

The suspension of your Medicare payments is based on reliable information that: [LIST SPECIFICS OF RELIABLE INFORMATION ON WHICH SUSPENSION DECISION IS BASED.]

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing within fifteen (15) days addressing why the suspension should not be initiated or should be

removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be initiated or should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

After we receive your rebuttal statement and evidence, it will be determined within fifteen (15) days whether the facts justify initiating the suspension as described above per 42 CFR 405.375(a).

However, the decision to suspend Medicare funds will not be delayed beyond the date specified in this notice while your statement is being reviewed. (See 42 CFR 405.375(a).) We will send you separate written notice of the determination not to initiate, or to continue, or to terminate the suspension. (See 42 CFR 405.375(b).) This separate notice will contain specific findings on the conditions by which your facility's suspension is continued or removed, as well as an explanatory statement of the determination.

If suspension is initiated, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. (See 42 CFR 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. However, payment will not be made as long as the suspension is in effect. Suspended funds will be used to recoup any determined overpayments pursuant to 42 CFR 405.372(e).

If you have any questions, please contact me at [TELEPHONE NUMBER].

Sincerely,

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER][FAX NUMBER]

16.1 - OIG/OI Case Referral Fact Sheet Format - (Rev. 3, 11-22-00)

Heading	Description of Information to Include
Subject's Name	Provider/Physician/Supplier/Individual/Corporation>
Allegation	Simply stated (kickback/false claims, etc.)
Source of Complaint	Simply stated - (beneficiary/competitor/OIG)
Contractor Investigator - (Contact person)	If the contact person is not the case investigator, include both the contact person and the investigator's names and telephone numbers. Also include the reference number, if applicable (OI case number if assigned by the RO.
Subject's Address	Home; and Office/Business
Corporate/Business Name Used	If other than subject's name
Overpayment Estimate (if known or calculated)	
History of Contact	List all contacts with OIG and note any guidance given with OIG

16.2 - OIG/OI Case Summary Format - (Rev. 3, 11-22-00)

Heading	Description of Information to Include
Summary of Original Allegations/Complaint Source	Date complaint was received; who made complaints; how actions were taken to corroborate information (pulled bills and payment information, contacted complainant); overpayment identified by complaint.
Citations	Code of Federal Regulation; Manual Provisions
Identify the Amount of the Actual Overpayment Established	Detail claim information related to allegation; i.e., number of claims submitted/paid; amount paid/ procedure codes involved; pertinent profile information.

Estimated Additional Overpayment/Scope of Alleged Fraud Be specific on how this estimated amount was determined, i.e., billing for specialized procedure and the total number of these procedures that were billed; therefore, if all were false, the overpayment would be \$_____ dollars.

Billing Information (Last 3 Years) (Report Data For Questions Procedures and Total Billings)19__ 19__ 19__

- Total covered charges-Part A;
- Total non-covered charges;
- Total DRG payments;
- Total Admissions; and,
- Total Medicare admissions.
- National pass-through costs, SNF or HHAs - Under reasonable cost payment (last 3 years):
- Total costs;
- Total allowable costs;
- Total Medicare payment;
- Total patient days; and
- Total Medicare patient days.

Medicare Coverage/Intermediary Payment Guidelines Summarized Be specific as to the Medicare coverage issue involved. Define necessary medical terms and describe the necessary medical procedures in layman's terms. Procedure code description.

Identify Copies of All Correspondence, Newsletters, Publications Briefly summarize all newsletters, publications, and/or correspondence related to the issue at hand. Attach a copy of each.

Additional Development

- Summarize the information received through interviews that corroborate the original complaint. Attach interview reports and copies of Medicare claims used to arrive at this summary.
- Summarize new allegations identified. Attach interview reports and copies of Medicare claims used to arrive at this summary.
- Summarize the information obtained that

appears to refute the original allegation or new allegations identified.

Background Information on Subject

Date of birth; any known disabilities; schools attended; State licenses; number of employees and names; previous investigation by contractor; previous complaint history; all other pertinent information.

Telephone Number(s)

Specialty

EIN/SSN

(Include **ALL** tax identification numbers)

Provider Number(s)

Date Issued; Related Numbers; and, Application (If required)

Details of Past Complaints (If Identified Above)

Summarize complaint history, including the details of actions taken and all other pertinent information.

Detailed Correspondence History with Subject

- Summarize all direct correspondence with subject regarding the allegation at hand (if contacted) and/or all other correspondence related to allegation(s) at hand.
- Alert OI to any congressional or press interest, or any public relations problem.

Other Agencies Involved

- If a referral has been made to any other agency, such as the licensing board of a State or a State Medicaid agency, show when it was done and who that material was directed to. Attach any correspondence sent to those agencies; and
- If aware of any other agency investigating the subject, include that information.

Other Pertinent Information

- Is this provider/facility a member of a chain within and/or outside the area? If so, identify the chain and all other facilities it owns or manages in the area;
- List all related organizations. Specify

whether they were identified by the provider or uncovered through audit;

- What is the subject's filing history? Were the bills denied? Why? Were the denials appealed? Who requested an appeal, and through what mechanism was the appeal requested? What was the outcome of the appeal? Were determinations made by a Hearing Officer and/or an Administrative Law Judge;
- Was a review of services done on the areas where this subject exceeded the norm of his peers? For example, if the complaint was for non-rendered lab work, did the subject exceed the norm in that area? List the areas as items that may need to be investigated; and
- List other items known that would assist the OIG in evaluating this case.

Complaints by current or former employees of the subject should always be considered for immediate contact with the office of investigations. OI may wish the contractor to restrict its case development to internal research.

List of Attachments

If additional information is needed, OI may request assistance. Where potential violations are detected in one facility of a chain, all intermediaries dealing with other members of the chain are alerted to the situation by the respective OIs. The MFIS notifies the RO, other carriers and intermediaries, and other State and local agencies within their network. If the problem extends beyond the MFIS's network, other MFIS s are contacted.

Retain a copy of the summary in the case file.

Exhibit 17 – Signature Attestation Form (for missing or illegible signatures)
(Rev.)

Exhibit 18 - Corrective Action Reporting Formats
(Rev. 360, Issued: 12-10-10, Effective: 12-01-10, Implementation: 01-12-11)

A. Corrective Actions Taken on CMS and OIG Identified Vulnerabilities Format

Contractor Name and Jurisdiction: (To be completed by AC/MAC)

Date Report Submitted to CMS: (To be completed by AC/MAC)

<i>Issue Name or Number (Completed by CMS)</i>	<i>Date (completed by CMS)</i>	<i>Description (completed by CMS)</i>	<i>Provider Type</i>	<i>Actions taken by AC/MAC</i>	<i>Date Actions Taken</i>	<i>Future Actions planned by AC/MAC (actual and possible)</i>	<i>Other Comments/Concerns (if applicable)</i>

B. Overpayment Recovery on OIG Claims Format

Contractor Name and Jurisdiction: (To be completed by AC/MAC)

Date Report Submitted to CMS: (To be completed by AC/MAC)

<i>OIG Report Number (e.g. A-01-09-00050) (completed by AC/MAC)</i>	<i>Overpayment Recovery (in dollars) (Completed by AC/MAC)</i>	<i>OPTIONAL Overpayment s referred or uncollectable (in dollars) (Completed by AC/MAC)</i>	<i>Reason for no review of claims and no recovery (if applicable) (Completed by AC/MAC)</i>	<i>Final Reporting Date for this audit (completed by CMS)</i>	<i>Other Comments or Actions Taken (if applicable)</i>

Exhibit 19 – Reserved for Future Use –

(Rev.)

Exhibit 20 – Reserved for Future Use - (Rev.)

Exhibit 21 – Regional Home Health Intermediaries/Jurisdictions - (Rev. 3, 11-22-00)

Associated Hospital Services of Maine

Connecticut	Maine	Massachusetts
New Hampshire	Rhode Island	Vermont

Palmetto Government Benefits Administration

Alabama	Arkansas	Florida
Georgia	Illinois	Indiana
Kentucky	Louisiana	Mississippi
New Mexico	North Carolina	Ohio
Oklahoma	South Carolina	Tennessee
Texas		

Blue Cross of California

Alaska	American Samoa	Arizona
California	Guan	Hawaii
Idaho	Nevada	Northern Mariana Islands
Oregon	Washington	

United Government Services

Michigan	Minnesota	New Jersey	New York
Puerto Rico	Virgin Islands	Wisconsin	

Wellmark, Inc

Colorado	Delaware	District of Columbia	Iowa
Kansas	Maryland	Missouri	Montana
Nebraska	North Dakota	Pennsylvania	South Dakota

Utah

Virginia

West Virginia

Wyoming

**Exhibit 22 - Office of Inspector General, Office of Investigations Field Offices
(Rev. 3, 11-22-00)**

Street Address	Mailing Address	States
BOSTON: Room 1405 JFK Federal Bldg. Boston, MA 02203 (617) 565-2660	HHS, OS, OIG, OI P.O. Box 8767 Boston, MA 02114	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
NEW YORK Room 3900 B Federal Building New York, NY 10278 (212) 264-1691	HHS, OS, OIG, OI P.O. Box 3209 Church St. Station New York, NY 10008	New Jersey New York Puerto Rico Virgin Islands
PHILADELPHIA Room 4430 3535 Market Street Philadelphia, PA 19104 (215) 596-6796	HHS, OS, OIG, OI P.O. Box 8049 Philadelphia, PA 19101	Delaware Pennsylvania West Virginia Maryland Except: - Prince Georges County - Montgomery County Virginia Except: - Fairfax County - Arlington County - City of Alexandria - City of Falls Church
ATLANTA Room 1404 101 Marietta Tower Atlanta, GA 30323 (404) 331-2131/2556	HHS, OS, OIG, OI P.O. Box 2288 Atlanta, GA 30301	Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
CHICAGO 23 rd Floor 105 West Adams St. Chicago, IL 60603 (312) 353- 2740	HHS, OS, OIG, OI 23 rd Floor 105 West Adams Street Chicago, IL 60603	Illinois Indiana Michigan Minnesota Ohio Wisconsin Missouri Iowa

DALLAS Room 4E1B 1100 commerce St. Dallas, TX 75242 (214) 767-8406	HHS, OS, OIG, OI Room 4E1B 1100 Commerce St. Dallas, TX 75242	Arkansas Louisiana New Mexico Oklahoma Texas
DENVER Room 327 1961 Stout Street Federal Office Bldg. Denver, CO 80294-3546 (303) 844-5621	HHS, OS, OIG, OI 1961 Stout Street Denver, CO 80294-3546	Colorado Kansas Montana Nebraska North Dakota South Dakota Wyoming Utah
SAN FRANCISCO Room 174 50 U.N. Plaza San Francisco, CA 94102 (415) 556-8880	HHS, OS, OIG, OI P.O. Box 42516 San Francisco, CA 94142-2516	Arizona California Guam Hawaii Nevada Samoa
SEATTLE SUB OFFICE Room 209, RX-81 2201 Sixth Avenue Seattle, WA 98121 (206) 442-0547	HHS, OS, OIG, OI P.O. Box 61220 Seattle, WA 98121	Alaska Idaho Oregon Washington
WASHINGTON, D.C. Field Office Room 5193 Cohen Bldg. 330 Independence Av. SW Washington, DC 20201 (202) 619-1900	HHS, OS, OIG, OI Room 5193 Cohen Bldg. 330 Independence Av SW Washington, DC 20201	District of Columbia Maryland Counties: - Prince Georges - Montgomery Counties - Virginia Counties Virginia Cities - Alexandria - Falls Church

Exhibit 23 - PIM Acronyms - (Rev. 3, 11-22-00)

Acronym	Meaning
ABG	Arterial Blood Gas
ABN	Advanced Beneficiary Notice
AC	Affiliated Contractor
ADL	Activities of Daily Living

ADMC	Advance Determination of Medicare Coverage
AIDE	Home Health Aide
AKA	Also Known As
ALJ	Administrative Law Judge
AMA	American Medical Association
AoA	Administration on Aging
ASC	Ambulatory Surgical Center
AUSA	Assistant United States Attorney
BESS	Part B Extract Summary System
BI	Benefit Integrity
CAC	Carrier Advisory Committee
CBR	Cost Benefit Ratio
CFO	Chief Financial Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMD	Contractor Medical Director
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalties Law
CMR	Comprehensive Medical Review
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPE	Contractor Performance Evaluation
CPT	Current Procedural Terminology
CWF	Common working File
DAP	DMERC Advisory Panel
DBA	Doing Business As
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, and Orthotic Supplier
DMERC	Durable Medical Equipment Regional Carrier
DOJ	Department of Justice

DRG	Diagnosis Related Groups
DX	Diagnosis
EMC	Electronic Media Claims
EOMB	Explanation of Medicare Benefits
EPO	Epoetin
ESRD	End Stage Renal Dialysis
FBI	Federal Bureau of Investigation
FHIBA	Federal Health Insurance Benefits Accounts
FI	Fiscal Intermediary
FID	Fraud Investigation Database
FMR	Focused Medical Review
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GPRA	Government Performance Results Act
GTL	Government Task Leader
HCFA	Health Care Financing Administration
HCIS	Healthcare Customer Information System
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
HI	Health Insurance
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HO	Hearings Officer
ICN/DCN	Internal Control Number/Document Control Number
IER	Interim Expenditure Report
IRP	Incentive Reward Program
IRS	Internal Revenue Service
LMRP	Local Medical Review Policy
MCM	Medicare Carrier Manual
MFCU	Medicaid Fraud Control Unit
MFIS	Medicare Fraud Information Specialist
MFSR	Medicare Focused Medical Review Status

MIM	Medicare Intermediary Manual
MIP	Medicare Integrity Program
MIP-PET	Medicare Integrity Program-Provider Education and Training
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSS	Medical social Services
N/A	Not Applicable
NCP	National Coverage Policy
NMFA	National Medicare Fraud Alert
NOU	Notice of Utilization
NPR	National Performance Review
NSC	National Supplier Clearinghouse
OCIG	Office of Counsel to the Inspector General
OCSQ	Office of Clinical Standards and Quality
OIFO	Office of Investigations Field Office
OIG	Office of Inspector General
OIGOAS	Office of Inspector General Office of Audit Services
OIG/OI	Office of Inspector General Office of Investigations
OP	Outpatient
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
PAL	Provider Audit List
PI	Program Integrity
PIM	Program Integrity Manual
PIN	Provider Identification Number
PIP	Periodic Interim Payments
PM	Program Memorandum
PM-PET	Program Management-Provider Education and Training
POC	Plan of Care
PPAC	Practicing Physicians Advisory Council
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board

PSC	Program Safeguard Contractor
PS&R	Provider Statistical and Reimbursement
PT	Physical Therapy
PTS	Provider Tracking system
QA	Quality Assurance
QIO	Quality Improvement Organization
RBS	Report of Benefit Savings
RCCO	Regional Chief Counsel's Office
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RMFA	Restricted Medicare Fraud alert
RMRP	Regional Medical Review Policy
RO	Regional Office
ROM	Range of Motion
RRB	Railroad Retirement Board
RT	Record Type
RVU	Relative Value Unit
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SLP	Speech-Language Pathology
SMI	Supplementary Medical Insurance
SME	Subject Matter Expert
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SOC	Start of Care
SSA	Social Security Administration
SSAFO	Social Security Administration Field Office
ST	Speech Therapy
SUR	State Utilization Review Units
the Act	the Social Security Act
TOB	Type of Bill
TPN	Total Parenteral Nutrition
UPIN	Unique Physician Identification Number

Exhibit 25 – Procedures and Forms for Obtaining Protected Health Information

Office of the Director

U.S. Department of Justice
Executive Office for United States Attorneys

Room 2616, RFK Main Justice Building
950 Pennsylvania Avenue, NW
Washington, DC 20530
(202) 514-2121

MEMORANDUM -Sent via Electronic Mail

DATE: April 11, 2003

TO: ALL UNITED STATES ATTORNEYS
ALL FIRST ASSISTANT UNITED STATES ATTORNEYS
ALL CRIMINAL CHIEFS
ALL CIVIL CHIEFS

FROM: Guy A. Lewis
Director

SUBJECT: Procedures and Forms for Obtaining Protected Health Information in Law Enforcement and Health Oversight Investigations; Guidance Materials Concerning New HIPAA Privacy Regulations.

ACTION REQUIRED: Please distribute to all Assistant United States Attorneys.

CONTACT PERSONS: Cam Towers Jones
Health Care Fraud Coordinator
Legal Programs
Telephone: (202) 353-8507

Andrea Gross
Affirmative Civil Enforcement Coordinator
Legal Programs
Telephone: (202) 305-3346

New medical privacy rules (located at 45 C.F.R., Parts 160 and 164) take effect on Monday, April 14, 2003. These rules will affect all Assistant United States Attorneys (AUSAs) who obtain medical information in the course of their work.

In order to assist AUSAs, the Executive Office for United States Attorneys (EOUSA) and the Civil and Criminal Divisions of the Department of Justice have prepared form materials which can be used to obtain medical records in law enforcement and health oversight investigations. Attached is a WordPerfect document titled "Updated Process, Model Letters, and Forms to Request Protected Health Information Pursuant to the HIPAA Privacy Regulation." This document includes (1) a description of the process for obtaining Centers for Medicare and Medicaid Services (CMS) data after April 14, 2003; (2) a form letter to be used in requesting information from CMS contractors; (3) a form letter to be used in requesting protected health information from entities other than CMS contractors (including federal agencies in affirmative civil and criminal health care fraud cases; and (4) potential paragraphs to be inserted in letters, subpoenas, or other forms of legal process requesting production of protected health information.

EOUSA and the Civil and Criminal Divisions of the Department of Justice have also prepared guidance about the regulation in a "question and answer" format. These guidance materials were distributed at the recent Health Care Fraud Coordinators Conference at the National Advocacy Center. An additional copy is also attached to this memorandum, for your information.

Copies of the documents attached to this memorandum will also be posted on the EOUSA ACEO and Health Care Fraud Web Page at: <http://www.usa.doj.gov/staffs/lp/ace/>.

If you have any questions regarding implementation of the privacy regulations, you may contact one of the people listed below:

Dan Anderson (Affirmative Civil)
Civil Division
(202) 616-2451

Ian DeWaal (Criminal)
Criminal Division
(202) 514-0669

Jim Gilligan (Civil Defensive/Federal Programs)
Civil Division
(202) 514-3358

Andrea Gross (Affirmative Civil)
Executive Office for United States Attorneys
(202) 305-3346

Cam Towers Jones (Criminal)
Executive Office for United States Attorneys
(202) 353-8507

Sherrí Keene (Civil Defensive IFTCA)
Civil Division
(202) 616-4272

Karen Morrissette (Criminal)
Criminal Division
(202) 514-0640

Attachments

cc: All United States Attorneys' Secretaries

**UPDATED PROCESS, MODEL LETTERS AND FORMS TO REQUEST
PROTECTED HEALTH INFORMATION PURSUANT TO THE PRIVACY ACT AND
HIPAA PRIVACY RULE**

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Updated Process for Law Enforcement Agency Requests to Obtain CMS/Medicare Data

1. The law enforcement agency should begin by consulting with the appropriate Medicare contractor (usually the Program Safeguard Contractor, but possibly also the Carrier, Fiscal Intermediary, Quality Improvement Organization, or CMS) to discuss the purpose or goal of the data request.¹ To illustrate, are data being sought to assess allegations of fraud; examine billing patterns; ascertain dollar losses to the Medicare program for a procedure, service or time period; conduct a random sample of claims for medical review, etc? Upon receiving a data request from a law enforcement agency, the Medicare contractor (e.g., PSC) will examine its sources of data for most recent 36-month period for the substantive matter/s in question or for the specific period requested by the law enforcement agency, if necessary. In consultation with the Medicare contractor, the law enforcement agency also should make known the following:

- type of data and “fields of information” needed
- name and/or other identifying information for provider/s (e.g., Tax Identification Number, Unique Physician Identification Number, etc.)
- time period necessary for the inquiry (approximate begin and end dates if the conduct is not ongoing currently), and
- format or medium for data to be provided (i.e., tape, CD-ROM, paper, etc.).

2. As part of the initial consultation process, the Medicare contractor and law enforcement agency should develop appropriate language to insert in the data request “standard form letter.” (A copy of an updated “standard form letter” from the law enforcement agency to Medicare contractor, along with various template paragraphs for insertion in the letter to ensure Privacy Act and HIPAA Privacy Rule compliance, are provided as attachments.) After consulting with the appropriate Medicare contractor, the law enforcement agency should send the signed standard form letter, identifying the appropriate authority under which the information is being sought and specifying the details of the request described above, to the Medicare contractor. The Medicare contractor will provide the relevant data, reports and findings to the requesting agency in the format/s requested within 30 days when data for the most recent 36-month period is being sought directly from the Medicare contractor. If it is necessary for the Medicare contractor to seek and acquire other data from CMS or another affiliated Medicare contractor, the time period required to provide the data to the requesting agency will extend beyond 30 days. (Currently, the average response period for data requests made to CMS is 14 weeks.)²

¹ *A current list of Program Safeguard Contractors (PSCs), task order areas of responsibility, geographic coverage, and point-of-contact information for the PSCs and for the Centers for Medicare and Medicaid Services (CMS) Government Task Leader (GTL) who oversees each PSC has been circulated to all United States Attorneys’ Offices and FBI field offices. This information also will be posted and updated on USABook’s Health Care Fraud page at <http://10.173.2.12/usao/eousa/ole/tables/subject/health.htm>. (If the PSC is not the appropriate source of information sought by the law enforcement agency, the PSC will direct the requesting law enforcement agency to the appropriate Medicare contractor or CMS/GTL.)*

² *The CMS Program Integrity Group is preparing a “Medicare Data Guide” for use by law enforcement and other agencies that will be posted on the CMS website in the near future.*

The guide will identify the various data files and fields of information that are available from Medicare contractors and CMS data centers to facilitate future requests for Medicare information.

3. If appropriate, the Medicare contractor will also use analytic tools to look for other possible indicia of fraud in addition to the specific alleged conduct that was the cause of the law enforcement agency's data request.

4. If, in the view of the requesting law enforcement agency, the Medicare contractor, or CMS, the Medicare contractor's "initial 36-month review" generally verifies the fraud allegations, or if potential fraud is uncovered through the use of analytic tools, and upon a subsequent request, the Medicare contractor will conduct a supplemental review of Medicare data. The supplemental review will meet the specific needs of the law enforcement agency based on the allegations under investigation and/or findings of the initial 36-month review. Such supplemental reviews may involve retrieving information from original Carrier and/or Fiscal Intermediary data files, as well as the National Claims History (NCH), Common Working File (CWF), or other Medicare data files that may be archived in order to cover the complete time frame involved in the allegations and/or allowed by the statute of limitations. The time period for fulfilling supplemental data requests will be negotiated on a case-by-case basis between CMS and the law enforcement agency making the data request.

5. While steps 1-4 describe the usual process to be followed for handling law enforcement agency requests for CMS/Medicare data, exceptions to this process will be necessary on a case-by-case basis when the law enforcement agency determines that conducting an initial review of the most recent 36-months of data would not be sufficient. For example, exceptions will be necessary if:

- a. The most recent 36 months of data would not be helpful to the investigation because the fraud being investigated is alleged to have occurred prior, or in large part prior to, that period.
- b. Changes in the payment system used for the type/s of claims in question cause the most current data to be inappropriate for attempting to verify allegations of possible fraud that occurred under a previous payment system.
- c. The purpose of the data request cannot be met using only the most recent 36 months of data (e.g., a statistical sampling plan that requires more than 36 months of data to implement the plan correctly and accurately).
- d. Litigation deadlines preclude conducting an initial review followed by a more comprehensive supplemental review.
- e. Items 5 a-d are illustrative not exhaustive.

6. Each agency (DOJ, FBI, CMS, etc.) will designate a "contact person" for advising their internal agency components and field offices about this updated process for making data requests to CMS/Medicare contractors, and for resolving any conflicts or disagreements that may occur involving specific requests for information.

USE DEPARTMENT OF JUSTICE LETTERHEAD

[DATE]

If this request for data is made to a Program Safeguard Contractor, Quality Improvement Organization (QIO), Fiscal Intermediary (FI), or Carrier, address to:

Name of contact person
Name of the PSC, QIO, FI, or Carrier
Address

and send a "cc:" to: Regional Office of the Inspector General
Director, Benefit Integrity and Law Enforcement Liaison, CMS

If this request for data is made to CMS, address to:

Centers for Medicare & Medicaid Services
Office of Financial Management
Program Integrity Group
Director, Benefit Integrity and Law Enforcement Liaison
C3-02-16
7500 Security Blvd
Baltimore, MD 21244

and send a "cc:" to: Regional Office of the Inspector General

Re: Request for disclosure of data in CMS Systems of Records

Dear [insert name]:

This letter is to request your assistance in obtaining CMS data from the [insert file name] on [insert type of data needed and providers for which data is needed] for claims during the following time period: [insert time period]. Please provide this data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case].

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Additionally, to ensure Privacy Act compliance, CMS has issued and published routine uses authorizing disclosure of data in CMS systems of records for such purposes. See 63 Federal Register 38414, July 16, 1998. The focus of our examination is the following: [insert general description of the nature of the law enforcement or health oversight activity being pursued].

You can be assured that the DOJ will take all appropriate measures to ensure that this data will be maintained and used in compliance with Section VI (Confidentiality Procedures) of the Health Care Fraud and Abuse Control Program Guidelines agreed to by the Attorney General and the Secretary of the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996.

I understand that CMS does not commit to processing my request if the estimated cost of doing so exceeds \$200,000, and that a CMS representative will contact me if the estimated cost exceeds that amount. Additionally, I understand that CMS officials may intercede should a DOJ request for CMS data create a substantial resource impact on the data processing capabilities of the CMS Data Center, a Medicare Fiscal Intermediary, Carrier, Program Safeguard Contractor, QIO, or other contractor. For requests initiated by the FBI or United States Attorney's offices, discussions to resolve such resource issues will be conducted between the appropriate CMS official and the appropriate FBI agent or Assistant United States Attorney (AUSA), or if necessary, the appropriate FBI or AUSA supervisor. For requests initiated by DOJ headquarters, or where regional resolution has been unsuccessful, CMS officials may refer such resource issues to the appropriate DOJ headquarters official.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, and office of DOJ official]

**USE DEPARTMENT OF JUSTICE LETTERHEAD
MODIFY AS APPROPRIATE FOR YOUR INVESTIGATION AND FOR THE
PARTICULAR RECIPIENT OF THE REQUEST (E.G., SUBPOENAED PERSON)**

[DATE]

Re: Request for production of protected health information

Dear [insert name]:

This letter is to request that you produce information/data from [source of records] on [insert type of data/information needed and providers for which information is needed] for claims during the following time period: [insert time period]. Please provide this information/data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case.]

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, office of DOJ official]

**POTENTIAL PARAGRAPHS TO BE INSERTED
IN LETTERS (OR SUBPOENAS, ETC)
REQUESTING PRODUCTION OF PROTECTED HEALTH INFORMATION.
PLEASE READ ALL PARAGRAPHS AND ENSURE THAT YOU HAVE
INCLUDED ALL NECESSARY PROVISIONS.**

HEALTH OVERSIGHT

You are requested to produce this information to the Department of Justice in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. 45 C.F.R. 164.512(d); 45 C.F.R. 164.501.

REQUIRED BY LAW³

The information sought in this request is required by law to be produced to the Department of Justice, pursuant to _____, (cite the applicable law or reference the legal process that is attached to this document.) Disclosure is therefore permitted under 45 C.F.R. 164.512(a).

(NOTE TO DRAFTER: IF THIS REQUEST ALSO FALLS WITHIN THE PROVISIONS OF 45 C.F.R. 164.512 (c), (e), OR (f)⁴ THEN YOU MUST ALSO MEET THE REQUIREMENT OF THAT SUBSECTION AND YOU MUST ALSO ASSERT THAT YOU HAVE MET THAT REQUIREMENT.

IF YOUR “REQUIRED BY LAW” REQUEST IS MADE IN A HEALTH OVERSIGHT CAPACITY, YOU SHOULD ASSERT THIS FACT SO THAT THE RECIPIENT OF THE REQUEST UNDERSTANDS THAT NO ADDITIONAL REQUIREMENTS NEED BE MET. 45 C.F.R. Section 164.512(d)(1))

³ *“Required by law” includes, but is not limited to: “Court orders and court ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.” 45 C.F.R. Section 164.501*

Any mandate contained in law that compels a covered entity to make a disclosure of protected health information and that is enforceable in a court of law is considered a disclosure required by law. 45 C.F.R. Section 164.501.

⁴ *45 C.F.R. Section 164.512(c) addresses disclosures about victims of neglect, abuse, or domestic violence (see paragraphs on page 14); 45 C.F.R. Section 164.512(e) addresses disclosures for judicial or administrative proceedings (see paragraphs on page 18). 45 C.F.R. Section 164.512(f) addresses disclosures for law enforcement purposes (see paragraphs 12 - 13). These sections have additional requirements.*

WHISTLEBLOWERS/VICTIMS OF WORKPLACE CRIME

(See 65 Fed. Reg. 250, page 82492)

This request for information is made to you in your capacity as a whistleblower, described at 45 C.F.R. 164.502(j)(1)(i) as “[an individual who] believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public. . .” You are requested to produce the information described in Attachment A, hereto, to the Department of Justice in its capacity as a health oversight agency, as permitted by 45 C.F.R. 164.502(j)(1)(ii).

OR

This request for information is made to you in your capacity as a victim of a criminal act and a member of the workforce of a covered entity. You are providing information about the suspected perpetrator of the criminal act, and should limit your disclosure to the following information: a) name and address; b) date and place of birth; c) social security number; d) ABO blood type and Rh factor; e) type of injury; f) date and time of treatment; g) date and time of death; h) distinguishing physical characteristics. This request is made pursuant to 45 C.F.R. 164.502(j)(2).

**Disclosures for law enforcement purposes pursuant to
process and as otherwise required by law (45 CFR 164.512(f)(1))**

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(1) in that:

[INSERT PARAGRAPH (i), (iiA), (iiB), OR (iiC) BELOW]

(i) the disclosure is required by law [specify the law];

OR

(iiA) the disclosure is in compliance with and limited by the relevant requirements of a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer [attach relevant copies];

OR

(iiB) the disclosure is in compliance with and limited by the relevant requirements of a grand jury subpoena [attach copy];

OR

(iiC) the disclosure is in compliance with and limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or similar process authorized by law [attach copy]. The undersigned further represents that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and de-identified information could not reasonably be used.

Disclosures of information about victims of crimes for law enforcement purposes in response to a law enforcement request (45 CFR 164.512(f)(3))

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(3) in that the requested information is about an individual who is or is suspected to be a victim of a crime and that:

[INSERT PARAGRAPH (i) OR (ii) BELOW]

(i) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement]; (examples at page 23)

OR

(ii) the covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance [specify nature of incapacity or emergency circumstance]. The undersigned law enforcement official represents that: the requested information is needed to determine whether a violation of law by a person other than the victim has occurred, and that such information is not intended to be used against the victim; immediate law enforcement activity which depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure. The undersigned further asserts that the circumstances are such that the covered entity, in the exercise of its professional judgment, should determine that the disclosure is in the best interests of the individual.

Disclosures about victims of abuse, neglect or domestic violence (45 C.F.R. 164.512(c))

If the covered entity reasonably believes that the individual (whose personally identifiable health information is requested) is a victim of abuse, neglect or domestic violence, this request for information is permitted by 45 C.F.R. 164.512(c)(1) because the disclosure is to _____, which is a government agency authorized by law to receive reports of such abuse, neglect, or domestic violence, and:

[INSERT PARAGRAPH (i) or (ii) or either (iiiA) or (iiiB) below]

i) the disclosure is required by law [specify the law] and complies with and is limited to the relevant requirements of such law;

OR

ii) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement];

OR, EITHER

iiiA) the disclosure is expressly authorized by statute or regulation, namely, [specify the law] and the covered entity believes the disclosure is necessary to prevent serious harm to the individual or other potential victims;

OR

iiiB) the disclosure is expressly authorized by statute or regulation [specify the law] and the individual is unable to agree because of incapacity [specify nature of incapacity], and the recipient law enforcement or public official authorized to receive the report [specify the agency] hereby represents that the protected health information which is sought is not intended to be used against the individual. The _____ [specify agency] further represents that an immediate enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

Locate and Identify

This request for protected health information is made by a law enforcement agency pursuant to the provisions of 45 C.F.R. 164.512(f)(2) which permit the disclosure of the enumerated limited information for identification and location purposes.

A covered entity is permitted to make a disclosure to a law enforcement officer under this paragraph for the purpose of identifying or locating a suspect, fugitive, material witness or a missing person. The following information may be disclosed: (A) name and address; (B) date and place of birth; (C) social security number; (D) ABO blood type and rh factor; (E) type of injury; (F) date and time of treatment; (G) date and time of death (if applicable); (H) a description of distinguishing physical characteristics, including, height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.

Decedents

(NOTE: This section of the regulation can only be used to permit a disclosure to a coroner, pursuant to a request by a coroner. Therefore, it will seldom be used in connection with requests in federal investigations, and even in those cases, the request must originate from a coroner.)

This request for protected health information is made by a [coroner] [medical examiner] pursuant to the provisions of 45 C.F.R. 164.512(g) which permit a covered entity to disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

Correctional institutions and other law enforcement custodial situations

This request for protected health information is made by a **[correctional institution][law enforcement agency]** with lawful custody of **[fill in name of prisoner/detainee]**. The undersigned represents that the protected health information is necessary for **(check all that apply):** () the provision of health care to this individual; () the health and safety of this individual or other inmates; () the health and safety of the custodial officers or employees of, or others at, the correctional institution; () the health and safety of this individual and custodial officers, or other persons responsible for transporting this inmate, or this individual's transfer from one institution, facility or setting to another; () law enforcement on the premises of the correctional institution; or () the administration and maintenance of the safety, security, and good order of the correctional institution. The requested disclosure of protected health information is permitted by the provisions of 45 C.F.R. 164.512(k)(5).

Judicial/Administrative

The Department of Justice, through its undersigned representative, requests this information for judicial and administrative proceedings. Consistent with 45 C.F.R. 164.512(e), this request is [**Insert one of the following alternatives**]:

- A. Pursuant to the order of [a court] [an administrative tribunal], and the only information disclosed is the protected health information expressly authorized by the order [**attach copy of order where appropriate**]; OR

Pursuant to a subpoena, discovery request, or other lawful process, that is not accompanied by a court-order or order of an administrative tribunal, and

Reasonable efforts have been made to ensure that the individual whose information is sought has been given notice of the request by way of a good faith attempt to provide written notice to the individual, as shown by the accompanying documentation [**attach copy of notice to individual and affidavit of service**]; and

The notice to the individual included sufficient information about the underlying litigation or proceeding to permit the individual to raise an objection to the [court] [administrative tribunal]; and

The time for the individual to raise objections to the [court] [administrative tribunal] has expired, and

No objections were filed, or

All objections filed by the individual have been resolved by the [court] [administrative tribunal] and the disclosures sought are consistent with such resolution.

OR [alternate, if patient has not been given notice]:

Reasonable efforts have been made to secure a qualified protective order that meets the requirements set forth in 45 C.F.R.. 164.512(e)(1)(v), and:

The parties to the underlying dispute which precipitated this request for protected health information have agreed to a qualified protective order and have presented it to the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate], OR

We have requested a qualified protective order from the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate].

Minimum Necessary

(NOTE: Do not use this language when the request is authorized by the patient or “required by law”⁵, because the “minimum necessary” standard does not apply to disclosures which are required by law.” 65 Fed. Reg. 250, 82530, 82600, 82715); 45 C.F.R. 164.502(b)(2)(v)

The information sought in this request is the “minimum necessary to accomplish the intended purpose of the . . . request.” 45 C.F.R. 164.502(b)(2)(v). (See 65 Fed. Reg. 82530 “A covered entity is not required to second guess the scope or purpose of the request...”)

⁵ *Required by law includes, but is not limited to: “Court orders and court ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.” 45 C.F.R. Section 164.501*

Any mandate contained in law that compels a covered entity to make a disclosure of protected health information and that is enforceable in a court of law is considered a disclosure required by law. 45 C.F.R. Section 164.501.

Insert Only When Suspension of Notification to Individual is Desired

The protected health information concerning the patients

[INSERT EITHER PARAGRAPH (i) OR (ii) BELOW]

(i) listed on Attachment A, hereto, which your organization disclosed to the Department of Justice on _____ (specify date) in response to a

OR

(ii) which is disclosed in response to the accompanying

_____ (insert type of request, e.g. grand jury subpoena, other subpoena, oral request, other) was requested in furtherance of a federal _____ law enforcement/health oversight (choose one) investigation. An accounting of this disclosure to the individuals concerned would, in this instance, be “reasonably likely to impede the [Department of Justice’s] activities. . . .” 45 C.F.R. Section 164.528(a)(2)(i). Therefore, pursuant to this request and as required by the provisions of 45 C.F.R. Sec. 164.528(a)(2), you must suspend the individual(s)’ right to receive an accounting of this disclosure of protected health information for (months/years).

PATIENT AUTHORIZATIONS

You are requested to release records pertaining to the individual(s) indicated on the enclosed form(s) titled "Authorization to Release Medical Information."

NOTE:

(1) Your state laws may contain medical record release requirements other than those set out on this form.

(2) If psychotherapy notes are requested, please use the separate authorization for this specific purpose. The regulations provide that an authorization for disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes. 45 CFR 164.508(b)(3)(ii).

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:

[Name of person or class of persons authorized to make disclosure]

PATIENT:

NAME:

BIRTH DATE:

RELEASE TO:

Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ including but not limited to:

1. Copy of complete chart, progress notes & interview notes, discharge summaries, operative reports, x-ray & all imagery, laboratory tests, pathology tissue, and all diagnostic studies whether in electronic data or other format.
2. Billing records

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

This Authorization will automatically expire upon completion of the litigation [provide case name and number] _____ now pending in U.S. District Court for the _____ District of _____.

 This Authorization will automatically expire upon completion of the administrative claim of _____ filed on _____.

 This Authorization shall be effective until _____.

OTHER CONDITIONS:

 x A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.

 x Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

OR PERSON AUTHORIZED TO SIGN FOR PATIENT:* _____

MONTH/DAY/YEAR

PRINT OR TYPE NAME

*Provide basis of

Authorization: _____

.

PATIENT AUTHORIZATION TO RELEASE PSYCHOTHERAPY INFORMATION

TO:

[Name of person or class of persons authorized to make disclosure]

PATIENT:

NAME:

BIRTH DATE:

RELEASE TO:

Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ including but not limited to:

1. All records of psychological or psychiatric testing or treatment, including complete chart, audio and visual recordings, and psychotherapy notes, and
2. Billing records.

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

This Authorization will automatically expire upon completion of the litigation [provide case name and number] _____ now pending in U.S. District Court for the _____ District of _____.

This Authorization will automatically expire upon completion of the administrative claim of _____ filed on _____.

The Authorization shall be effective until _____.

__ This Authorization shall be effective until _____.

OTHER CONDITIONS:

 x A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.

 x Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

**OR PERSON AUTHORIZED TO SIGN FOR
PATIENT:*** _____

MONTH/DAY/YEAR

PRINT OR TYPE NAME

*Provide basis of
Authorization: _____.

EXHIBIT 26 - DOJ Report (Excel Spreadsheet)

(Rev. 16, 11-28-01)

Contractor Name	Identification Number	Date of DOJ Request	Nature of Request	DOJ Tracking # (if provided)	Cost to Fill	SBR Y or N	Date of SBR Submission

Exhibit 27 - National Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

NATIONAL MEDICARE FRAUD ALERT TEMPLATE

Distribution of this Fraud Alert is Limited to the Following Audience: CMS regional offices, Medicare Contractor Benefit Integrity units, program safeguard contractors, Medicare Integrity Program (MIP) units, quality improvement organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Medicaid Program Directors

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION METHODOLOGY:

FID CASE (S):

STATUS:

CONTACT:

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS NMFA

DATE

Exhibit 28 - Restricted Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

RESTRICTED MEDICARE FRAUD ALERT TEMPLATE

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this alert.

Distribution is Limited to the Following Audience: CMS regional offices, Medicare contractor Benefit Integrity units, program safeguard contractors, quality improvement organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspector offices, and the Internal Revenue Service, and the State Medicaid Program Integrity Directors

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION METHODOLOGY:

FID CASE (S):

STATUS:

CONTACT:

NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT PURSUANT TO EXEMPTION (b) (2), (b)(5) AND (b)(7)(E) OF THE FOIA. ITS CONTENTS SHOULD NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN APPROVAL OF THE BENEFITS INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS RMFA

DATE

Exhibit 29 – Reserve for Future Use

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Exhibit 30 - Treatment Codes

(Rev. 23, 03-18-02)

A. Skilled Nursing

These represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

- | | |
|---|--|
| A1 * Skilled Observation and Assessment
(Inc. V.S.,
Response to Med.,
etc) | Includes all skilled observation and assessment of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes |
|---|--|

		may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)
A2	Foley Insertion	Insertion and/or removal of the Foley catheter by nurse.
A3	Bladder Instillation	Instilling medications into the bladder.
A4*	Open Wound Care/Dressing	Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) on an addendum, when necessary. See A28 for observation uncomplicated surgical incision.
A5*	Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss, etc.)	Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance on an addendum when necessary. Use this code only if the decubitus being treated presents the following characteristics: 1 -- Partial tissue loss with signs of infection such as foul odor or purulent drainage; 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone. For care of decubitus not meeting this definition, see A29.
A6*	Venipuncture	The HHA specifies the test and frequency to be performed under physician's orders.
A7*	Restorative Nursing	Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g., routine range of motion exercises).
A8	Post Cataract Care	Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.4.A.)
A9	Bowel/Bladder Training	Includes training of patients who have neurological or muscular problems or other

		conditions where the need for bowel or bladder training is clearly identified. (See MIM §3114.4.E.1.)
A10	Chest Physio (Including postural drainage)	Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.
A11	Adm. of Vitamin B-12	Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines. (See MIM §3117.4.)
A12	Adm. Insulin	Preparation of insulin syringes for administration by the patient or other person, or the administration by the nurse.
A13	Adm. Other IM/Subq	Administration of any injection other than vitamin B-12 or insulin ordered by the physician.
A14	Adm. IVs/ Clysis	Administration of intravenous fluids or clysis or intravenous medications.
A15	Teach Ostomy or Ileo conduit care	Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.
A16	Teach Nasogastric Feeding	Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.
A17	Reinsertion Nasogastric	Includes changing the tube by the nurse.
A18	Teach Gastrostomy Feeding	Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.
A19	Teach Parenteral Nutrition	Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.
A20	Teach Care of Trach	Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.
A21	Adm. Care of Trach	Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.

- A22 Teach Inhalation Rx. Teaching patient or other person to administer therapy and care for equipment.
- A23* Adm. Inhalation Rx Administration of inhalation treatment and care of equipment by the nurse.
- A24 Teach Adm. of Injection Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)
- A25 Teach Diabetic Care Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).
- A26 Disimpaction/F.U. Enema Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.
- A27* Other (Spec. Under Orders) Includes any skilled nursing or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (Form CMS-485).
- A28* Wound Care/Dressing – Closed Incision/Suture Line Skilled observation and care of surgical incision/suture line including application of dry sterile dressing. (See A4.)
- A29* Decubitus Care Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, other than that described in A5. The HHA describes size (depth and width) and appearance on the addendum.
- A30 Teach Care of Any Indwelling Catheter Teaching patient or other person to care for indwelling catheter.
- A31 Management and Evaluation of Patient Care Plan The complexity of necessary unskilled services require skilled management of a registered nurse to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
- A32* Teaching and Training (other) (spec. under Orders) Specify under physician orders.

* Code which requires a more extensive descriptive narrative for physician's orders.

B. Physical Therapy (PT)

These codes represent all services to be performed by the physical therapist. If services are provided by a nurse, they are included under A7. The following is a further explanation of each service:

- | | | |
|----|-----------------------------------|--|
| B1 | Evaluation | Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides). |
| B2 | Therapeutic Exercise | Exercises designed to restore function. Specific exercise techniques (e.g., Proprioceptive Neuromuscular Facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques, which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion. |
| B3 | Transfer Training | To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques. |
| B4 | Establish or Upgrade Home Program | To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as an adjunct to PT programs. |
| B5 | Gait Training | Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.). |
| B6 | Pulmonary Physical Therapy | Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction. |
| B7 | Ultra Sound | Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local |

	metabolic activity are desirable.
B8 Electro Therapy	Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, Transcutaneous Electrical Nerve Stimulation (TENS), Functional Electrical Stimulation (FES), biofeedback, High Voltage Galvanic Stimulation (HVGS), etc.).
B9 Prosthetic Training	Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.
B10 Fabrication Temporary Devices	Includes fabrication of temporary prostheses, braces, splints, and slings.
B11 Muscle Re-education	Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.
B12 Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
B13 Reserved	
B14 Reserved	
B15 Other (Spec. Under Orders)	Includes all PT services not identified above. Specific therapy services are identified under physician's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

C. Speech Therapy (ST)

These codes represent the services to be performed by the speech therapist. The following is a further explanation of each service.

C1 Evaluation	Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
C2 Voice Disorders	Procedures and treatment for patients with

Treatments	an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.
C3 Speech Articulation Disorders Treatments	Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements – usually referred to as apraxia/dyspraxia.
C4 Dysphagia Treatments	Includes procedures designed to facilitate and restore a functional swallow.
C5 Language Disorders Treatments	Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.
C6 Aural Rehabilitation	Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.
C7 Reserved	
C8 Non-oral Communications	Includes any procedures designed to establish a non-oral or augmentive communication system.
C9* Other (Spec. Under Orders)	Speech therapy services not included above. Specify service to be rendered under physician's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

D Occupational Therapy

These codes represent the services to be rendered by the occupational therapist. The following is a further explanation of each service:

D1 Evaluation	Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and
---------------	--

		safety and recommending modifications.
D2	Independent Living/Daily Living Skills (ADL Training)	Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.
D3	Muscle Re-education	Includes therapy designed to restore function lost due to disease or surgical intervention.
D4	Reserved	
D5	Perceptual Motor Training	Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities, which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.
D6	Fine Motor Coordination	Refers to the skills and the performance in fine motor and dexterity activities.
D7	Neurodevelopmental Treatment	Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses, which are coordinated at subcortical and cortical levels.
D8	Sensory Treatment	Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.
D9	Orthotics Splinting	Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.
D10	Adaptive Equipment	Refers to the provision of special devices

(Fabrication and Training)	that increase independent functions.
D11* Other	Occupational therapy services not quantified above.

* Code which requires a more extensive descriptive narrative for physician's orders.

E. Medical Social Services (MSS)

These codes represent the services to be rendered by the medical social service worker. The following is a further explanation of each service:

E1 Assessment of Social and Emotional Factors	Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.
E2 Counseling for Long-Range Planning and Decision making	Assessment of patient's needs for long term care including: Evaluation of home and family situation; enabling patient/family to develop an in-home care system; exploring alternatives to in-home care; or arrangement for placement.
E3 Community Resource Planning	The promotion of community centered services(s) including education, advocacy, referral and linkage.
E4* Short Term Therapy	Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.
E5 Reserved	
E6* Other (Specify Under Orders)	Includes other medical social services related to the patient's illness and need for care. Problem resolution associated with high risk indicators endangering patient's mental and physical health including: Abuse/neglect, inadequate food/medical supplies; and high suicide potential. The service to be performed must be written under doctor's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

F. Home Health Aide

These codes represent the services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. The following is a further explanation of each service:

F1	Tub/Shower Bath	Assistance with tub or shower bathing.
F2	Partial/Complete Bed Bath	Bathing or assisting the patient with bed bath.
F3	Reserved	
F4	Personal Care	Includes shaving of patient or shampooing the hair.
F5	Reserved	
F6	Catheter Care	Care of catheter site and/or irrigations under nursing supervision.
F7	Reserved	
F8	Assist with Ambulation	Assisting the patient with ambulation as determined necessary by the nurse care plan.
F9	Reserved	
F10	Exercises	Assisting the patient with exercises in accordance with the plan of care.
F11	Prepare Meal	May be furnished by the aide during a visit for personal care.
F12	Grocery Shop	May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.
F13	Wash Clothes	This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.
F14	Housekeeping	Household services incidental to care and which do not substantially increase the time spent by the home health aide.
F15*	Other (Specify Under Orders)	Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified

in Form CMS-485, Item 21.

- Code which requires a more extensive descriptive narrative for physician's orders.
-

Exhibit 31 - Form CMS-485, Home Health Certification and Plan of Care (Rev. 23, 03-18-02)

View Form CMS-485 (PDF, 10 KB)

Exhibit 32 - Harkin Grantee Winframe Database Access and Operation Instructions - (Rev. 32, 10-25-02)

View the Harkin Grantee Winframe Database Access and Operation Instructions (PDF, 298 KB)

Exhibit 33 - Harkin Grantee Model Form -- (Rev. 32, 10-25-02)

View the Harkin Grantee Model Form (PDF, 74.6 KB)

HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM

DATE:

From: (Your Name) _____ **Organization:**

Address: _____ City: _____ State: _____

Zip: _____

Phone: (With Area Code)
Applicable)

Fax #

E-Mail (If

Beneficiary Name:

Medicare #:

Medicaid #:

Date of Birth:

Address:

Phone #: (With Area Code)

City: _____ **State:** _____ **Zip:** _____

Name of Complainant (If Different From Beneficiary):

Address: _____ **Phone #: (With Area Code)** _____

City: _____ **State:** _____ **Zip:** _____

Complaint Against: (Name of facility, provider, physician, lab, supplier, etc.)
Claim # (If appropriate)

Date(s) of Service:

Business Address: _____ **Phone: (With Area Code)** _____

Provider Number:

City: _____ **State:** _____ **Zip:** _____

Description of Complaint:

Please describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page if you need more room. If you feel you were billed for services or supplies that were not provided, continue on with the non-rendered service section below.

Non-rendered Services Section:

Did you see any provider that day? _____ If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)

Was the service(s) provided on another day? _____ If yes, when?

Have you ever seen the provider listed? _____ If yes, when?

Have you contacted the provider/supplier regarding this billing? _____ Yes
_____ No

If yes, to whom did you speak and what was the result of the conversation?

I authorize _____ and (insert name of project) to discuss my complaint for the purpose of investigating possible fraud or abuse.

I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.

Signature

Date

If receiving a telephone complaint write "telephone complaint" on the signature line

Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: (insert name of project)

Exhibit 34 - Argus Field Descriptions and Formats - (Rev.)

STRUCTURE OF ARGUS.DBF

All Character fields are to be LEFT JUSTIFIED.

Leading Zeroes and Blanks are to be OMITTED.

All Numeric fields are to be RIGHT JUSTIFIED.

All dates must be in the form YYMMDD.

Field #	Name	HUBC Field#	HUBC Name	Type	Length	Description
1	Carrier	7	Processing Carrier	Character	5	ID of Carrier who

						processed claim
2	HICN	3	CLAIM NUMBER	Character	12	Claim Number
3	SURNAME	4A	BEN NAME-SURNAME	Character	6	First six positions of Beneficiary's last name
4	F_INITIA	4B	BEN NAME-FIRST INITIAL	Character	1	First initial of Beneficiary's first name
5	DCN	23	DOCUMENT CONTROL NUM	Character	5	Carrier assigned claim control number
6	PAID_DT	26	DATE CLAIM PAID/DENIED	Numeric	6	Date claim paid/Denied
7	RENDERIN	79	PROVIDER NUMBER	Character	10	Carrier assigned ID number for the physician performing services
8	REFERRIN	24	REFERRING PHYSICIAN	Character	14	Carrier assigned ID number for the referring, prescribing or ordering physician
9	TYPE_SER	59	TYPE OF SERVICE	Character	1	Represents the type of service as specified by HCFA 0-Whole Blood or Packed Red Cells 1-Medical Care 2-Surgery 3-Consultation 4-Diagnostic X-Ray 5-Diagnostic Laboratory 6-Radiation Therapy 7-Anesthesia 8-Assistance at Surgery 9-Other Medical Service A-Used DME B-High risk Mammography C-Low risk Mammography F-Ambulatory surgical Center (Facility)

Usage) G-
 Immunosuppressive
 drugs received within
 12 months of a
 Medicare covered
 transplant I-Install
 purchase DME L –
 Renal supplier in
 home M-Monthly
 Capitation Payment
 (Dialysis) N-Kidney
 Donor P-Lump Sum
 purchase of DME R-
 Rental of DME T-
 Psychological
 Therapy U-
 Occupational

 V-Pneumococcal
 Vaccine W-Physical
 Therapy Y-Second
 opinion on Elective
 Surgery Z-Third
 opinion on Elective
 Surgery

10	PROC_CD	68	HCPCS PROC CODE	Character 5	HCPCS code used to process claim
11	PROC_CD1	69A	PROC CODE MODIFIER 1	Character 2	Procedure
12	PROC_CD2	69B	PROC CODE MODIFIER 2	Character 2	Code modifier 1 and 2 used to process the claim
13	PLACE_SE	76	PLACE OF SERVICE	Character 2	Field denotes the place of service. 11- Office 12-Home 21- Inpatient Hospital 22- Outpatient Hospital 23-Emergency Room Hospital 24- Ambulatory Surgical Center 25-Birthing Center 26-Military Treatment Facility 31-Skilled Nursing

Facility 32-Nursing
 Facility 33-Custodial
 Care Facility 34-
 Hospice 41-
 Ambulance - Land
 42-Ambulance - Air
 51-Inpatient
 Psychiatric Facility
 52-Psychiatric
 Facility Partial
 Hospitalization 53-
 Community Mental
 Health Center 54-
 Intermediate Care
 Facility/Mental
 Retarded 55-
 Residential
 Substance Abuse
 Treatment Facility
 56-Psychiatric
 Residential
 Treatment Center 61-
 Comprehensive
 Inpatient
 Rehabilitation
 Facility 62-
 Comprehensive
 Outpatient
 Rehabilitation
 Facility 65-End Stage
 Renal Disease
 Treatment
 71-State or local
 Public Health Clinic
 72-Rural Health
 Clinic 81-
 Independent
 Laboratory 99-Other
 Skilled Facility

14 NUMB_SER 80 NUMBER OF SERVICES Numeric 3

Total number of services processed for this line item

15 UNITS_SE 66 UNITS Numeric 3

Total units associated with services needing

						unit reporting such as miles, anesthesia, time units, volume of oxygen or blood
16	FROM_DT	77	FIRST EXPENSE DATE	Numeric	6	Beginning date of service
17	TO_DATE	78	LAST EXPENSE DATE	Numeric	6	Ending date of service
18	EOMB_COD	81	EOMB ACTION CODE	Character	2	Codes used on EOMB and reported in MCM §7012
19	SUBM_CHA	70	SUBMITTED CHARGE	Numeric	7	Total submitted charge for this line item
20	ALLW_CHA	71	ALLOWED CHARGE	Numeric	7	Total allowed charge for this line item
21	PD_PATIE	91	REIMBURSEMENT PATIENT	Numeric	7	Amount of payment being made to patient
22	PD_PROV	92	REIMBURSEMENT PROVIDER	Numeric	7	Amount of payment being made to provider
23	DEDUCT	93	CASH DEDUCTIBLE APPLIED	Numeric	3	Charged to beneficiary
24	PMT_DNL	18	PAYMENT, DENIAL CODE	Character	1	Code for payment denial. Shows who payment was made to or if claim was denied. 0-Denied 1-Physician/Supplier 2-Beneficiary 3-Both physician, supplier and beneficiary 4-Hospital (hospital based physicians) 5-Both hospital and beneficiary 6-Group Practice Prepayment Plan 7-Other entries (e.g. Employer, union) 8-Federally

						funded entities 9-PA services A-Beneficiary under limitation of liability B-Physician/Supplier under limitation of liability X-MSP cost avoided Y-IRS/SSA data match project MSP cost avoided
25	PHYS-IDENT	5	UPIN-REFERRING	Character	6	UPIN (Unique Physician Identification Number of Referring PHYS)
26	SUPP-IDENT	100	UPIN-SUPPLIER	Character	6	UPIN (of Physician Supplier Actually Performing/Providing the Service)
27	DIAGNOSIS	45A	DIAG CODE PRIMARY	Character	5	Diagnosis Code Primary
28	DIAGSEC	45B	DIAG CODE 1ST SECONDARY	Character	5	Diagnosis Code First Secondary
29	DIAG2SEC	45C	DIAG CODE 2ND SECONDARY	Character	5	Diagnosis Code Second-Secondary.

Exhibit 34.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 77, 05-28-04)

File Formats Error! Bookmark not defined.

Claims Universe File				
Claims Universe Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Contractor Type	X(1)	7	7	Spaces
Universe Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: **Contractor ID**

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: **Record Type**
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: **Universe Date**
Definition: Date the universe of claims entered the standard system
Validation: Must be a valid date not equal to a Universe Date sent on any previous Claims Universe file
Remarks: Format is CCYYMMDD. May use standard system batch processing date
Requirement: Required

Claims Universe File				
Claims Universe Claim Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	2"
Claim Control Number	X(15)	7	21	Spaces
Beneficiary HICN	X(12)	22	33	Spaces
Billing Provider	X(15)	34	48	Spaces
Line Item Count	S9(2)	49	50	Zeroes
Line Item group: The following group of Fields occurs from 1 to 52 Times (depending on Line Item Count).				

From and Thru values relate to the 1st line item

Performing Provider Number	X(15)	51	65	Spaces
Performing Provider Specialty	X(2)	66	67	Spaces
HCPCS Procedure Code	X(5)	68	72	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the standard system to uniquely identify the claim
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider Number
Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier
Validation: NA
Remarks: Must be present if claim contains the same billing/pricing provider number on all lines. Otherwise move all zeroes to this field
Requirement: Required

Data Element: Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Performing Provider Number
Definition: Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Performing Provider Specialty
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: HCPCS Procedure Code
Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Number of Claims	9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer record
Requirement: Required

Data Element: Number of Claims
Definition: Number of claim records on this file (Do not count header or trailer record.)
Validation: Must be equal to the number of claims records on the file
Remarks: N/A
Requirement: Required

Sampled Claims Transaction File			
Field Name	Picture	From	Thru
Contractor ID	X(5)	1	5
Claim Control Number	X(15)	6	20
Beneficiary HICN	X(12)	21	32

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number

Data Element: Claim Control Number
Definition: Number assigned by the standard system to uniquely identify the claim

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number

Sampled Claims Resolution File				
Sampled Claims Resolution Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Contractor Type	X(1)	7	7	Spaces
File Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: File Date
Definition: Date the Sampled Claims Resolution file was created
Validation: Must be a valid date not equal to a File Date sent on any previous Sampled Claims Resolution file
Remarks: Format is CCYYMMDD
Requirement: Required

Sampled Claims Resolution File
Sampled Claims Resolution Detail Record (one record per claim)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Claim Type	X(1)	7	7	Space
Assignment Indicator	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Original Claim Control Number	X(15)	10	24	Spaces
Claim Control Number	X(15)	25	39	Spaces
Beneficiary HICN	X(12)	40	51	Spaces
Beneficiary Name	X(30)	52	81	Spaces
Beneficiary Date Of Birth	X(8)	82	89	Spaces
Billing Provider Number	X(15)	90	104	Spaces
Referring Provider Number	X(15)	105	119	Spaces
Paid Amount	9(7)v99	120	128	Zeroes

Sampled Claims Resolution File
 Sampled Claims Resolution Detail Record (one record per claim)

Field Name	Picture	From	Thru	Initialization
Claim ANSI Reason Code 1	X(8)	129	136	Spaces
Claim ANSI Reason Code 2	X(8)	137	144	Spaces
Claim ANSI Reason Code 3	X(8)	145	152	Spaces
Claim Entry Date	X(8)	153	160	Spaces
Claim Adjudicated Date	X(8)	161	168	Spaces
Line Item Count	9(2)	169	170	Zeroes

Line Item group:

The following group of fields occurs from 1 to 52 times (depending on Line Item Count).

From and Thru values relate to the 1st line item

Performing Provider Number	X(15)	171	185	Spaces
Performing Provider Specialty	X(2)	186	187	Spaces
HCPCS Procedure Code	X(5)	188	192	Spaces
HCPCS Modifier 1	X(2)	193	194	Spaces
HCPCS Modifier 2	X(2)	195	196	Spaces
HCPCS Modifier 3	X(2)	197	198	Spaces
HCPCS Modifier 4	X(2)	199	200	Spaces
Number of Services	999v9	201	204	Zeroes
Service From Date	X(8)	205	212	Spaces
Service To Date	X(8)	213	220	Spaces
Place of Service	X(2)	221	222	Spaces
Type of Service	X(1)	223	223	Spaces
Diagnosis Code	X(5)	224	228	Spaces
CMN Control Number	X(15)	229	243	Spaces
Submitted Charge	9(7)v99	244	252	Zeroes
Medicare Initial Allowed Charge	9(7)v99	253	261	Zeroes
ANSI Reason Code 1	X(8)	262	269	Spaces
ANSI Reason Code 2	X(8)	270	277	Spaces
ANSI Reason Code 3	X(8)	278	285	Spaces
ANSI Reason Code 4	X(8)	286	293	Spaces
ANSI Reason Code 5	X(8)	294	301	Spaces

ANSI Reason Code 6	X(8)	302	309	Spaces
ANSI Reason Code 7	X(8)	310	317	Spaces
Manual Medical Review Indicator	X(1)	318	318	Space
Resolution Code	X(5)	319	323	Spaces
Final Allowed Charge	9(7)v99	324	332	Zeroes
Filler		X(25)	333	
Spaces				357

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Claim record
Requirement: Required

Data Element: Claim Type
Definition: Type of claim
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Assignment Indicator
Definition: Code indicating whether claim is assigned or non-assigned
Validation: Must be 'A' or 'N'
Remarks: A = Assigned
N = Non-assigned
Requirement: Required

Data Element: Mode of Entry Indicator
Definition: Code that indicates if the claim is paper or EMC
Validation: Must be 'E' or 'P'
Remarks: E = EMC
P = Paper

Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number
Definition: Number assigned by the standard system to provide a crosswalk to pull all claims associated with the sample claim
Validation: N/A
Remarks: N/A
Requirement:

Data Element: Claim Control Number

Definition: Number assigned by the standard system to uniquely identify the claim

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Beneficiary Name

Definition: Name of the beneficiary

Validation: N/A

Remarks: First, middle and last names must be strung together to form a formatted name (e.g., John E Doe)

Requirement: Required

Data Element: Beneficiary Date of Birth

Definition: Date on which beneficiary was born.

Validation: Must be a valid date

Remarks: Month, day and year on which the beneficiary was born

Requirement: Required

Data Element: Billing Provider Number

Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier.

Validation: Must be present if claim contains the same billing/pricing provider number on all lines

Remarks: N/A

Requirement: Required for all claims, assigned and non-assigned, containing the same billing/pricing provider on all lines

Data Element: Referring Provider Number

Definition: Number assigned by the Standard System to identify the referring provider.

Validation: N/A

Remarks: Enter zeros if there is no referring provider.

Requirement: Required.

Data Element: Paid Amount

Definition: Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.

Validation: N/A

Remarks: N/A

Requirement: Required.

Data Element: Claim ANSI Reason Code 1

Claim ANSI Reason Code 2

Claim ANSI Reason Code 3

Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.

Data Element: Claim Entry Date
Definition: Date claim entered the standard claim processing system
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Adjudicated Date
Definition: Date claim completed adjudication
Validation: Must be a valid date. Format must be CCYYMMDD
Remarks: This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made
Requirement: Required

Data Element: Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Performing Provider Number
Definition: Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Performing Provider Specialty
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Referring Provider Number
Definition: Number assigned by the standard system to identify the referring provider
Validation: N/A
Remarks: Enter zeros if there is no referring provider
Requirement: Required

Data Element: HCPCS Procedure Code
Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
Definition: Codes identifying special circumstances related to the service

Validation: N/A
Remarks: N/A
Requirement: Required if available

Data Element: Number of Services
Definition: The number of service rendered in days or units
Validation: N/A
Remarks: The last position should contain the value to the right of the decimal in the number of services. Put a zero in the last position for whole numbers.
Requirement: Required

Data Element: Service From Date
Definition: The date the service was initiated
Validation: Must be a valid date less than or equal to Service To Date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Service To Date
Definition: The date the service ended
Validation: Must be a valid date greater than or equal to Service From Date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Place of Service
Definition: Code that identifies where the service was performed
Validation: N/A
Remarks: Must be a value in the range of 00 - 99
Requirement: Required

Data Element: Type of Service
Definition: Code that classifies the service
Validation: The code must match a valid CWF type of service code
Remarks: N/A
Requirement: Required

Data Element: Diagnosis Code
Definition: Code identifying a diagnosed medical condition resulting in the line item service
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: CMN Control Number
Definition: Number assigned by the standard system to uniquely identify a Certificate of Medical Necessity
Validation: N/A
Remarks: Enter a zero if no number is assigned
Requirement: Required on DMERC claims

Data Element: Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Medicare Initial Allowed Charge

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: N/A

Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.

Requirement: Required

Data Element: ANSI Reason Code 1

ANSI Reason Code 2

ANSI Reason Code 3

ANSI Reason Code 4

ANSI Reason Code 5

ANSI Reason Code 6

ANSI Reason Code 7

Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO', 'APPAM', 'DENAM', 'REDAM'.

Data Element: Manual Medical Review Indicator

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'Y' or 'N'

Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC' or 'REO', 'APPAM', 'DENAM', 'REDAM'.

Remarks:

APP = Approved as a valid submission
APPMR = Approved after manual medical review routine
APPMC = Approved after manual medical review complex. If this codes is selected, set the Manual Medical Review Indicator to 'Y.'
DENMR = Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMR = Denied after manual medical review routine
DENMC = Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this codes is selected, set the Manual Medical Review Indicator to 'Y.'
DEO = Denied for non-medical reasons, other than denied as unprocessable.
RTP = Denied as unprocessable (return/reject)
REDMR = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine

REDMC = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'

REO = Reduced for non-medical review reasons.

APPAM = Approved after automated medical review

DENAM = Denied after automated medical review

REDAM = Reduced after medical review

Requirement: Required.

Data Element: Final Allowed Charge
Definition: Final Amount allowed for this service or equipment after any reduction or denial
Validation: N/A
Remarks: This represents the contractor's value of the claim gross of co-pays and deductibles
Requirement: Required

Data Element: Filler
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement: None

Sampled Claims Resolution File				
Sampled Claims Resolution Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Number of Claims	9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer record
Requirement: Required

Data Element: Number of Claims
Definition: Number of sampled claim resolution records on this file (Do not count header or trailer record.)
Validation: Must be equal to the number of sampled claims resolution records on the file
Remarks: N/A
Requirement: Required

Provider Address File				
Provider Address Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Contractor Type	X(1)	7	7	Spaces
File Date	X(8)	8	15	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: File Date
Definition: Date the Provider Address file was created
Validation: Must be a valid date not equal to a File Date sent on any previous Provider Address file
Remarks: Format is CCYYMMDD
Requirement: Required

Provider Address File
 Provider Address Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Provider Number	X(15)	7	21	Spaces
Provider Name	X(25)	22	46	Spaces
Provider Address 1	X(25)	47	71	Spaces
Provider Address 2	X(25)	72	96	Spaces
Provider City	X(15)	97	111	Spaces
Provider State Code	X(2)	112	113	Spaces
Provider Zip Code	X(9)	114	122	Spaces
Provider Phone Number	X(10)	123	132	Spaces
Provider Fax Number		X(10)	133	142 Spaces
Provider Type		X(1)	143	143 Spaces
Filler	X(25)	144	168	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Detail record
Requirement: Required

Data Element: Provider Number
Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier or referring provider
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Provider Name
Definition: Provider's name
Validation: N/A
Remarks: This is the name of the billing/pricing provider or referring provider must be formatted into a name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).
Requirement: Required

Data Element: Provider Address 1
Definition: 1st line of provider's address
Validation: N/A
Remarks: This is the payee address1of the billing/pricing provider or referring provider
Requirement: Required

Data Element: Provider Address 2
Definition: 2nd line of provider's address
Validation: N/A

Remarks: This is the address2 of the billing/pricing provider or referring provider
Requirement: Required if available

Data Element: Provider City
Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the billing/pricing provider or referring provider
Requirement: Required

Data Element: Provider State Code
Definition: Provider's billing state code
Validation: Must be a valid state code
Remarks: This is the state of the billing/pricing provider or referring provider
Requirement: Required

Data Element: Provider Zip Code
Definition: Provider's billing zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code of the billing/pricing provider or referring provider. Provide 9-digit zip code if available, otherwise provide 5-digit zip code
Requirement: Required

Data Element: Provider Phone Number
Definition: Provider's telephone number
Validation: Must be a valid telephone number
Remarks: This is the phone number of the billing/pricing provider or referring provider
Requirement: None

Data Element: Provider Fax Number
Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: This is the fax number of the billing/pricing provider or referring provider
Requirement: None

Data Element: Provider Type
Definition: 1=billing/pricing provider 2= referring provider
Validation: Must be a valid provider type
Remarks: This field indicates whether the information provided on the record is for the billing/pricing provider or referring provider
Requirement: Required

Data Element: Filler
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement:

Provider Address File				
Provider Address Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Number of Records	9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS Contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer record
Requirement: Required

Data Element: Number of Records
Definition: Number of provider address records on this file (do not count header or trailer record)
Validation: Must be equal to the number of provider address records on the file
Remarks: N/A
Requirement: Required

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system's claims history file. It should not include header or trailer records.

**Exhibit 34.6 – CERT PSC Contractor Feedback Data Entry Screen
Version 1.01
(Rev. 77, 05-28-04)**

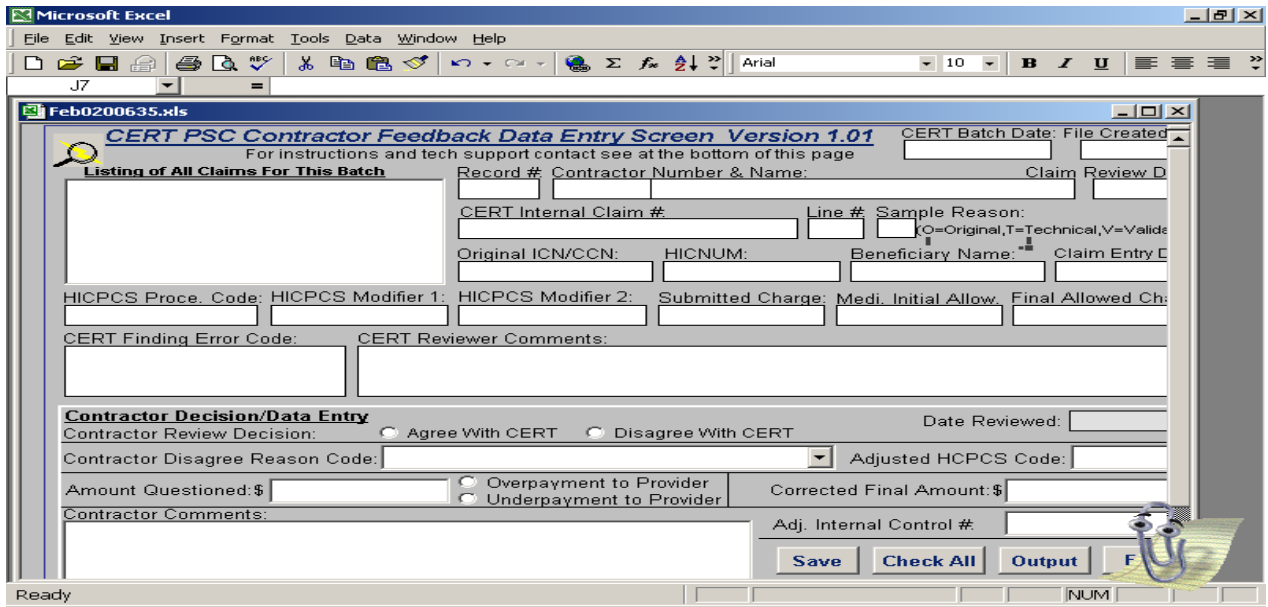


Figure 1: CERT PSC Contractor Feedback Data Entry Screen

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the CERT Contractor Resolution Process (CCRP), even where your staff have previously conducted routine or complex MR.

The CMS will conduct a routine quality assurance review of the CERT program including review of claims with error and non-error findings.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

Exhibit 34.7 - Data Items Included on CERT Reports (Rev. 77, 05-28-04)

The CMS Central Office Clinical Panel (COCP) will receive the following for each line submitted to the CCRP:

Relevant information from the medical record for the disagreed upon line of service, Explanations from the CERT PSC and the AC of their decisions, and Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The COCP will make a decision based upon all information presented to them.

To insure that regional offices (ROs) have an opportunity to be involved in the CCRP, the COCP will invite the participation of RO clinicians in the process.

The COCP at a minimum will consist of four individuals. There will be physician representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PIG). There will be at least one registered nurse on this panel. The COCP will request the participation of consortia staff; requests will be made at least one month before participation is expected. The panel may request the assistance of complex medical review experts, coding experts, or clinical specialists. A list of all participants must accompany the final report from the panel.

Members of panels will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CMS will provide final results from the COCP reviews to you in the CERT Quarterly Error Reconciliation Report (see attachment 5 for the report format); CMS will include in this report only those lines the COCP has confirmed to be in error after the COCP has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. You will pay to the billing providers amounts that you have denied in error and the CERT PSC has identified as such. The CMS does not require collection or payment for errors in coding that do not affect the amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact you identified.

On an annual basis, the COCP will conduct random reviews of the decisions on requests submitted to the CCRP. The QA findings shall be sent to the CERT PSC, AC, and applicable parties (i.e., RO or CO).

Exhibit 34.8 - Acceptable 'No Resolution' Reasons (Rev. 77, 05-28-04)

The following are valid reasons for a 'no resolution' claim:

1. Only six line items may be submitted on each HCFA 1500 claim form.
 2. The patient's Health Insurance Claim Number (HICN) is missing; incomplete or invalid (i.e., not in the proper format) or no valid HICN can be found.
 3. The provider number is missing or incomplete.
 4. No services are identified on the bill.
 5. The current HCFA 1500 form and the current UB-92 form are not used.
 6. The front and back of the HCFA 1500 (12/90) claim form are required on the same sheet and they are not displayed this way.
 7. The patient's address is missing.
 8. Block 11 (insured' policy group or FECA Number) of the HCFA 1500 is not completed.
 9. The beneficiary's signature information is missing.
 10. The ordering physician's name and/or UPIN is missing or invalid (block 17,17A of the HCFA 1500).
 11. The place of service code is missing or invalid (block 24B of the HCFA 1500).
 12. The submitted charges are missing (block 24F of the HCFA 1500).
 13. The days or units are missing (block 24G of the HCFA 1500).
 14. The signature is missing from block 31 of the HCFA 1500.
 15. An itemized receipt is missing.
 16. The name of the store is not on the receipt that includes the price of the item.
 17. A breakdown of charges is not provided.
 18. The Certificate of Medical Necessity (CMN) was not with the claim.
 19. The CMN form is incomplete or invalid.
 20. Dates of service are missing or incomplete (block 24A of the HCFA 1500).
-
21. A provider notifies the contractor that claim(s) were billed in error and requests the claim be deleted.
 22. The provider goes into the claims processing system and deletes a claim.
 23. The patient's name does not match any HICN.
 24. Valid procedure codes were not used and/or services are not described (block 24D of the HCFA 1500).
 25. A description for the item is missing.
 26. The initial date on the CMN is invalid or incomplete.

Problems 1-20 are valid reasons for a 'no resolution' claim and ACs should RTP, deny, or void/cancel/delete the claims (while maintaining an audit trail). ACs should handle problems 21-26 by denying the claims and recording the decision in the AC's claims processing system. Under no circumstances should denied claims be totally deleted from the claims processing system (i.e., contractors must maintain an audit trail for all deleted claims).

**Exhibit 34.9 - Types of Replies from Providers in Non-Responder Cases
(Rev. 77, 05-28-04)**

- A – Provider indicates they have or they will submit the requested medical record to the CERT contractor.
- E1 – Provider indicates that another department within the provider is responsible for fulfilling documentation requests.
- E2 – Provider indicates that a different provider – a third party – has the relevant medical record.
- F – Provider indicates they have the medical record but refuse to provide it without payment for copying/ mailing charges
- G – Provider indicates they have the medical record but refuse to provide it for some other reason.
- H – Extenuating Circumstances (fire, flood, explosion etc.)
- I – Other

Exhibit 34.10 – OIG Referral of Non-Responding Providers⁶

Referral #	1	2	3	4	5	6	7	8
Contractor Number								
Billing Provider ID #								
CID #								
Date of referral to OIG								
Dates of service								
HCPCS/ Revenue Code								
Cumulative \$ value of claims from this billing provider ID								
# and date of AC phone calls to billing provider where this claim was discussed								
Name of person contacted at the provider								
Phone # of the person contacted								
Type of Reply								
# and date of AC faxes to billing provider where this claim was mentioned								
# and date of AC letters to billing provider sent where this claim was mentioned								
If Type of Reply = "Other," briefly explain								
If Type of Reply = E2, list the contact info for the third party								
# and date of AC phone calls to third party where this claim was discussed								
Type of Reply								
If Type of Reply = "Other," briefly explain								
# and date of AC faxes to third party where this claim was mentioned								
# and date of AC letters sent to third party where this claim was mentioned								

⁶ The Revised OIG Referral is an Excel Spreadsheet. This table is being used only as a visual aide and should not be used to refer recalcitrant providers.

Exhibit 34.11 - Office Of Audit Services - Regions

<u>Region</u>	<u>Name</u>	<u>States</u>	<u>E-mail Address</u>
I	Boston	Connecticut New Hampshire Maine Rhode Island Massachusetts Vermont	PFUR1@oig.hhs.gov
II	New York	New Jersey New York Puerto Rico (Virgin Islands)	PFUR2@oig.hhs.gov
III	Philadelphia	District of Columbia Virginia Maryland West Virginia Pennsylvania	PFUR3@oig.hhs.gov
IV	Atlanta	Alabama/Cahaba Georgia Mississippi Kentucky South Carolina/Palmetto Florida Tennessee North Carolina	PFUR4@oig.hhs.gov
V	Chicago	Minnesota Indiana Illinois Ohio Michigan Wisconsin	PFUR5@oig.hhs.gov
VI	Dallas	Arkansas Oklahoma Louisiana Texas (THE) New Mexico	PFUR6@oig.hhs.gov
VII	Kansas City	Colorado Missouri North Dakota Wyoming Iowa Montana South Dakota Kansas Nebraska Utah	PFUR7@oig.hhs.gov

Region

Name

States

E-mail Address

IX

San Francisco

Alaska
Hawaii
Oregon
Arizona
Idaho
Washington
California
Nevada

PFUR9@oig.hhs.gov

Exhibit 34.12 Fee-For-Service Appeal Processes

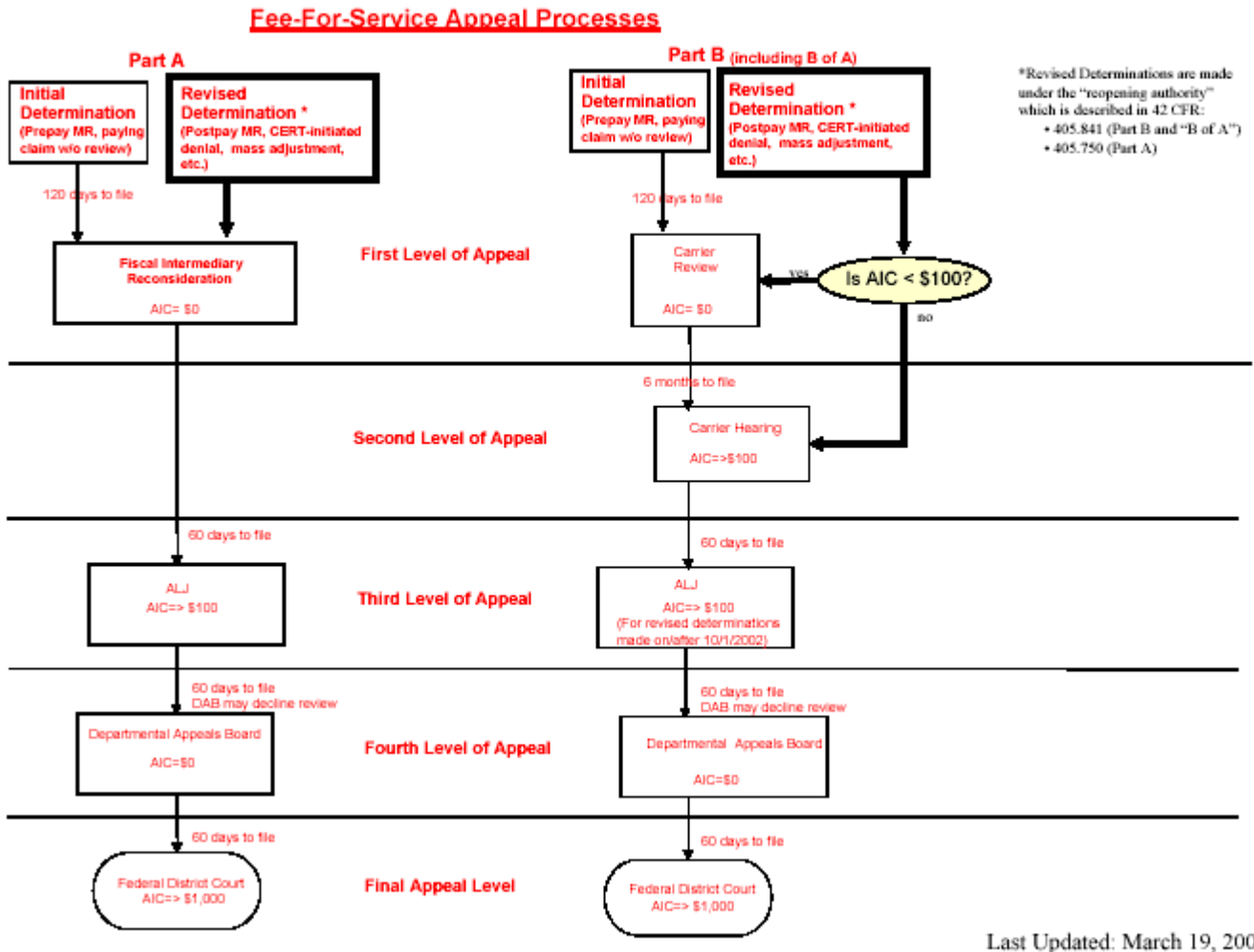


Exhibit 35 – Memorandum of Understanding (MOU) with Law Enforcement

DEPARTMENT OF JUSTICE ACCESS TO MEDICARE CONTRACTOR INFORMATION

Combating Medicare fraud is a goal shared by the Department of Justice (DOJ), Department of Health and Human Services Office of the Inspector General (OIG), and the Health Care Financing (HCFA). Investigating and prosecuting such cases typically requires access to information and documents from Medicare contractors. To ensure that law enforcement's need for this information is met consistent with Medicare contractors' other responsibilities, DOJ, OIG, and HCFA agree to the following procedures:

1. DOJ can request in writing information and documents related to an ongoing civil or criminal health care fraud investigation or prosecution directly from a Medicare contractor. DOJ includes personnel at the Federal Bureau of Investigation (FBI), United States Attorneys Offices, and the Department of Justice in Washington, D.C., including but not limited to the Criminal Division and Civil Division.
2. When DOJ requests information from a Medicare contractor, it must notify the Regional OIG in writing.

OIG approval is not necessary for DOJ requests for information from a Medicare contractor. OIG notification is intended to prevent duplication in investigative efforts.

3. HCFA approval is not necessary before a Medicare contractor can provide information requested to DOJ.
4. It is presumed that a Medicare contractor will furnish DOJ officials with information and documents related to a civil or criminal health care fraud investigation or prosecution in a timely fashion. However, if a Medicare contractor objects to the request on the basis that it is unduly burdensome in terms of the volume of information requested, the timing of the request, or the format in which DOJ seeks the information, the Medicare contractor may take the following steps:
 - a. Contact the requesting DOJ official to explain the basis of the objection. All parties agree to make good faith efforts to reach a resolution that accommodates DOJ's legitimate law enforcement needs and the Medicare contractor's budgetary constraints or other needs.

Legitimate requests include but are not limited to requests for the following documents:

- (1) information contained on claim forms and other records maintained on individual providers or suppliers;
- (2) billing procedure updates and other Medicare publications furnished to providers or suppliers;
- (3) contractor correspondence to and from providers/suppliers;
- (4) billing history of beneficiaries;
- (5) analysis performed by Fraud and Abuse Units;

- (6) data analysis routinely done by Medicare contractors such as utilization reviews.

DOJ recognizes that general data analysis is typically the prerogative of the Medicare contractor and HCFA and, therefore, agrees to limit requests for data analysis not otherwise performed by the Medicare contractor. HCFA recognizes that OIG and DOJ may have legitimate law enforcement needs for data analysis in ongoing investigations and proceedings. Where DOJ requests data analysis not otherwise performed by the contractor, DOJ should discuss the request with the Medicare contractor to explain the need for such analysis and to determine whether there is an alternative format for a contractor to provide the information.

- b. Where the FBI has sought the information, the FBI may involve in the resolution a representative of the United States Attorney's Office, DOJ's Criminal Division or Civil Division.
 - c. If the Medicare contractor and the requesting DOJ official cannot reach an accommodation, then they may seek the intervention of HCFA's Associate Regional Administrator. It is anticipated that such an appeal will be a rare occurrence prevented by reasonable requests and timely and comprehensive responses.
5. Periodic meetings between DOJ, OIG, HCFA regional officials, and the Medicare contractors should be held at the local levels. Similar meetings between DOJ, OIG, and HCFA should be held at the national levels. Such meetings offer an opportunity to discuss trends in fraudulent practices; to devise possible solutions to stopping ongoing fraud; to report the status of DOJ health care fraud cases—consistent with DOJ's enforcement needs and limitations on permissible disclosure of such information; to resolve problems, if any, concerning requests for information; and generally, to foster cooperation among law enforcement, HCFA, and Medicare contractors.
 6. DOJ, OIG, and HCFA agree to conduct training to familiarize their respective personnel on the activities and needs of the others.
 7. DOJ will handle the information and documents obtained from Medicare contractors consistent with existing statutory and regulatory provisions protecting confidentiality of patient records including, but not limited to, the Privacy Act of 1974.
 8. Contractors requiring further instructions or clarification regarding any aspect of this policy, including the application of any statute or regulation, may contact the appropriate Associate Regional Administrator.

This policy will be revisited six months from the date of its adoption.

_____/s/
GERALD M. STERN
Special Counsel for Health Care Fraud
Department of Justice
Services

_____/s/
JUNE GIBBS BROWN
Inspector General
Department of Health and Human

_____/s/
BRUCE VLADECK
Administrator
Health Care Financing Administration

_____/4/29/94
DATE

36 - Overview of the CERT Process (Rev. 67,02-27-04)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all ACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the ACs' claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the AC or full PSC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate AC or full PSC for follow-up. ACs/full PSCs then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Exhibit 36.1 - CERT File Descriptions For Part A Contractors and Standard Systems

(Rev. 224; Issued: 10-16-07; Effective/Implementation: 12-03-07)

Claims Universe File				
Claims Universe Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Universe Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 1 = Header record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file

Validation: Claim Universe files prior to 10/1/2007 did not contain this field.

Codes:

B = Record Format as of 10/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file

Validation: Must be 'A' or 'R'

Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.

Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.

All others will be contractor type 'A'.

Remarks: A = FI only

R = RHHI only or both FI and RHHI

Requirement: Required

Data Element: Universe Date

Definition: Date the universe of claims entered the shared system

Validation: Must be a valid date not equal to a universe date sent on any previous claims universe file

Remarks: Format is CCYYMMDD. May use shared system batch processing date; however the Universe Date must not equal the universe date on any previous claims universe file.

Requirement: Required

Claims Universe File				
Claims Universe Claim Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	“2”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Internal Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces
Billing Provider Number	X(9)	44	52	Spaces
Billing Provider NPI	X(10)	53	62	Spaces
Type of Bill	X(3)	63	65	Spaces
Claim From Date	X (8)	66	73	Spaces
Claim Through Date	X (8)	74	81	Spaces
Condition Code 1	X (2)	82	83	Spaces
Condition Code 2	X (2)	84	85	Spaces
Condition Code 3	X (2)	86	87	Spaces
Condition Code 4	X (2)	88	89	Spaces
Condition Code 5	X (2)	90	91	Spaces
Condition Code 6	X (2)	92	93	Spaces
Condition Code 7	X (2)	94	95	Spaces
Condition Code 8	X (2)	96	97	Spaces
Condition Code 9	X (2)	98	99	Spaces
Condition Code 10	X (2)	100	101	Spaces
Condition Code 11	X (2)	102	103	Spaces
Condition Code 12	X (2)	104	105	Spaces
Condition Code 13	X (2)	106	107	Spaces
Condition Code 14	X (2)	108	109	Spaces
Condition Code 15	X (2)	110	111	Spaces
Condition Code 16	X (2)	112	113	Spaces
Condition Code 17	X (2)	114	115	Spaces
Condition Code 18	X (2)	116	117	Spaces
Condition Code 19	X (2)	118	119	Spaces
Condition Code 20	X (2)	120	121	Spaces
Condition Code 21	X (2)	122	123	Spaces
Condition Code 22	X (2)	124	125	Spaces
Condition Code 23	X (2)	126	127	Spaces
Condition Code 24	X (2)	128	129	Spaces
Condition Code 25	X (2)	130	131	Spaces
Condition Code 26	X (2)	132	133	Spaces
Condition Code 27	X (2)	134	135	Spaces
Condition Code 28	X (2)	136	137	Spaces
Condition Code 29	X (2)	138	139	Spaces
Condition Code 30	X (2)	140	141	Spaces
Claim Demonstration Number	X(2)	142	143	Spaces
PPS Indicator Code	X(1)	144	144	Spaces
Claim State	X(2)	145	146	Spaces

Claims Universe File				
Claims Universe Claim Record				
Field Name	Picture	From	Thru	Initialization
Beneficiary State	X(2)	147	148	Spaces
Claim Total Charge Amount	9(8)V99	149	158	Zeroes
Revenue Code Count	9(3)	159	161	Zero
Revenue Code group:				

The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)				
--	--	--	--	--

From and Thru values relate to the 1 st line item				
Revenue Center Code	X(4)	162	165	Spaces
HCPCS	X(5)	166	170	Spaces
Revenue Center Total Charge	9(8)V99	171	180	Zeroes

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Internal Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: Billing Provider Number

Definition: First nine characters of number assigned by Medicare to identify the billing/pricing provider or supplier.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required by May 23, 2007 for claims using HIPAA standard Transactions

Data Element: Type of Bill

Definition: Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set.
Remarks: N/A
Requirement: Required

Data Element: Claim from Date

Definition: The first day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Claim through Date

Definition: The last day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: Condition Code 1

Condition Code 2
Condition Code 3

Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as defined in the Claims Processing Manual (pub 100-4) chapter 25 (Completing and Processing UB-92 Data Set)
Remarks: N/A
Requirement: Required if claim has a condition code

Data Element: Claim Demonstration Identification Number

Definition: The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: N/A
Requirement: Required when available on claim.

Data Element: PPS Indicator Code alias Claim PPS Indicator Code

Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS), (2) Unknown or (0) not PPS.
Validation: 0 = Not PPS
1 = PPS
2 = Unknown
Remarks: N/A
Requirement: Required

Data Element: Claim State

Definition: 2 character abbreviation identifying the state in which the service is furnished
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states or blank
Remarks: N/A
Requirement: Required if on claim record

Data Element: Beneficiary State

Definition: 2 character abbreviation designating the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS)
http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states or blank
Remarks: N/A
Requirement: Required if on claim record

Data Element: Claim Total Charge Amount

Definition: The total charges for all services included on the institutional claim
Validation: N/A
Remarks: This field should contain the same amount as revenue center code 0001/total charges.
Requirement: Required

Data Element: Revenue Code Count

Definition: Number indicating number of revenue code lines on the claim. Include line 1 in the count
Validation: Must be a number 01 – 450
Remarks: N/A
Requirement: Required

Claim Line Item Fields**Data Element: Revenue Code**

Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid National Uniform Billing Committee (NUBC) approved code
Remarks: Include an entry for revenue code '0001'
Requirement: Required

Data Element: HCPCS Procedure Code or HIPPS Code

Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code
Validation: Must be a valid HCPCS/CPT-4 code
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXXY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on bill

Data Element: Revenue Center Total Charge

Definition: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided

Validation: N/A

Remarks: N/A

Requirement: Required

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeros

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 3=Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Transaction File				
Claims Transaction Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Transaction Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Transaction file
Validation: Claim Transaction files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Transaction Date

Definition: Date the Transaction file was created

Validation: Must be a valid date not equal to a Transaction date sent on any previous claims
Transaction file

Remarks: Format is CCYYMMDD. May use shared system batch processing date

Requirement: Required

Sampled Claims Transaction File				
Sampled Claims Transaction File Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
 Validation: Must be a valid CMS contractor ID
 Remarks: N/A
 Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
 Validation: N/A
 Remarks: 2 = claim record
 Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
 Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
 Codes:
 B = Record Format as of 10/1/2007
 Remarks: N/A
 Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
 Validation: Must be 'A' or 'R'
 Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
 Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
 All others will be contractor type 'A'.

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
 Validation: N/A
 Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
 Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number

Validation: N/A

Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.

Claims Transaction File				
Claims Transaction Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeros

DATA ELEMENT DETAIL

Data Element: Contractor ID

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 1 = Header record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file

Validation: Claim Universe files prior to 10/1/2007 did not contain this field.

Codes:

B = Record Format as of 10/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file

Validation: Must be 'A' or 'R'

Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.

Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.

All others will be contractor type 'A'.

Remarks: A = FI only

R = RHHI only or both FI and RHHI

Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file

Validation: Must be equal to the number of claim records on the file

Remarks: Do not count header or trailer records

Requirement: Required

Claims Resolution File				
Claims Resolution Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Resolution Date

Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(20)	69	88	Spaces
Beneficiary First Name	X(10)	89	98	Spaces
Beneficiary Middle Initial	X(1)	99	99	Spaces
Beneficiary Date of Birth	X(8)	100	107	Spaces
Beneficiary Gender	X(1)	108	108	Spaces
Billing Provider Number	X(9)	109	117	Spaces
Attending Physician UPIN	X(6)	118	123	Spaces
Claim Paid Amount	9(8)V99	124	133	Zeroes
Claim ANSI Reason Code 1	X(8)	134	141	Spaces
Claim ANSI Reason Code 2	X(8)	142	149	Spaces
Claim ANSI Reason Code 3	X(8)	150	157	Spaces
Claim ANSI Reason Code 4	X(8)	158	165	Spaces
Claim ANSI Reason Code 5	X(8)	166	173	Spaces
Claim ANSI Reason Code 6	X(8)	174	181	Spaces
Claim ANSI Reason Code 7	X(8)	182	189	Spaces
Statement covers From Date	X(8)	190	197	Spaces
Statement covers Thru Date	X(8)	198	205	Spaces
Claim Entry Date	X(8)	206	213	Spaces
Claim Adjudicated Date	X(8)	214	221	Spaces
Condition Code 1	X(2)	222	223	Spaces
Condition Code 2	X(2)	224	225	Spaces
Condition Code 3	X(2)	226	227	Spaces
Condition Code 4	X(2)	228	229	Spaces
Condition Code 5	X(2)	230	231	Spaces
Condition Code 6	X(2)	232	233	Spaces
Condition Code 7	X(2)	234	235	Spaces
Condition Code 8	X(2)	236	237	Spaces
Condition Code 9	X(2)	238	239	Spaces
Condition Code 10	X(2)	240	241	Spaces
Condition Code 11	X(2)	242	243	Spaces
Condition Code 12	X(2)	244	245	Spaces
Condition Code 13	X(2)	246	247	Spaces
Condition Code 14	X(2)	248	249	Spaces
Condition Code 15	X(2)	250	251	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization
Condition Code 16	X(2)	252	253	Spaces
Condition Code 17	X(2)	254	255	Spaces
Condition Code 18	X(2)	256	257	Spaces
Condition Code 19	X(2)	258	259	Spaces
Condition Code 20	X(2)	260	261	Spaces
Condition Code 21	X(2)	262	263	Spaces
Condition Code 22	X(2)	264	265	Spaces
Condition Code 23	X(2)	266	267	Spaces
Condition Code 24	X(2)	268	269	Spaces
Condition Code 25	X(2)	270	271	Spaces
Condition Code 26	X(2)	272	273	Spaces
Condition Code 27	X(2)	274	275	Spaces
Condition Code 28	X(2)	276	277	Spaces
Condition Code 29	X(2)	278	279	Spaces
Condition Code 30	X(2)	280	281	Spaces
Type of Bill	X(3)	282	284	Spaces
Principal Diagnosis Code	X(5)	285	289	Spaces
Other Diagnosis Code 1	X(5)	290	294	Spaces
Other Diagnosis Code 2	X(5)	295	299	Spaces
Other Diagnosis Code 3	X(5)	300	304	Spaces
Other Diagnosis Code 4	X(5)	305	309	Spaces
Other Diagnosis Code 5	X(5)	310	314	Spaces
Other Diagnosis Code 6	X(5)	315	319	Spaces
Other Diagnosis Code 7	X(5)	320	324	Spaces
Other Diagnosis Code 8	X(5)	325	329	Spaces
Principal Procedure	X(4)	330	333	Spaces
Principal Procedure Date	X(6)	334	339	Spaces
Other Procedure 1	X(4)	340	343	Spaces
Other Procedure 1 Date	X(6)	344	349	Spaces
Other Procedure 2	X(4)	350	353	Spaces
Other Procedure 2 Date	X(6)	354	359	Spaces
Other Procedure 3	X(4)	360	363	Spaces
Other Procedure 3 Date	X(6)	364	369	Spaces
Other Procedure 4	X(4)	370	373	Spaces
Other Procedure 4 Date	X(6)	374	379	Spaces
Other Procedure 5	X(4)	380	383	Spaces
Other Procedure 5 Date	X(6)	384	389	Spaces
Claim Demonstration Identification Number	9(2)	390	391	Zeroes
PPS Indicator	X(1)	392	392	Spaces
Action Code	X(1)	393	393	Spaces
Patient Status	X(2)	394	395	Spaces
Billing Provider NPI	X(10)	396	405	Spaces
Claim Provider Taxonomy Code	X(25)	406	430	Spaces
Medical Record Number	X(17)	431	447	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization
Patient Control Number	X(20)	448	467	Spaces
Attending Physician NPI	X(10)	468	477	Spaces
Attending Physician Last Name	X(16)	478	493	Spaces
Attending Physician First Name	X(8)	494	501	Spaces
Attending Physician Middle Initial	X(1)	502	502	Spaces
Operating Physician UPIN	X(6)	503	508	Spaces
Operating Physician NPI	X(10)	509	518	Spaces
Operating Physician Last Name	X(16)	519	534	Spaces
Operating Physician First Name	X(8)	535	542	Spaces
Operating Physician Middle Initial	X(1)	543	543	Spaces
Other Physician UPIN	X(6)	544	549	Spaces
Other Physician NPI	X(10)	550	559	Spaces
Other Physician Last Name	X(16)	560	575	Spaces
Other Physician First Name	X(8)	576	583	Spaces
Other Physician Middle Initial	X(1)	584	584	Spaces
Date of Admission	X(8)	585	592	Spaces
Type of Admission	X(1)	593	593	Spaces
Source of Admission	X(1)	594	594	Spaces
DRG	X(3)	595	597	Spaces
Occurrence Code 1	X(2)	598	599	Spaces
Occurrence Code 1 Date	X(8)	600	607	Spaces
Occurrence Code 2	X(2)	608	609	Spaces
Occurrence Code 2 Date	X(8)	610	617	Spaces
Occurrence Code 3	X(2)	618	619	Spaces
Occurrence Code 3 Date	X(8)	620	627	Spaces
Occurrence Code 4	X(2)	628	629	Spaces
Occurrence Code 4 Date	X(8)	630	637	Spaces
Occurrence Code 5	X(2)	638	639	Spaces
Occurrence Code 5 Date	X(8)	640	647	Spaces
Occurrence Code 6	X(2)	648	649	Spaces
Occurrence Code 6 Date	X(8)	650	657	Spaces
Occurrence Code 7	X(2)	658	659	Spaces
Occurrence Code 7 Date	X(8)	660	667	Spaces
Occurrence Code 8	X(2)	668	669	Spaces
Occurrence Code 8 Date	X(8)	670	677	Spaces
Occurrence Code 9	X(2)	678	679	Spaces
Occurrence Code 9 Date	X(8)	680	687	Spaces
Occurrence Code 10	X(2)	688	689	Spaces
Occurrence Code 10 Date	X(8)	690	697	Spaces
Occurrence Code 11	X(2)	698	699	Spaces
Occurrence Code 11 Date	X(8)	700	707	Spaces
Occurrence Code 12	X(2)	708	709	Spaces
Occurrence Code 12 Date	X(8)	710	717	Spaces
Occurrence Code 13	X(2)	718	719	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization
Occurrence Code 13 Date	X(8)	720	727	Spaces
Occurrence Code 14	X(2)	728	729	Spaces
Occurrence Code 14 Date	X(8)	730	737	Spaces
Occurrence Code 15	X(2)	738	739	Spaces
Occurrence Code 15 Date	X(8)	740	747	Spaces
Occurrence Code 16	X(2)	748	749	Spaces
Occurrence Code 16 Date	X(8)	750	757	Spaces
Occurrence Code 17	X(2)	758	759	Spaces
Occurrence Code 17 Date	X(8)	760	767	Spaces
Occurrence Code 18	X(2)	768	769	Spaces
Occurrence Code 18 Date	X(8)	770	777	Spaces
Occurrence Code 19	X(2)	778	779	Spaces
Occurrence Code 19 Date	X(8)	780	787	Spaces
Occurrence Code 20	X(2)	788	789	Spaces
Occurrence Code 20 Date	X(8)	790	797	Spaces
Occurrence Code 21	X(2)	798	799	Spaces
Occurrence Code 21 Date	X(8)	800	807	Spaces
Occurrence Code 22	X(2)	808	809	Spaces
Occurrence Code 22 Date	X(8)	810	817	Spaces
Occurrence Code 23	X(2)	818	819	Spaces
Occurrence Code 23 Date	X(8)	820	827	Spaces
Occurrence Code 24	X(2)	828	829	Spaces
Occurrence Code 24 Date	X(8)	830	837	Spaces
Occurrence Code 25	X(2)	838	839	Spaces
Occurrence Code 25 Date	X(8)	840	847	Spaces
Occurrence Code 26	X(2)	848	849	Spaces
Occurrence Code 26 Date	X(8)	850	857	Spaces
Occurrence Code 27	X(2)	858	859	Spaces
Occurrence Code 27 Date	X(8)	860	867	Spaces
Occurrence Code 28	X(2)	868	869	Spaces
Occurrence Code 28 Date	X(8)	870	877	Spaces
Occurrence Code 29	X(2)	878	879	Spaces
Occurrence Code 29 Date	X(8)	880	887	Spaces
Occurrence Code 30	X(2)	888	889	Spaces
Occurrence Code 30 Date	X(8)	890	897	Spaces
Value Code 1	X(2)	898	899	Spaces
Value Amount 1	9(8)V99	900	909	Zeroes
Value Code 2	X(2)	910	911	Spaces
Value Amount 2	9(8)V99	912	921	Zeroes
Value Code 3	X(2)	922	923	Spaces
Value Amount 3	9(8)V99	924	933	Zeroes
Value Code 4	X(2)	934	935	Spaces
Value Amount 4	9(8)V99	936	945	Zeroes
Value Code 5	X(2)	946	947	Spaces

Sampled Claims Resolution File**Sampled Claims Resolution Claim Detailed Record**

Field Name	Picture	From	Thru	Initialization
Value Amount 5	9(8)V99	948	957	Zeroes
Value Code 6	X(2)	958	959	Spaces
Value Amount 6	9(8)V99	960	969	Zeroes
Value Code 7	X(2)	970	971	Spaces
Value Amount 7	9(8)V99	972	981	Zeroes
Value Code 8	X(2)	982	983	Spaces
Value Amount 8	9(8)V99	984	993	Zeroes
Value Code 9	X(2)	994	995	Spaces
Value Amount 9	9(8)V99	996	1005	Zeroes
Value Code 10	X(2)	1006	1007	Spaces
Value Amount 10	9(8)V99	1008	1017	Zeroes
Value Code 11	X(2)	1018	1019	Spaces
Value Amount 11	9(8)V99	1020	1029	Zeroes
Value Code 12	X(2)	1030	1031	Spaces
Value Amount 12	9(8)V99	1032	1041	Zeroes
Value Code 13	X(2)	1042	1043	Spaces
Value Amount 13	9(8)V99	1044	1053	Zeroes
Value Code 14	X(2)	1054	1055	Spaces
Value Amount 14	9(8)V99	1056	1065	Zeroes
Value Code 15	X(2)	1066	1067	Spaces
Value Amount 15	9(8)V99	1068	1077	Zeroes
Value Code 16	X(2)	1078	1079	Spaces
Value Amount 16	9(8)V99	1080	1089	Zeroes
Value Code 17	X(2)	1090	1091	Spaces
Value Amount 17	9(8)V99	1092	1101	Zeroes
Value Code 18	X(2)	1102	1103	Spaces
Value Amount 18	9(8)V99	1104	1113	Zeroes
Value Code 19	X(2)	1114	1115	Spaces
Value Amount 19	9(8)V99	1116	1125	Zeroes
Value Code 20	X(2)	1126	1127	Spaces
Value Amount 20	9(8)V99	1128	1137	Zeroes
Value Code 21	X(2)	1138	1139	Spaces
Value Amount 21	9(8)V99	1140	1149	Zeroes
Value Code 22	X(2)	1150	1151	Spaces
Value Amount 22	9(8)V99	1152	1161	Zeroes
Value Code 23	X(2)	1162	1163	Spaces
Value Amount 23	9(8)V99	1164	1173	Zeroes
Value Code 24	X(2)	1174	1175	Spaces
Value Amount 24	9(8)V99	1176	1185	Zeroes
Value Code 25	X(2)	1186	1187	Spaces
Value Amount 25	9(8)V99	1188	1197	Zeroes
Value Code 26	X(2)	1198	1199	Spaces
Value Amount 26	9(8)V99	1200	1209	Zeroes
Value Code 27	X(2)	1210	1211	Spaces

Sampled Claims Resolution File**Sampled Claims Resolution Claim Detailed Record**

Field Name	Picture	From	Thru	Initialization
Value Amount 27	9(8)V99	1212	1221	Zeroes
Value Code 28	X(2)	1222	1223	Spaces
Value Amount 28	9(8)V99	1224	1233	Zeroes
Value Code 29	X(2)	1234	1235	Spaces
Value Amount 29	9(8)V99	1236	1245	Zeroes
Value Code 30	X(2)	1246	1247	Spaces
Value Amount 30	9(8)V99	1248	1257	Zeroes
Value Code 31	X(2)	1258	1259	Spaces
Value Amount 31	9(8)V99	1260	1269	Zeroes
Value Code 32	X(2)	1270	1271	Spaces
Value Amount 32	9(8)V99	1272	1281	Zeroes
Value Code 33	X(2)	1282	1283	Spaces
Value Amount 33	9(8)V99	1284	1293	Zeroes
Value Code 34	X(2)	1294	1295	Spaces
Value Amount 34	9(8)V99	1296	1305	Zeroes
Value Code 35	X(2)	1306	1307	Spaces
Value Amount 35	9(8)V99	1308	1317	Zeroes
Value Code 36	X(2)	1318	1319	Spaces
Value Amount 36	9(8)V99	1320	1329	Zeroes
Claim Final Allowed Amount	9(8)V99	1330	1339	Zeroes
Claim Deductible Amount	9(8)V99	1340	1349	Zeroes
Claim State	X(2)	1350	1351	Spaces
Claim Zip Code	X(9)	1352	1360	Spaces
Beneficiary State	X(2)	1361	1362	Spaces
Beneficiary Zip Code	X(9)	1363	1371	Spaces
Total Line Item Count	9(3)	1372	1374	Zeroes
Record Line Item Count	9(3)	1375	1377	Zeroes
Line Item group: The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to 100 times for the Record (depending on Record Line Item Count)				
From and Thru values relate to the 1st line item				
Field Name	Picture			Initialization
Revenue center code	X(4)	1378	1381	Spaces
SNF-RUG-III code	X(3)	1382	1384	Spaces
APC adjustment code	X(5)	1385	1389	Spaces
HCPCS Procedure Code	X(5)	1390	1394	Spaces
HCPCS Modifier 1	X(2)	1395	1396	Spaces
HCPCS Modifier 2	X(2)	1397	1398	Spaces
HCPCS Modifier 3	X(2)	1399	1400	Spaces
HCPCS Modifier 4	X(2)	1401	1402	Spaces
HCPCS Modifier 5	X(2)	1403	1404	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization
Line Item Date	X(8)	1405	1412	Spaces
Line Submitted Charge	9(8)V99	1413	1422	Zeroes
Line Medicare Initial Allowed Charge	9(8)V99	1423	1432	Zeroes
ANSI Reason Code 1	X(8)	1433	1440	Spaces
ANSI Reason Code 2	X(8)	1441	1448	Spaces
ANSI Reason Code 3	X(8)	1449	1456	Spaces
ANSI Reason Code 4	X(8)	1457	1464	Spaces
ANSI Reason Code 5	X(8)	1465	1472	Spaces
ANSI Reason Code 6	X(8)	1473	1480	Spaces
ANSI Reason Code 7	X(8)	1481	1488	Spaces
ANSI Reason Code 8	X(8)	1489	1496	Spaces
ANSI Reason Code 9	X(8)	1497	1504	Spaces
ANSI Reason Code 10	X(8)	1505	1512	Spaces
ANSI Reason Code 11	X(8)	1513	1520	Spaces
ANSI Reason Code 12	X(8)	1521	1528	Spaces
ANSI Reason Code 13	X(8)	1529	1536	Spaces
ANSI Reason Code 14	X(8)	1537	1544	Spaces
Manual Medical Review Indicator	X(1)	1545	1545	Spaces
Resolution Code	X(5)	1546	1550	Spaces
Line Final Allowed Charge	9(8)V99	1551	1560	Zeroes
Line Cash Deductible	9(8)V99	1561	1570	Zeroes
Special Action Code/Override Code	X(1)	1571	1571	Zeroes
Units	9(7)	1572	1578	Zeroes
Filler	X(25)	1579	1603	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
 Validation: Must be a valid CMS contractor ID
 Remarks: N/A
 Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
 Validation: N/A
 Remarks: 2 = Claim record
 Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Record Number

Definition: The sequence number of the record. A claim may have up to five records.
Validation: Must be between 1 and 5
Remarks: None
Requirement: Required

Data Element: Mode of Entry Indicator

Definition: Code that indicates if the claim is paper, EMC, or unknown
Validation: Must be 'E', 'P', or 'U'
Remarks: E = EMC
P = Paper
U = Unknown
Use the same criteria to determine EMC, paper, or unknown as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number

Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the contractor or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: For all records in the resolution file, the Original Claim Control must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Internal Control Number

Definition: Number currently assigned by the Shared System to uniquely identify the claim
Validation: N/A
Remarks: Use the Original Claim Control Number if no adjustment has been made to the claim. This number may be different from the Original Claim Control Number if the shared system has assigned a new Claims Control Number to an adjustment to the claim requested.
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Last Name

Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name

Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial

Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Date of Birth

Definition: Birth date of the beneficiary
Validation: Must be a valid date
Remarks: CCYYMMDD on which the beneficiary was born
Requirement: Required

Data Element: Beneficiary Gender

Definition: Gender of the beneficiary
Validation: 'M' = Male, 'F' = Female, or 'U' = Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider Number

Definition: First nine characters of number used to identify the billing/pricing provider or supplier
Validation: Must be present
If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the first line of the claim
Remarks: N/A
Requirement: Required for all claims

Data Element: Attending Physician UPIN

Definition: The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Paid Amount

Definition: Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier and represents what CMS paid to the institutional provider, physician, or supplier, i.e. The Claim Paid Amount is the net amount paid after co-insurance and deductibles are applied.
Validation: N/A
Remarks: N/A
Requirement: Required

**Data Element: Claim ANSI Reason Code 1
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6
Claim ANSI Reason Code 7**

Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed
Validation: Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.
Remarks: Format is GRRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI reason codes on the bill

Data Element: Statement Covers from Date

Definition: The beginning date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Statement Covers thru Date

Definition: The ending date of the statement
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Entry Date

Definition: Date claim entered the shared claim processing system, the receipt date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Adjudicated Date

Definition: Date claim completed adjudication, i.e., process date
Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Condition Code 1
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: N/A
Requirement: Required if there is a condition code for the bill.

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.).
This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as “frequency” code
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: N/A
Requirement: Required

Data Element: Principal Diagnosis

Definition: The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
Validation: Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Remarks: The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.
Requirement: Required

Data Element: Other Diagnosis Code 1
Other Diagnosis Code 2
Other Diagnosis Code 3
Other Diagnosis Code 4
Other Diagnosis Code 5
Other Diagnosis Code 6
Other Diagnosis Code 7
Other Diagnosis Code 8

Definition: The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be present during treatment
Validation: Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Remarks: Report the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Requirement: Required if available on the claim record.

Data Element: Principal Procedure and Date

Definition: The ICD-9-CM code that indicates the principal procedure performed during the period covered by the institutional claim. And the Date on which it was performed.

Validation: Must be a valid ICD-9-CM procedure code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Remarks: The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

- The date applicable to the principal procedure is shown numerically as MM-DD-YY in the “date” portion.

Requirement: Required for inpatient claims.

**Data Element: Other Procedure and Date 1
Other Procedure and Date 2
Other Procedure and Date 3
Other Procedure and Date 4
Other Procedure and Date 5**

Definition: The ICD-9-CM code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.

Validation: Must be a valid ICD-9-CM procedure code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Remarks: The date applicable to the procedure is shown numerically as MM-DD-YY in the “date” portion.

Requirement: Required if on claim record.

Data Element: Claim Demonstration Identification Number

Definition: The number assigned to identify a demonstration project.

Validation: Must be numeric or zeroes

Remarks: 01-RUGS
02-HHA
03-TELEMED
04-UMWA
05-CHOICES
06-CABG
07-COE
08-MPPP
15-ESRD
30-LUNG
31-VA
37-MMCD
38-ENCOUNTER
39-CENTRALIZED BILLING PPV & FLU
40-INDIAN HEALTH SERVICE

Requirement: Required if available on claim record

Data Element: PPS Indicator

Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS) or (0) not PPS.

Validation: 0 = Not PPS
1 = PPS

Remarks: N/A

Requirement: Required

Data Element: Action Code

Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.

Validation: Must be a valid action code as listed in <http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf>
1 = Original debit action (includes non-adjustment RTI correction items) – it will always be a 1 in regular bills.
2 = Cancel by credit adjustment – used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)

Remarks: N/A

Requirement: Required

Data Element: Patient Status

Definition: This code indicates the patient's status as of the "Through" date of the billing period.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks:

Code Structure

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short-term general hospital for inpatient care.
- 03 Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
- 04 Discharged/transferred to an ICF
- 05 Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05).
Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.
- 06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).
- 07 Left against medical advice or discontinued care
- 08 Discharged/transferred to home under care of a home IV drug therapy provider To be DISCONTINUED effective 10/1/05.
- *09 Admitted as an inpatient to this hospital
- 10-19 Reserved for National Assignment
- 20 Expired (or did not recover - Religious Non Medical Health Care Patient)
- 21-29 Reserved for National Assignment
- 30 Still patient or expected to return for outpatient services
- 31-39 Reserved for National Assignment
- 40 Expired at home (Hospice claims only)
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
- 42 Expired - place unknown (Hospice claims only)
- 43 Discharged/transferred to a Federal hospital (effective for discharges after October 1, 2003)
Usage Note: Applies to discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
- 44-49 Reserved for national assignment
- 50 Discharged/transferred to Hospice – home
- 51 Discharged/transferred to Hospice - medical facility
- 52-60 Reserved for national assignment
- 61 Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
- 62 Discharged/transferred to an inpatient rehabilitation facility

Code Structure

	including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66-70	Reserved for national assignment
71	Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003)
72	Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003)
73-99	Reserved for national assignment

Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.

Validation: N/A

Remarks: N/A.

Requirement: Required for providers using HIPAA standard transactions

Data Element: Claim Provider Taxonomy Code

Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.

Validation: Must be present

- If multiple taxonomy codes are associated with a provider number, provide the first one in sequence.

Remarks: N/A

Requirement: Required when available.

Data Element: Medical Record Number

Definition: Number assigned to patient by hospital or other provider to assist in retrieval of medical records

Validation: N/A

Remarks: N/A

Requirement: Required if available on claim record

Data Element: Patient Control Number

Definition: The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment.

Validation: N/A

Remarks: N/A

Requirement: Required if available on claim record

Data Element: Attending Physician NPI

Definition: NPI assigned to the Attending Physician.

Validation: N/A

Remarks: Left justify

Requirement: Required when available on claim record.

Data Element: Attending Physician Last Name

Definition: Last Name (Surname) of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Attending Physician First Name

Definition: First name (Given Name) of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Attending Physician Middle Initial

Definition: Middle Initial of the attending physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician UPIN

Definition: The UPIN submitted on the claim used to identify the physician identification numbers associated with the physician who performed the principal procedure.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Operating Physician NPI

Definition: NPI assigned to the Operating Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Operating Physician Last Name

Definition: Last Name (Surname) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician First Name

Definition: First name (Given Name) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician Middle Initial

Definition: Middle Initial of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician UPIN

Definition: The UPIN submitted on the claim used to identify other physician associated with the claim.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Other Physician NPI

Definition: NPI assigned to the Other Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Other Physician Last Name

Definition: Last Name (Surname) of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician First Name

Definition: First name (Given Name) of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Other Physician Middle Initial

Definition: Middle Initial of the other physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Date of Admission

Definition: The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
Validation: Must be a valid date
Remarks: Format date as CCYYDDD
Requirement: Required if on claim record.

Data Element: Type of Admission

Definition: The code indicating the type and priority of an inpatient admission associated with the service on an intermediary claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Code Structure:

- 1 Emergency - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 Urgent- The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.

- 3 Elective - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
- 4 Newborn - Use of this code necessitates the use of a Special Source of Admission codes.
- 5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
- 6-8 - Reserved for National Assignment
- 9 Information Not Available – Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

Requirement: Required on inpatient claims only.

Data Element: Source of Admission

Definition: The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Code Structure (For Emergency, Elective, or Other Type of Admission):

- | | | |
|---|--|--|
| 1 | Physician Referral | <p>Inpatient: The patient was admitted to this facility upon the recommendation of their personal physician.</p> <p>Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).</p> |
| 2 | Clinic Referral | <p>Inpatient: The patient was admitted to this facility upon the recommendation of this facility's clinic physician.</p> <p>Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.</p> |
| 3 | HMO Referral | <p>Inpatient: The patient was admitted to this facility upon the recommendation of a HMO physician.</p> <p>Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a HMO physician.</p> |
| 4 | Transfer from a Hospital | <p>Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient</p> <p>Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.</p> |
| 5 | Transfer from a SNF | <p>Inpatient: The patient was admitted to this facility as a transfer from a SNF where they were an inpatient.</p> <p>Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where they are an inpatient.</p> |
| 6 | Transfer from Another Health Care Facility | <p>Inpatient: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled level of care.</p> |

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where they are an inpatient.
7	Emergency Room	Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	Inpatient: The means by which the patient was admitted to this facility is not known.
A	Transfer from a Critical Access Hospital (CAH)	Outpatient: For Medicare outpatient bills, this is not a valid code. Inpatient: The patient was admitted to this facility as a transfer from a CAH where they were an inpatient.
B	Transfer From Another Home Health Agency	Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH where the patient is an inpatient. The patient was admitted to this home health agency as a transfer from another home health agency
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the same home health episode period.

D-Z Reserved for national assignment.
Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)

Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.

Validation: Must be valid per the DRG DEFINITIONS MANUAL

Remarks: N/A

Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1

Occurrence Code and Date 2

Occurrence Code and Date 3

Occurrence Code and Date 4

Occurrence Code and Date 5
Occurrence Code and Date 6
Occurrence Code and Date 7
Occurrence Code and Date 8
Occurrence Code and Date 9
Occurrence Code and Date 10
Occurrence Code and Date 11
Occurrence Code and Date 12
Occurrence Code and Date 13
Occurrence Code and Date 14
Occurrence Code and Date 15
Occurrence Code and Date 16
Occurrence Code and Date 17
Occurrence Code and Date 18
Occurrence Code and Date 19
Occurrence Code and Date 20
Occurrence Code and Date 21
Occurrence Code and Date 22
Occurrence Code and Date 23
Occurrence Code and Date 24
Occurrence Code and Date 25
Occurrence Code and Date 26
Occurrence Code and Date 27
Occurrence Code and Date 28
Occurrence Code and Date 29
Occurrence Code and Date 30

Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks:

- Event codes are two alpha-numeric digits, and dates are shown as eight numeric digits (MM-DD-CCYY)
- When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value codes, if there is another payer involved.

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1
Value Codes and Amounts 2
Value Codes and Amounts 3
Value Codes and Amounts 4
Value Codes and Amounts 5
Value Codes and Amounts 6
Value Codes and Amounts 7
Value Codes and Amounts 8
Value Codes and Amounts 9
Value Codes and Amounts 10
Value Codes and Amounts 11
Value Codes and Amounts 12
Value Codes and Amounts 13
Value Codes and Amounts 14

Value Codes and Amounts 15
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Value Codes and Amounts 29
Value Codes and Amounts 30
Value Codes and Amounts 31
Value Codes and Amounts 32
Value Codes and Amounts 33
Value Codes and Amounts 34
Value Codes and Amounts 35
Value Codes and Amounts 36

Definition: Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.

Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set

Remarks:

- The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).
- Negative amounts are not allowed except in the last entry.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence.
- Use the first line before the second, etc.

Requirement: Required if available on claim record

Data Element: Claim Final Allowed Amount

Definition: Final Allowed Amount for this claim.

Validation: N/A

Remarks: The Gross Allowed charges on the claim. This represents the amount paid to the provider plus any beneficiary responsibility (co-pay and deductible)

Requirement: Required.

Data Element: Claim Deductible Amount

Definition: Amount of deductible applicable to the claim.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim State

Definition: 2 character indicator showing the state where the service is furnished
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Claim Zip Code

Definition: Zip code of the physical location where the services were furnished.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Beneficiary State

Definition: 2 character indicator showing the state of beneficiary residence
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Zip Code

Definition: Zip code associated with the beneficiary residence.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Total Line Item Count

Definition: Number indicating number of service lines on the claim
Validation: Must be a number 001 - 450
Remarks: N/A
Requirement: Required

Data Element: Record Line Item Count

Definition: Number indicating number of service lines on this record
Validation: Must be a number 001 - 100
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Revenue Center Code

Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid NUBC-approved code
Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing UB-92 Data Set
Remarks: Include an entry for revenue code '0001'

Requirement: Required

Data Element: SNF-RUG-III Code

Definition: Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.

Validation: N/A

Remarks: N/A

Requirement: Required for SNF inpatient bills

Data Element: APC Adjustment Code

Definition: The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code.

The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

This field may contain a HIPPS code. If a HHPPS HIPPS code is down coded, the down coded HIPPS will be reported in this field.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.

Validation: N/A

Remarks: Left justify the APC Adjustment Code

Requirement: Required if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code

Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code

Validation: Must be a valid HCPCS/CPT-4 or HIPPS code

Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXXY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on claim record

Data Element: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
HCPCS Modifier 5

Definition: Codes identifying special circumstances related to the service

Validation: N/A

Remarks: N/A

Requirement: Required if available

Element: Line Item Date

Definition: The date the service was initiated

Validation: Must be a valid date.

Remarks: Format is CCYYMMDD

Requirement: Required if on bill and included in the shared system

Data Element: Line Submitted Charge

Definition: Actual charge submitted by the provider or supplier for the service or equipment

Validation: N/A

Remarks: This is a required field. CR3997 provided direction on how to populate this field if data is not available in the claim record.

Requirement: Required

Data Element: Line Medicare Initial Allowed Charge

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: Must be a numeric value.

Remarks: This is a required field. Use the value in FISS field FSSCPDCL-REV-COV-CHRG-AMT to populate this field (per CMS Change Request 3912)

Requirement: Required

Data Elementals Reason Code 1

ANSI Reason Code 2

ANSI Reason Code 3

ANSI Reason Code 4

ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 14

Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GGRRRRRR where: G is the group code and RRRRRR is the adjustment reason code
Requirement: Report all ANSI Reason Codes included on the bill.

Data Element: Manual Medical Review Indicator

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.
Validation: Must be 'Y' or 'N'
Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'
Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is

considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', 'REO', 'DENAM', 'REDAM', INACT

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
INACT	Claim is inactive as identified by "I" Status

Requirement: **Required**

Data Element: Final Allowed Charge

Definition: Final amount paid to the provider for this service or equipment plus patient responsibility.

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Cash Deductible

Definition: The amount of cash deductible the beneficiary paid for the line item service.

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Special Action/Override Code

Definition: Code used to identify special actions taken in determining payment of this line item.

Validation: Must be valid

0-Both deductible Action Code and coinsurance apply Override Code (1)

1-Deductible does not apply

2-Coinsurance does not apply

3-Neither deductible nor coinsurance apply

4-No charge or unites associated with this Revenue Center Code. (Used when multiple HCPCS codes are used for a single Revenue Center Code).

5-RHC or CORF Psychiatric the following alpha codes may be used for MSP processing, and only coded on the total charges line item Revenue Center Code equals 001

M-Override Code EGHP

N-Overrode Code Non EGHP

Remarks: N/A

Requirement: Required

Data Element: Units

Definition: The total number of services or time periods provided for the line item.

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Filler

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeros

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Provider Address File				
Claims Provider Address Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Provider Address Date

Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Provider Address File				
Provider Address Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(25)	25	49	Spaces
Provider Address 1	X(25)	50	74	Spaces
Provider Address 2	X(25)	75	99	Spaces
Provider City	X(15)	100	114	Spaces
Provider State Code	X(2)	115	116	Spaces
Provider Zip Code	X(9)	117	125	Spaces
Provider Phone Number	X(10)	126	135	Spaces
Provider Phone Number Extension	X(10)	136	145	Spaces
Provider FAX Number	X(10)	146	155	Spaces
Provider Type	X(1)	156	156	Spaces
Provider Address Type	9(3)	157	159	1
Provider E-mail Address	X(75)	160	234	Spaces
Provider Federal Tax number or EIN	9(10)	235	244	Zeroes
Filler	X(51)	245	295	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 2 = Detail record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Provider Address file

Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.

Codes:

B = Record Format as of 10/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file

Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Sequence Number

Definition: Number occurrence number of addresses when there are multiple addresses for a provider.
Validation: Must be between 1 and 3
Remarks: Enter 1 if there is only one address for a provider
Requirement: Required

Data Element: Provider Number

Definition: Number assigned by Medicare to identify the provider
Validation: N/A
Remarks: Left justify
Requirement: Required

Data Element: Provider Name

Definition: Provider's name
Validation: N/A
Remarks: This is the business name associated with the provider number. Must be formatted into a name for mailing (e. g., Roger A Smith M.D. or Medical Associates, Inc.)
Requirement: Required

Data Element: Provider Address 1

Definition: First line of provider's address
Validation: N/A
Remarks: This is the first line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Address 2

Definition: Second line of provider's address
Validation: N/A
Remarks: This is the line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider City

Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the provider number
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider State Code

Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state associated with the address of the provider number.
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Zip Code

Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code associated with the address furnished for the provider number identified in this record.

- Provide 9-digit zip code if available, otherwise provide 5-digit zip code

Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider Phone Number

Definition: Provider's phone number
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Phone Number Extension

Definition: Provider's phone number extension
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Fax Number

Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Type

Definition: 1=Billing Provider Number (OSCAR)
2=Attending Physician Number (UPIN)
3=Operating Physician Number (UPIN)
4=Other Physician Number (UPIN)
5=Billing Provider NPI
6=Attending Physician NPI
7=Operating Physician NPI
8=Other Physician NPI
Validation: Must be 1-8
Remarks: This field identifies the type of provider number whose name, address, phone number and identification information are included in the record
Requirement: Required

Data Element: Provider Address Type

Definition: The type of Provider Address furnished.

Validation: 1 = Master Address (FISS)
Legal Address (APASS)
2 = Remittance Address (FISS)
3 = Check Address (FISS) (APASS)
4 = MSP Other Address (FISS)
5 = Medical Review Address (FISS) (APASS)
6 = Other Address (FISS) (APASS)
7 = Chain Address (APASS)
8 = Correspondence Address
9 = Medical Record Address

Remarks: The first “address type” for each provider will always be a “1.” Subsequent occurrences of addresses for the same provider will have the “address type” to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855A. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients’ Medical Records as indicated on the 855A. This information is required if the Patients’ Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient’s medical records are maintained.

Requirement: Required Billing Provider Numbers. Furnish as available for other types of provider numbers

Data Element: Provider E-Mail Address

Definition: Provider’s e-mail address

Validation: Must be a valid e-mail address

Remarks: N/A

Requirement: Required if available

Data Element: Provider Federal Tax Number or EIN

Definition: The number assigned to the billing provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).

Validation: Must be present

Remarks: N/A

Requirement: Required for all Billing Provider Numbers. For all other types of provider numbers, the tax number is required when available

Data Element: Filler

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Claims Provider Address File				
Claims Provider Address Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = FI only
R = RHHI only or both FI and RHHI
Requirement: Required

Data Element: Number of Records

Definition: Number of provider address records on this file
Validation: Must be equal to the number of provider address records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Exhibit 36.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 209; Issued: 06-12-07; Effective: 07-01-07; Implementation: 07-02-07)

Claims Universe File				
Claims Universe Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Universe Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
 Validation: Must be a valid CMS contractor ID
 Remarks: N/A
 Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
 Validation: N/A
 Remarks: 1 = Header record
 Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
 Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
 Codes:
 B = Record Format as of 7/1/2007
 Remarks: N/A
 Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
 Validation: Must be 'B' or 'D'
 Remarks: B = Part B
 D = DMERC
 Requirement: Required

Data Element: Universe Date

Definition: Date the universe of claims entered the shared system
 Validation: Must be a valid date not equal to a universe date sent on any previous claims universe file
 Remarks: Format is CCYYMMDD.

- Shared System logic may use shared system batch processing date as long as the date is not equal to the universe date sent on any previous claims universe file.

Requirement: Required

Claims Universe File				
Claims Universe Claim Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces
Billing Provider Number	X(15)	36	50	Spaces
Billing Provider NPI	X(10)	51	60	Spaces
Claim Submitted Charge Amount	9(7)v99	61	69	Zeroes
Claim Demonstration Number	X(2)	70	71	Spaces
Claim State	X(2)	72	73	Spaces
Beneficiary State	X(2)	74	75	Spaces
Billing Provider Specialty	X(2)	76	77	Spaces
Line Item Count	9(2)	78	79	Zeroes
Line Item group: The following group of Fields occurs from 1 to 52 Times (depending on Line Item Count).				

From and Thru values relate to the 1st line item

Performing Provider Number	X(15)	80	94	Spaces
Performing Provider Specialty	X(2)	95	96	Spaces
HCPCS Procedure Code	X(5)	97	101	Spaces
From Date of Service	X(8)	102	109	Spaces
To Date of Service	X(8)	110	117	Spaces
Line Submitted Charge	9(7)v99	118	126	Zeroes
Performing Provider NPI	X(10)	127	136	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 2 = claim record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider Number

Definition: Number assigned by the NSC or Carrier to identify the billing/pricing provider or supplier
Validation: NA
Remarks: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

- Enter the PIN, for the performing provider of service/supplier who is **not** a member of a group practice.
- Enter the group PIN, for the performing provider of service/supplier who is a member of a group practice.
- Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.
- If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the performing provider on the first line of the claim.

Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required as available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Data Element: Claim Submitted Charge Amount

Definition: The total submitted charges on the claim (the sum of line item submitted charges).

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Claim Demonstration Number

Definition: Also known as Claim Demonstration Identification Number. The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

Validation: Must be a Valid Demo ID

Remarks: N/A

Requirement: Required when available on claim.

Data Element: Claim State

Definition: State abbreviation identifying the state in which the service is furnished

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states

Remarks: When services on a single claim are furnished in multiple states, enter the state identifier for the first detail line.

Requirement: Required

Data Element: Beneficiary State

Definition: State abbreviation identifying the state in which the beneficiary resides.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states

Remarks: N/A

Requirement: Required, when available

Data Element: Billing Provider Specialty

Definition: Code indicating the primary specialty of the Billing provider or supplier

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Line Item Count

Definition: Number indicating number of service lines on the claim

Validation: Must be a number 01 – 52

Remarks: N/A

Requirement: Required

Claim Line Item Fields**Data Element: Performing Provider Number**

Definition: Number assigned by the NSC or Carrier to identify the provider who performed the service or the supplier who supplied the medical equipment

Validation: N/A

Remarks: Enter the PIN of the performing provider. When several different providers of service or suppliers are billing on the same claim, show the individual PIN in the corresponding line item.

Requirement: Required

Data Element: Performing Provider Specialty

Definition: Code indicating the primary specialty of the performing provider or supplier
 Validation: N/A
 Remarks: N/A
 Requirement: Required

Data Element: HCPCS Procedure Code

Definition: The HCPCS/CPT-4 code that describes the service
 Validation: N/A
 Remarks: N/A
 Requirement: Required

Data Element: From Date of Service

Definition: The date the service was initiated
 Validation: Must be a valid date less than or equal to To Date of Service
 Remarks: Format is **CCYYMMDD**
 Requirement: Required

Data Element: To Date of Service

Definition: The date the service ended
 Validation: Must be a valid date greater than or equal to From Date of Service
 Remarks: Format is **CCYYMMDD**
 Requirement: Required

Data Element: Line Submitted Charge

Definition: Actual charge submitted by the provider or supplier for the service or equipment
 Validation: N/A
 Remarks: N/A
 Requirement: Required

Data Element: Performing Provider NPI

Definition: NPI assigned to the Performing Provider.
 Validation: N/A
 Remarks: N/A.
 Requirement: Required as available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL**Data Element: Contractor ID**

Definition: Contractor's CMS assigned number
 Validation: Must be a valid CMS contractor ID

Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file
Validation: Must be equal to the number of claim records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Claims Transaction File				
Claims Transaction Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Transaction Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 1 = Header record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Transaction file

Validation: Claim Transaction files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor

Validation: Must be 'B' or 'D'

Remarks: B = Part B

D = DMERC

Requirement: Required

Data Element: Transaction Date

Definition: Date the Transaction File was created

Validation: Must be a valid date not equal to a Transaction date sent on any previous claims Transaction file

Remarks: Format is CCYYMMDD. May use shared system batch processing date

Requirement: Required

Sampled Claims Transaction File				
Sampled Claims Transaction File Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces

DATA ELEMENT DETAIL**Data Element: Contractor ID**

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 2 = claim record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file

Validation: Claim Universe files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.

Claims Transaction File				
Claims Transaction Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 3 = Trailer Record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:

Remarks: B = Record Format as of 7/1/2007
 N/A
 Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
 Validation: Must be 'B' or 'D'
 Remarks: B = Part B
 D = DMERC
 Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file
 Validation: Must be equal to the number of claim records on the file
 Remarks: Do not count header or trailer records
 Requirement: Required

Claims Resolution File				
Claims Resolution Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
 Validation: Must be a valid CMS contractor ID
 Remarks: N/A
 Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
 Validation: N/A
 Remarks: 1 = Header record
 Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
 Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
 Codes:
 B = Record Format as of 7/1/2007
 Remarks: N/A
 Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
 Validation: Must be 'B' or 'D'

Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Resolution Date

Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
Requirement: Required

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	
Assignment Indicator	X(1)	9	9	Spaces
Mode of Entry Indicator	X(1)	10	10	Spaces
Original Claim Control Number	X(15)	11	25	Spaces
Claim Control Number	X(15)	26	40	Spaces
Beneficiary HICN	X(12)	41	52	Spaces
Beneficiary Last Name	X(20)	53	72	Spaces
Beneficiary First Name	X(10)	73	82	Spaces
Beneficiary Middle Initial	X(1)	83	83	Spaces
Beneficiary Date Of Birth	X(8)	84	91	Spaces
Billing Provider Number	X(15)	92	106	Spaces
Referring/Ordering UPIN	X(6)	107	112	Spaces
Claim Allowed Amount	9(7)v99	113	121	Zeroes
Claim ANSI Reason Code 1	X(8)	122	129	Spaces
Claim ANSI Reason Code 2	X(8)	130	137	Spaces
Claim ANSI Reason Code 3	X(8)	138	145	Spaces
Claim Entry Date	X(8)	146	153	Spaces
Claim Adjudicated Date	X(8)	154	161	Spaces
Beneficiary Gender	X(1)	162	162	Spaces
Billing Provider NPI	X(10)	163	172	Spaces
Referring/Ordering Provider NPI	X(10)	173	182	Spaces
Claim Paid Amount	9(7)v99	183	191	Zeroes
Beneficiary Paid Amount	9(7)v99	192	200	Zeroes
Claim Diagnosis Code 1	X(5)	201	205	Spaces
Claim Diagnosis Code 2	X(5)	206	210	Spaces
Claim Diagnosis Code 3	X(5)	211	215	Spaces
Claim Diagnosis Code 4	X(5)	216	220	Spaces
Claim Diagnosis Code 5	X(5)	221	225	Spaces
Claim Diagnosis Code 6	X(5)	226	230	Spaces
Claim Diagnosis Code 7	X(5)	231	235	Spaces
Claim Diagnosis Code 8	X(5)	236	240	Spaces
Claim Zip Code	X(5)	241	245	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	Picture	From	Thru	Initialization
Claim Pricing State	X(2)	246	247	Spaces
Beneficiary Zip Code	X(5)	248	252	Spaces
Beneficiary State	X(2)	253	254	Spaces
Claim Demonstration Number	X(2)	255	256	Spaces
Line Item Count	9(2)	257	258	Zeroes
Line Item group: The following group of fields occurs from 1 to 52 times (Depending on Line Item Count).				

From and Thru values relate to the 1st line item

Sampled Claims Resolution File				
Sampled Claims Resolution Detail Record (one record per claim)				
Field Name	Picture	From	Thru	Initialization
Performing Provider Number	X(15)	259	273	Spaces
Performing Provider Specialty	X(2)	274	275	Spaces
HCPCS Procedure Code	X(5)	276	280	Spaces
HCPCS Modifier 1	X(2)	281	282	Spaces
HCPCS Modifier 2	X(2)	283	284	Spaces
HCPCS Modifier 3	X(2)	285	286	Spaces
HCPCS Modifier 4	X(2)	287	288	Spaces
Number of Services	999v9	289	292	Zeroes
Service From Date	X(8)	293	300	Spaces
Service To Date	X(8)	301	308	Spaces
Place of Service	X(2)	309	310	Spaces
Type of Service	X(1)	311	311	Spaces
Diagnosis Code	X(5)	312	316	Spaces
CMN Control Number	X(15)	317	331	Spaces
Line Submitted Charge	9(7)v99	332	340	Zeroes
Line Medicare Initial Allowed Charge	9(7)v99	341	349	Zeroes
ANSI Reason Code 1	X(8)	350	357	Spaces
ANSI Reason Code 2	X(8)	358	365	Spaces
ANSI Reason Code 3	X(8)	366	373	Spaces
ANSI Reason Code 4	X(8)	374	381	Spaces
ANSI Reason Code 5	X(8)	382	389	Spaces
ANSI Reason Code 6	X(8)	390	397	Spaces
ANSI Reason Code 7	X(8)	398	405	Spaces
Manual Medical Review Indicator	X(1)	406	406	Space
Resolution Code	X(5)	407	411	Spaces
Line Final Allowed Charge	9(7)v99	412	420	Zeroes
Performing Provider NPI	X(10)	421	430	Spaces
Performing Provider UPIN	X(6)	431	436	Spaces
Miles/Time/Units/Services Indicator	X(1)	437	437	Spaces

Code				
Line Deductible Applied	9(7)v99	438	446	Zeroes
Line Co-Insurance	9(7)V99	447	455	Zeroes
Line Paid Amount	9(7)v99	456	464	Zeroes
Line MSP Code	X(1)	465	465	Spaces
Line MSP Paid Amount	9(7)v99	466	474	Zeroes
Line Pricing Locality	X(2)	475	476	Spaces
Line Zip Code	X(5)	477	481	Spaces
Line Pricing State Code	X(2)	482	483	Spaces
Filler	X(25)	484	508	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: Contractor ID

Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = Claim record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Assignment Indicator

Definition: Code indicating whether claim is assigned or non-assigned
Validation: Must be 'A' or 'N'
Remarks: A = Assigned
N = Non-assigned
Requirement: Required

Data Element: Mode of Entry Indicator

Definition: Code that indicates if the claim is paper or EMC
Validation: Must be 'E' or 'P'
Remarks: E = EMC
P = Paper
Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: Required

Data Element: Original Claim Control Number

Definition: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the contractor or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: Must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Claim Control Number

Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary HICN

Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Last Name

Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name

Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial

Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks: N/A
Requirement: Required when available

Data Element: Beneficiary Date of Birth

Definition: Date on which beneficiary was born.
Validation: Must be a valid date
Remarks: **CCYYMMDD** on which the beneficiary was born
Requirement: Required

Data Element: Billing Provider Number

Definition: Number assigned by the NSC or Carrier to identify the billing/pricing provider or supplier.
Validation: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

- Enter the PIN, for the performing provider of service/supplier who is **not** a member of a group practice.
- Enter the group PIN, for the performing provider of service/supplier who is a member of a group practice.
- Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.
- If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the performing provider on the first line of the claim.

Remarks: N/A
Requirement: **Required**

Data Element: Referring/Ordering UPIN

Definition: UPIN assigned to identify the referring/ordering provider.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient

Requirement: Required when available on the claim record.

Data Element: Claim Allowed Amount

Definition: Final Allowed Amount for this claim.
Validation: N/A
Remarks: The total allowed charges on the claim (the sum of line item allowed charges)
Requirement: Required.

**Data Element: Claim ANSI Reason Code 1
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3**

Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GRRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.

Data Element: Claim Entry Date

Definition: Date claim entered the shared claim processing system
Validation: Must be a valid date

Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: Claim Adjudicated Date

Definition: Date claim completed adjudication
Validation: Must be a valid date. Format must be CCYYMMDD
Remarks: This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made
Requirement: Required

Data Element: Beneficiary Gender

Definition: Gender of the Beneficiary.
Validation: M=Male
F=Female
U=Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI

Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required when available. This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Data Element: Referring/Ordering Provider NPI

Definition: NPI assigned to the Referring/Ordering Provider.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient

Requirement: Required when available on the claim record.

Data Element: Claim Paid Amount

Definition: Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.
Validation: N/A
Remarks: Amount of payment made from the Medicare trust fund for the services covered by the claim record
Requirement: Required.

Data Element: Beneficiary Paid Amount

Definition: Amount paid by Beneficiary to the provider.
Validation: N/A
Remarks: N/A
Requirement: Required if available.

Data Element: Claim Diagnosis Code 1
Claim Diagnosis Code 2
Claim Diagnosis Code 3
Claim Diagnosis Code 4
Claim Diagnosis Code 5
Claim Diagnosis Code 6
Claim Diagnosis Code 7
Claim Diagnosis Code 8

Definition: The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided

Validation: Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

- Ambulance supplier (specialty 59)—amb
- Independent Clinical Lab (specialty 69)--lab

Requirement: Claim Diagnosis 1 is required for ALL claims. Claim diagnosis codes 2-8 should be submitted if contained on the claim record.

Data Element: Claim Zip Code

Definition: Zip Code used to identify where the service was furnished.

Validation: Must be a valid Zip Code

Remarks: For DMERC Claims use the zip code for beneficiary residence.
For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, except in the listed situations.

- For ambulance services, identify the zip code where the patient was picked up.
- If the service was furnished in the patient's home, use the zip code from the patient's home address.
- For electronic claims, if multiple zip codes are identified enter the zip code for the line with the highest allowed amount. (If this logic is too cumbersome to implement, we can live with enter the zip code from the first line)

Requirement: Required.

Data Element: Claim Pricing State

Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states

Remarks: Furnish the state associated with the Claim Zip Code.
Requirement: Required.

Data Element: Beneficiary Zip Code

Definition: Zip Code associated with the beneficiary residence.
Validation: Must be a valid Zip Code
Remarks: Use the zip code for beneficiary residence.
Requirement: Required.

Data Element: Beneficiary State

Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states
Remarks: N/A
Requirement: Required

Data Element: Claim Demonstration Number

Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: N/A
Requirement: Required when available on claim.

Data Element: Line Item Count

Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: Performing Provider Number

Definition: Number assigned by the shared system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Performing Provider Specialty

Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: Must be a valid Provider Specialty per IOM 10.4 ch26 10.8
Remarks: N/A
Requirement: Required

Data Element: HCPCS Procedure Code

Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

**Data Element: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4**

Definition: Codes identifying special circumstances related to the service
Validation: N/A
Remarks: N/A
Requirement: Required if available

Data Element: Number of Services

Definition: The number of service rendered in days or units
Validation: N/A
Remarks: The last position should contain the value to the right of the decimal in the number of services. Put a zero in the last position for whole numbers.
Requirement: Required

Data Element: Service from Date

Definition: The date the service was initiated
Validation: Must be a valid date less than or equal to Service to Date
Remarks: Format is **CCYYMMDD**
Requirement: Required

Data Element: Service to Date

Definition: The date the service ended
Validation: Must be a valid date greater than or equal to Service from Date
Remarks: Format is **CCYYMMDD**
Requirement: Required

Data Element: Place of Service

Definition: Code that identifies where the service was performed
Validation: N/A
Remarks: Must be a value in the range of 00 □ 99
Requirement: Required

Data Element: Type of Service

Definition: Code that classifies the service
Validation: The code must match a valid CWF type of service code
Remarks: N/A
Requirement: Required

Data Element: Diagnosis Code

Definition: Code identifying a diagnosed medical condition resulting in the line item service
Validation: Must be a valid ICD-9-CM diagnosis code

- CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA,

NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

- Ambulance supplier (specialty 59)—**amb**
- Independent Clinical Lab (specialty 69)—**lab**

Requirement: Required

Data Element: CMN Control Number

Definition: Number assigned by the shared system to uniquely identify a Certificate of Medical Necessity

Validation: N/A

Remarks: Enter a zero if no number is assigned

Requirement: Required on DMERC claims

Data Element: Line Submitted Charge

Definition: Actual charge submitted by the provider or supplier for the service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Line Medicare Initial Allowed Charge

Definition: Amount Medicare allowed for the service or equipment before any reduction or denial

Validation: N/A

Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.

- Use MPFDB, Clinical Lab FS, Ambulance FS, ASC FS, drug and injectable FS, or DME fee schedule as appropriate.

Requirement: Required

Data Element: ANSI Reason Code 1

ANSI Reason Code 2

ANSI Reason Code 3

ANSI Reason Code 4

ANSI Reason Code 5

ANSI Reason Code 6

ANSI Reason Code 7

Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed

Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes

Remarks: Format is GRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO', 'APPAM', 'DENAM', 'REDAM'.

Data Element: Manual Medical Review Indicator

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor’s history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. .

Validation: Must be 'Y' or 'N'

Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'

Requirement: Required

Data Element: Resolution Code

Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor’s history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be ‘APP’, ‘APPMR’, ‘APPMC’, ‘DENMR’, ‘DENMC’, ‘DEO’, ‘RTP’, ‘REDMR’, ‘REDMC’, ‘REO’, ‘DENAM’, ‘REDAM’, ‘DELET’, or ‘TRANS’,

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical

Resolution Code	Description
	review.
APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMC	Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable (return/reject)
REDAM	Reduced after medical review
REDMR	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC	Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO	Reduced for non-medical review reasons.
DELET	Claim deleted from processing system—AC maintains record of claim on system
TRANS	Claim was originally submitted to the wrong contractor and has been transferred to the contractor with jurisdiction.

Requirement: Required

Data Element: Line Final Allowed Charge

Definition: Final Amount allowed for this service or equipment after any reduction or denial

Validation: N/A

Remarks: This represents the contractor's value of the service/item gross of co-pays and deductibles

Requirement: Required

Data Element: Performing Provider NPI

Definition: NPI assigned to the Performing Provider.

Validation: N/A

Remarks: N/A.

Requirement: This element will be required by final implementation of NPI for providers that use HIPPA standard transactions.

Data Element: Performing Provider UPIN

Definition: Unique Physician Identifier Number (UPIN) that identifies the physician supplier actually performing/providing the service.

Validation: N/A

Remarks: N/A.

Requirement: Required, **when available**.

Data Element: Miles/Time/Units/Services Indicator

Definition: Code indicating the units associated with services needing unit reporting on the line item for the carrier claim.

Validation: Must be a valid Indicator as identified in IOM 10.4 ch26 10.10

- 0 - No allowed services
- 1- Ambulance transportation miles
- 2- Anesthesia Time Units
- 3 - Services
- 4- Oxygen units
- 5- Units of Blood

Remarks: N/A

Requirement: Required

Data Element: Line Deductible Applied

Definition: Amount of deductible applied for this service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Line Co-Insurance Amount

Definition: Amount of co-insurance due for this service or equipment

Validation: N/A

Remarks: N/A

Requirement: Required

Data Element: Line Paid Amount

Definition: Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim

Validation: N/A

Remarks: This represents the contractor's value of the claim after co-pays and deductibles

Requirement: Required

Data Element: Line MSP Code

Definition: Code indicating primary payor for services on this line item

- Validation:
- A-Working Aged
 - B-ESRD
 - D-No-Fault
 - E-Workers' Compensation
 - F-Federal (Public Health)
 - G-Disabled
 - H-Black Lung
 - I-Veterans
 - L-Liability

Remarks: N/A

Requirement: Required , **when contained on the claim record.**

Data Element: Line MSP Paid Amount

Definition: The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).

Validation: N/A

Remarks: Amount paid by Primary Payer

Requirement: Required , **when contained on the claim record.**

Data Element: Line Pricing Locality

Definition: Code denoting the carrier-specific locality used for pricing this claim.

Validation: Must be a valid pricing locality

- Enter '00' for claims priced at a statewide locality.

Requirement: Required.

Data Element: Line Zip Code

Definition: Zip Code used to determine claim pricing locality.

Validation: Must be a valid Zip Code

Remarks: For DMERC Claims use the zip code for beneficiary residence.
 For Carrier Claims, use the zip code identified in item 32 of the HCFA 1500, unless the service was furnished in the patient's home. If the service was furnished in the patient's home, use the zip code from the patient's home address.

Requirement: Required.

Data Element: Line Pricing State

Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states

Remarks: Furnish the state associated with the **Line Zip Code**.

Requirement: Required.

Data Element: Filler

Definition: Additional space TBD

Validation: N/A

Remarks: N/A

Requirement: None

Claims Resolution File				
Claims Resolution Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL**Data Element: Contractor ID**

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 3 = Trailer Record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Resolution file

Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor

Validation: Must be 'B' or 'D'

Remarks: B = Part B

D = DMERC

Requirement: Required

Data Element: Number of Claims

Definition: Number of claim records on this file

Validation: Must be equal to the number of claim records on the file

Remarks: Do not count header or trailer records

Requirement: Required

Claims Provider Address File				
Claims Provider Address Header Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'1'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	Spaces

DATA ELEMENT DETAIL**Data Element: Contractor ID**

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 1 = Header record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Provider Address file

Validation: Claim Provider Address files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor

Validation: Must be 'B' or 'D'

Remarks: B = Part B

D = DMERC

Requirement: Required

Data Element: Provider Address Date

Definition: Date the Provider Address File was created.

Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file

Remarks: Format is CCYYMMDD. May use shared system batch processing date

Requirement: Required

Provider Address File				
Provider Address Detail Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Number/NPI	X(15)	9	23	Spaces
Provider Name	X(25)	24	48	Spaces
Provider Address 1	X(25)	49	73	Spaces
Provider Address 2	X(25)	74	98	Spaces
Provider City	X(15)	99	113	Spaces
Provider State Code	X(2)	114	115	Spaces
Provider Zip Code	X(9)	116	124	Spaces
Provider Phone Number	X(10)	125	134	Spaces
Provider Phone Number Extension	X(10)	135	144	Spaces
Provider Fax Number	X(10)	145	154	Spaces
Provider Type	X(2)	155	156	Spaces
Provider Address Order	X(2)	157	158	Spaces
Provider Address Type	9(3)	159	161	Zero
Provider E-mail Address	X(75)	162	236	Spaces
Provider Federal Tax number or EIN	9(10)	237	246	Zeroes
Provider Taxonomy Code	9(10)	247	256	Zeroes
Provider License Number	X(16)	257	272	Spaces
Provider License State	X(2)	273	274	Spaces
Filler	X(25)	275	299	Spaces

DATA ELEMENT DETAIL

Data Element: Contractor ID

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record
Validation: N/A
Remarks: 2 = claim record
Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: Provider Number/NPI

Definition: Number assigned by the AC/NSC or NPI agency to identify the provider
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Provider Name

Definition: Provider's name
Validation: N/A
Remarks: This is the name of the provider
The provider name must be formatted into a business name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).
Requirement: Required

Data Element: Provider Address 1

Definition: 1st line of provider's address
Validation: N/A
Remarks: This is the address1 of the provider
Requirement: Required

Data Element: Provider Address 2

Definition: 2nd line of provider's address
Validation: N/A
Remarks: This is the address2 of the provider
Requirement: Required if available

Data Element: Provider City

Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the provider's address.
Requirement: Required

Data Element: Provider State Code

Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state of the provider's address.
Requirement: Required

Data Element: Provider Zip Code

Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code of the provider's address. Provide 9-digit zip code if available, otherwise provide 5-digit zip code
Requirement: Required

Data Element: Provider Phone Number

Definition: Provider's telephone number
Validation: Must be a valid telephone number
Remarks: This is the phone number
Requirement: None

Data Element: Provider Phone Number Extension

Definition: Provider's telephone number Extension
Validation: Must be a valid telephone number
Remarks: This is the phone number
Requirement: None

Data Element: Provider Fax Number

Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: This is the fax number of the provider
Requirement: None

Data Element: Provider Type

Definition: 1=billing/pricing provider number (Assigned by carrier or NSC)
2= referring/ordering provider (UPIN)
3=Performing/rendering provider (Assigned by carrier or NSC)
4=Entity is both billing/pricing and performing/rendering provider
5=Entity is both referring/ordering and performing/rendering provider
6=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider)
7=billing/pricing provider number (NPI)
8= referring/ordering provider (NPI)
9=Performing/rendering provider (NPI)
10=Entity is both billing/pricing and performing/rendering provider (NPI)
11=Entity is both referring/ordering and performing/rendering provider (NPI)
12=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider) (NPI)

Validation: Must be a valid provider type
Remarks: This field indicates for which provider number associated with a sampled claim the address information is furnished.
Requirement: Required

Data Element: Address Order

Definition: The order in which the records of provider addresses for the provider are entered into the provider address file detailed record. This field in combination with the Contractor ID, Provider number, and Provider Type will make each record in the file unique.

Validation: Must be a valid number between 01 and 99

Remarks: This field indicated the order in which records containing the addresses for a provider are entered into the detail file. For instance, if there are three addresses for a provider, the record for the first address for that provider will contain an '01' in this field; and the record for the second address for that provider will contain a '02' in this field.

Requirement: Required

Data Element: Provider Address Type

Definition: The type of Provider Address furnished.

Validation: 1 = Practice Address (MCS)
Provider address (VMS)
2 = Pay To Address (MCS)
Payee Address (VMS)
3 = Billing Address (VMS)
4 = Correspondence Address
5 = Medical Record Address

Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained

Requirement: Required

Data Element: Provider E-Mail Address

Definition: Provider's e-mail address

Validation: Must be a valid e-mail address

Remarks: N/A

Requirement: Required if available

Data Element: Provider Federal Tax Number or EIN

Definition: The number assigned to the provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).

Validation: Must be present

Remarks: N/A

Requirement: Required for all provider numbers

Data Element: Provider Taxonomy Code

Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.

Validation: Must be present

Remarks: If multiple taxonomy codes are available, furnish the first one listed.

Requirement: Required if available

Data Element: Provider License Number

Definition: The professional business license required to provide health care services.

Validation: Must be present

Remarks: N/A

Requirement: Required if available

Data Element: Provider License State

Definition: Identify the state that issued the providers professional business license

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) http://www.usps.com/ncsc/lookups/usps_abbreviations.html#states

Remarks: N/A

Requirement: Required if available

Data Element: Filler

Definition: Additional space TBD

Validation: N/A

Remarks: N/A

Requirement:

Claims Provider Address File				
Claims Provider Address Trailer Record (one record per file)				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'3'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	Zeroes

DATA ELEMENT DETAIL**Data Element: Contractor ID**

Definition: Contractor's CMS assigned number

Validation: Must be a valid CMS contractor ID

Remarks: N/A

Requirement: Required

Data Element: Record Type

Definition: Code indicating type of record

Validation: N/A

Remarks: 3 = Trailer Record

Requirement: Required

Data Element: Record Version Code

Definition: The code indicating the record version of the Provider Address file

Validation: Provider Address files prior to 7/1/2007 did not contain this field.

Codes:

B = Record Format as of 7/1/2007

Remarks: N/A

Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor

Validation: Must be 'B' or 'D'

Remarks: B = Part B

D = DMERC

Requirement: Required

Data Element: Number of Records

Definition: Number of provider records on this file

Validation: Must be equal to the number of provider records on the file

Remarks: Do not count header or trailer records

Requirement: Required

Exhibit 36.3 - Language for Inclusion in Provider Letter (Rev. 67, 02-27-04)

In order to improve the processing and medical decision making involved with payment of Medicare claims, CMS began a new program effective August 2000. This program is called CERT and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (AdvanceMed of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. AdvanceMed's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that the contractor decisions regarding the claims were accurate and based on sound policy. CMS will use the AdvanceMed findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by AdvanceMed. On a monthly basis, AdvanceMed will request a small sample of claims, approximately 200 from each contractor, as the claims are entered into their system. AdvanceMed will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., questions of medical necessity or inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How are providers and suppliers of sampled claims impacted by CERT?

You may be asked during AdvanceMed's review to provide more information such as medical records or certificates of medical necessity so that AdvanceMed can verify that billing was proper and that claims processing procedures were appropriate. You will be advised what documentation is need and the name of your contact.

General questions regarding the CERT initiative may be directed to the CERT Program, at (804) 264-1778. Otherwise, providers and suppliers will be contacted **ONLY** if their claim(s) is selected and AdvanceMed requires additional information.

MISCELLANEOUS CHARTS THAT I HAVE REMOVED

The transmission name for the Sampled Claims Transaction Files are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTTRN
A00020	P#CER.#NCHPSC.A00020.CERTTRN
A00030	P#CER.#NCHPSC.A00030.CERTTRN
A00040	P#CER.#NCHPSC.A00040.CERTTRN
A00090	P#CER.#NCHPSC.A00090.CERTTRN
A00101	P#CER.#NCHPSC.A00101.CERTTRN
A00130	P#CER.#NCHPSC.A00130.CERTTRN
A00131	P#CER.#NCHPSC.A00131.CERTTRN
A00140	P#CER.#NCHPSC.A00140.CERTTRN
A00150	P#CER.#NCHPSC.A00150.CERTTRN
A00160	P#CER.#NCHPSC.A00160.CERTTRN
A00180	P#CER.#NCHPSC.A00180.CERTTRN
A00181	P#CER.#NCHPSC.A00181.CERTTRN
A00190	P#CER.#NCHPSC.A00190.CERTTRN
A00230	P#CER.#NCHPSC.A00230.CERTTRN
A00250	P#CER.#NCHPSC.A00250.CERTTRN
A00260	P#CER.#NCHPSC.A00260.CERTTRN
A00270	P#CER.#NCHPSC.A00270.CERTTRN
A00308	P#CER.#NCHPSC.A00308.CERTTRN
A00310	P#CER.#NCHPSC.A00310.CERTTRN
A00320	P#CER.#NCHPSC.A00320.CERTTRN
A00332	P#CER.#NCHPSC.A00332.CERTTRN
A00340	P#CER.#NCHPSC.A00340.CERTTRN
A00350	P#CER.#NCHPSC.A00350.CERTTRN
A00363	P#CER.#NCHPSC.A00363.CERTTRN
A00370	P#CER.#NCHPSC.A00370.CERTTRN
A00380	P#CER.#NCHPSC.A00380.CERTTRN
A00400	P#CER.#NCHPSC.A00400.CERTTRN
A00410	P#CER.#NCHPSC.A00410.CERTTRN
A00430	P#CER.#NCHPSC.A00430.CERTTRN
A00450	P#CER.#NCHPSC.A00450.CERTTRN
A00452	P#CER.#NCHPSC.A00452.CERTTRN
A00453	P#CER.#NCHPSC.A00453.CERTTRN
A00460	P#CER.#NCHPSC.A00460.CERTTRN
A50333	P#CER.#NCHPSC.A50333.CERTTRN
A52280	P#CER.#NCHPSC.A52280.CERTTRN
A57400	P#CER.#NCHPSC.A57400.CERTTRN
A57401	P#CER.#NCHPSC.A57401.CERTTRN

AC Number	Holding File
635	P#CER.#NCHPSC.D00635.CERTTRAN
811	P#CER.#NCHPSC.D00811.CERTTRAN
885	P#CER.#NCHPSC.D00885.CERTTRAN

	AC Number	Holding File
5655	P#CER.#NCHPSC.D05655.CERTTRAN	
10555	P#CER.#NCHPSC.D10555.CERTTRAN	
510	P#CER.#NCHPSC.B00510.CERTTRAN	
520	P#CER.#NCHPSC.B00520.CERTTRAN	
528	P#CER.#NCHPSC.B00528.CERTTRAN	
570	P#CER.#NCHPSC.B00570.CERTTRAN	
580	P#CER.#NCHPSC.B00580.CERTTRAN	
621	P#CER.#NCHPSC.B00621.CERTTRAN	
623	P#CER.#NCHPSC.B00623.CERTTRAN	
630	P#CER.#NCHPSC.B00630.CERTTRAN	
640	P#CER.#NCHPSC.B00640.CERTTRAN	
650	P#CER.#NCHPSC.B00650.CERTTRAN	
655	P#CER.#NCHPSC.B00655.CERTTRAN	
660	P#CER.#NCHPSC.B00660.CERTTRAN	
700	P#CER.#NCHPSC.B00700.CERTTRAN	
740	P#CER.#NCHPSC.B00740.CERTTRAN	
780	P#CER.#NCHPSC.B00780.CERTTRAN	
781	P#CER.#NCHPSC.B00781.CERTTRAN	
801	P#CER.#NCHPSC.B00801.CERTTRAN	
803	P#CER.#NCHPSC.B00803.CERTTRAN	
805	P#CER.#NCHPSC.B00805.CERTTRAN	
820	P#CER.#NCHPSC.B00820.CERTTRAN	
824	P#CER.#NCHPSC.B00824.CERTTRAN	
825	P#CER.#NCHPSC.B00825.CERTTRAN	
865	P#CER.#NCHPSC.B00865.CERTTRAN	
880	P#CER.#NCHPSC.B00880.CERTTRAN	
889	P#CER.#NCHPSC.B00889.CERTTRAN	
900	P#CER.#NCHPSC.B00900.CERTTRAN	
901	P#CER.#NCHPSC.B00901.CERTTRAN	
973	P#CER.#NCHPSC.B00973.CERTTRAN	
974	P#CER.#NCHPSC.B00974.CERTTRAN	
2050	P#CER.#NCHPSC.B02050.CERTTRAN	
5130	P#CER.#NCHPSC.B05130.CERTTRAN	
5440	P#CER.#NCHPSC.B05440.CERTTRAN	
5535	P#CER.#NCHPSC.B05535.CERTTRAN	
14330	P#CER.#NCHPSC.B14330.CERTTRAN	
16360	P#CER.#NCHPSC.B16360.CERTTRAN	
16510	P#CER.#NCHPSC.B16510.CERTTRAN	
21200	P#CER.#NCHPSC.B21200.CERTTRAN	
31140	P#CER.#NCHPSC.B31140.CERTTRAN	

Within 5 working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

The target data set names for the current Sampled Claim Resolution Files are listed below:

AC Number	Target File
635	P#CER.#NCHPSC.D00635.CERTRSLN
811	P#CER.#NCHPSC.D00811.CERTRSLN
885	P#CER.#NCHPSC.D00885.CERTRSLN
655	P#CER.#NCHPSC.D05655.CERTRSLN
10555	P#CER.#NCHPSC.D10555.CERTRSLN
510	P#CER.#NCHPSC.B00510.CERTRSLN
520	P#CER.#NCHPSC.B00520.CERTRSLN
528	P#CER.#NCHPSC.B00528.CERTRSLN
570	P#CER.#NCHPSC.B00570.CERTRSLN
580	P#CER.#NCHPSC.B00580.CERTRSLN
621	P#CER.#NCHPSC.B00621.CERTRSLN
623	P#CER.#NCHPSC.B00623.CERTRSLN
630	P#CER.#NCHPSC.B00630.CERTRSLN
640	P#CER.#NCHPSC.B00640.CERTRSLN
650	P#CER.#NCHPSC.B00650.CERTRSLN
655	P#CER.#NCHPSC.B00655.CERTRSLN
660	P#CER.#NCHPSC.B00660.CERTRSLN
700	P#CER.#NCHPSC.B00700.CERTRSLN
740	P#CER.#NCHPSC.B00740.CERTRSLN
780	P#CER.#NCHPSC.B00780.CERTRSLN
781	P#CER.#NCHPSC.B00781.CERTRSLN
801	P#CER.#NCHPSC.B00801.CERTRSLN
803	P#CER.#NCHPSC.B00803.CERTRSLN
805	P#CER.#NCHPSC.B00805.CERTRSLN
820	P#CER.#NCHPSC.B00820.CERTRSLN
824	P#CER.#NCHPSC.B00824.CERTRSLN
825	P#CER.#NCHPSC.B00825.CERTRSLN
865	P#CER.#NCHPSC.B00865.CERTRSLN
880	P#CER.#NCHPSC.B00880.CERTRSLN
889	P#CER.#NCHPSC.B00889.CERTRSLN
900	P#CER.#NCHPSC.B00900.CERTRSLN
901	P#CER.#NCHPSC.B00901.CERTRSLN
973	P#CER.#NCHPSC.B00973.CERTRSLN
974	P#CER.#NCHPSC.B00974.CERTRSLN
2050	P#CER.#NCHPSC.B02050.CERTRSLN
5130	P#CER.#NCHPSC.B05130.CERTRSLN
5440	P#CER.#NCHPSC.B05440.CERTRSLN
5535	P#CER.#NCHPSC.B05535.CERTRSLN
14330	P#CER.#NCHPSC.B14330.CERTRSLN
16360	P#CER.#NCHPSC.B16360.CERTRSLN
16510	P#CER.#NCHPSC.B16510.CERTRSLN
21200	P#CER.#NCHPSC.B21200.CERTRSLN

31140

P#CER.#NCHPSC.B31140.CERTSLN

The target data set names for the current Provider Address Files are listed below:

AC Number	Target File
635	P#CER.#NCHPSC.D00635.CERTPROV
811	P#CER.#NCHPSC.D00811.CERTPROV
885	P#CER.#NCHPSC.D00885.CERTPROV
5655	P#CER.#NCHPSC.D05655.CERTPROV
10555	P#CER.#NCHPSC.D10555.CERTPROV
510	P#CER.#NCHPSC.B00510.CERTPROV
520	P#CER.#NCHPSC.B00520.CERTPROV
528	P#CER.#NCHPSC.B00528.CERTPROV
570	P#CER.#NCHPSC.B00570.CERTPROV
580	P#CER.#NCHPSC.B00580.CERTPROV
621	P#CER.#NCHPSC.B00621.CERTPROV
623	P#CER.#NCHPSC.B00623.CERTPROV
630	P#CER.#NCHPSC.B00630.CERTPROV
640	P#CER.#NCHPSC.B00640.CERTPROV
650	P#CER.#NCHPSC.B00650.CERTPROV
655	P#CER.#NCHPSC.B00655.CERTPROV
660	P#CER.#NCHPSC.B00660.CERTPROV
700	P#CER.#NCHPSC.B00700.CERTPROV
740	P#CER.#NCHPSC.B00740.CERTPROV
780	P#CER.#NCHPSC.B00780.CERTPROV
781	P#CER.#NCHPSC.B00781.CERTPROV
801	P#CER.#NCHPSC.B00801.CERTPROV
803	P#CER.#NCHPSC.B00803.CERTPROV
805	P#CER.#NCHPSC.B00805.CERTPROV
820	P#CER.#NCHPSC.B00820.CERTPROV
824	P#CER.#NCHPSC.B00824.CERTPROV
825	P#CER.#NCHPSC.B00825.CERTPROV
865	P#CER.#NCHPSC.B00865.CERTPROV
880	P#CER.#NCHPSC.B00880.CERTPROV
889	P#CER.#NCHPSC.B00889.CERTPROV
900	P#CER.#NCHPSC.B00900.CERTPROV
901	P#CER.#NCHPSC.B00901.CERTPROV
973	P#CER.#NCHPSC.B00973.CERTPROV
974	P#CER.#NCHPSC.B00974.CERTPROV
2050	P#CER.#NCHPSC.B02050.CERTPROV
5130	P#CER.#NCHPSC.B05130.CERTPROV
5440	P#CER.#NCHPSC.B05440.CERTPROV
5535	P#CER.#NCHPSC.B05535.CERTPROV
14330	P#CER.#NCHPSC.B14330.CERTPROV
16360	P#CER.#NCHPSC.B16360.CERTPROV

16510	P#CER.#NCHPSC.B16510.CERTPROV
21200	P#CER.#NCHPSC.B21200.CERTPROV
31140	P#CER.#NCHPSC.B31140.CERTPROV

The target data set names for the current Claims History Replica Files are listed below:

AC Number	Target File
635	P#CER.#NCHPSC.D00635.CERTRPLI
811	P#CER.#NCHPSC.D00811.CERTRPLI
885	P#CER.#NCHPSC.D00885.CERTRPLI
5655	P#CER.#NCHPSC.D05655.CERTRPLI
10555	P#CER.#NCHPSC.D10555.CERTRPLI
510	P#CER.#NCHPSC.B00510.CERTRPLI
520	P#CER.#NCHPSC.B00520.CERTRPLI
528	P#CER.#NCHPSC.B00528.CERTRPLI
570	P#CER.#NCHPSC.B00570.CERTRPLI
580	P#CER.#NCHPSC.B00580.CERTRPLI
621	P#CER.#NCHPSC.B00621.CERTRPLI
623	P#CER.#NCHPSC.B00623.CERTRPLI
630	P#CER.#NCHPSC.B00630.CERTRPLI
640	P#CER.#NCHPSC.B00640.CERTRPLI
650	P#CER.#NCHPSC.B00650.CERTRPLI
655	P#CER.#NCHPSC.B00655.CERTRPLI
660	P#CER.#NCHPSC.B00660.CERTRPLI
700	P#CER.#NCHPSC.B00700.CERTRPLI
740	P#CER.#NCHPSC.B00740.CERTRPLI
780	P#CER.#NCHPSC.B00780.CERTRPLI
781	P#CER.#NCHPSC.B00781.CERTRPLI
801	P#CER.#NCHPSC.B00801.CERTRPLI
803	P#CER.#NCHPSC.B00803.CERTRPLI
805	P#CER.#NCHPSC.B00805.CERTRPLI
820	P#CER.#NCHPSC.B00820.CERTRPLI
824	P#CER.#NCHPSC.B00824.CERTRPLI
825	P#CER.#NCHPSC.B00825.CERTRPLI
865	P#CER.#NCHPSC.B00865.CERTRPLI
880	P#CER.#NCHPSC.B00880.CERTRPLI
889	P#CER.#NCHPSC.B00889.CERTRPLI
900	P#CER.#NCHPSC.B00900.CERTRPLI
901	P#CER.#NCHPSC.B00901.CERTRPLI
973	P#CER.#NCHPSC.B00973.CERTRPLI
974	P#CER.#NCHPSC.B00974.CERTRPLI
2050	P#CER.#NCHPSC.B02050.CERTRPLI
5130	P#CER.#NCHPSC.B05130.CERTRPLI
5440	P#CER.#NCHPSC.B05440.CERTRPLI
5535	P#CER.#NCHPSC.B05535.CERTRPLI
14330	P#CER.#NCHPSC.B14330.CERTRPLI

16360	P#CER.#NCHPSC.B16360.CERTRPLI
16510	P#CER.#NCHPSC.B16510.CERTRPLI
21200	P#CER.#NCHPSC.B21200.CERTRPLI
31140	P#CER.#NCHPSC.B31140.CERTRPLI

Target data set names for the sampled claim resolution files are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRSLN
A00020	P#CER.#NCHPSC.A00020.CERTRSLN
A00030	P#CER.#NCHPSC.A00030.CERTRSLN
A00040	P#CER.#NCHPSC.A00040.CERTRSLN
A00090	P#CER.#NCHPSC.A00090.CERTRSLN
A00101	P#CER.#NCHPSC.A00101.CERTRSLN
A00130	P#CER.#NCHPSC.A00130.CERTRSLN
A00131	P#CER.#NCHPSC.A00131.CERTRSLN
A00140	P#CER.#NCHPSC.A00140.CERTRSLN
A00150	P#CER.#NCHPSC.A00150.CERTRSLN
A00160	P#CER.#NCHPSC.A00160.CERTRSLN
A00180	P#CER.#NCHPSC.A00180.CERTRSLN
A00181	P#CER.#NCHPSC.A00181.CERTRSLN
A00190	P#CER.#NCHPSC.A00190.CERTRSLN
A00230	P#CER.#NCHPSC.A00230.CERTRSLN
A00250	P#CER.#NCHPSC.A00250.CERTRSLN
A00260	P#CER.#NCHPSC.A00260.CERTRSLN
A00270	P#CER.#NCHPSC.A00270.CERTRSLN
A00308	P#CER.#NCHPSC.A00308.CERTRSLN
A00310	P#CER.#NCHPSC.A00310.CERTRSLN
A00320	P#CER.#NCHPSC.A00320.CERTRSLN
A00332	P#CER.#NCHPSC.A00332.CERTRSLN
A00340	P#CER.#NCHPSC.A00340.CERTRSLN
A00350	P#CER.#NCHPSC.A00350.CERTRSLN
A00363	P#CER.#NCHPSC.A00363.CERTRSLN
A00370	P#CER.#NCHPSC.A00370.CERTRSLN
A00380	P#CER.#NCHPSC.A00380.CERTRSLN
A00400	P#CER.#NCHPSC.A00400.CERTRSLN
A00410	P#CER.#NCHPSC.A00410.CERTRSLN
A00430	P#CER.#NCHPSC.A00430.CERTRSLN
A00450	P#CER.#NCHPSC.A00450.CERTRSLN
A00452	P#CER.#NCHPSC.A00452.CERTRSLN
A00453	P#CER.#NCHPSC.A00453.CERTRSLN
A00460	P#CER.#NCHPSC.A00460.CERTRSLN
A50333	P#CER.#NCHPSC.A50333.CERTRSLN
A52280	P#CER.#NCHPSC.A52280.CERTRSLN
A57400	P#CER.#NCHPSC.A57400.CERTRSLN
A57401	P#CER.#NCHPSC.A57401.CERTRSLN

P#CER.#NCHPSC.A*****.CERTPROV. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the provider address files are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTPROV
A00020	P#CER.#NCHPSC.A00020.CERTPROV

AC Number	Holding File
A00030	P#CER.#NCHPSC.A00030.CERTPROV
A00040	P#CER.#NCHPSC.A00040.CERTPROV
A00090	P#CER.#NCHPSC.A00090.CERTPROV
A00101	P#CER.#NCHPSC.A00101.CERTPROV
A00130	P#CER.#NCHPSC.A00130.CERTPROV
A00131	P#CER.#NCHPSC.A00131.CERTPROV
A00140	P#CER.#NCHPSC.A00140.CERTPROV
A00150	P#CER.#NCHPSC.A00150.CERTPROV
A00160	P#CER.#NCHPSC.A00160.CERTPROV
A00180	P#CER.#NCHPSC.A00180.CERTPROV
A00181	P#CER.#NCHPSC.A00181.CERTPROV
A00190	P#CER.#NCHPSC.A00190.CERTPROV
A00230	P#CER.#NCHPSC.A00230.CERTPROV
A00250	P#CER.#NCHPSC.A00250.CERTPROV
A00260	P#CER.#NCHPSC.A00260.CERTPROV
A00270	P#CER.#NCHPSC.A00270.CERTPROV
A00308	P#CER.#NCHPSC.A00308.CERTPROV
A00310	P#CER.#NCHPSC.A00310.CERTPROV
A00320	P#CER.#NCHPSC.A00320.CERTPROV
A00332	P#CER.#NCHPSC.A00332.CERTPROV
A00340	P#CER.#NCHPSC.A00340.CERTPROV
A00350	P#CER.#NCHPSC.A00350.CERTPROV
A00363	P#CER.#NCHPSC.A00363.CERTPROV
A00370	P#CER.#NCHPSC.A00370.CERTPROV
A00380	P#CER.#NCHPSC.A00380.CERTPROV
A00400	P#CER.#NCHPSC.A00400.CERTPROV
A00410	P#CER.#NCHPSC.A00410.CERTPROV
A00430	P#CER.#NCHPSC.A00430.CERTPROV
A00450	P#CER.#NCHPSC.A00450.CERTPROV
A00452	P#CER.#NCHPSC.A00452.CERTPROV
A00453	P#CER.#NCHPSC.A00453.CERTPROV
A00460	P#CER.#NCHPSC.A00460.CERTPROV
A50333	P#CER.#NCHPSC.A50333.CERTPROV
A52280	P#CER.#NCHPSC.A52280.CERTPROV
A57400	P#CER.#NCHPSC.A57400.CERTPROV
A57401	P#CER.#NCHPSC.A57401.CERTPROV

P#CER.#NCHPSC.A*****.CERTRPLI. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the claims history replica file are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRPLI
A00020	P#CER.#NCHPSC.A00020.CERTRPLI
A00030	P#CER.#NCHPSC.A00030.CERTRPLI
A00040	P#CER.#NCHPSC.A00040.CERTRPLI
A00090	P#CER.#NCHPSC.A00090.CERTRPLI
A00101	P#CER.#NCHPSC.A00101.CERTRPLI
A00130	P#CER.#NCHPSC.A00130.CERTRPLI
A00131	P#CER.#NCHPSC.A00131.CERTRPLI
A00140	P#CER.#NCHPSC.A00140.CERTRPLI

AC Number	Holding File
A00150	P#CER.#NCHPSC.A00150.CERTRPLI
A00160	P#CER.#NCHPSC.A00160.CERTRPLI
A00180	P#CER.#NCHPSC.A00180.CERTRPLI
A00181	P#CER.#NCHPSC.A00181.CERTRPLI
A00190	P#CER.#NCHPSC.A00190.CERTRPLI
A00230	P#CER.#NCHPSC.A00230.CERTRPLI
A00250	P#CER.#NCHPSC.A00250.CERTRPLI
A00260	P#CER.#NCHPSC.A00260.CERTRPLI
A00270	P#CER.#NCHPSC.A00270.CERTRPLI
A00308	P#CER.#NCHPSC.A00308.CERTRPLI
A00310	P#CER.#NCHPSC.A00310.CERTRPLI
A00320	P#CER.#NCHPSC.A00320.CERTRPLI
A00332	P#CER.#NCHPSC.A00332.CERTRPLI
A00340	P#CER.#NCHPSC.A00340.CERTRPLI
A00350	P#CER.#NCHPSC.A00350.CERTRPLI
A00363	P#CER.#NCHPSC.A00363.CERTRPLI
A00370	P#CER.#NCHPSC.A00370.CERTRPLI
A00380	P#CER.#NCHPSC.A00380.CERTRPLI
A00400	P#CER.#NCHPSC.A00400.CERTRPLI
A00410	P#CER.#NCHPSC.A00410.CERTRPLI
A00430	P#CER.#NCHPSC.A00430.CERTRPLI
A00450	P#CER.#NCHPSC.A00450.CERTRPLI
A00452	P#CER.#NCHPSC.A00452.CERTRPLI
A00453	P#CER.#NCHPSC.A00453.CERTRPLI
A00460	P#CER.#NCHPSC.A00460.CERTRPLI
A50333	P#CER.#NCHPSC.A50333.CERTRPLI
A52280	P#CER.#NCHPSC.A52280.CERTRPLI
A57400	P#CER.#NCHPSC.A57400.CERTRPLI
A57401	P#CER.#NCHPSC.A57401.CERTRPLI

Assumptions and Constraints

- **Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.**
- Files must be transmitted to the CERT operations center via CONNECT:Direct.
- CMS or the CERT contractor will provide Medicare contractors with dataset names for all files that will be transmitted to the CERT operations center.
- The CERT contractor will provide the Medicare contractors with the dataset names with which the sampled claims transaction file will be transmitted.
- Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted.
- Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor to support CERT implementation and will provide

updates within 60 calendar days before each expected implementation of a change in the data dictionary. .

Below are details on how those requirements must be implemented.

1. Coordinate with the CERT contractor to provide the requested information in an electronic format for claims identified in the sample.

The CERT contractor will make all requests for information or data through letters, e-mail, or via the Network Data Mover (NDM) to the CERT point of contact of each Medicare contractor. Instructions for responding to requests via the NDM will be provided after a test of the process with the DMERCs has been completed. Medicare contractors are required to provide responses in electronic format as described in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Responses provided in electronic form must be made within five working days of a request.

2. Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims processed during the day.

The FI and RHHI data centers and contractors should use the file formats from Attachment 1 for this section. Use CONNECT:Direct to transmit the files. The target filename for transmission to the CERT test environment in the CMSDC is D#CER.#NCHPSC.A*****.CERTUNV. Target file names for transmission to the CERT production environment in the CMSDC is P#CER.#NCHPSC.A*****.CERTUNV. The Medicare contractor data center must replace the "*****" in each file name with the contractor ID number of the contractor for which the file is being submitted.

Carrier and DMERC data centers and contractors should use the file formats from the Attachment 2 for this transmission. Use CONNECT:Direct to transmit the files. Target filenames for transmission to the CERT test environment in the CMSDC are listed below:

Claims Universe File

D#CER.#NCHPSC.B*****CERTUNV
Sampled Claims Resolution File
D#CER.#NCHPSC.B*****.CERTRSLN
Provider Address File
D#CER.#NCHPSC.B*****CERTPROV
Claims History Replica File
D#CER.#NCHPSC.B*****CERTRPLI
Sampled Claims Transaction File
D#CER.#NCHPSC.B*****.CERTTRAN

Target file names for transmission to the CERT production environment in the CMSDC are listed below:

Claims Universe File
P#CER.#NCHPSC.B*****.CERTUNV
Sampled Claims Resolution File
P#CER.#NCHPSC.B*****.CERTSLN
Provider Address File
P#CER.#NCHPSC.B*****.CERTPROV
Claims History Replica File
P#CER.#NCHPSC.B*****.CERTPLI
Sampled Claims Transaction File
P#CER.#NCHPSC.B*****.CERTTRAN

Each Medicare contractor in Phases 1, 2, and 3 of CERT has identified a CMSDC NDM User ID they will use to transmit the files. Notify the CERT contractor at the address included in the "**How to Contact and Make Submissions to the CERT Operations Center**" section above of any NDM user ID changes or additions. Medicare contractors in Phases after 3 must provide CMSDC User IDs to the CERT operations center at least 30 calendar days before their first sample is due.

3. On a periodic basis, generally monthly, the CERT contractor will make a request via the NDM for the Medicare contractor to return a sampled claims resolution file, claims history replica file, and provider address file for every claim in listed in the sampled claims transaction file that has completed adjudication by the Medicare contractor. The contents of the sampled claims transaction file will consist of all claims that recently were selected in the sample for the first time and any claims remaining from prior requests that had not completed the adjudication process by the Medicare contractor at the time of the previous request.
4. Provide the CERT contractor with the Sample Claims Resolution file, claims history replica file, and provider address file within five working days of a CERT request.

Within 5 working days of a CERT request, provide for every claim listed in the sampled claims transaction file that has undergone payment adjudication (i.e., denial, reduction, return, payment approval, etc) all sampled claims resolution files, all claims history replica files, and a single provider address file in the formats contained in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Note that more than one sampled claims resolution file and claims history replica file may be provided under circumstances where the Claim Control Number has changed since its original assignment and claim activity has occurred. Standard systems are expected to provide a look up list, where necessary, to associate the last Claim Control Number submitted to the CERT contractor from the standard system with new Claim Control Numbers assigned to the claim subsequent to that submission. If there are claims adjustments that have not been adjudicated when the sample claims transaction file is received, those adjustments do not need to be included in a sample claims resolution file.

Included in the requirements for the sampled claims resolution file is a requirement to report the manual medical review indicator for each line on the sampled claim. We have defined this item as follows:

Data Element: **Complex Manual Medical Review Indicator**

Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medical expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance, if relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'Y' or 'N' or blank

Remarks: Set to 'Y' if service was subjected to complex manual medical review, 'N' if the service was subjected to routine manual medical review, and leave it blank if the service was subjected to automated review.

Requirement: Not required

A line level MR indicator field is included on the standard system claim records. Providing a Value for the MR indicator on the standard system claim record will allow CERT to distinguish among automated MR, complex MR, and routine MR. Contractors that **do not** enter MR indicators on the review line in question, will not have the opportunity to dispute that line of service.

The contractor must enter the necessary data to allow the standard processing intermediary shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. We expect contractors to manually put this indicator on the claim. Contractors must enter the following indicators on the claim to document the type of review that they performed (automated, routine, or complex):

Situation	Payment Decision Contractor	Enters
Contractor receives documentation and performs complex manual medical review on one or more specific lines of service for that claim.	-Approved -Denied -Reduced	Y in the detail level (line level) complex manual medical review indicator for each line of complex manual medical review. Leave the claim level manual review indicator blank.
Contractor performs routine manual medical review on one or more specific lines of service for that claim.	-Approved -Denied -Reduced	N in the detail level (line level) routine manual medical review indicator for each line of routine manual medical review. Leave the claim level manual review indicator blank.
Contractor does not perform complex or routine manual medical review. The system performs automated medical review on any line of service.	-Approved -Denied -Reduced	Leave claim and line level manual medical review indicators blank.

By July 1, 2003, the manual medical review indicator for FIs and RHHIs was implemented. The following requirements went into effect at that time.

- A. Contractors must insure that standard system maintainers correctly implement standard system modifications that automatically place the appropriate manual medical review indicator on each line in the sample claims resolution file.
- B. If manual review is not performed on the line the manual medical review indicator must be blank. If manual review is performed on a line, the manual medical review indicator must be either a “Y” or an “N.”
- C. The manual medical review indicator must be “Y” for all lines for which the Medicare contractor has received medical records. When

the contractor asks for medical records but the provider does not send every one of the notes that the contractor requested, put a "Y" for the lines corresponding to missing notes.

- D. Contractor staff must manually enter information needed to decide if medical records were obtained for lines where that information cannot be obtained from the system claims processing modules.

The medical review indicator was automated for carriers and DMERCs at the beginning of Phases I-III.

Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.

This requirement applies only when the routine processing cycle does not run. For example, if the Medicare contractor routinely processes claims every other day, zero count records do not have to be submitted for days on which processing is not routinely done. To ensure the CERT contractor knows when to expect records, CMS requests that the Medicare contractor send a copy of their processing schedule, if they do not process claims every day, to the CERT contractor ten working days before they are required to begin sending processed records or ten working days after receipt of this PM, whichever is later. Send the list to the address listed in the "**How to Contact and Make Submissions to the CERT Operations Center**" section above.

Files must be transmitted to the CERT operations center via CONNECT:Direct. Following are the target dataset names for all files that will be transmitted to the CERT operations center.

A manual monthly process is in place to upload the sampled claims transaction file containing the data for all Medicare contractors to the mainframe. A batch job is executed to separate the sampled claim transaction file into smaller files based on Medicare contractor. The files are placed into the function send mode of the NDM process. The files are then transmitted to each Medicare contractor data center (schedule to be determined).

The format for the transmission name for the sampled claims transaction files is P#CER.#NCHPSC.A***.CERTTRN for FIs and RHHIs, P#CER.#NCHPSC.B*****.CERTTRN for FIs, and P#CER.#NCHPSC.D*****.CERTTRN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.**

Within 5 working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

The format for the data set name for the sampled claims resolution files is P#CER.#NCHPSC.A***.CERTSLN for FIs and RHHIs, P#CER.#NCHPSC.B*****.CERTSLN for FIs, and P#CER.#NCHPSC.D*****.CERTSLN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.**

Target data set names for the provider address files are in the format: P#CER.#NCHPSC.A***.CERTPROV for FIs and RHHIs, P#CER.#NCHPSC.B*****.CERTPROV for FIs, and P#CER.#NCHPSC.D*****.CERTPROV for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.**

Target data set names for the claims history replica file is in the format: P#CER.#NCHPSC.A***.CERTPLI for FIs and RHHIs, P#CER.#NCHPSC.B*****.CERTPLI for FIs, and P#CER.#NCHPSC.D*****.CERTPLI for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.**

The CERT contractor will retrieve the target files on the 6th workday after transmission of the Sampled Claims Transaction Files. The files will be processed through a screening module on the mainframe and then transferred to the CERT database. If a file is not received by COB of the 5th day, it will be processed in the following month's sample.

Transmittal of the Sampled Claims Transactions File will be handled via the NDM and may include an e-mail notification to the Medicare contractor concerning any deviations from established schedules and other information as appropriate. Medicare contractors must provide the CERT contractor with an e-mail address for requests. At least 30 calendar days before the due date for implementation of CERT, send the address to the CERT operations center at the address listed in the "**How to Contact and Make Submissions to the CERT Operations Center**" section.

Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted within 24 hours (one business day) of notification.

Requests for retransmissions will be made to the CERT point of contact via telephone. Retransmissions must be made in one of the following formats included in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs) as appropriate:

- Claims universe file
- Sampled claims resolution file,
- Claims history replica file, and/or
- Provider address file

The NDM retransmissions to the data sets described above. If you transmission fails, call the CERT operations center for instructions.

Standard system contractor will provide a data dictionary of the claims history replic file to the CERT contractor before implementation of CERT or when it becomes available and will provide updates as necessary.

The data dictionary must be provided within ten working days after receipt of this PM or within 10 days of the data dictionary becoming available, whichever is later. Send it in Microsoft Word 97 format to the CERT operations center at the address provided in the " **How to Contact and Make Submissions to the CERT Operations Center**" section. Updates must be provided to the CERT contractor at least 60 calendar days before a change is implemented in the standard system that will affect the data transmitted in files for CERT.

Exhibit 36.6 – CERT PSC Contractor Feedback Data Entry Screen Version 1.01 (Rev. 67, 02-27-04)

Microsoft Excel
File Edit View Insert Format Tools Data Window Help
J7
Feb0200635.xls
CERT PSC Contractor Feedback Data Entry Screen Version 1.01
For instructions and tech support contact see at the bottom of this page
CERT Batch Date: File Created
Listing of All Claims For This Batch
Record # Contractor Number & Name: Claim Review Date
CERT Internal Claim # Line # Sample Reason:
Original ICN/CCN: HICNUM: Beneficiary Name: Claim Entry Date
HICPCS Proc. Code: HICPCS Modifier 1: HICPCS Modifier 2: Submitted Charge: Medi. Initial Allow. Final Allowed Ch:
CERT Finding Error Code: CERT Reviewer Comments:
Contractor Decision/Data Entry
Contractor Review Decision: Agree With CERT Disagree With CERT Date Reviewed:
Contractor Disagree Reason Code: Adjusted HCPCS Code:
Amount Questioned:\$ Overpayment to Provider Underpayment to Provider Corrected Final Amount:\$
Contractor Comments: Adj. Internal Control #
Save Check All Output
Ready NUM

Figure 1: CERT PSC Contractor Feedback Data Entry Screen

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the CCRP, even where your staff have previously conducted routine or complex MR.

The CMS will conduct a routine quality assurance review of the CERT program including review of claims with error and non-error findings.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

Exhibit 36.7 - Data Items Included on CERT Reports (Rev. 67, 02-27-04)

The COCP will receive the following for each line submitted to the CCRP:

Relevant information from the medical record for the disagreed upon line of service,

Explanations from the CERT PSC and the AC of their decisions, and

Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The COCP will make a decision based upon all information presented to them.

To insure that regional offices (ROs) have an opportunity to be involved in the CCRP, the COCP will invite the participation of RO clinicians in the process.

The COCP at a minimum will consist of four individuals. There will be physician representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PIG). There will be at least one registered nurse on this panel. The COCP will request the participation of consortia staff; requests will be made at least one month before participation is expected. The panel may request the assistance of complex medical review experts, coding experts, or clinical specialists. A list of all participants must accompany the final report from the panel.

Members of panels will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CMS will provide final results from the COCP reviews to you in the CERT Quarterly Error Reconciliation Report (see attachment 5 for the report format); CMS will include in this report only those lines the COCP has confirmed to be in error after the COCP has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. You will pay to the billing providers amounts that you have denied in error and the CERT PSC has identified as such. The CMS does not require collection or payment for errors in

coding that do not affect the amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact you identified.

On an annual basis, the COCP will conduct random reviews of the decisions on requests submitted to the CCRP. The QA findings shall be sent to the CERT PSC, AC, and applicable parties (i.e., RO or CO).

Exhibit 37 - Office of Inspector General, Office of Investigations Data Use Agreement
(Rev. 176, Issued: 11-24-06, Effective: 12-26-06, Implementation: 12-26-06)

DUA #: _____
(to be completed by CMS Staff)

OFFICE OF INSPECTOR GENERAL, OFFICE OF INVESTIGATIONS DATA USE AGREEMENT

I, _____, representing the Office of Inspector General (OIG), Office of Investigations (OI), will observe the following in the use of the Centers for Medicare & Medicaid Services (CMS) files released to me:

A. Purpose: _____

B. The following CMS data file(s) is/are covered under this Agreement.

Description of Data/File	Year(s)	System of Record (to be completed by CMS Staff)

1. The files will be used only for purposes authorized by the Inspector General Act of 1978 or other applicable law.
2. No information in the files released to the OIG will be used or disclosed except in strict accordance with all applicable confidentiality laws and regulations. Where practicable and consistent with OIG oversight responsibilities, the OIG will notify CMS of files extracted or derived from these files are disclosed pursuant to Federal disclosure and confidentiality laws.
3. The information sought in this request is required to be produced to the Office of Investigations pursuant to the Inspector General Act 1978, U.S.C. App. The information is also sought by the OIG in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA)

Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 164.501; 164.512(a); and 164.512(d).

4. _____ will be designated as custodian of these files and will be responsible for establishment and maintenance of security arrangements to prevent unauthorized use. If the custodianship is transferred within the organization, CMS will be notified.
5. No listings or information from individual records, with identifiers will be published or otherwise released outside of those deemed appropriate by OIG to perform the legal scope of OIG duties and responsibilities.
6. The OIG needs to retain these files for up to 10 years. CMS will contact the OIG representative at the end of 5 years to confirm either that data will be destroyed or that OIG has a continuing need for the data. CMS will document its tracking system to indicate OIG's need for retention or destruction.

OIG Representative- Printed:		Phone Number:		Email Address:	
Street Address:		City:		State:	Zip Code:
Signature:				Date:	
Name of Custodian of Files, If Different:		Phone Number:		E-mail Address:	
Street Address:		City:		State:	Zip Code:
CMS Representative- Printed:					
Signature:				Date:	

38 - Qualified Independent Contractor (QIC) Jurisdictions (as of March 2005

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Task Order	Contractor	Covered States
Part A EAST QIC	Maximus, Inc.	Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, Washington DC
Part A WEST	First Coast	

QIC	Service Options, Inc. (FCSO)	Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, American Samoa
Administrative QIC (AD QIC)	Q2A	N/A-Administrative QIC does not process reconsiderations.

Exhibit 39 - Carrier Record Requirements
 (Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Carrier Record Requirements

Field		M.D.s/D.O.s	Other
Doctor's			
Number	Item	Record	Record
1.	Record Code	Required	Required
2.	Record Status	Required	Required
3.	Last Name	Required	Required
4.	First Name	Required	Required
5.	Middle Name/Initial	Required	Required
6.	Name Suffix	Required	Required
7.	Street (Billing Address)	Required	Required
8.	City (Billing Address)	Required	Required
9.	State (Billing Address)	Required	Required
10.	ZIP Code (Billing Address/ show 9 digits)	Required	Required
11.	Street (Business Address)	Required	Required
12.	City (Business Address)	Required	Required
13.	State (Business Address)	Required	Required
14.	ZIP Code (Business Address/ show 9 digits)	Required	Required
15.	State Licensed In	Required	Required
16.	Physician/Health Care Practitioner State License number	Required	Required
17.	Date of Birth	Required	Required
18.	Medical School Graduated	Required	Required
19.	Medical School Year Graduated	Required	Required
20.	Date of Death	If Available	If Available
21.	Credentials	Required	Required
22.	Primary Specialty Code	Required	Required
23.	Primary Board Certification Indicator	If Available	If Available
24.	Secondary Specialty Code	If Available	If Available
25.	Secondary Board Certification Indicator	If Available	If Available
26.	Type of Sanction Code	If Available	If Available
27.	Effective Date of Sanction		If Available If Available
28.	Number of Sanctioned Years	If Available	If Available
29.	Deactivate Resident/Intern Practice/Opt Out code	Required	Required
30.	Group Practice Indicator	Required	Required
31.	Physician/Health Care Practitioner Participation Indicator	Required	Required
32.	Tax Identification Number	Required	Required
33.	Carrier Provider Number	Required	Required
34.	Registry's Assigned UPIN	N/A	N/A
35.	NHIC Number	N/A	N/A

36. Incoming Carrier Number	Required	Required
37. Registry Assigned Error Codes/ Notification Codes	Required	Required
38. Record Validation Field	N/A	N/A
39. Special Processing Indicator	N/A	N/A
40. Special Processing Data	N/A	N/A
41. Individual Social Security Number Required *	N/A	Required
42. Filler		

N/A = Not Applicable on initial data submission

* Health Care Practitioners Only

Exhibit 40 - UPIN Carrier Record Layout
 (Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

UPIN CARRIER RECORD LAYOUT

Fld. No.	Position	No. of Cols.	Item	Description	Comments
1.	001	1	Record Code 9	1 = Add 2 = Add Develop/Return 3 = Assigned UPIN 4 = Registry Usage 5 = MPIER Update 6 = Update Develop/Return 7 = Notifications	
2.	002	1	Record Status 9	1 = Medical Doctor 2 = Other Doctor 3 = Non Physician/ Practitioner 4 = Group Practice	
3.	003-022	20	Last Name X(20)	Physician/Health Care Practitioner's Professional Last Name. Valid Characters A-Z and Blanks.	Left justify Use Fields 3, 4, 5, and 6 for group name
4.	023-036	14	First Name X(14)	Physician/Practitioner's Professional First Name. Valid Characters A-Z and Blank.	Left justify
5.	037-042	6	Middle Name/Initial X(06)	Physician/Health Care Practitioner's Professional Middle Name or Initial. Valid Characters A-Z and Blank	Left justify
6.	043-045	3	X(03)	Name Suffix. Practitioner's Name Suffix Example: JR, SR, III. Valid Characters A-Z and Blank.	Physician/Health Care Left justify
7.	046-070	25	Street X(25)	Billing Street Address	Left justify

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no info leave field blank

Fld. No.	Position	No. of Cols.	Item	Description	Comments
8.	071-085	15	City X(15)	City of Billing Address	Left justify
9.	086-087	2	State X(02)	State of Billing Address	Standard U.S. post office State abbreviations.
10.	088-096	9	ZIP Code 9(09)	ZIP Code of Billing Address	Must report 9 position zip code
11.	097-121	25	Street X(25)	Business Street Address The practice or physical site address.	Left justify
12.	122-136	15	City X(15)	City of Business Address	Left justify
13.	137-138	2	State X(02)	State of Business Address	Standard U.S. post office State abbreviations.
14.	139-147	9	ZIP Code 9(09)	ZIP Code of Business Address	Must report 9 position zip code.
15.	148-149	2	State Licensed or operating in X (02)	State in which the physician/Health Care Practitioner is Licensed or This Practice Setting.	Standard U.S. post office State abbreviations.
16.	150-161	12	Physician/ Health Care Practitioner State License/ Registration Number X (12)	The State License Number or Registration Number for this Practice Setting.	Right justify and precede with zeroes.
17.	162-169	8	Date of Birth 9(08)	(MMDDYYYY)	**
18.	169-173	5	Medical School Graduated Code X(05)	Medical School Code	Refer to Exhibit 3.

19.	174-177	4	Medical School Year Graduated 9(04)	(YYYY)	Year of Graduation
Fld. No.	Position	No. of Cols.	Item	Description	Comments
20.	178-185	8	Date of Death 9(08)	(MMDDYYYY)	**
21.	186-188	3	Credentials X (03)		MD= Medical Doctor DO=Doctor of Osteopathy CH=Chiropractor DDM=Doctor of Dental Medicine DDS=Doctor of Dental Surgery DPM=Podiatrist OD= Doctor of Optometry CSW=Clinical Social Worker PT=Physical Therapist CP=Clinical Psychologist CNA=Certified Nurse Anesthetist AA= Anesthesia Assistant NP= Nurse Practitioner OT= Occupational Therapist GRP= Group Practice (USE ONLY WITH RECORD STATUS 5) RNA=Certified Registered Nurse Anesthetist PSY=Psychologist PA= Physician Assistant RN= Registered Nurse LPN= Licensed Practical Nurse CNM= Certified Nurse Midwife MSC=Mammography Screening Center AMB=Ambulance Service Supplier IDF=Independent Diagnostic Screening facility CNS = Clinical Nurse Specialist AU= Audiologist PXS= Portable X-Ray Supplier IPL=Independent Physiological Laboratory

22.	189-190	2	Primary Specialty Code 9(02)	Specialty Code Specified in Part 4 of MCM §2207	
23.	191	1	Primary Board Certification Indicator X(01)	Y or N or U for Unknown	
Fld. No.	Position	No. of Cols.	Item	Description	Comments
24.	192-193	2	Secondary Specialty Code 9(02)	Secondary Specialty Code For This Practice Setting.	
25.	194	1	Secondary Board Certification Indicator X(01)	Y=Yes N = No U = Unknown	
26.	195	1	Type of Sanction Code X(01)	Refer to Exhibit 4	
27.	196-199	4	Effective Date of Sanction 9(06)	(MMYY) Windowing	
28.	200-201	2	Number of Sanctioned Yrs 9(02)	Length of Sanction 01-99	
29.	202	1	Deactivate Resident/Intern Practice Code X(01)	D=Deactivate R =Resident I =Intern P =Practice O =OPT Out	
30.	203	1	Group Practice Indicator 9(01)	1=Group 4 =Solo	
31.	204	1	Physician/Health Care Practitioner/Group Practice Participation Indicator X(01)	Y=Yes The participation N=No decision is the latest recorded.	

32.	205-218	14	Tax Identification Employer Identification no. X(14)	Any number Number you assigned which permits Identifying cross-referencing Records For One Individual	
33.	219-232	14	Carrier Provider Number X(14) (Use UPIN for Record Status 5 only)		The number you have provided the Physician/Practitioner for billing Medicare
Fld. No.	Position	No. of Cols.	Item	Description	Comments
34.	233-238	6	Registry's Number the Assigned UPIN Registry X(06)	Leave blank	This space reserved for UPIN assignment
35.	239-248	10	NHIC Number 9(10)	Exception Turnaround Numbering	Assigned by Registry and correction process
36.	249-253	5	Incoming Carrier Number 9(05)	CMS Contractor Number; Multi-state Contractor Use The Distinct Number of Each Jurisdiction.	
37.	254-268	15	Registry Assigned Error Codes Or Notification Codes X(15)	Leave blank	Used for Registry error resolution/auto notification
38.	269	1	Record Validation Field X(1)	Y=Yes N=No	Indicate that you have validated the record with State Licensure Board
39.	270	1	Special Processing X(1)		Used to indicate special processing record is being submitted.
				Acceptable Values: Y = Indicates additional settings being added. 1 = Indicates change to Providers Name.	Record Code "1" with UPIN Record Code "5" OLD LAST NAME in Field
40.	271-290	20	Special Processing Data X(20)		Used to cross check the change to a Provider's name or Provider Number.
			Name Change	Include the Providers <u>LAST</u> name only as it appears on the MPIER prior to the change.	Record Code "5" Providers NEW name in Fields 3, 4, 5, 6. UPIN Field 34.

			Provider Number Change	Include the Carrier assigned Number as it appears on the MPIER prior to the change.	Record Code "5" includes the NEW provider Number in Field 33 UPIN in Field 34.
			Individual Social Security Number	Physician/Health Care Practitioner Personal SSN	Record returned To you will contain the 10 Digit UPIN
41.	292-301	10	10 X(10)	Physician/Health Care Practitioner/Group	Record will contain 10-digit UPIN
42	302-306	5	5 Digit X(5)	Filler	Return record

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no information leave field blank.

40.1 - Trailer Record Data Elements
 (Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Fld. No.	Position	No. of Cols.	Item	Description	Comments
1.	001	1	Record Code 9(01)	9 = Trailer Record	
2.	002-006	5	Incoming Carrier Number 9(05)		CMS Contractor Number; Multistate Contractors Use The Distinct Number Of Each Jurisdiction
3.	007-014	6	File Creation 9(06)	(MMDDYYYY) Month, Day, And Year Of File Creation.	
4.	015-029	15	Number of Records Sent 9(15)	Total Number Of Records On The File. Do Not Include The Trailer Record.	Right justified and precede with zeroes.
5.	030-306	273	Filler X(277)		

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no information leave field blank.

Exhibit 41.1 - List of Medical School in the U.S.
(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

LIST OF MEDICAL SCHOOLS IN THE U.S.

ALABAMA

- 00102 University of Alabama School of Medicine, Birmingham, AL 3529
- 00104 Birmingham Medical College
- 00106 University of South Alabama College of Medicine, Mobile, AL 37788

ARIZONA

- 00301 University of Arizona College of Medicine, Tucson, AZ 85724

ARKANSAS

- 00401 University of Arkansas College of Medicine, Little Rock, AR 77205
- 00402 College of Physicians and Surgeons, Little Rock, AR 77205

CALIFORNIA

- 00501 Cooper Medical College, San Francisco, CA 94143
- 00502 University of California, San Francisco School of Medicine, San Francisco, CA 94143
- 00504 California Eclectic Medical College, Los Angeles, CA 90033
- 00505 Hahneman Medical College of the Pacific, San Francisco, CA 94305

- 00506 University of Southern California School of Medicine, Los Angeles, CA 90033
- 00507 College of Physicians and Surgeons of San Francisco, CA
- 00508 Oakland College of Medicine and Surgery
- 00509 College of Physicians and Surgeons, Los Angeles, CA 90024
- 00511 Stanford University School of Medicine, Palo Alto, CA 94305
- 00512 Loma Linda University School of Medicine, Loma Linda, CA 92350
- 00513 Pacific Medical College, Los Angeles
- 00514 University of California, UCLA School of Medicine, Los Angeles, CA 90024
- 00515 University of California, California College of Medicine, Irvine, CA 92717
- 00516 University of California, Irvine, California College of Medicine Irvine, CA 92717
- 00517 University of California, Irvine, California College of Medicine, Irvine, CA 92717
- 00518 University of California, San Diego School of Medicine, La Jolla, CA 92093
- 00519 University of California, Davis School of Medicine, Davis, CA 95616
- 00576 College of Osteo of the Pacific, Pomona, CA 91766

COLORADO

- 00702 University of Colorado School of Medicine, Denver, CO 80262
- 00705 Denver and Gross College of Medicine Denver, CO 80262

CONNECTICUT

00801 Yale University School of Medicine, New Haven, CT 06510
00802 University of Connecticut School of Medicine, Farmington, CT 06032

DISTRICT OF COLUMBIA

01001 George Washington University School of Medicine, Washington, DC 20037
01002 Georgetown University School of Medicine, Washington, DC 20007
01003 Howard University College of Medicine, Washington, DC 20059

FLORIDA

01102 University of Miami School of Medicine, Miami, FL 33101
01103 University of Florida College of Medicine, Gainesville, FL 32610
01104 University of South Florida College of Medicine, Tampa, FL 33612
01175 Southeastern College of Osteo Medicine, Miami, FL 33162

GEORGIA

01201 Medical College of Georgia, Augusta, GA 30912
01205 Emory University School of Medicine, Atlanta, GA 30322
01209 Georgia College of Eclectic Medicine and Surgery, Atlanta, GA 30314
01211 Atlanta College of Physicians and Surgeons, Atlanta, GA 30322
01212 Atlanta School of Medicine Atlanta, GA 31207
01218 Hospital Medical College Eclectic, Atlanta, GA 31207
01219 Southern College of Medicine and Surgery, Atlanta, GA 30314
01221 Morehouse School of Medicine, Atlanta, GA 31207
01222 Mercer University School of Medicine, Macon, GA 31207

HAWAII

01401 University of Hawaii John A. Burns School of Medicine, Honolulu, HI 96822

ILLINOIS

01601 Rush Medical College of Rush University, Chicago, IL 60612
01602 University of Chicago, Pritzker School of Medicine, Chicago, IL 60637
01604 The Hahneman Medical College and Hospital, Chicago, IL 60637
01605 College of Medicine and Surgery, Chicago, IL 60658
01606 Northwestern University Medical School, Chicago, IL 60611
01608 Bennett Medical College, Chicago, IL 60639
01609 Northwestern University Women Medical School, Chicago, IL 60637
01610 Chicago Homeopathic Medical College, Chicago, IL 60612
01611 University of Illinois at Chicago Health Science Center, Chicago, IL 60612
01613 Harvey Medical College, Chicago, IL 60637
01614 National Medical University, Chicago 60639
01615 Hering Medical College, Chicago, IL 60638

ILLINOIS

01616 Jenner Medical College, Chicago, IL 60637
01617 Illinois Medical College, Chicago, IL 60637
01618 Dunham Medical College, Chicago, IL 60637

01619 American Medical Missionary College, Battle Creek, Chicago, IL 60637
01622 Chicago College of Medicine and Surgery
01623 Dearborn Medical College, Chicago, IL 60637
01642 University of Health Sciences/ Chicago Medical School, North Chicago, IL 60064
01643 Loyola University of Chicago, St. Louis School of Medicine, Maywood, IL 60153
01644 The General Medical College, Chicago, IL 60615
01645 Southern Illinois University School of Medicine, Springfield, IL 62708
01675 Chicago College of Osteopathy, Chicago, IL 60615

INDIANA

01705 Physiological Medical College of Indiana, Indianapolis, IN 46202
01708 Medical College of Indiana, Indianapolis, IN 46224
01709 Central College of Physicians and Surgeons, Indianapolis, IN 46223
01717 Eclectic Medical College of Indiana, Indianapolis, IN 46224
01718 Indiana Medical College, Indianapolis, IN 46224

INDIANA

01719 School of Medicine of Purdue University, Indianapolis, IN 46202
01720 Indiana University School of Medicine, Indianapolis, IN 4622

IOWA

01801 College of Physicians and Surgeons, Keokuk, IA 52632
01803 University of Iowa College of Medicine, Iowa City, IA 52242
01804 State University of Iowa College of Homeopathic Medicine, Iowa City, IA 52242
01806 Drake University College of Medicine, Des Moines, IA 50311
01808 Sioux City College of Medicine, Sioux City, IA 50312
01810 Keokuk Medical College, College of Physicians and Surgeons, Keokuk, IA 52632
01875 University of Osteopathic Medicine and Health Sciences, Des Moines, IA 50312

KANSAS

01902 University of Kansas School of Medicine, Kansas City, KS 66103
01903 Kansas Medical College, Topeka, KS 66606
01904 College of Physicians and Surgeons, Kansas City, KS 66110
01907 Western Eclectic College of Medicine and Surgery, Kansas City, KS 66102

KENTUCKY

02001 Kentucky School of Medicine, Louisville, KY 40292
02002 University of Louisville School of Medicine, Louisville, KY 40292
02004 Louisville Medical College, Louisville, KY 40292
02005 Hospital College of Medicine, Louisville, KY

KENTUCKY

02006 Louisville National Medical College, Louisville, KY 40292
02008 Southwestern Homeopathic Medical College and Hospital, Louisville, KY
40546
02009 Kentucky University Medical Department, Louisville, KY 40292
02011 Louisville Hospital Medical College, Louisville, KY 40292
02012 University of Kentucky College of Medicine Lexington, KY 40536

LOUISIANA

02101 Tulane University School of Medicine, New Orleans, LA 70112
02104 Flint Medical College of New Orleans University, New Orleans, LA 70112
02105 Louisiana State University School of Medicine in New Orleans, New Orleans,
LA 70112
02106 Louisiana State University School of Medicine in Shreveport, Shreveport, LA
71130

MAINE

02201 Bowdoin Medical School, Brunswick-Portland ME 04003
02275 University of New England, College of Osteo Medicine, Biddeford, ME 04005

MARYLAND

02301 University of Maryland School of Medicine, Baltimore, MD 21201
02303 College of Physicians and Surgeons of Baltimore, Baltimore, MD 21201
02304 Baltimore Medical College, Baltimore, MD 21201
02305 Womans Medical College of Baltimore, Baltimore, MD 21201
02306 Baltimore University School of Medicine, Baltimore, MD 21201
02307 Johns Hopkins University School of Medicine, Baltimore, MD 21205
02308 Atlantic Medical College, Baltimore, MD 21201
02309 Maryland Medical College, Baltimore, MD 21201
02311 Maryland College of Eclectic Medicine and Surgery, Baltimore, MD 21201
02312 Uniformed Services University of the Health Sciences, Bethesda, MD 20014

MASSACHUSETTS

02401 Harvard Medical School, Boston, MA 02115
02405 Boston University School of Medicine, Boston, MA 02118
02406 College of Physicians and Surgeons, Boston, MA 02111
02407 Tufts University School of Medicine, Boston, MA 02111
02415 Middlesex University School of Medicine, Waltham, MA 02154
02416 University of Massachusetts Medical School, Worcester, MA 01605

MICHIGAN

02501 University of Michigan Medical School, Ann Arbor, MI 48109
02505 University of Michigan Homeopathic Medical School, Ann Arbor, MI 48209
02507 Wayne State University School of Medicine, Detroit, MI 48201
02508 Michigan College of Medicine and Surgery, Detroit, MI 48201
02512 Michigan State University College of Human Medicine, East Lansing, MI
48824

02576 Michigan State University College of Osteopathic Medicine, East Lansing, MI 48824

MINNESOTA

02604 University of Minnesota Medical School, Minneapolis, MN 55455

02605 Minneapolis College of Physicians and Surgeons

02607 University of Minnesota, Duluth School of Medicine, Duluth, MN 55812

02608 Mayo Medical School, Rochester, MN 55905

MISSISSIPPI

02701 University of Mississippi School of Medicine, Jackson, MS 39216

02702 Mississippi Medical College, Meridian, MS 39305

MISSOURI

02801 Missouri Medical College, St. Louis, MO 63110

02802 Washington University School of Medicine, St Louis, MO 63110

02803 University of Missouri, Columbia School of Medicine, Columbia, MO 65212

02805 Homeopathic Medical College of Missouri, St. Louis, MO 63141

02807 St. Louis College of Physicians and Surgeons

02808 Kansas City Medical College

02810 National University of Arts and Sciences Medical Department, St. Louis, MO 63110

02820 University Medical College of Kansas City Kansas City, MO 64111

02822 Ensworth Medical College, St. Joseph, MO 64507

02826 Kansas City Homeopathic Medical College

02828 Barnes Medical College, St. Louis, MO 63110

02830 Woman's Medical College, Kansas City, MO 63111

02833 Eclectic Medical University, Kansas City, MO 63111

02834 Saint Louis University School of Medicine, St Louis, MO 63104

02835 Southwest School of Medicine and Hospital, Kansas City, MO 63111

02843 Kansas City College of Medicine and Surgery

02844 Kansas City University of Physicians and Surgeons

02845 Mid West Medical College, Kansas City, MO (See 02843)

02846 University of Missouri, Kansas City School of Medicine, Kansas City, MO 64108

02878 The University of Health Sciences, College of Osteo Medicine, Kansas City, MO 64124

02879 Kirksville College of Osteopathic Medicine, Kirksville, MO 63501

NEBRASKA

03004 Lincoln Medical College, Eclectic, Lincoln, NE 68501

03005 University of Nebraska College of Medicine, Omaha, NE 68105

03006 Creighton University School of Medicine, Omaha, NE 68178

03007 Nebraska College of Medicine, Lincoln, NE 69508

NEVADA

03101 University of Nevada School of Medicine, Reno, NV 89507

NEW HAMPSHIRE

03201 Dartmouth Medical School, Hanover, NH 03756

NEW JERSEY

03305 UMDNJ-New Jersey Medical School, Newark, NJ 07103

03306 UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ 08854

03375 UMDNJ New Jersey School of Osteo Medicine, Camden, NJ 08103

NEW MEXICO

03401 University of New Mexico School of Medicine, Albuquerque, NM 87131

NEW YORK

03501 Columbia University College of Physicians and Surgeons, New York, NY 10032

03503 Albany Medical College of Union University, Albany, NY 12208

03506 State University of New York at Buffalo School of Medicine, Buffalo, NY 14214

03508 State University of New York Downstate Medical Center, Brooklyn, NY 12203

03509 New York Medical College, Valhalla, NY 10595

03510 Bellevue Hospital Medical College, New York, NY 10016

03511 New York Medical College and Hospital for Women, New York 10025

03513 Eclectic Medical College of the City of New York

03515 State University of New York Health Science Center of Syracuse, Syracuse, NY 13210

03519 New York University School of Medicine, New York, NY 10016

03520 Cornell University Medical College, New York, NY 10021

03543 Fordham University School of Medicine, New York, NY 10027

03545 University of Rochester School of Medicine and Dentistry, Rochester, NY 14642

03546 Albert Einstein College of Medicine of Yeshiva University, New York, NY 10461

03547 Mount Sinai School of Medicine of City University of New York, New York NY 10029

03548 State University of New York at Stony Brook, School of Medicine, Stony Brook, NY 11794

03575 New York College of Osteo Medicine of New York Institute of Technology, Old Westbury, NY 11568

NORTH CAROLINA

03601 University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC 27514

03603 Leonard Medical School, Raleigh, NC 27604

03604 North Carolina Medical College, Charlotte, NC 28223

03605 Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, NC 27103

03607 Duke University School of Medicine, Durham, NC 27710

03608 East Carolina University School of Medicine, Greenville, NC 27834

NORTH DAKOTA

03701 University of North Dakota School of Medicine, Grand Forks, ND 58201

OHIO

03801 Medical College of Ohio, Cincinnati, OH 44115

03802 Eclectic Medical College, Cincinnati, OH 44115

03803 Starling Medical College, Columbus, OH 45210

03806 Case Western Reserve University School of Medicine, Cleveland, OH 44206

03808 Cincinnati College of Medicine and Surgery

03809 Miami Medical College, Cincinnati, OH 44106

03811 University of Wooster Medical Department, Cleveland, OH 44206

03819 Toledo Medical College

03823 Cleveland Medical College, Homeopathic Cleveland, OH 45210

03825 Ohio Medical University Columbus, OH 45210

03826 Cleveland Pulte Medical College

03840 Ohio State University College of Medicine, Columbus, OH 43210

03841 University of Cincinnati College of Medicine, Cincinnati, OH 45267

03843 Medical College of Ohio at Toledo, Toledo, OH 43699

03844 Northeastern Ohio Universities College of Medicine, Rootstown, OH 44272

03845 Wright State University School of Medicine, Dayton, OH 45401

03875 Ohio University of Osteo Medicine, Athens, OH 45701

OKLAHOMA

03901 University of Oklahoma College of Medicine, Oklahoma City, OK 73190

03905 Oral Roberts University School of Medicine, Tulsa, OK 74171

03979 Oklahoma College of Osteopathic Medicine and Surgery, Tulsa, OK 47127

OREGON

04001 Willamette University Medical Department, Salem, OR 97304

04002 Oregon Health Sciences University School of Medicine, Portland, OR 97201

PENNSYLVANIA

04101 University of Pennsylvania School of Medicine, Philadelphia, PA 19104

04102 Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA 19107

04107 Medical College of Pennsylvania, Philadelphia, PA 19129

04109 Hahnemann University College of Medicine, Philadelphia, PA 19102

04111 Medico Chirurgical College of Philadelphia, Philadelphia, PA 19102

04112 University of Pittsburgh School of Medicine, Pittsburgh, PA 15261

04113 Temple University School of Medicine, Philadelphia, PA 19140

04114 Pennsylvania State University College of Medicine, Hershey, PA 17033

04177 Philadelphia College of Osteopathic Medicine, Philadelphia, PA 191431

PUERTO RICO

04201 University of Puerto Rico School of Medicine, San Juan, PR 00936

04202 Ponce School of Medicine, Ponce, PR 00732

04203 Universidad Central del Caribe Escuela de Medicina, Cayey, PR 00633

04204 University De Ciencias Med San Juan Bautista, Hato Rey, PR 00917

RHODE ISLAND

04301 Brown University Program in Medicine, Providence, RI 02912

SOUTH CAROLINA

04501 Medical University of South Carolina College of Medicine, Charleston, SC 29425

04504 University of South Carolina School of Medicine, Columbia, SC 29208

SOUTH DAKOTA

04601 University of South Dakota School of Medicine, Vermillion, SD 57069

TENNESSEE

04701 University of Nashville Medical Department

04705 Vanderbilt University School of Medicine, Nashville, TN 37232

04706 University of Tennessee College of Medicine, Memphis, TN 38163

04707 Meharry Medical College School of Medicine, Nashville, TN 37208

04708 Memphis Hospital Medical College

04709 Chattanooga Medical College

04710 Lincoln Memorial University Medical Department, Knoxville, TN 37920

04711 University of the South Medical Department, Sewanee, TN 37375

04713 Knoxville Medical College

04714 University of West Tennessee College of Medicine and Surgery, Memphis, TN

37402 04715 College of Physicians and Surgeons, Memphis, TN 37208

04720 East Tennessee State University, Quillen-Dishner College of Medicine, Johnson City, TN 37614

TEXAS

04802 University of Texas Medical Branch at Galveston, Galveston, TX 77550

04803 Fort Worth School of Medicine

04804 Baylor College of Medicine, Houston, TX 77030

04805 Physiological Medical College of Texas, Dallas, TX 76203

04806 Southern Methodist University Medical Department, Dallas, TX

04807 Gate City Medical College, Dallas, TX 76204

04812 University of Texas Southwestern Medical School at Dallas, Dallas, TX 75235

04813 University of Texas Medical School at San Antonio, San Antonio, TX 78284

04814 University of Texas Medical School at Houston, Houston, TX 77225

04815 Texas Tech University Health Science Center School of Medicine, Lubbock, TX 79430

04816 Texas A & M University College of Medicine, College Station, TX 77843
04878 Texas College of Osteopathic Medicine, Lubbock, TX 79430

UTAH

04901 University of Utah School of Medicine, Salt Lake City, UT 84132

VERMONT

05002 University of Vermont College of Medicine, Burlington, VT 05405

VIRGINIA

05101 University of Virginia School of Medicine, Charlottesville, VA 22908

05104 Medical College of Virginia Commonwealth University School of Medicine,
Virginia, Richmond, VA 23298

05106 University College of Medicine, Richmond, VA 23298

05107 Eastern Virginia Medical School, Norfolk, VA 23501

WASHINGTON

05404 University of Washington School of Medicine, Seattle, WA 98195

05415 Washington College of Physicians and Surgeons, Seattle, WA 98196

WEST VIRGINIA

05501 West Virginia University School of Medicine, Morgantown, WV 26506

05502 Marshall University School Medicine, Huntington, WV 25701

05575 West Virginia School of Osteopathic Medicine, Lewisburg, WV 24901

WISCONSIN

05602 Wisconsin College of Physicians and Surgeons, Milwaukee, WI 53226

05603 Milwaukee Medical College

05605 University of Wisconsin Medical School, Madison, WI 53706

05606 Medical College of Wisconsin, Milwaukee, WI 53226

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Exhibit 41.2 - Directory of Podiatric Medical Colleges
(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

DIRECTORY OF PODIATRIC MEDICAL COLLEGES

30000	California College of Podiatric Medicine 1210 Scott St., San Francisco, CA 94120
30100	Dr. William M. Scholl School of College of Podiatric Medicine 1001 North Dearborn St., Chicago, IL 60610
30200	New York College of Podiatric Medicine 53 East 124th St., New York, NY 10035
30300	Ohio College of Podiatric Medicine 10515 Carnegie Ave., Cleveland, OH 44106
30400	Pennsylvania College of Podiatric Medicine Eighth at Rale St, Philadelphia, PA 19107
30500	Barry University School of Podiatric Medicine 11300 Northeast Second Ave., Miami Shores, FL 33161
30600	College of Podiatric Medicine and Surgery, University of Osteopathic Medicine and Health Sciences 3200 Grand Ave., Des Moines, IA 50312

**Exhibit 41.3 - American Optometric Association Council on
Optometric Education**

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

**List of Accredited Professional Optometric Degree Programs
June 1986**

40000 University of Alabama in Birmingham
School of Optometry
Birmingham, AL 35292

40010 University of California
School of Optometry
Minor Hall
Berkeley, Ca 94720

40020 Ferris State College
College of Optometry
Big Rapids, MI 49307

AMERICAN OPTOMETRIC ASSOCIATION
COUNCIL ON OPTOMETRIC EDUCATION

40030 University of Houston
College of Optometry
Houston, TX 77004

40040 Illinois College of Optometry
3241 South Michigan Avenue
Chicago, IL 60616

40050 Indiana University
School of Optometry
Bloomington, IN 47405

40060 Inter-American University of Puerto Rico
School of Optometry
San Juan, PR 00936

40070 University of Missouri
St. Louis, MO 63121

40080 University of Montreal
School of Optometry
Montreal, P.Q.
Canada H3C 3J7

40090 New England

College of Optometry
Boston, MA 02115

40100 Berkeley Northeastern State University
College of Optometry
Tahlequah, Ok 74464

40110 State University of NY
State College of Optometry
New York, NY 10010

40120 The Ohio State University
College of Optometry
Columbus, OH 43210

40130 Pacific University
College of Optometry
Forest Grove, OR 97116

40140 Pennsylvania College of Optometry
Philadelphia, PA 19141

40150 South California College of Optometry
Fullerton, CA 96231

40160 Southern College of Optometry
Memphis, TN 38104

40170 University of Waterloo
School of Optometry
Waterloo, Ontario
Canada N2L 3G1

Exhibit 41.4 - List of Chiropractic Schools in the U.S.
(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

List of Chiropractic Schools in the U.S

Code

50010	Adio Institute of Straight Chiropractic Levittown, PA 19056 Changed name to Pennsylvania College of Straight Chiropractic - (1984)
50020	Atlantic States Chiropractic Institute Brooklyn, NY 10021 Merged with Columbia Institute of Chiropractic
50030	Bebout College of Chiropractic Indianapolis, IN 46224
50040	Booker T. Washington Chiropractic College Kansas City, MO 66103 50050
50050	Logan College Oklahoma City, OK 73190 Formerly Carver-Denny Chiropractic College Merged with Logan College of Chiropractic - (1958)
50060	Los Angeles College of Chiropractic Formerly California Chiropractic College (1963) Los Angeles, CA 90024
50065	Central States College of Physiatrics and Chiropractic Eaton, OH 45320
50070	Canadian Memorial Chiropractic College Toronto, Ontario M4G 3E6 50080
50080	Chiropractic Institute of New York New York, NY 10022
50090	Crisco Chiropractic College (Proposed) Crisco, TX 77650

* Schools in business since 1950

**Schools not listed use code 5000

50100 Cleveland Chiropractic College
Los Angeles, CA 90004

50110 Cleveland Chiropractic College
Kansas City, MO 64131

50120 Columbia College of Chiropractic
Baltimore, MD 21201

50130 Columbia College of Chiropractic
Alameda, CA 94501

50140 Columbia College of Chiropractic
and Naturopathy Sacramento, CA 95860

50150 Columbia Institute of Chiropractic
New York, NY 10025

50160 Hollywood College of Chiropractic
Hollywood, CA 90024

50170 Lafayette Institute
Philadelphia, PA 19104

50180 Life Chiropractic College
San Lorenzo, CA 94580

50190 Lincoln Chiropractic College
Marietta, GA 30060

50200 Reaver School of Chiropractic
Dayton, OH 45401

50210 Restview Chiropractic College
University of Chiropractic
Seattle, WA 98196

50220 San Francisco College of Chiropractic
San Francisco, CA 94128
Formerly West Coast Chiropractic
College; Name changed to Metropolitan
College of Chiropractic - 1944

50230 Sherman College of Straight Chiropractic, Spartanburg, SC 29304

50240 Western States College of Chiropractic, Portland, OR 97230

50250 University of Pasadena, College of Chiropractic, Pasadena, CA 91108

50260 University of Natural Healing Arts, Denver CO 80262

50270 National College of Chiropractic, Lombard IL 60148
50280 New York Chiropractic College, Glen Head, NY 11545
50290 Northwestern College of Chiropractic, Bloomington, MN 55431
50300 Palmer College of Chiropractic – West, Sunnyvale, CA 94087
50310 Palmer College of Chiropractic, Davenport, IA 52803

Exhibit 42 - Sanction Codes

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Sanction Codes *

CODE	DESCRIPTION
A - 1128(a)(1) -	Program-related conviction
B - 1128(a)(2) -	Conviction for patient abuse or neglect
C - 1128(b)(1) -	Conviction relating to fraud
D - 1128(b)(2) -	Conviction relating to obstruction of an investigation
E - 1128(b)(3) -	Conviction relating to controlled substances
F - 1128(b)(4) -	License revocation or suspension
G - 1128(b)(5) -	Suspension or exclusion under a Federal or State health care program
H - 1128(b)(6) -	(Formerly 1862(d)(1)(B) and (C)) - Excessive claims or furnishing of unnecessary or substandard items or services
I - 1128(b)(7) -	Fraud, kickbacks and other prohibited activities (including 1162(d)(1A))
J - 1128(b)(8) -	(Formerly 1128(b) - Entities owned or controlled by a sanctioned individual
K - 1128(b)(9)	Failure to disclose required information
L - 1128(b)(10) -	Failure to supply requested information on subcontractors and suppliers
M - 1128(b)(11) -	Failure to provide payment information
N - 1128(b)(12) -	Failure to grant immediate access
O - 1128(b)(13) -	Failure to take corrective action
P - 1128(b)(14) -	Default on health education loan or scholarship obligations
Q - 1128Aa -	(Formerly 1128(c) - Imposition of a civil money penalty or assessment
R - 1156(b) -	(Formerly 1160) - PRO recommendation
U -	UNKNOWN (Physician is sanctioned, but type of sanction unknown)

* If a physician has more than one sanction, show the code of the sanction with the longest duration.

Exhibit 43 - Carrier Transmittal Sheet
(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

A.

UPIN Carrier Data Transmittal

Deliver to:

1. Carrier Number:
2. *Name and Address of
Carrier

UPIN Records Included in this Transmittal

3. Date Prepared:

4. Date Shipped:

B. 1 UPIN Data Records: Tape Diskette

Volume Serial Number: _____

B. 2 Total Records

B. 3 Type Records:

Medical Doctor/D.O. Records
Other Doctor Records

C. 1

We have successfully processed the above file
(no reel will be returned).

C. 2

We are unable to accept your UPIN Data Records.
See below for information on reason for return.

Reason for return:

* Enter complete name and address of persons to whom all questions may be addressed.

(Rev. 311, Issued: 11-13-09, Effective: 12-14-09, Implementation: 12-14-09)

Standard Core
Joint Operating Agreement

Between
RACs and PSCs/ZPICs

Recovery Audit Contractors (RACs)
Program Safeguard Contractors (PSCs)
Zone Program Integrity Contractors (ZPICs)

Revision History Log

Version	Date	Changed By	Description of Change	Approval Required
V01				
V02				

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1. Introduction

1.1. Purpose of this JOA

This Joint Operating Agreement (JOA) is designed to promote cooperation between Recovery Audit Contractors (RACs) and the Program Safeguard Contractors (PSCs) or Zone Program Integrity Contractors (ZPICs) by establishing and maintaining shared expectations for the interaction among these Parties to the JOA.

1.2. Parties

Parties to the JOA are identified in Appendix Z. Please see Section 2.5 below in this JOA for information regarding completion of this appendix.

1.3. Jurisdictions, Contacts, Roles, and Responsibilities

This information is provided in Appendices B and C. Section 2.2 below in this JOA describes the process for completion of these appendices. Please note that there are multiple tabs in these Microsoft (MS) Excel Workbook appendix files to facilitate use of this information.

1.4. Confidentiality

Given the nature of the work performed by the RAC and the PSC/ZPIC, information contained within this JOA is to be shared only with members of the RAC, PSC/ZPIC, and CMS teams.

1.5. Liability

Although both the RAC and PSC/ZPIC each individually have a contractual relationship with CMS, there is no privity of contract between the RAC and the PSC/ZPIC.

Each contractor will be indemnified and protected by limitations on liability according to the terms of its respective contract with CMS. In light of the provisions of each contractors current contracts with CMS and the constraints of law, no amendments to their respective contracts are made through this JOA with respect to indemnification or limitations on liability.

1.6. Funding

Nothing in this JOA will obligate any parties to perform any tasks that add significant cost and are outside current scope of work unless adequate funding for these tasks is received from CMS.

2. Document Maintenance

2.1. Standard Core JOA

The Standard Core JOA is established and maintained by CMS to apply standardized best practices for the interaction between the RAC and PSC/ZPIC contractors. This Standard Core JOA is purposely designed so that it does not need to reflect contractor specific information, which is instead contained in the JOA Appendix Documents. This JOA should not be modified from the standard without consulting with the TO COTRs.

2.2. JOA Appendices

List of Appendices – Appendix A lists all JOA appendices, identifies the name of the team responsible for collecting and incorporating updates, and briefly describes how each appendix is to be created and maintained.

Distributed Update Responsibilities – Appendix documents are separated to facilitate maintenance.

The Contact List, for example, is divided into separate files by team so that each team can make and distribute updates to their list without having to coordinate input from other teams. If a contractor holds multiple contracts with CMS and if this contractor wants a separate Contact List for each contract to facilitate updates by different teams, this is allowed. The multiple tabs within each Contact List Excel Workbook facilitate differentiation between multiple task orders on a single contract.

Use Across Multiple JOAs – The templates for these appendix documents, such as the Contact List templates, have been formatted so that they can be applied to multiple JOAs, eliminating the need to maintain similar/duplicate information across multiple JOAs.

Document Owner – The name of the individual person on each team who will update each appendix will be identified by that team at the top of each of their appendix documents. This facilitates identification of the person to whom updates should be sent.

Templates – CMS provides a standard template for each appendix which can be amended by each party if necessary to effectively convey the information for their team. To promote consistency, please apply the standard template to the greatest degree practical.

2.3. Required Roles

To promote proper direction of communication, each RAC and PSC/ZPIC will identify, in its Contact List, a Primary and an Alternate for each of the following Required Roles:

- JOA POC – Joint Operating Agreement Point of Contact – This individual is responsible for serving as the lead contractor point of contact in establishing and maintaining the JOA content and in leading the resolution of any JOA-related issues that may arise.
- JOA Approver – One individual from the RAC and one individual from the PSC/ZPIC will be identified to approve the JOA.
- Operational Lead – This individual is responsible for serving as the lead point of contact in performing ongoing operational work under the terms of the JOA. This standard title is used in the JOA because various teams use different titles for the individuals that they have serving in this role, and the JOA can not effectively incorporate all of those titles. Each party will identify their Operational Lead in their Contact List, and they are welcome to add in the Contact List any other appropriate titles for this individual as well.

2.4. Managing Change

Change Suggestions – Recommendations for updates to JOA documents are encouraged and are to be sent to the Document Owner.

Revision History – Each Document Owner is to identify changes to JOA documents in the Revision History Log.

Version Number – The version number is used to make sure that everyone is looking at the same version of a document. The Document Owner is to increment the JOA version number each time the JOA is sent out for approval. Multiple updates can be consolidated into the same version number. The version number is imbedded as the last characters (ex: V01) of each file name.

Process Note: In MS Excel, updates to the version number in the file name are automatically propagated to the top of each printed Excel document. In MS Word, select “File, Print Preview” when the version number in the file name is updated to cause the updated version number to be propagated from the file name to the top of the document.

2.5. Approval of Standard Core JOA

CMS Approval of All Versions of the JOA

- CMS will solicit input, make updates, distribute, and refine this Standard Core JOA as necessary. Through this cycle of change, CMS will have reviewed and approved all updates.

RAC and PSC/ZPIC Approval of the First JOA

- CMS directs that all Parties to the JOA (the RAC and PSC/ZPIC) are to sign (using hand written signature) the first jointly approved version of the JOA.
- To accomplish this, the JOA Approvers are to hand-write their signature on two copies of Appendix Z, the JOA Approval Form, which they are then to mail (one copy each) to the primary RAC JOA POC and PSC/ZPIC TO COTR who are responsible for their retention and for providing a copy of these upon request.
- To facilitate communication of status, the JOA Approvers are also to send out an email to these individuals indicating that they have approved the JOA.

RAC and PSC/ZPIC Approval of Ongoing Updates

- As CMS makes subsequent updates to the Standard Core JOA, CMS will advise contractors via Email if the new version is sufficiently changed to require approval. CMS will also update the last column of the Revision History table of the JOA to keep a record of which versions require approval.
- A hand written signature is not required for ongoing updates. Instead, an electronic signature (an electronic copy of the approver's signature) is to be used as the signature.
- To provide approval for ongoing updates, the JOA Approver is to fill out Appendix Z, paste in their electronic signature, and then send this completed document via email to the Primary and Alternate JOA POC for the RAC and PSC/ZPIC TO COTR. The Primary JOA POCs and TO COTRs are responsible for retaining these emails and for providing a copy of these upon request.

No Approval Required on Appendix Updates – No approval is required on updates to the appendices.

Timing of Approvals – Parties are to provide approval within 10 business days of receipt of an updated Standard Core JOA. If parties have an issue with the JOA, they are to raise this issue within 10 business days. If no issues are identified before the end of this period, the JOA updates will be considered approved.

Distribution – Each JOA POC will disseminate information regarding the update within their organization.

3. Communication

Communication is a crucial component that will occur at multiple levels using multiple tools and techniques as described below.

3.1. JOA Checkpoint Meetings

Purpose – These meetings provide a forum for communication on topics of mutual interest among the Parties to the JOA. Topics will include a discussion of any issues with coordination among the parties the status of any changes to the JOA documents.

Location – These meetings will most often take place via conference call. In those instances where a RAC and a PSC/ZPIC are located close enough to allow a short drive, some participants may join in-person.

Frequency – The meetings will occur at minimum on a quarterly basis for the first year after the signing of the first JOA and then at least semi-annually thereafter.

Meeting Dates – CMS representatives need to attend multiple of these meetings across contractors, so CMS will work with contractors to coordinate spreading of these meetings over time. At the conclusion of each meeting, the participants will determine mutually agreeable timing (and location where appropriate) for the next meeting; information that will then be confirmed via email. Changes will be communicated through the JOA POC via email.

Facilitation – Responsibility for facilitating the meeting will rotate between the RAC and the PSC/ZPIC. This will include preparation of the agenda, providing a dial in number, facilitating the discussion, and capturing and distributing meeting minutes.

Meeting Minutes – Are to be distributed within five business days of the meeting and should clearly identify Action Items for review in the next meeting.

Participation – Invitees are to minimally include the applicable CMS COTRs and the Primary and Alternate JOA POC. The JOA POC will invite other participants as appropriate.

3.2. Other Workgroup Meetings

Purpose – In addition to the JOA Checkpoint meetings, the Parties to the JOA will interact on a regular basis in smaller workgroups to address specific needs.

Location, Timing, and Facilitation – Will be similar to the Checkpoint Meetings.

Formation – Recommendations for new workgroups should be considered at the JOA Checkpoint Meetings.

3.3. Issue Escalation and Resolution Process

Issues will be escalated if necessary for resolution via the following process:

1. Source – The RAC and the PSC/ZPIC individuals identifying the issue will work with their counter-parts first to attempt to resolve the issue.
2. JOA POCs – If they are unable to come to a resolution, the matter will be brought to the attention of the RAC Contractor JOA POC and the PSC/ZPIC JOA POC (identified in the Contractor Contact List Appendices).
3. Operational Leads – If they are unable to come to a resolution, the matter will be escalated to the RAC Operational Lead and the PSC/ZPIC Operational Lead (identified in the Contractor Contact List Appendices).
4. CMS Contract Officer Technical Representatives (COTRs) – If they are unable to come to a resolution, the Operational Leads will bring the matter to the attention of the CMS COTRs (identified in the CMS Contact List Appendices).
5. JOA Alternative Dispute Resolution (ADR) Team – In the event the dispute between the RAC and the PSC/ZPIC cannot be resolved, the issues will be directed in writing to the CMS RAC and PSC/ZPIC Contracting Officers, Project Officers, and COTRs for resolution by the JOA ADR) team. The ADR team will issue a written determination to both the RAC and the PSC/ZPIC.

Timing of Issue Escalation and Resolution – The speed with which issues are escalated and resolved will be dependent on the priority of the issue, with higher impact issues receiving quicker attention by all parties. As a general guideline, parties should endeavor to resolve or escalate an issue within 1-3 days of its receipt, or they should reply to all parties to advise them of the reasons for additional time needed for action.

3.4. Non-Compliance

If a party does not comply with a provision of the JOA, notification and resolution will take place as follows:

1. Notification – If a party does not comply with a provision of the JOA, the Operational Lead for that party will notify the Operational lead for the other party.
2. Resolution – A non-compliance is often one-time event with no significant impact which can often be quickly resolved and prevented in the future through the interaction of the Operational Leads. In these circumstances, escalation is not required.
3. Escalation – If a non-compliance creates an impact that either party feels requires escalation either for notification purposes or for issue resolution

purposes, then the Operational Leads will notify the CMS COTRs. If necessary, the ADR process described above will be applied to achieve closure.

3.5. Communication Regarding CMS Changes

As part of ongoing operations, the RAC and the PSC/ZPIC Contractor staff will both review documents received from CMS, including Transmittals, Program Memoranda, Change Requests and Notes. The RAC and the PSC/ZPIC Contractor will continue to determine their own operational impact and will provide comments and escalate issues to CMS independently, as appropriate.

All issues that are determined to have an impact on any RAC or PSC/ZPIC Contractor operations included in this JOA will be submitted to the RAC and PSC/ZPIC JOA POCs for discussion at the next JOA Checkpoint Meeting, or sooner if appropriate.

3.6. Securing Email Information

CMS has indicated that it is not appropriate to send emails containing beneficiary or provider identifiers (including names and numbers) even if those identifiers are contained within a password-protected attachment. Each JOA Participant is responsible for obtaining, understanding, interpreting, and implementing its own policies and procedures regarding use of email containing beneficiary or provider identifiers. CMS Secure Email may be used to send protected information to CMS and other users of this email system. If Secure Email is not available, send this information via an encrypted CD through registered mail.

4. Identification and Action on Fraudulent Behavior

4.1. Identification and Notification of Fraud by the RAC

RAC Responsibility – When the RAC encounters an issue that meets the criteria of potential fraud, the RAC will notify the RAC PO who will forward this to the Director of the Division of Benefit Integrity Management Operations.

Indicators of Fraud – The following are indicators of fraud that must be reported to the RAC PO. The RAC should use their best judgment to determine if other findings may constitute fraudulent behavior. Section 6.2 of this Standard Core JOA provides information regarding training for the RAC staff to identify fraud.

- Submission of false claims
- Services being rendered by unlicensed individuals
- Ordered services being provided without a legitimate physician order
- Claims for beneficiaries or providers that are deceased
- Non-compliance with medical record requests

4.2. Coordination with Law Enforcement

The PSC/ZPIC will interact with Law Enforcement related to potential fraudulent activity. The RAC must not contact Law Enforcement with fraud suspicions; they must contact the RAC PO. Law enforcement may contact the RAC with recovery inquiries but any other LE RFIs shall be referred by the RAC directly to the PSC/ZPIC.

4.3. High Risk Areas

CMS may identify High Risk areas within a PSC/ZPIC jurisdiction. These are areas that are known to have wide-spread fraud. The PSCs/ZPICs are required to take aggressive, rapid and innovative measures to curtail fraud in these areas and this may impact the RAC's ability to perform audits in these areas. The PSC/ZPICs will have the ability, in High Risk Areas, to suppress providers in order to protect the PSC/ZPIC and Law Enforcement's ability to identify, prevent and prosecute fraudulent activities.

5. Training

5.1. Training provided by the PSC/ZPIC

Purpose – Fraud detection and awareness training will be provided to assist the RAC in identifying fraudulent behavior, including indicators that RAC staff should look for and examples of real fraud scenarios.

Audience – This training is designed for members of the RAC team.

Initial and Annual Training – The PSC/ZPIC will provide this training at the start of working together as contractors and on at least an annual basis thereafter.

New Employee Training – The RAC will be responsible to provide this on-going training for new RAC employees throughout the year using the materials provided by the PSC/ZPIC.

Participation Requirement – Training participation is required to at least one session per year to be provided by the PSC or ZPIC. PSCs and ZPICs can rotate the responsibility for training and must avoid duplication across contracts.

Training on Changes – Additional training will be provided by the PSC/ZPIC when substantive changes are identified in fraud detection and awareness.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R360PI</u>	12/10/2010	Corrective Action Reporting	01/12/2011	7241
<u>R311PI</u>	11/13/2009	Recovery Audit Contractors (RACs)	12/14/2009	6684
<u>R264PI</u>	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
<u>R224PI</u>	10/16/2007	Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier	12/03/2007	5043
<u>R220PI</u>	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
<u>R213PI</u>	06/29/2007	Various Benefit Integrity Revisions	07/30/2007	5630
<u>R209PI</u>	06/12/2007	Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier	07/02/2007	5044
<u>R201PI</u>	05/11/2007	Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier - Replaced by Transmittal 224	12/03/2007	5043
<u>R197PI</u>	04/06/2007	Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier - Replaced by Transmittal 209	07/02/2007	5044
<u>R176PI</u>	11/24/2006	Various Benefit Integrity (BI) Clarifications	12/26/2006	5368
<u>R144PI</u>	03/31/2006	Various Benefit Integrity (BI) Clarifications	05/01/2006	4247
<u>R143PI</u>	03/17/2006	Demand Letters	04/17/2006	3954
<u>R141PI</u>	02/24/2006	Modification to the UPIN Process	N/A	4191
<u>R118PI</u>	08/12/2005	Various Benefit Integrity (BI) Clarifications	09/12/2005	3896
<u>R106PI</u>	03/14/2005	Inclusion of Interventional Pain Management Specialists on Carrier Advisory Committee (CAC) Membership	04/04/2005	3721
<u>R096PI</u>	01/14/2005	Consent Settlements	02/14/2005	3626
<u>R077PI</u>	05/28/2004	Comprehensive Error Rate Testing (CERT) Requirements	06/28/2004	3229

<u>R071PI</u>	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
<u>R067PI</u>	02/27/2004	Comprehensive Error Rate Testing (CERT) Requirements	03/12/2004	2976
<u>R047PI</u>	07/25/2003	Definitions	08/08/2003	2517
<u>R044PI</u>	07/25/2003	Replacing Contractor MR Web Sites with Medicare Coverage Database	10/01/2003	2592
<u>R032PI</u>	10/22/2002	Harkin Grantee, Fraud Alerts	10/25/2002	2333
<u>R023PI</u>	03/18/2002	Adds New Exhibits	05/02/2002	1981
<u>R017PIM</u>	12/12/2001	Reorganizes chapter 3, sections 4, 5, and 6 and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.	04/01/2002	1891
<u>R016PIM</u>	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732
<u>R014PIM</u>	09/26/2001	Local Medical Review Policy (LMRP) Format and Submission/Requirements	10/01/2001	1859
<u>R009PIM</u>	07/30/2001	LMRP Process	NA	1021
<u>R003PIM</u>	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
<u>R001PIM</u>	06/2000	Initial Release of Manual	NA	931

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