Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1306

SUBJECT: Program Integrity Management Reporting (PIMR) System

This Program Memorandum (PM) replaces PM AB-00-34, Change Request (CR) 1035, dated May, 2000. It provides instructions for implementing PIMR for carriers and clarifies information in CR 1035.

The new PIMR system changes reporting requirements for medical review (MR) and fraud currently found in the Intermediary Manual, Part 2 §2301 and Part 3 §3939, and the Carriers Manual, Part 3 §§7504.2, 7535-7537, and 14021.

HCFA's Program Integrity Group is developing a new system for improving the management of cost, savings, and workload data relative to the medical review unit and fraud unit. The PIMR System will replace: The Report of Benefit Savings (RBS); The Medical Review System 1 (MRS-1); The Focused Medical Review (FMR) Report; and The Medicare Focused Medical Review Status Report (MFSR).

The relevant FMR and MFSR data will be collected through PIMR. Mainly this data relates to how problems are resolved. Certain aspects of the FMR and MFSR systems will not be continued; we will not obtain data on procedure and diagnostic codes that define aberrancies in the future. However, we will obtain the data (i.e., how aberrancies are resolved) we are currently obtaining on aberrancies on each provider type and provider subtype. HCFA will obtain that information obtained through interfaces with the standard systems.

PIMR Data required for the new system that HCFA cannot extract from existing systems will be collected from contractors monthly. Standard systems will transfer most of the data requested directly from contractor standard systems to the central office (CO) computer. Final reporting requirements standard systems and other sources must meet are provided below. Specific reporting requirements for data that contractors must manually enter are in the first section of this memorandum.

Interface Design

Interface Identification

The PIMR system will require summarized data from other HCFA databases on a monthly basis. The databases include the Contractor Standard Systems, Contractor Reporting of Operational and Workload Data (CROWD), Contractor Administrative Cost and Financial Management System (CAFM), Fraud Investigative Database (FID), Incentive Reward Program (IRP), and Medicare Accounts Receivable System (MARS). HCFA will use a Data Transfer Utility to map and transfer the data. Mapping will be the responsibility of HCFA.

General Data Definitions

The new system will require standard system data that can be classified under four different categories of activity measures: effort, workload, denials, and referrals. All definitions including the ones for fully automated edits and Correct Coding Initiative (CCI) edits apply to all program integrity activities and not just MR.

Necessary changes in the MCM, MIM, or the program manual for Program Integrity will be forthcoming. These instructions are ***reporting*** instructions; **they are not instructions for how to perform MR or benefit integrity activities, or requirements for performing those activities.**

For the purposes of PIMR, MR is defined as review of claims that occurs when review staff :

1. Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims or

2. Investigate complaints, determine whether an educational contact resulted in changed behavior, or identify situations that require prepayment edits or the development of a local medical review policy (LMRP).

MR can be preformed either before or after the claim has been paid.

Part B only: When this document refers to "Part B only", it means the requirement applies only to carriers and DMERCs.

Units: Reporting units may be reviews, claims, services, referrals, etc. Units are defined for each item. Units are usually reviews. Where they are not, the instructions clearly indicate the units contractors are to report.

Counting Claims, Line Items, and Services: Claims may be counted multiple times if line items on the claims fall into multiple categories. For instance, if a claim contains some line items that are subjected to manual complex review and others that are subjected to manual routine review, the claim is included in the claim count for both categories (i.e., the action codes: manual complex review and manual routine review; See "Activity Types" section below for further definitions). For counts of claims without reference to categories into which different line items on the claim might fall, e.g., claim count by bill type, count each claim only once.

A claim can be counted multiple times if each edit is performed on a different line item. For example, line item 1 is offset by a CCI edit (21001l) and line item 2 is subjected to manual routine review (21002F). To continue this example, the claim may not be counted twice if line item 1 is offset by the CCI and subjected to Manual Routine Focused Review and no other line item on the claim is subjected to a CCI edit or Manual Routine Focused Review.

Line items are counted only once per category, even if there are multiple services for the line item. Contractors must report on level of activity, not the number of services provided. Number of services will not be reported in PIMR. That information will be obtained from the National Claims History file, the HCFA repository for claims records, or summary databases such as HCFA Customer Information System (HCIS) or Part B Extract and Statistical System (BESS).

Do not edit line items twice. Catch problems with a line item with the first edit. In addition, do not duplicate CCI or COTS edits with local edits.

Count the workload and costs for MR of claims, line items, and services on bills that are denied after MR has been completed. For example, if a claim is denied post Common Working File (CWF) for any other reason, even though it may have had MR activities prior to denying, include that claim in PIMR reporting under claims available for medical review. Another example: if an MR edit/audit denies or suspends a claim prior to going to CWF, that counts as a claim available for MR and, if after working the edits or audits the claim denies post CWF, it also counts as a claim available for MR. Include the costs and workload for claims that meet the conditions of either example in the PIMR report.

Handling Claims with Multiple Reviews: There are two types of multiple reviews: (1) ones due to multiple line items on a claim and (2) ones that result from two different categories of review for the same item or items, e.g., a line item that is subject to prepayment review and postpayment review. For case 1, count the line item and claim once for each line item review. In the second case, you also count the line item and claim once for each category of review.

We expect the second situation to occur infrequently. If a line item receives a complex review prepayment, we do not expect it to be subjected to postpayment review except in rare cases in which new information became available on the claim, such as a complaint or an indication of potential fraud resulting from data analysis.

Definition of Coding Decisions: Where used in this memorandum, the term "coding decisions" generally refers to MR decisions. For example, coding decisions include each of the following:

1. A contractor reviews product information for a DMEPOS item, finds that the wrong code has been billed, changes the code to the correct code, and completes the claim.

2. In the situation described above, the contractor denies the claim line with the wrong code and uses the message that the supplier has incorrectly coded the item.

3. A local rebundling edit automatically denies a Column II code billed on the same date of service as a Column I code.

Re-review of Denials: Once a line item is denied, the provider must appeal the denial if he/she disagrees; the provider may not resubmit the line item as a new claim. Contractors must not count the re-review of a claim that has been previously fully or partially denied as a review.

Claims Paid Under Waiver

We do not require that claims paid under waiver be reported separately. Include the costs, workload, and savings for reviews of claims paid under waiver in the statistics for claims not paid under waiver.

The following subsections provide a brief description of the data under each category.

Effort Data: Effort is the number of claims, line items, reviews, etc., to be reported.

Cost - Dollars extracted from CAFM directly associated with each of the activities types described in later sections. Round to the nearest dollar.

FTE - Full-time-equivalent personnel counts extracted from CAFM directly associated with the direct personnel cost of each of the activity types described in later sections.

Workload Data: Workload is the number of full-time-equivalents required to perform a task.

Units - The number of workload units vary by activity types. Units may include the counts of edits, MRs, special studies, fraud cases, and data analysis. Where a unit is not specified, the unit desired is number of reviews.

Total No. of Claims - Number of claims a specific activity reviews during the reporting period.

No. of Line Items (Part B only) - Number of individual lines a specific activity reviews during the reporting period.

Billed Dollars - The actual charges submitted by providers or suppliers during the reporting period. Round to the nearest dollar.

Allowed Dollars -The amount of the charges which are approved for payment on claims prior to medical review. Round to the nearest dollar.

Denial Data: Denials are our measure of savings in both dollars and workload units.

A denial is a claim for which a portion or all of the Medicare approved amount (initial charges allowed) was subsequently denied due to MR. The amount reported is not affected by reduction to zero due to offsetting, i.e., if what is paid after MR is reduced to zero by an

offset, the difference between the approved amount and the amount before offset is the savings the contractor reports.

A **technical denial,** for PIMR purposes, is defined as a denial that results because the claim cannot be read by the processing system or a payment decision cannot be made because sufficient information is not included on the claim. Examples of an unreadable claims are ones that do not include a Health Insurance Claim Number or provider number. Examples of claims with insufficient information are claims that do not include a billed amount or procedure code.

No. Denied Claims - Number of claims denied by each activity during the reporting period.

No. Denied Line Items (Part B) - Number of line items (Part B only) denied by each activity during the reporting period.

Denied Dollars - The portion of the Medicare approved amount (initial charges allowed) subsequently denied after MR. Round to the nearest dollar.

Eligible Dollars - Amount of charges initially billed by the provider or supplier and eligible for payment on valid claims after MR. Count dollars eligible for medical review even if they are subsequently denied by CWF processing. Round to the nearest dollar.

Reversed Claims - Number of claims reversed during this period from claims denied during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

More specifically, reversed claims are claims containing one or more edit denied/reduced items/services that were allowed as the result of carrier reviews, administrative law judge hearings, or civil court hearings during the quarter being reported. We refer to reopenings as carrier reviews in the definition. Reversals offset savings/denials to produce net savings/denials in the PIMR reporting.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Reversed Line Items - Number of line items (Part B only) reversed during this period from line items denied during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Reversed Dollars - Amount of dollars reversed during this period from dollars denied during this or a prior period. Round to the nearest dollar. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

Report reversals in the section that the denial that was reversed occurred, i.e., if the denial occurred prepayment, report its reversal in the prepayment section; if the denial occurred postpayment, report the reversal in the postpayment section.

Denial Reasons - Categories explaining why a claim was denied or why an edit was developed. A listing is included in the reporting specifications. Current reason codes are used where possible; some existing reason codes may have to be mapped to the new codes for reporting purposes.

We summarized denial reasons for reporting at a very high level. That level gives us

sufficient information to meet our current needs. We also attempted to stay at a high enough level of summary that contractors can easily comply with our requirements without having to revise their denial reason codes.

The denial reason codes are unique 6 character codes. Reason codes are:

APPLIES TO ALL CONTRACTORS

100001 = Documentation does not support service,
100002 = Service is not otherwise covered clinical trial service,
100003 = Items/services excluded,
100004 = Requested information not received,
100005 = Services not billed under the appropriate revenue or procedure code,
100006 = Services not documented in record,
100007 = Services not medically reasonable and necessary, and
100019 = Other.

APPLIES MAINLY TO FISCAL INTERMEDIARIES (included for completeness)

100008 = Skilled nursing facility demand bills,
100009 = Daily nursing visits are not intermittent/part time,
100010 = Specific visits did not include personal care services,
100011 = Home health demand bills,
100012 = Ability to leave home unrestricted,
100013 = Physician's order not timely,
100014 = Service not ordered/not included in treatment plan,
100015 = Services not included in plan of care,
100016 = No physician certification,
100017 = Incomplete physician order, and
100018 = No individual treatment plan

Overpayment Assessments Dollars - Amount in dollars from those that were paid in error and should be collected from the provider or supplier. Report extrapolated dollars. Round to the nearest dollar.

Overpayment Assessments Claims - Number of claims from those that were paid in error and should be collected from the provider or supplier. Report number of claims from the sample that were in error.

Overpayment Collected Dollars - Amount in dollars from those paid in error and collected from the provider or supplier during the reporting period. Round to the nearest dollar. Where collected dollars attributable to MR cannot be distinguished from collected dollars attributable to other activities, allocate collected dollars on the basis of cumulative overpayments assessed and not collected in each category.

Overpayment Collected Claims - Number of claims from those paid in error and collected from the provider or supplier during the reporting period. Round to the nearest dollar. Collected overpayments do not have to be linked to the specific claims from which they resulted.

Referral Data: Referrals are the number of cases transferred between entities internal (e.g., the MR unit to professional relations) or external (e.g., the MR unit to a State licensing agency) to the contractor. Accumulate referral data by claim. The fraud unit may have to supply some data on the outcome of referrals, i.e., accepted and referred to OIG. A referral does not include such activities as a medical reviewer calling a provider to clarify or correct a billing error. A referral occurs only when one entity refers a provider or case to an entity other than a provider. In most instances, referrals occur postpayment; however, they may occur prepayment. Report referrals in the section (i.e., prepayment or postpayment) to which they apply.

$ Referred to Fraud Unit - Dollar amount (i.e., questioned dollars) referred to the Fraud Unit at the contractor. These are referrals within the contractor's organization.

 # Referrals Accepted - Number of referrals accepted by the Fraud Unit. These are referrals within the contractor's organization. A referral may be an individual claim or a number of claims or line items; report the number of referrals, not the number of claims or line items.

$ Referrals Accepted - Dollar amount (i.e., questioned dollars) of referrals accepted by the Fraud Unit. These are referrals within to contractor's organization.

 # Referred To Law Enforcement (OIG) - Outcome of MR where a claim is determined to be the result of fraudulent activities, and the claim(s) or provider(s) is referred to the Department of Health and Human Services, Office of the Inspector General (DHHS OIG). A referral may be an individual claim or a number of claims or line items; report the number of referrals, not the number of claims or line items.

 # Referrals Accepted by Law Enforcement (OIG) - Number of referrals accepted by the Law Enforcement Authorities other than the DHHS OIG. If you do not know that the referral has been accepted, do not report it as accepted.

Other Referrals - Include actions, such as a referral for provider education based on medical review, if you determine that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization.

Other referral reason codes are unique 6 character codes that apply to other referrals or actions. Reason codes include:

200001 = Develop LMRP,
200002 = Overpayment recovery,
200003 = Requirement of a corrective action plan (e.g., clarifications of coding guidelines),
200004 = Suspension of payment,
200005 = Education (e.g., referral to the medical director for a follow-up call),
200006 = Development of denial rationales for each claim denied,
200007 = Individual provider training (e.g., formal training, a structure course given for an individual provider),
200008 = Provider bulletin issued,
200009 = Provider seminar/workshop,
200010 = Additional or provider specific MR,
200011 = Comprehensive MR,
200012 = Focused MR because of percent increase in a measure of provider activity,
200013 = Continuous prepay MR,
200014 = Referral to a fraud unit,
200015 = Develop an edit, and
200016 = Other.

General Reporting Levels

Depending on the situation, the data elements defined above are reported by several different categories or levels of detail. These levels include: contractor number, year/month, provider type, bill/subtype, edit code, and activity type. The levels are defined below.

Contractor Number - A unique number HCFA assigned to each contractor. You must report for each contract number served by the standard system.

Year/Month - The fiscal year and month in which the data is reported. The format is YYYY/MM. For example, the first month (i.e., October, 1998) of fiscal year 1999 is 199901. **Note that the date for the example is not a calendar date.**

Provider Type - Provider types are defined in Attachment 2. For Part B, code as Physician if the study addresses both physicians and suppliers.

Bill/Subtype - Bill types will be used in the future for Part A, and subtypes are for Part B. These are the second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types may be based on procedure codes. Procedure code modifiers are not used to identify bill type or bill subtype. In deciding on the bill types for Part B, base the decision on the specialty of the performing (i.e., rendering) provider if there is a billing number for that provider. Otherwise, use the specialty of the rendering provider if there is no performing provider billing number. (See Attachment 2.)

Edit Code -Locally developed automated edits are edits for which the contractor developed some or all of the logic. These do not include COTS, CCI, or National edits unless the contractor modified the edit to include other logic; report a modified COTS, CCI, or National edit as a local edit only and do not include it in the COTS, CCI, or national categories. The data for locally developed edits must be reported for each individual edit by edit code. Data at the automated edit level applies only to specific prepayment activity types. That decision reflects the current needs of HCFA, i.e., to identify the effectiveness and costs of manual edits. If additional needs arise in the future, we will either revise PIMR (if the requirement is long term) or make a special request (immediate and short term needs).

Each contractor assigns their own numbers to the edits and describes the edits (i.e., specify procedure, diagnosis, and type of provider) in a registry that is a separate part of the system. Edit numbers are not standardized across contractors.

An edit code is described in the manual entry database on the basis of procedure code, diagnosis code, and specialty. A narrative description of each code is also entered as part of the description. The description includes a description of criteria applied by the edit. The lists of procedure codes and diagnosis codes may be given in the form of ranges of codes. The edit code should correspond to an action code where possible. In the case of procedure code/diagnosis code pair edits, ranges may be used to describe the edits.

One edit may describe both physician and non-physician services. For example, if an edit tests for the number of laboratory tests a provider may perform on a beneficiary, the limit applies to both physicians and non-physicians.

If a claim suspends for manual review for reasons other than failing a MR automated edit, report it in the automated edit category.

Classification of edit data into Categories I, II, and III no longer applies in PIMR. We currently do not have a need for that information. The edit description provided for each edit provides an indication if the edit is provider specific. If the need arises to obtain data by provider specific edits, we can do that on an ad hoc basis.

DMERC rebundling edits are defined as locally developed edits for purposes of these requirements.

Do not include information on global surgery edits that are part of the Medicare Fee Schedule database in PIMR reporting

Activity Type - A set of MR activities performed by the Medicare contractor. There are essentially five different categories of activities: prepayment MS, other prepayment Reviews, postpayment MRs, claims processing, and other activities. They are defined below:

Prepayment Medical Reviews

These reviews occur prior to payment decisions. A Manual Prepay MR is a manual review of claim data or supporting documentation, when necessary, by health professionals or trained medical review staff. They include manual reviews that result from automated edits

(not automated reviews) fully or partially suspending claims for medical review. These are reviews that result in human review whether reviewed initially by automated MR edits or not. If a claim suspends for manual review for reasons other than failing a medical review automated edit, report it in the automated edit category.

The above data elements are transferred for the reporting period for each of the following activities:

Automated Edits: An automated edit is one that never suspends for human intervention. It is an edit that pays or denies claims, i.e., processes the claim to completion without stopping for resolution. Determine if a claim falls into the automated edit category on a claim by claim basis. Report the number of denials that result from automated edits where this element is required. Note that PIMR does not ask for reports on automated edit payments; it asks only for reports on automated edit denials.

Fully automated MR edits are another category of prepayment MR. Fully automated MR edits result in a claim or line item being paid or denied without manual review. An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system and is denied in whole or in part because the service(s) is non-covered or not coded correctly; that means that an automated review is reported in PIMR only when it denies a part or all of a line item. The data referred to here is any resulting data that does not become associated with a manual MR. Specific data elements are transferred for the reporting period categorized as one of the following edit types:

Locally Developed - edits for which the contractor developed some or all of the logic. This does not include COTS, CCI, or National edits unless the contractor has modified the edit to include other logic. The data for locally developed edits must be reported for each individual edit by edit code.

National - fully automated MR edits that HCFA creates and the contractors do not modify. They are exactly the same for all Part B carriers; they allow no deviations whatsoever. Basically, these edits encompass all:

(A) Non-covered services, i.e., services (1) specifically stated as non-covered by the Coverage Issues Manual (CIM) (2) for which a CPT code has been assigned and (3) that can be fully automated without any manual intervention, or

(B) Any covered service where CIM extends coverage only for certain conditions.

In other instances where HCFA has specified coverage conditions but latitude is given to the carrier to limit coverage (i.e., develop LMRP to apply diagnoses) in order to auto-adjudicate, consider those services as automated locally developed edits because diagnoses could be slightly different in each State.

Further examples of national automated edits include:

Any National Policy driven by diagnosis. (Example: 23 new National Lab Policies that have not been issued),

Edits set up for services that are always non covered. (example: routine physicals, V code denials as routine, etc), and

Edits that auto-deny for assistants at surgery.

The data reported for national edits are not reported for each individual edit, but as a sum. Only data from claims denied by national edits are required for national edits.

Activity code 2001N, national automated edits, includes all edits specifically required by

HCFA except CCI and COTS. National automated edits never suspend for manual review. All criteria in them may be applied via computer.

COTS - Commercial Off the Shelf (COTS) edits are fully automated MR edits that are purchased or leased from a commercial source and are not modified by the contractor. CCI edits are not included in this category. The data reported for COTS edits are not reported for each individual edit, but as a sum. Only data from claims denied by COTS edits are be required for COTS edits.

CCI - Correct Coding Initiative (CCI) edits are fully automated MR edits that are developed under the CCI and are provided to the contractor. COTS edits are not included in this category. The data reported for CCI edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by CCI edits will be required for "CCI edits."

Manual Routine Focused Reviews - Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. This includes a review of any of the contractor's internal documentation, such as claims history file or policy documentation. A review is considered routine if a medical record is requested from a provider and not received. Routine focused reviews refer to routine MR conducted on a continuing basis and target all claims that meet an established or pre-existing set of criteria. Include prior authorization reviews in this category.

Manual Routine Random Reviews - These are routine reviews done on claims selected using a process of random selection of a representative sample of claims for a given time period. They may be done based on the information contained in the claims records, attached to the claims records, or in the contractor's history files. A review is considered routine if a medical record is requested from a provider and not received. These are reviews that help determine if systematic errors in billing are occurring, and they identify problem providers that escape detection through focused medical reviews.

Manual Complex Focused Reviews - 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. 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. Manual Complex Focused Reviews are complex MRs conducted on a continuing basis and targeted at all claims that meet an established or pre-existing set of criteria.

Manual Complex Random Reviews - 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. 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. These are complex reviews that are done on claims selected using a process of random selection of a representative sample of claims for a given period. These are reviews that help determine if systematic errors in billing are occurring, and they identify problem providers who escape detection through FMRs.

Other Prepayment Reviews

There are other prepay reviews which are not a result of automated edits kicking out claims for manual review. Those reviews are the result of special requests.

PIMR will not require specific review activities such as Directed OIG Reviews or Directed Law Enforcement Reviews. Review requirements will be set by other program

instructions or, as in the case with the examples, by requests from agencies outside of HCFA. PIMR instructions indicate only what contractors are required to report.

The following provides a definition of each review:

Directed Fraud Unit Reviews - Prepay reviews directed by or directly supporting the Fraud Unit. These are reviews that the MR unit did not start or that the fraud unit requested after the MR unit started the review.

Directed OIG Reviews - Prepay reviews directed by or directly supporting, the HHS Office of the Inspector General. These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review.

Directed Law Enforcement Reviews - Prepay reviews directed by or directly supporting law enforcement. These are reviews that the MR unit did not start or that law enforcement requested after the MR unit started the review.

Directed PRO - Prepay reviews directed by or directly supporting the Peer Review Organization. These are reviews that the MR unit did not start or that the PRO requested after the MR unit started the review.

Postpayment Medical Reviews

Postpayment reviews occur after a decision to pay is made. The following Manual Postpay Reviews require the specific data.

CMR In-house Reviews - CMR is a process to determine if a provider or group of providers is providing non-covered or medically unnecessary services. CMRs are usually targeted at providers who have demonstrated aberrant billing or practice patterns. They also serve as the basis for overpayment assessment and projection. CMR in-house reviews are performed at the contractor's facility.

CMR On-site Reviews - CMR is a process to determine if a provider or group of providers is providing non-covered or medically unnecessary services. CMRs are usually targeted at providers who have demonstrated aberrant billing or practice patterns. They also serve as the basis for overpayment assessment and projection. CMR reviews performed at the provider's or supplier's facility are considered CMR on-site reviews.

Other Postpay Reviews - Postpayment reviews that are not part of a CMR. They are:

Reviews of claims for purposes other than CMR, such as investigating a complaint or following up to determine if an educational contact resulted in changed behavior;

Reviews that provide the basis for a decision to initiate suspension of payment for a given provider;

Reviews that identify situations that require prepayment edits or LMRPs; and

Reviews that result in referrals to the fraud unit with recommendations for administrative sanctions (including civil and criminal prosecution) for providers who fail to correct their inappropriate practices.

PIMR does not require specific review activities, such as CMR reviews. Review requirements will be set by other program instructions or by requests from agencies outside HCFA. PIMR instructions only indicate what contractors are required to report.

Directed Fraud Unit Reviews - Postpay reviews directed by or directly supporting the Fraud Unit. These are reviews that the MR unit did not start or that the fraud unit requested after the MR unit started the review.

Directed HCFA CFO Reviews - Postpay reviews directed by or directly supporting the CFO Audit. These are reviews that the MR unit did not start or that HCFA or OIG requested to support the CFO audit after the MR unit started the review.

Directed OIG Reviews - Postpay reviews directed by or directly supporting the Department of Health and Human Services Office of the Inspector General (DHHS OIG). These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review.

Directed Law Enforcement Reviews - Postpay reviews directed by or directly supporting law enforcement other than the DHHS OIG. These are reviews that the MR unit did not start or that law enforcement other than the DHHS OIG requested after the MR unit started the review.

Directed ORT or Wedge Reviews - Postpay reviews performed under Operation Restore Trust (ORT) or reviews that support joint agency/State MR activities. These are reviews that the MR unit did not start or that ORT requested after the MR unit started the review.

Directed PRO - Postpay reviews directed by or directly supporting the PRO. These are reviews that the MR unit did not start or that the RO requested after the MR unit started the review.

Claims Processing

Claims processing involves information from a contractor's claim processing system. A claim is an electronic or paper request submitted in the prescribed HCFA format to carriers for payment for Part B health services rendered by a provider (e.g., physician, or supplier) to a Medicare beneficiary. Data is required for specific data elements for the following categories:

Claims Received - The number of provider/supplier requests for payment received within a given period that undergo review in accordance with HCFA regulations and manual instructions. The claims are paid, denied, or suspended.

Claims Paid - Claims reviewed and adjudicated that meet the claims payment and MR criteria for payment for the reporting period.

Claims Available for MR - Claims considered valid by the contractor's claims processing function. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data, or claims that are not subject to medical review by the contractor.

Other Activities

Other activities that Medicare contractors perform require specific data. Those activities are described below:

Data Analysis - Data analysis is defined as the review of claims information and other related data sources to identify patterns of over utilization or abuse by claim characteristics individually or in the aggregate.

Operationally, data analysis is all activities needed to identify aberrancies and to monitor the effectiveness of certain PI activities. Data analysis activities are:

(1) Detection analysis - This analysis is conducted for the purpose of identifying where PI problems exist. It includes the following activities:

- Identification of problems requiring prepayment edits, including the determination of measurements to be used in an edit;

- Analysis of claims information in the form of a table to identify or verify aberrancies, e.g., profiling of physicians or other provider profiling. Specific examples are Ratios I or II or FMR reports, upcoding reports, overutilization reports, or concurrent care reports;

- Identification of problems requiring LMRPs, including all activities required identify the problems and to identify problems that necessitate the development of an LMRP;

- Acquiring data needed to decide if an edit is necessary;

- Requesting and receiving claims data necessary to identify the values to which submitted information is to be compared;

- Conducting training for staff involved in PI data analysis; and

- Participation on HCFA PI data analysis workgroups.

(2) Effectiveness analysis - This analysis is conducted for the purpose of evaluating the effectiveness of contractor actions to correct PI problems once the problems have been verified. It includes the following activities:

- Analysis of claims information in the form of a table to monitor the effectiveness of LMRPs, educational activities, and referrals from the MR unit to the fraud unit or overpayment collection unit, e.g., profiling of physicians or other provider profiling. Specific examples are Ratios I or II or FMR reports, upcoding reports, overutilization reports, or concurrent care reports.

- Initial evaluation and quarterly reevaluation of edits to decide their effectiveness. In this category, include the gathering of data and analysis of information in the form of a table, as well as computer time needed to produce information in table form.

- Conduct of evaluations to determine the overall effectiveness of PI activities.

Special Studies - Special studies are defined as activities or projects with unique identifications designed to develop and demonstrate a new approach to fraud, abuse, or waste protection. Special studies include data collections, analyses, and surveys at the request of CO or ROs that are classified in other categories for PIMR reporting.

Edit Development - Edit development is the effort necessary to create a computerized logic test developed with the assistance of health professionals that compares the data elements on a Medicare claim for the purposes of (1) making a coverage or local coding determination or (2) suspending a claim so such determinations can be made by health professionals or trained MR staff prior to payment of the claim. Use the term edit instead of “screen or audit.”

Contractor Policy Development - Contractor Policy Development involves determining that LMRP is needed, using or adapting an existing LMRP or model policy, or developing an LMRP using medical consultants, input from professional organizations, and information from medical literature to address aberrant utilization under benefit category for an item/service.

Court Ordered MR - A Court Ordered MR is a review that is required by a judicial order as evidenced by a subpoena or writ and not requested by law enforcement, the OIG, a PRO, or the fraud unit.

Contractor/standard system interface, see Attachments.

The *effective date* for this Program Memorandum (PM) is January 1, 2001 for all Part B standard systems except Verizon.

The *implementation date* for this PM is January 1, 2001 for all Part B standard systems except Verizon. Contractors may implement needed changes any time before the implementation date if they wish.

These instructions should be implemented within your current operating budget.

This PM may be discarded September 1, 2001.

If you have any questions, contact:
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John Stewart, OFM/PIG/DMS, jstewart@hcfa.gov

Attachments

ATTACHMENT 1

Contractor/Standard System Interface

The following sections identify the data elements required from the contractor standard systems to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

PostPay Medical Review Data

The following table provides a definition of the PostPay Medical Review data required by the PIMR system from the contractor standard systems. We will provide a module as part of PIMR to allow contractors to enter postpayment data into the system. These specifications are provided for standard systems maintainers that wish to develop modules to transfer post payment data directly to PIMR from the standard system. Standard systems are not required to develop such modules

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Entity Attribute Name	Definition	Physical Design
PMR Postpay Review PMR_PSPY_RVW	Contractor Number CTRR_NUM	A unique identification number assigned to a Medicare contractor for data collection purposes.	CHAR(5), PK
PMR Postpay Review PMR_PSPY_RVW	Year/Month YR_MO_TXT	Defines the year and month to which the data applies.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Provider Type PROV_TYPE_CD	Provides a unique identifier for each provider type. Provider types and codes are defined in Attachment 2. For Part B, code as "Physician" if the study addresses both physicians and suppliers.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Bill/Sub Type BILL_TYPE_CD	Provides a unique identifier in the future for each Bill Type (Part A) and currently for Sub Type (Part B). Specific codes, which will be included in the system, are defined in Attachment 2. For Part B, codes as "999999."	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Activity Type Code ACTY_TYPE_CD	Defines a unique identification code associated with the Postpay Review activity. This code is used to track workload, denials, and referrals resulting from each activity.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Review Identifier RVW_NUM	Provides a number to differentiate reviews under each Contractor and Postpay activity. The PIMR System will automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractor┗ should leave this field blank.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Claims CLM_CNT	Provides the total number of claims reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Line Items LINE_ITM_CNT	Provides the total number of line items reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
	Billed Dollars BILD_AMT	Provides the dollar amount charged by the provider or supplier who was under review for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)

PIMR Logical and Physical Name	Entity Attribute Name	Definition	Physical Design
PMR Postpay Review PMR_PSPY_RVW	Allowed Dollars ALWB_AMT	Provides the amount of the charges, which were approved, for payment on claims prior to the Postpay review for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Denied Line Items DNL_LINE_ITEM_CNT	Provides the number of line items that were denied for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Denied Dollars DNL_AMT	Provides the dollar amount that was denied for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Eligible Dollars ELGBL_AMT	Provides the amount of the charges which were billed by the provider that are still eligible for payment after the review for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Reversed Claims RVRS_CLM_CNT	Provides the number of claims, which were initially denied postpayment but were reversed as a result of appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Reversed Line Items RVRS_LINE_ITM_CNT	Provides the number of line items which were initially denied postpayment but were reversed as a result of each appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Reversed Dollars RVRS_AMT	Provides the amount in dollars, which were initially denied postpayment but were reversed as a result of appeals and or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Overpayment Assessed Dollars OVPY_ASMT_AMT	Provides the amount in dollars which were originally paid in error but should be collected from the provider or supplier as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype. For Part B, report only one figure for each activity type. Code provider type and sub type "999999" for these report s.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Overpayment Collected Dollars OVPY_COL_AMT	Provides the amount in dollars, which were originally paid in error but was collected from the provider or supplier as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Review Date RVW_DT	Provides the beginning data of each Postpay review as entered into the system	DATE
PMR Postpay Review PMR_PSPY_RVW	Reason Code RSN_CD	Defines a unique identification code by denial reason for each Postpay review that results in a denial.	CHAR(6)
PMR Postpay Review PMR_PSPY_RVW	Other Referral Reason OTH_RFRL_RSN_CD	Defines a unique identification code by "other referrals" from each Postpay review that results in a referral other than fraud referral.	CHAR(6)
PMR Postpay Review PMR_PSPY_RVW	Number Referred to Fraud FRD_RFRL_CNT	Provides the number of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Dollar Referred to Fraud FRD_RFRL_AMT	Provides the dollar amount of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Number Referred to Other OTH_RFRL_CNT	Provides the number of referrals other than fraud referrals that were referred to another	NUMERIC(10)

activity as a result of the Postpay Review.

PIMR Logical and Physical Name	Entity Attribute Name	Definition	Physical Design
PMR Postpay Review PMR_PSPY_RVW	Dollar Referred to Other OTH_RFRL_AMT	Provides the dollar amount of referrals other than fraud referrals that were referred to another activity as a result of the Postpay Review.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Number Accepted ACPT_CNT	Provides the number of referrals accepted by the Fraud Unit or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Dollars Accepted ACPT_AMT	Provides the dollar amount of referrals accepted by the Fraud Unit or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Updated By UPDT_BY_TXT	Provides the User Identification of the last person who updated the record.	CHAR(8)

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTTR_NUM)
Year/Month (YEAR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Review Identifier (RVW_NUM)

1.0 Prepay Medical Review Data

The following table provides a definition of the Prepay Medical Review data required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Year/Month YR_MO_TXT	A code, which specifies the year and month for the data, reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N Automated National Edit, 21001C = Automated COTS Edit, 21001 I = Automated CCI Edit, 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21016 = Directed Fraud Unit Review, 21017 = Directed OIG Review, 21018 = Directed Law Enforcement Review, 21019 = Directed by PRO.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Edit Code EDIT_CD	A unique code assigned to each locally developed automated edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002F, 21002R, 21003F, and 21003R. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_RVW
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in Attachment 2.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes are defined in Attachment 2.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Units UNIT_CNT	The number of units that vary by activity. Activity types 21001L, 21001N, 21001C, and 21001I include number of edits associated with that activity used during the reporting period. All other Activity Types refer to the number of reviews associated with that activity during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
Claims CLAIM_CNT	The number of claims a specific activity type reviews during the reporting. This does not apply to activity types 21001N, 21001C, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
Line Items (Part B) LINE_ITM_CNT	The number of individual lines a specific activity type reviews during the reporting period. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
Billed Dollars BILD_AMT	The actual charges submitted by providers or suppliers during the reporting period. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW
Allowed Dollars ALWB_AMT	The amount of the charges which are approved for payment on claims prior to medical. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW
Denied Claims DND_CLM_CNT	The number claims denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_RVW
Denied Line Items (Part B) DND_LINE_ITM_CNT	The number of line items denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_RVW

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Denied Dollars DND_AMT	The amount of charges which were billed by the provider or supplier and subsequently denied after Medical Review. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_PPAY_RVW
Eligible Dollars ELGLL_AMT	The amount of charges which were billed by the provider or supplier and are eligible for payment on valid claims after Medical Review . This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_PPAY_RVW
Reversed Claims RVRS_CLM_CNT	The number of claims that were reversed during this period from claims that had been denied during this or prior periods. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_RVW
Reversed Line Items RVRS_LINE_ITM_CNT	The number of line items (Part B) that were reversed during this period from line items that had been denied during this or prior periods. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_RVW
Reversed Dollars RVRS_AMT	The amount of dollars that were reversed during this period from dollars that had been denied during this or prior periods. This does not apply to activity type codes 1016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_PPAY_RVW
# Referrals RFRL_CNT	The number of claims(s) or providers referred to the Fraud Unit during the reporting period. This does not apply to Activity Types 21001L, 21001N, 21001C, 21001I, 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_FRD_RFRL
$ Referrals RFRL_AMT	The dollar amount referred to the Fraud Unit at the contractor broken down by Provider Type and Bill/Subtype. This does not apply to Activity Types 21001L, 21001N, 21001C, 21001I, 21016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_FRD_RFRL
# Referrals Accepted ACPT_CNT	The number of referrals accepted by the Fraud Unit during the reporting period. This data only applies to Activity Types 21002F, 21002R, 21003F, 21003R, and 21016.	NUMERIC(10)	PMR_FRD_RFRL
$ Referrals Accepted ACPT_AMT	The dollar amount of referrals accepted by the Fraud Unit during the reporting period. This data only applies to Activity Types 21002F, 21002R, 21003F, 21003R, and 21016.	NUMERIC(13)	PMR_FRD_RFRL

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Edit Code (EDIT_CD)

2.0 Denial Reasons

The following table provides a definition of the data associated with reason for denial, which is required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PPAY_DNL
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_DNL
Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N Automated National Edit, 21001C = Automated COTS Edit, 21001 I = Automated CCI Edit, 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21016 = Directed Fraud Unit Review, 21017 = Directed OIG Review, 21018 = Directed Law Enforcement Review, 21019 = Directed by PRO.	CHAR(6), PK	PMR_PPAY_DNL
Edit Code EDIT_CD	A unique code assigned to each locally developed automated edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002F, 21002R, 21003F, and 21003R. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_DNL
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in Attachment 2.	CHAR(6), PK	PMR_PPAY_DNL
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Bill/subtype codes are defined in Attachment 2.	CHAR(6), PK	PMR_PPAY_DNL
Reason Code RSN_CD	A unique 6 character code that applies to either Reasons for Denials. Reason Codes include 100001 = Documentation does not support service, 100002 = Investigation/experimental, 100003 = Items/services excluded, 100004 = Requested information not received, 100005 = Services not billed under the appropriate revenue/procedure code, 100006 = Services not documented in record, 100007 = Services not medically reasonable and necessary, 100008 = Skilled Nursing Facility demand bills, 100009 = Daily nursing visits are not intermittent/part time, 100010 = Specific visits did not include personal care services, 100011 = Home Health demand bills, 100012 = Ability to leave home unrestricted, 100013 = Physicians order not timely, 100014 = Service not ordered/not included I treatment plan, 100015 = Services not included in plan of care, 100016 = No physician certification, 100017 = Incomplete physician order, 100018 = No individual treatment plan 100019 = Other.	CHAR(6), PK	PMR_PPAY_DNL
Denied Claims DNL_CLM_CNT	The number claims denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_DNL
Denied Dollars DNL_AMT	The amount of charges which were billed by the provider or supplier and subsequently denied after Medical Review. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_PPAY_DNL

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Edit Code (EDIT_CD)

Reason Code (RSN_CD)

3.0 Other Referrals

The following table provides a definition of the data associated with other referrals or actions resulting from medical review activities, which is required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_OTH_RFRL
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_OTH_RFRL
Activity Type ACTY_TYPE_CD	A unique 6 character code associated with each of the following activities: 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21007 = Data Analysis, and 28000 = Special Studies.	CHAR(6), PK	PMR_OTH_RFRL
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in Attachment 2.	CHAR(6), PK	PMR_OTH_RFRL
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes are defined in Attachment 2.	CHAR(6), PK	PMR_OTH_RFRL
Reason Code RSN_CD	A unique 6 character code that applies to Other Referrals or Actions. Reason Codes include 200001 = Local Medical Review Policy, 200002 = Overpayment recovery, 200003 = Requirement of a corrective action plan, 200004 = Suspension of Payment, and 200005 = Education, 200006 = Denial rationales for each claim denied, 200007 = Individual provider training, 200008 = Provider bulletin issued, 200009 = Provider seminar/workshop, 200010 = Medical Review, 200011 = Comprehensive Medical Review, 200012 = Focused Medical Review % increased, 200013 = Prepay medical review, 200014 = Referral to a fraud unit, 200015 = Develop an edit, and 200016 = Other.	CHAR(6), PK	PMR_OTH_RFRL
Other Referrals RFRL_CNT	The number of referrals include, such as a referral for provider education based on medical review, where it has been determined that the provider or supplier needs further claim submission education, either individually or in a group setting. Referrals are categories by the Reason Codes above. The are broken down by Provider Type, Bill/Subtype, and "Other Referral Reason Code. This only applies to activity types 21002F, 21002R, 21003F, 21003R, 21017, and 21018.	NUMERIC(10)	PMR_OTH_RFRL

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Reason Code (RSN_CD)

4.0 Claims Processing Data

The following table provides a definition of the Claims Processing data required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_CLM_PRCS
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_CLM_PRCS
Activity Type ACTY_TYPE_CD	A unique 6 character code. Code as "999999" for all Part B claims.	CHAR(6), PK	PMR_CLM_PRCS
Bill/Subtype BILL_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_CLM_PRCS
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2. Code as "999999 " for all Part B.	CHAR(6), PK	PMR_CLM_PRCS
Claims Received CLM_RCV_CNT	The number of claims received from providers/suppliers for claims processing within the report.	NUMERIC(10)	PMR_CLM_PRCS
Line Items Received LINE_ITM_RCV_CNT	The number of line items (Part B only) received from providers/suppliers for claims processing within the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Billed Dollars Received BILD_RCV_AMT	The amount in dollars of claims received from providers/suppliers for claims processing within the report period.	NUMERIC(13)	PMR_CLM_PRCS
Claims Paid CLM_PD_CNT	The number of claims reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Line Items Paid LINE_ITM_PD_CNT	The number of line items reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Dollars Paid PD_AMT	The amount in dollars reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(13)	PMR_CLM_PRCS
Claims Available for MR CLM_AVL_CNT	The number of claims considered valid by contractor's claims processing function. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data, or claims that are not subject to medical review by the contractor .	NUMERIC(10)	PMR_CLM_PRCS

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD

THE REQUIREMENTS FOR CAFM, CROWD, FID, MARS, AND IRP ARE INCLUDED IN THIS CR FOR INFORMATION PURPOSES ONLY

THIS CR DOES NOT REQUIRE CONTRACTORS AND STANDARD SYSTEMS TO COLLECT AND REPORT THE INFORMATION SPECIFIED IN THESE REQUIREMENTS. THAT WILL BE DONE AT A LATER TIME AND IN AN UPDATE TO THE EXISTING INSTRUCTIONS FOR THE APPLICABLE SYSTEM

(CAFM Interface)

The following section identifies the data elements required from CAFM to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CAFM system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_EFRT PMR_EDIT_DVPT
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_EFFORT PMR_EDIT_DVLPMT
Activity Type ACTY_TYPE_CD	A unique 6-character code associated with each MR activity to allow reporting by Activity. Activities include: 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21004 = Postpay Non-CMR, 21005 = Postpay Onsite CMRs, 21006 = In-House CMRs, 21007= Data Analysis, 21008 = Policy Development, 21016 = Prepay Directed Fraud Unit Review, 21017 = Prepay Directed OIG Review, 21018 = Prepay Directed Law Enforcement Review, 21019 = Prepay Directed by PRO, 21020 = Postpay Directed Fraud Unit Review, 21021 = Postpay HCFA CFO Review, 21022 = Postpay Directed OIG Review, 21023 = Postpay Directed Law Enforcement Review, 21024 = Postpay Directed by PRO, 21025 Postpay Directed ORT, 21026 = Edit Development, 21026S = Edit Development Setup, 21026T = Edit Development - Test, 21027 = Court Ordered Medical Review, 21028 = Fraud, 21029 = Fraud Sources, and 28000 = Special Studies.	CHAR(6), PK	PMR_EFRT PMR_EDIT_DVPT (DVPT_STUS_CD for activities 21026S and 21026T only)
Cost CST_AMT	The dollars reported as the direct cost from CAFM associated with each Activity Type Code.	NUMERIC(13)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
FTE FTE_CNT	The full-time-equivalent personnel from CAFM associated with the direct personnel cost of each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
Units UNIT_CNT EDIT_CNT	The number of workload units that vary by each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_ TXT)
Provider Type (PROV_ TYPE_ CD) (Except for Edit Development)
Bill/Subtype (BILL_ TYPE_ CD) (Except for Edit Development)
Activity Type (ACTY_ TYPE_ CD)

(FID Interface)

The following section identifies the data elements required from FID to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

1.0 Fraud Case Data

The following table provides a definition of the fraud case data required by the PIMR system from the FID system.

Note: The ideal interface or flat file format exported from the FID System would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE	CASE CONTRACTOR	Contractor Identifier CNTRCTR_ID	Use CASE_ID to map case related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, which specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE	ACTION	Action Date ACTN_DT *Note: Action Date and Action Taken should be a key in the FID ACTION table if data is to be captured by each action.*	If ACTN_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE	PRVDR	Provider Type Text PRVDR_TYPE_TXT	Use CASE_ID to map case to Contractor by CNTRCTR_ID and to Provider Type by PRVDR_TYPE_TXT
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE	BILL_TYPE	Bill Type Identifier BILL_TYPE_ID	Use CASE_ID to map case related data to a Bill Type by BILL_TYPE_ID.
Fraud Source Code FRD_SRC_CD	A unique code that identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal Sources. Beneficiary Integrity - Non IRP and Medical Review Referrals fall under 100004.	CHAR(6), PK	PMR_FRD_CASE	ALGTN_SRC	Allegation Source Text ALGTN_SRC_TXT	Use CASE_ID to map case related data to a fraud source by ALGTN_SRC_TXT.
Fraud Status FRD_STUS_CD	A unique 1 character code which identifies fraud status. Fraud status codes include A = Active, C = Closed, N = Not Applicable. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1) PK	PMR_FRD_CASE	ACTN	Action Text ACTN_TXT	Set FRD_STUS_CD to "A" for all cases the are identified as Opened in ACTN_TXT for all ACTN_DT's within the Year/Month period. Set FRD_STUS_CD to "C" for all cases the are identified as Closed in ACTN_TXT for all ACTN_DT's within the Year/Month period.
Number Cases CASE_CNT	The number of fraud cases broken down by each combination of the keys above for the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID _CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT for ACTN_DT within the YEAR_Month_TXT.
# of Referrals RFRL_CNT	The number of cases referred to the OIG during the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID_CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
						and ACTN_TXT where ACTN_TXT denotes OIG Referral in ACTN for ACTN_DT within the within the YEAR_Month_TEXT.
# Referrals Accepted ACPT_CNT	The number of cases accepted by OIG during the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID_CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT where ACTN_TXT denotes OIG Referral in ACTN for ACTN_DT within the within the YEAR_Month_TEXT.

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD

2.0 Payment Suspension Data

The following table provides a definition of the payment suspension data required by the PIMR system from the FID system.

Note: The ideal interface or flat file format exported from the FID System would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_SPSN	SUSPNSN_ CNTRCTR	Contractor Identifier CNTRCTR_ID	Use SUSPNSN_ID to map suspension related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, which specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN	SUSPNSN	Effective Date EFCTV_DT	If EFCTV_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_ CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_SPSN	SUSPNSN	Provider Type Text PRVDR_TYPE_T XT	Each suspension record includes PRVDR_TYPE_TXT to allow filtering of data.
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Definitions and codes are currently under currently under review.	CHAR(6), PK	PMR_SPSN	SUSPNSN	BILL_TYPE_ID	Each suspension record includes BILL_TYPE_ID to allow filtering of data.
Suspension Type SPSN_TYPE_CD	A unique code, which identifies the type of suspension for the data set. Suspension types include BI = Benefit Integrity and MR = Medical Review.	CHAR(2), PK	PMR_SPSN	SUSPNSN	Suspension Type Text SUSPNSN_TYPE _CD	Map each FID suspension type to either BI or MR.
Suspended Providers SPSN_PROV_CNT	The number of providers which received Payment Suspensions during the reporting period. Payment Suspensions are defined as the withholding of payment by an intermediary or carrier from a provider or supplier of an approved Medicare Payment amount before a determination of the amount of the overpayment exits.	NUMERIC(10)	PMR_SPSN	SUSPNSN	SUM(Suspension Identifier) SUM(SUSPNSN_I D)	SUM(SUSPNSN_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Claims SPSN_CLAIM_CNT	The number of suspended claims associated with suspended providers for the reporting period.	NUMERIC(10)	PMR_SPSN	SUSPNSN	CLM_SUBMSN_ CNT	SUM(CLM_SUBMSN _ CNT) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Dollars SPSN_AMT	The amount in dollars associated with suspended providers for the reporting period.	NUMERIC(13)	PMR_SPSN	SUSPNSN	Suspension Amount SUSPNSN_AMT	SUM(SUSPNSN_AM T) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Suspension Type (SPSN_TYPE_CD)

(MARS Interface)

The following section identifies the data elements required from MARS to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

1.0 Medical Review Overpayment Data

The following table provides a definition of the medical review overpayment data required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PSPY_RVW
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PSPY_RVW
Activity Type ACTY_TYPE_CD	A unique code associated with each MR activity to allow reporting by Activity. Activities include: 21004 = Postpay Non-CMR, 21005 = Postpay Onsite CMRs, 21006 = In-House CMRs, 21020 = Postpay Directed Fraud Unit Review, 21021 = Postpay HCFA CFO Review, 21022 = Postpay Directed OIG Review, 21023 = Postpay Directed Law Enforcement Review, 21024 = Postpay Directed by PRO, 21025 Postpay Directed ORT, 21027 = Court Ordered Medical Review.	CHAR(6), PK	PMR_PSPY_RVW
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	VARCHAR(6), PK	PMR_PSPY_RVW
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	VARCHAR(6), PK	PMR_PSPY_RVW
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_PSPY_RVW
Overpayment Collected Claims OVPY_COL_CNT	Number of claims from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_PSPY_RVW

Level of Detail:

The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Activity Type (ACTY_TYPE_CD)

2.0 Fraud Case Overpayment Data

Fraud overpayments are requested repayments identified as part of a fraud investigation and referred to a collection unit (internal or external to a Medicare contractor) for recovery. Only overpayments requested by the contractor fraud unit or other law enforcement entity following action by the contractor fraud unit are considered fraud case overpayments. The following table provides a definition of the overpayment data associated with fraud cases required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Fraud Status Code FRD_STUS_CD	A unique code that identifies status of fraud cases. Fraud status codes include A = Active and C = Closed. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1), PK	PMR_FRD_CASE
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims associated with fraud cases that involved claims paid in error and that should be collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars associated with fraud cases from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_FRD_CASE
Overpayment Collected Claims OVPY_COL_CNT	Number of claims associated with fraud cases from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars associated with fraud cases from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_FRD_CASE

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Fraud Source (FRD_SRC_CD)
Fraud Status (FRD_STUS_CD)

3.0 Payment Suspension Overpayment Data

The following table provides a definition of the overpayment data associated with payment suspensions required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_SPSN
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_SPSN
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	VARCHAR(6), PK	PMR_SPSN
Suspension Type SPSN_TYPE_CD	A unique code that identifies the type of suspensions for the data set. Suspension types include BI = Benefit Integrity and MR = Medical Review.	CHAR(2), PK	PMR_SPSN
Recovered Dollars OVPY_COL_AMT	Amount in dollars associated with suspended providers from that which were paid in error and have been collected from the provider and supplier during the reporting period. Recovered dollars are the actual dollars recovered after issuing a demand letter and lifting the payment suspension.	NUMERIC(13)	PMR_SPSN

Level of Detail:

The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Suspension Type (SPSN_TYPE_CD)

(CROWD Interface)

The following section identifies the data elements required from CROWD to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CROWD system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints and 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	Provides the number of complaints received from Law Enforcement during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

Level of Detail:

The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD) (Except for Edit Development)
Bill/Subtype (BILL_TYPE_CD) (Except for Edit Development)
Fraud Source Code (FRD_SRC_CD)

(IRP Interface)

The following section identifies the data elements required from IRP to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CROWD system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 2.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes from IRP include 100002 = IRP Complaints and 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	Provides the number of complaints received during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

Level of Detail:

The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD) (Except for Edit Development)
Bill/Subtype (BILL_TYPE_CD) (Except for Edit Development)
Fraud Source Code (FRD_SRC_CD)

ATTACHMENT 2
CARRIER PROVIDER TYPE AND SUBTYPE

DESCRIPTION OF CARRIER PROVIDER TYPE

PROVIDER TYPE CODE	SPECIALTY CODE RANGE	RANGE DESCRIPTION
1	01 - 41, 45, 46, 48, 66, 70, 76-79, 81-86, 90-94, and 98-99	PHYSICIAN
2	42-44, 47, 49-65, 67-69,71-75, 80, 87-89, 95-97, and A0-A8	NON-PHYSICIAN

DESCRIPTION OF CARRIER PROVIDER SUBTYPE

PROVIDER TYPE CODE	HCPCS CODE RANGE	PROVIDER SUBTYPE
1	00100 - 01999	ANESTHESIA
2	10040 - 69999	SURGERY
3	70010 - 79999	RADIOLOGY
4	80049 - 89399	PATHOLOGY
5	90281 - 98939 98944 - 99099	MED EXCEPT ANESTHESIA
6	99141 - 99199	MED EXCEPT ANESTHESIA
7	99201 - 99499	EVALUATION & MANAGE
8	A0000 - A0999	TRANSPORTATION SRVS
9	A2000 - A2999 98940 - 98943	CHIROPRACTIC
10	A4000 - A8999	DMEPOS
11	B4000 - B9999	DMEPOS
12	E0100 - E1830	DMEPOS
13	G0000 - G9999	MED EXCEPT ANESTHESIA
14	H5000 - H6000	MED EXCEPT ANESTHESIA
15	K0000 - K9999	DMEPOS
16	L0100 - L9999	DMEPOS
17	M0000 - M0799	MED EXCEPT ANESTHESIA
18	M0900 - M0999	ESRD
19	P2000 - P9999	PATHOLOGY
20	V0000 - V5399	MED EXCEPT ANESTHESIA
21	ALL OTHER CODES	OTHER