CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1089	**Date: May 11, 2012**
	Change Request 7787

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits

I. SUMMARY OF CHANGES: The purpose of this CR is to implement the requirements developed under CR 7669, Transmittal 1049, and to make the changes to the CWF and shared systems that will allow the Fraud Prevention System (FPS) to review claims approved for payment by CWF and to make a payment determination that is returned to the shared systems for appropriate action with as minimal impact on the current claims flow as possible.

EFFECTIVE DATE: January 7, 2013
IMPLEMENTATION DATE: Analyze, Design and Testing: October 1, 2012
Coding, Testing and Implementation: January 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One Time Notification

Pub. 100-20	Transmittal: 1089	Date: May 11, 2012	Change Request: CR 7787

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits

Effective Date: **January 1, 2013**

Implementation Date: **Analyze, Design and Testing: October 1, 2012**
Coding, Testing and Implementation: January 7, 2013

I. GENERAL INFORMATION

A. Background:

The loss of taxpayer dollars through waste, fraud, and abuse drives up health care costs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, rather than simply tracking down fraudulent providers and pursuing fake claims. CMS' program integrity mission also encompasses the operations and oversight necessary to ensure that CMS makes accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible Medicare beneficiaries. Reversing the traditional pay-and-chase approach to program integrity is the main goal of the National Fraud Prevention Program (NFPP), a long-term, sustainable approach that incorporates innovative technologies in integrated solutions. The NFPP is being implemented by the Center for Program Integrity (CPI), the CMS component that is accountable for the prevention and detection of fraud, waste, abuse and other improper payments under the Medicare and Medicaid programs.

The vision of the NFPP is to implement proven predictive modeling tools via the Fraud Prevention System (FPS) that can stop payment on high risk claims. However, before applying the tools on claims prepayment or taking action on providers, it is essential that the algorithms are rigorously tested to: 1) avoid a high rate of false positives to ensure that claims are paid for legitimate providers without disruption or additional costs to honest providers, 2) in no way degrade access to care for legitimate beneficiaries, and 3) identify the most efficient analytics in order to appropriate target resources to the highest risk claims or providers. As the FPS is implemented, it is also imperative that the models and analytics are "retrained" and "learn" from how the investigations conclude. For example, if the models identified 100 targets, and 20 were investigated and found to be legitimate, the models will be refined to account for the characteristics of the 20 legitimate targets.

The FPS will become mature in June 2012. CPI seeks the ability to use FPS in conjunction with Common Working File (CWF) and the shared systems as an additional prepayment check to ensure proper claims payment. CR 7669, Transmittal 1049 requested analysis and design hours requiring the CWF, shared systems maintainers, and the Medicare Administrative Contractors (MACs) to collaborate with CMS and the FPS contractor to develop requirements for implementing the required changes.

The purpose of this CR is to implement the requirements developed under CR 7669 and make the changes to the CWF in a split CR between the October 2012 release and the January 2013 release. The remainder of the shared systems will implement in January of 2013 under a different CR number. This change will allow the FPS to review claims approved for payment by CWF and make a payment determination that is returned to the shared systems for appropriate action with as minimal impact on the current claims flow as possible.

B. Policy:

Section 4241 of the Small Business Jobs Act of 2010 (Public Law 111-240) mandates the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in the Medicare FPS program. The system implemented through this legislation has significant potential to improve CMS' ability to prevent payment of fraudulent claims. These tools have been used successfully in the financial and telecommunication sectors and have applicability to Medicare. The legislation requires the program to be in place by July 1, 2011.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	REQUIREMENTS FOR OCTOBER 2012										
7787.1	CWF shall send only FFS claims that are not excluded to FPS for processing. See Attachment A for the list of conditions that should be excluded and will not be sent to FPS.									X	
7787.2	CWF shall create a new FPS response record layout for Part A claims (HUIP/ HUOP/HUHC/HUHH). **NOTE**: FPS will return only responses for claims rejected with a denial from the FPS model back to CWF. See Attachment B1 for the Part A format.									X	FPS Contractor
7787.3	CWF shall create a new FPS response record layout for Part B/DME claims (HUBC/HUDC). Note: FPS will return only responses for claims rejected with a denial from the FPS model back to CWF. See Attachment B2 for the Part B/DME format.									X	FPS Contractor
7787.4	CWF shall create FPS balancing software to ensure that claims sent to and denials received from FPS are accounted for on a daily basis.									X	
7787.5	CWF shall support the Hosts to gather the following information on FPS responses to claims submitted on a daily basis. • Total Claims Files sent to FPS • Response time for FPS to process each claims file and return to CWF host									X	CWF Host

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7787.6	Contractors and shared system maintainers shall participate in calls every other week or when meaningful information is available to discuss the requirements of a January 2013 CR to be written for implementation by the remainder of the systems.						X	X	X	X	FPS Contractor
	REQUIREMENTS JANUARY 2013 RELEASE										
7787.7	CWF shall process FFS claims within a two-business day period. • CWF will process claims for FPS denials on Day 1 • CWF will process claims for CWF Edits on Day 2 • Responses combined from Day1 and Day2 will be returned to MACs on Day2 **NOTE**: Shared Systems may need to re-evaluate 5-day limit to reprocess claims due to the "one business day" addition to CWF processing. Example – Thanksgiving weekend. See Attachment C for CWF 2-Day flow chart									X	FPS Contractor CWF Host
7787.8	CWF shall modify the CWF Claims transmit formats for Part A and Part B/DME to include the new FPS fields in both the header and detail line item: See Attachment D for the claims records and transmit changes.									X	
7787.9	CWF shall create new UR error code XXXX to identify claims that were rejected due to FPS denials for both Part A and Part B. New UR XXXX will be transmitted via Trailer 08.									X	
7787.10	CWF shall generate a new trailer to return Part A FPS response data to the MACS. Trailer will be generated for claim header or detail line. See Attachment E1 for the Part A response trailer layout.									X	
7787.11	CWF shall generate a new trailer to return Part B/DME FPS response data to the MACS. Trailer will be									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	generated for claim header or detail line. See Attachment E2 for the Part B/DME response trailer layout.										
7787.12	The attached CWF edits shall take precedence over FPS denials. • Consistency edits • Eligibility and Entitlement edits See Attachment F for a list of the CWF edits that precedes FPS.									X	
7787.13	CWF shall not send to FPS claims that have UR XXXX in the Override Edit field at the header level. Claims that have FPS UR XXXX in the Override Edit field for one or more line items for partially denied claims will be sent to FPS and FPS shall ignore the overriding lines. **NOTE**: This situation could arise out of provider appeals where ruling is made in favor of the provider and the provider resends the claim to be processed.									X	
7787.14	CWF shall modify the AMEN Process to trigger the MAC cycles based on response from FPS and not receipt of claims from MAC. This may not be in the order the files were submitted to the CWF host by the MACs. However, all files will get processed after receipt of denials from FPS. **NOTE**: If FPS has not sent a file in a particular day, CWF will open a remedy ticket similar to what is currently done when satellite files are not received.									X	
7787.15	CWF shall support the Hosts to enable modification of their operating procedures to incorporate an additional single business day to run the MAC CWF Cycles.									X	CWF Host
7787.16	CWF shall modify the NCH record formats for Part A and Part B/DME (CABEHUIP, CABEHUOP, CABEHIBC, CABECLIN) to include the following fields in both the header and detail line item: – FPS Model – FPS CARC									X	NCH

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	– FPS RARC – FPS MSN										
7787.17	CWF shall modify the Interactive Testing Facility (ITF) system to include the following fields on the header and detail line item: – FPS Model – FPS CARC – FPS RARC – FPS MSN									X	
7787.18	CWF shall modify the History and internal record layouts to include the following fields in the header and detail line item level – FPS Model – FPS CARC – FPS RARC – FPS MSN **NOTE**: FPS will utilize the CWF Override Edit codes to determine which claim or line item denied due to FPS was overridden by CWF edits.									X	
7787.19	CWF shall modify the CWF HIMR screens to include the following fields on the header and detail line item level. – FPS Model – FPS CARC – FPS RARC – FPS MSN									X	
7787.20	The FPS contractor shall provide a non technical description for each denial reason code.										FPS Contractor
7787.21	CWF and FPS to work collaboratively throughout the life cycle of this CR.									X	FPS Contractor
7787.22	CWF shall include Error code UR XXXX for FPS denials in the ORPT report for MACs.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: NA

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

Pre-Implementation Contact(s):

Rose Salloum 410-786-0190 Rose.Salloum-Byram@cms.hhs.gov
Maura McHale Allison 410-786-2093 MauraMcHaleAllison@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

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

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENT A

CR7787

List of conditions that should be excluded and will not be sent to FPS:

1. Any claim where HMO Paid Indicator is 1 on the claim. These are considered paid by HMO and not Medicare.

   NOTE:

   – Clinical Trial Claim does not process as HMO Paid but FFS when the BENE is in a Managed Care Plan and is identified with Condition Code 30 (part a claims) and Modifier Q0 or Q1 for Part B.

   – Condition Code 78 on a Part A claims is for implantable defibrillators when allowed; and does not process as HMO Paid but FFS for a BENE in a MA Plan.

   – Condition Code KZ on a Part B claims is for Implantable defibrillators when allowed; and does not process as HMO Paid but FFS for a BENE in a MA Plan.

2. IME/GME for Inpatient (HUIP) where Condition Code is 04/69. They do not update spell and involve BENEs with risk HMO. They do not show HMO Paid as 1 because of teaching payment is made to the provider.
3. Donor Post Kidney Transplant where Patient Relationship is '39'. By-pass all utilization logic in CWF for Part A claims.
4. Encounter claims, which no longer process in CWF, but the code is still in place if a claim is submitted and meets the following criteria:

   – TOB 11Z is identified as abbreviated Encounter

   – Full Encounter was identified with Condition Code 04, HMO Paid 1, and HMO ID present but this is how regular contractors submit claims based on current instructions from CMS for #1 above.

5. NOEs and NOAs will not be considered even though they are FFS but are not claims and do not carry data in the detail line.

   – Inpatient (HUIP) NOAs (TOBs 11A and 11D) do not update claim history and only update an auxiliary file.

   – Outpatient (HUOP) NOEs (TOB 89A, 89B, or 89D) do not update claim history and only update auxiliary file for MCCD.

   – Hospice (HUHC) NOEs (TOB 8xA thru 8xE) are not posted to history and only update Hospice auxiliary file.

6. Maintenance transactions will be excluded

   – HUCM (CMN for DME),

   – HUSP (MSP update),

   – HURD (ESRD), HUBO (BOI), or

   – HUEP (LIBBY Project)

7. Should DEMO claims not be considered for initial implementation and CMS needs to make this decision. Below may or may not be FFS but are DEMO claims identified with a DEMO #. CWF

has some bypass conditions that apply to regular processing and mostly the DEMO impacts how they are paid.

Definition	DEMO #	Claim Type Impacted
RUGS	01	SNF
TELEMED	03	PART B
UMWA (United Mine Workers)	04	INPATIENT
CHOICES	05	INP, OUTP, Part B
CABG	06	INPATIENT, Part B
COE (Centers of excellence)	07	INPATIENT, Part B
MPPP	08	INPATIENT, Part B
ESRD	15	INPT, OUTP, PART B
LUNG	30	INPATIENT, PART B
VA	31	INPT, OUTP, PART B
MCCD	37	OUT PATIENT, PART B
ENCOUNTER	38	INPT, OUTP, PART B
PART B PPV, FLU	39	PART B
INDIAN HEALTH SERVICE	40	PART B
HOME BOUND	44	HOME HEALTH
CHIROPRACTIC	45	PART B
LOW VISION	46	OUTPATIENT, PT B
ADULT DAYCARE	48	HOME HEALTH
HEMODIALYSIS	49	OUTPATIENT
LAB COMPETITIVE BIDDING	51	PART B,
EXTENDED STAY	53	INPT, OUTP
ACE	54	INPT, PT B
ACA SECTION 3113 LAB	56	OUTP, PTB
MAPCP	58	PART B
PMD	60	PART B, DME
EWIF	70	DME

CWF will be introducing DEMO#s 61, 62, 63, and 64 in the April release (CMS CR 7711) but CWF coding for any of these DEMO numbers are to be done in subsequent CMS CRs.

CWF is currently doing analysis on DEMO 59 in CMS CR 7594 (Pioneer ACO Model) in July but CWF coding will be done in a subsequent CMS CR.

8. CWF “Cancel only” claims will be excluded
   - HUIP, HUOP, HUHH, and HUHC with action code ‘4’
   - HUBC and HUDC with entry code ‘3’
9. CWF “Add History” claim types will be excluded
   - HUOP with action code ‘7’
   - HUBC and HUDC with Entry Code ‘9’
10. CWF Claims set with header override edits error code UR XXXX.

Attachment B1

CR7787

Part A format from FPS:
Record length variable = 2546 to 27295 bytes
Bytes: 1 - 2500 of Claim header layout +
2501 - 2545 of FPS header denial data +
2546 - 27295 for detail line items (1 – 450 occurrences)

Field	Size	Usage	Remarks
FPSA Claim Header data	2500	X	Return Claim Header information as is. CWF needs this information to build a full response record.
FPSA Header Denial data			FPS to return response in this section
1. FPSA Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
2. FPSA Header Model	2	X	0 – 9, A - Z
3. FPSA Header CARC	3	X	See WPI published CARC list
4. FPSA Header RARC	4	X	See WPI published RARC list
5. FPSA Header MSN Code	10	X	MSN code
6. FPSA Line Item Count	3	9	Total number of line items denied by FPS (0 if FPSA Claim Denial Type = 'H') (1–450 if FPSA Claim Denial Type = D)
7. Header Filler	22	X	TBD – for future fields
8. FPSA Line Items data	55		Line item count occurs xx times depending on FPSA line item count
a. Line Item No	3	9	001 thru 450
b. Revenue Code	4	X	Revenue code
c. HCPCS Code	5	X	HCPCS
d. Financial Date	7	C3 4	CCYYDDD (packed)
e. FPSA Line Model	2	X	0 – 9, A - Z
f. FPSA Line CARC	3	X	See WPI published CARC list
g. FPSA Line RARC	4	X	See WPI published RARC list
h. FPSA Line MSN Code	10	X	MSN code
i. Filler	20	X	TBD – for future fields

Attachment B2

CR7787

Part B/DME format from FPS:

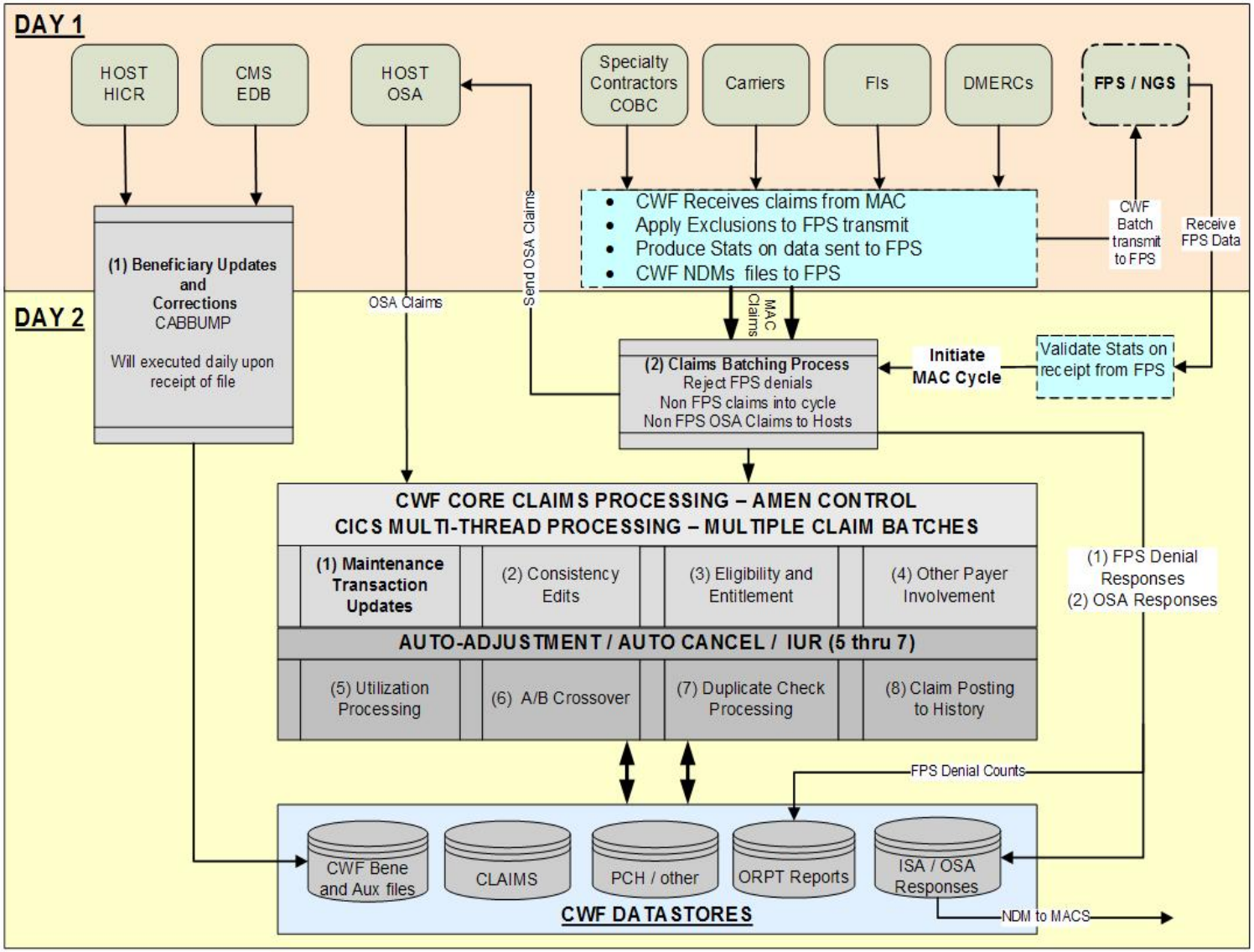
Record length variable = 646 to 27295 bytes
Bytes = 1 - 600 for Claim header layout +
601 - 645 for FPS header denial data +
646 - 27295 for detail line items (1-13 occurrences)

Field	**Size**	**Usage**	**Remarks**
FPSB Claim Header data	600	X	Return Claim Header information as is. CWF needs this information to build a full response record
FPSB Denial data			FPS to return response in this section
1. FPSB Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
2. FPSB Header Model	2	X	0 – 9, A - Z
3. FPSB Header CARC	3	X	See WPI published CARC list
4. FPSB Header RARC	4	X	See WPI published RARC list
5. FPSB Header MSN Code	10	X	MSN code
6. FPSB Line Item Count	2	9	Total number of line items denied by FPS (0 if FPSB Claim Denial Type = 'H') (1–13 if FPSB Claim Denial Type = D)
7. Header Filler	23	X	TBD – for future fields
8. FPSB Line Items data	54		Line item count occurs xx times depending on FPSB line item count
a. Line Item No	2	9	1 thru 13
b. HCPCS Code	5	X	HCPCS
c. From Date	7	C3 4	CCYYDDD (packed)
d. Thru Date	7	C3 4	CCYYDDD (packed)
e. FPSB Line Model	2	X	0 – 9, A - Z
f. FPSB Line CARC	3	X	See WPI published CARC list
g. FPSB Line RARC	4	X	See WPI published RARC list
h. FPSB Line MSN Code	10	X	MSN code
i. Filler	20	X	TBD – for future fields

ATTACHMENT C

CR7787

CWF 2 DAY FLOW



ATTACHMENT D

CR7787

Claim Record and Transmit changes:

CABEHUIN / CABEHUON Part A Header Claim

FPS Model	2	X	0 – 9, A - Z
FPS CARC	3	X	See WPI published CARC list
FPS RARC	4	X	See WPI published RARC list
MSN Code	10	X	MSN code

CABETLIN Part A Detail Line Item

FPS Line Model	2	X	0 – 9, A - Z
FPS Line CARC	3	X	See WPI published CARC list
FPS Line RARC	4	X	See WPI published RARC list
MSN Code	10	X	MSN code

CABEHUBC Part B Header

FPS Model	2	X	0 – 9, A - Z
FPS CARC	3	X	See WPI published CARC list
FPS RARC	4	X	See WPI published RARC list
MSN Code	10	X	MSN code

CABEHUBC Part B Detail Line Item

FPS Line Model	2	X	0 – 9, A - Z
FPS Line CARC	3	X	See WPI published CARC list
FPS Line RARC	4	X	See WPI published RARC list
MSN Code	10	X	MSN code

ATTACHMENT E1

CR7787

Part A FPS response trailer layout from CWF to MACs:

Record length variable = 45 bytes to 24,795 bytes
Bytes = 1 - 45 for trailer header data +
46 - 24795 for FPS detail line item data (1 – 450 occurrences)

Field	**Size**	**Usage**	**Remarks**
1. FPSA Trailer Code	2	X	Value to be determined
2. FPSA Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
3. FPSA Header Model	2	X	0 – 9, A - Z
4. FPSA Header CARC	3	X	See WPI published CARC list
5. FPSA Header RARC	4	X	See WPI published RARC list
6. FPSA Header MSN Code	10	X	MSN code
7. FPSA Line Item Count	3	9	Total number of line items denied by FPS (0 if FPSA Claim Denial Type = 'H') (1–450 if FPSA Claim Denial Type = D)
8. Header Filler	20	X	TBD – for future fields
9. FPSA Line Items	55		Line item count occurs xx times depending on FPSA line item count
a. Line Item No	3	9	001 thru 450
b. Revenue Code	4	X	Revenue code
c. HCPCS Code	5	X	HCPCS
d. Financial Date	4	C3 4	CCYYDDD (packed)
e. FPSA Line Model	2	X	0 – 9, A - Z
f. FPSA Line CARC	3	X	See WPI published CARC list
g. FPSA Line RARC	4	X	See WPI published RARC list
h. FPSA Line MSN Code	10	X	MSN code
i. Filler	20	X	TBD – for future fields

ATTACHMENT E2

CR7787

Part B/DME FPS response trailer layout from CWF to MACs:

Record length variable = 45 bytes to 747 bytes
Bytes = 1 - 45 for trailer header data +
46 - 747 for FPS detail line item data (1 – 13 occurrences)

Field	**Size**	**Usage**	**Remarks**
1. FPSB Trailer Code	2	X	Value to be determined
2. FPSB Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
3. FPSB Header Model	2	X	0 – 9, A - Z
4. FPSB Header CARC	3	X	See WPI published CARC list
5. FPSB Header RARC	4	X	See WPI published RARC list
6. FPSB Header MSN Code	10	X	MSN Codes
7. FPSB Line Item Count	2	9	Total number of line items denied by FPS (0 if FPSB Claim Denial Type = 'H') (1–13 if FPSB Claim Denial Type = D)
8. Header Filler	21	X	TBD – for future fields
9. FPSB Line Items data	54		Line item count occurs xx times depending on FPSB line item count
a. Line Item No	2	9	1 thru 13
b. HCPCS Code	5	X	HCPCS
c. From Date	4	C3 4	CCYYDDD (packed)
d. Thru Date	4	C3 4	CCYYDDD (packed)
e. FPSB Line Model	2	X	0 – 9, A - Z
f. FPSB Line CARC	3	X	See WPI published CARC list
g. FPSB Line RARC	4	X	See WPI published RARC list
h. FPSB Line MSN Codes	10	X	MSN Codes
i. Filler	20	X	TBD – for future fields

Attachment F

CR 7787

CWF Edits that precedes FPS:

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
5050	50	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Record has been deleted by CMS.
5052	51 55	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Identification Incorrect - The name and/or claim number shown on the Bill is incorrect or claim number is not in file.
5056	50	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Identification - The Beneficiary number requested by this Claim is not available to the HOST.
5200	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	No Entitlement - There is no record of the Beneficiary's Entitlement to the Type of Services shown on the claim.
5210	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Services After Benefits Terminated.
5211	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	The statement From/Thru Date is greater than the Date of Death on Beneficiary Master Record. (This edit is bypassed for Denied Claims Denied Lines.)
5212	UR			HHA	HOSP	INPT	OUTP	SNF		ELIG	The claim has a patient status of Beneficiary deceased with a Thru Date prior to another claim with a patient status of Beneficiary deceased.
5220	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Services Prior to Date of Entitlement.

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
5231	UR					INPT				UTIL	Services overlap GHO entitlement and no edit is present in the Detail Override Edit Table. OR Services overlap CHOICES/ESRD Managed Care Demonstration entitlement and the CHOICES/ESRD Identification Number is not present.
5232	UR	PARTB	DME							UTIL	Services overlap GHO entitlement and no edit is present in the Detail Override Edit Table. OR Services overlap CHOICES/ESRD Managed Care Demonstration entitlement and the CHOICES/ESRD Identification Number is not present.
5233	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	For PPS claims and claims with Provider Numbers beginning with ‘210’ the Admission Date falls within a risk GHO Paid period but no GHO Paid Code or Condition Code ‘69’ is indicated on the claim OR For Non-PPS Inpatient and SNF claims the Statement Dates fall within or overlap a risk GHO period but no GHO Paid Code or Condition Code '69' is indicated on the claim.
5234	UR			HHA		INPT	OUTP	SNF		UTIL	Beneficiary Master Record with GHO data and incoming claim record is missing GHO Identification Number. (Error does not apply to GHO option one.)
5235	UR			HHA		INPT	OUTP	SNF		UTIL	For PPS claims the Admission Date falls within a risk GHO period the Dates of Service fall within a Hospice Election Period; and Condition Code '07' is not present on the claim.

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
5236	UR			HHA		INPT	OUTP	SNF		UTIL	For PPS claims the Admission Date is not within a Risk GHO period but the GHO Pay Code on the claim is '1' or the Condition Code '69' is present; the Admission Date falls within a risk GHO period but the Statement Dates fall on or after the Hospice Revocation Date but before the month following the Revocation Date the GHO Pay Code indicated on the claim is other than zero or the Condition Code '69' is present however a risk GHO is not liable for claims during the month of Hospice Revocation; or the Statement Dates are within a Hospice period and the claim has a Condition Code '07' indicating treatment of a non-terminal illness. This includes abbreviated Encounter (TOB '11z') records.
524Z	UR	PARTB	DME							UTIL	Service Dates fall within Hospice Period. Bypassed for all CHOICES and ENCOUNTER claims.
525Z	UR	PARTB	DME							UTIL	Service Dates fall within a risk GHO and Hospice Election Period. This edit will be bypassed for all CHOICES claims.
538H	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	Services billed while Beneficiary is incarcerated
538K	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	Information from SSA indicates Beneficiary has been Deported.
6801	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP indicated on claim, no Auxiliary record exists. This indicates no record found. This reject edit will return a disposition 'UR' with an '08' Trailer with error code stated.

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
6802	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP indicated on claim, no direct match on Auxiliary record iteration, or dates match on claim, but no direct match on MSP type.
6803	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP Auxiliary record exits, no MSP is indicated on the claim, but Dates of Service match.
6805	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP conditional payment claim, but no MSP record with a Validity Indicator equal to 'I' or 'Y' is present for these Dates of Service.
6806	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP Override Code is 'M' or 'N', and no MSP record found with overlapping Date of Service. OR MSP cost avoid of 'E', 'F', 'G', 'H', 'J', 'K', 'Q', 'T', 'U', 'V', 'X', 'Y', '00', '12', '13', '14', '25', or '26', with no MSP record with overlapping Dates of Service that was originated by contractor '11100', '11101', '11102', '11103', '11104', '11105', '11106', '11107', '11108', '11109', '11110', '11112', '11113', '11114', '11125', '11126', '33333', '55555', '77777', '88888', or '99999', found.
6810	UR			HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	Part A claim was processed and only a Part B (Insurer type 'K') matching record was found.
6811	UR	PARTB	DME						MSP	UTIL	DMEPOS claim was processed, and only a Part A (Insurer Type 'J') matching record was found.
6812	UR	PARTB	DME						MSP	UTIL	MCCD Part B (HUBC) record with Demo Number '37' and Medicare is not primary.

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
6815	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	Beneficiary has an MSP Type record 'W' on the Auxiliary file and the incoming claim contains payment. (full or conditional)
6816	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	No matching 'D', 'E', 'H' or 'L' occurrence on MSP Auxiliary file, OR matching 'D', 'E', 'H' or 'L' diagnosis is not a one-on-one or 'within the family' match.
6817	UR	PARTB	DME							UTIL	No matching 'D', 'E', 'H' or 'L' occurrence, on MSP Auxiliary file, OR matching 'D', 'E', 'H' or 'L' diagnosis is not a one-on-one or 'within the family' match.
6818	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	The MSP Auxiliary file contains an 'L', but the diagnosis on the claim and on the MSP occurrence are not a one-on-one or 'within the family' match.
7010	CR			HHA	HOSP		OUTP	SNF		UTIL	The edited Inpatient or Outpatient claim has From/Thru Dates that overlaps a Hospice election period, and not indicated as treatment of a non-terminal condition (Condition Code '07').