Medicare Program Integrity Manual
Exhibits

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(Rev. 71, 4-09-04)

Exhibit 1 - Definitions

(Rev. 71, 04-09-04)

A

Abuse

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

Affiliated Contractor (AC)

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

B-C

Carrier

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

Case

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

Contractor

Contractor includes all intermediaries, carriers, DMERCs, RHHIs, and PSCs.

Centers for Medicare & Medicaid Services (CMS)

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

Closed Case

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

D-E

Department of Justice (DOJ)

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

Demand Bill or Demand Claim

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

F

Federal Bureau of Investigation (FBI)

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

Fraud

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

G-H

I

Inpatient hospital claims

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. For benefit integrity purposes, claims for inpatient hospital services, hospital "swing" bed services, hospital-based ASC services, and procedures on the ASC list performed in the hospital outpatient hospital setting are reviewed by Quality Improvement Organizations, not intermediaries.

Intermediary

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

J-K-L

Local Medical Review Policy (LMRP)

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

M

Medicare Contractor (Benefit Integrity)

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

Medicare Contractor (Medical Review)

Medicare contractors include intermediaries and carriers that have not transitioned their MR to a PSC.

Misrepresented

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

N

Noncovered (Not Covered)

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

O

Office of Audit Services (OAS)

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

Office of Counsel to the Inspector General (OCIG)

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

Office of Inspector General (OIG)

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

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;

- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor*, AC, Medicare contractor,* and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

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

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

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

Offset

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

P

Program Safeguard Contractor (PSC)

The PSC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract.

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatientphysical therapy, comprehensive outpatient rehabilitation facility, renal dialysis

facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DMERCs, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization (QIO)

The Peer Review Improvement Act of 1982 established the Utilization and Quality Control Peer Review Organization (PRO) program. The PRO name has changed to Quality Improvement Organization. CMS contracts with independent physician organizations in each state to administer the QIO program. Their purpose is to ensure that the provisions of the Act are met. Under their contracts with CMS, QIOs are required to review the medical services provided to Medicare beneficiaries in settings such as acute care hospitals, specialty hospitals, or ambulatory surgical centers.

Recoupment

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

Reliable Information

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

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

provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

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

S

Services

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

Suspension of Payment

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

T-U-V-W-X

Exhibit 3 - Description of CAC Members - (Rev. 3, 11-22-00)

3.1 - Physicians - (Rev. 3, 11-22-00)

Medicare defines physicians as:

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

Do not include other practitioners on this committee.

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

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

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

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

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

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

- National Medical Association (representative of either the local or State chapter or its equivalent, if one exists); and
- Medicare managed care organizations. In order to enhance the consistency of decision making between Medicare managed care plans and traditional fee-for-service, Medicare managed care organizations shall also have representation on the CAC. The number of managed care representatives on the CAC should be based on the Medicare penetration (enrollment) rates for that State; one representative for those States with penetration rates of less than 5 percent and two representatives for those States with penetration rates of 5 percent or higher. The State HMO association should periodically submit nominees for membership on the CAC.
- Physician representatives for each of the following: 1) Chiropractic; 2) Maxillofacial/Oral surgery; 3) Optometry; and 4) Podiatry.

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

- Allergy;
- Anesthesia;
- Cardiology;
- Cardiovascular/Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Family Practice;
- Gastroenterology;
- Gerontology
- General Surgery;
- Hematology;
- Internal Medicine;
- Infectious Disease;
- Medical Oncology;
- Nephrology;
- Neurology;
- Neurosurgery;
- Nuclear Medicine;

- Obstetrics/Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;
- Pathology;
- Pediatrics;
- Peripheral Vascular Surgery;
- Physical Medicine and Rehabilitation;
- Plastic and Reconstructive Surgery;
- Psychiatry;
- Pulmonary Medicine;
- Radiation Oncology;
- Radiology;
- Rheumatology; and
- Urology

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

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

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

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

Include two representatives of the beneficiary community:

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

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

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

Carriers invite the following to be members:

- A representative from the State Hospital Association;
- *QIO* Medical Director;
- Intermediary Medical Director;
- Medicaid Medical Director (or designee); and
- A representative of an association representing administrative practices, such as the American Group Practice Association or the Medical Group Management Association.

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

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

Reliable evidence includes but is not limited to the following:

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

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

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 allows the federal government to pay a reward to individuals who report evidence of suspected fraud and abuse against the Medicare program. Implementing regulations, issued on June 8, 1998, were

effective on July 8, 1998 and provide that a complainant may be rewarded up to 10 percent of the amount recovered, but not more than $1,000. Not everyone is eligible for the reward, though. To be eligible for a reward:

- The information you give has to lead to a recovery of at least $100;
- The suspected fraud must be acts or omissions that are grounds for the government to impose sanctions provided under certain provisions of the law;
- There isn't another reward that you qualify for under another government program;
- You must not have participated in the sanctionable offense with respect to which payment is being made;
- If the person or organization is already under investigation; and
- You are not an immediate family member or an employee of the Department of Health and Human Services, its contractors or subcontractors, the Social Security Administration, the Office of the Inspector General, a State Medicaid Agency, the Department of Justice, the FBI, or any other federal, State, or local law enforcement agency at the time he or she came into possession, or divulged information leading to a recovery of Medicare funds.

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

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

Dear_____:

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

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

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

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

Sincerely,

[Contractor Information]

Enclosures

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

[To be completed by contractor.]

Provider/Supplier Name

Case Number

REWARD CLAIM FORM

Date

Dear [Contractor Information]:

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

CLAIMANT INFORMATION

Name_____

Street Address_____

City, State, Zip code_____

Telephone Number_____

Claimant (or Representative) Signature_____

REPRESENTATIVE INFORMATION

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

Name_____

Street Address_____

City, State, Zip code_____

Telephone Number_____

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

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

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

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

A - Screen Use

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

B - Options

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

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

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

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

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

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

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

Click here to view an exhibit of the Pending Case List Screen.

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

1 - View Comments

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

2 - Edit Case

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

3 - View Report

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

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

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

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

Click here to view an exhibit of the New Case Screen.

Click on the new case button to get the new case screen. You must enter a FID number at this time to enter new case information. You can move from one data field to another by either using the Tab key or the mouse to move the cursor to that data field. After entering all available information, you must remember to click on the enter provider information to access the provider detail screen and click on the enter complainant information to access the complainant detail screen. You may also edit the provider information or complainant information using this same approach. If the provider number is not entered at this time, the system will not allow you to save this provider information. The case number and complainant's first, middle initial and last name must be entered to allow you to save the complainants information.

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

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

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

Click here to view an exhibit of the Closed Case List Screen.

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

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

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

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

Click here to view an exhibit of the Report Menu Screen.

Click here to view an exhibit of the IRP Cases List Screen.

Click here to view an exhibit of the View Case Detail Screen.

Click here to view an exhibit of the Edit Case Detail Screen.

Click here to view an exhibit of the Comments Screen.

Click here to view an exhibit of the Provider Detail Screen.

Click here to view an exhibit of the Provider Edit Detail Screen.

Click here to view an exhibit of the View Allegations Screen.

Click here to view an exhibit of the View Edit Allegations Screen.

Click here to view an exhibit of the View Complainant Detail Screen.

Click here to view an exhibit of the Case Report Screen.

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

A - BRIEF LIST

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

B - DETAIL LIST

- All Cases

C - LIST BY CONTRACTOR

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

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

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

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

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

Field Name	**Mandatory During Conversion? (7/24/2002 – 5/1/2003)**	**Mandatory After Conversion? (5/1/2003 - Forward)**	**Field Description**	**Type of Field**
Contractor Name	Mandatory	Mandatory	The name of the Contractor.	Picklist (Select one)
Contractor Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The unique identifier assigned to a Contractor by CMS.	Automatic Fill-in
Contractor Type	Mandatory	Mandatory	The type of contractor responsible for the policy.	Picklist (Select one)
LMRP Database ID Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	A unique identification number assigned to an LMRP by the LMRP Data Entry System.	Automatic Fill-in
LMRP Version Number	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	A unique identification number assigned to an LMRP, each time it is edited, by the LMRP Data Entry System	Automatic Fill-in Integer beginning with an "L"
LMRP Title	Mandatory	Mandatory	A one-line description of the topic or subject matter of the policy.	Text
Contractor's Policy Number	Optional	Optional	The unique policy identifier designated by the policy author to an LMRP.	Text

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
AMA CPT Copyright Statement	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The copyright statement in each LMRP: "CPT codes, descriptions and other data only are copyright 2002 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."	Automatic Fill-in
CMS National Coverage Policy	Optional	Optional	The associated CMS National Coverage Determination or Coverage Provision in an Interpretive Manual. A description if a National Coverage Determination or Provision is being expanded, adds greater clarification and/or codes.	Memo
Primary Geographic Jurisdiction	Mandatory	Mandatory	The geographical area [i.e., state(s)] to which the policy applies.	Picklist (Select one or more)
Secondary Geographic Jurisdiction	Optional	Mandatory (for FIs and RHHIs who have a secondary geographic jurisdiction)	The secondary geographic area [i.e., state(s)] for those facilities (primarily for chain organizations) that nominate a FI or RHHI to process their claims.	Picklist (Select one or more)
Oversight Region	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The CMS region that has oversight responsibility for a CMS contractor's LMRP development process even though that contractor may operate in more than one CMS region.	Automatic Fill-in
CMS Consortium	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The consortium associated with the Oversight Region.	Automatic Fill-in
DMERC Region LMRP Covers	Mandatory (System will auto-fill)	Mandatory (System will auto-fill)	The region that the DMERC policy covers.	Automatic Fill-in
Original Policy Effective Date	Mandatory	Mandatory	The date the policy originally went into effect. Also includes optional	Date (mm/dd/yyyy)

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			descriptive text indicating what the effective date refers to.	
Entire Policy Ending Date	Optional	Mandatory (System will auto-fill)	The date the entire policy is no longer in effect (i.e., policy retired).	Automatic Fill-in
Revision Effective Date	Optional	Mandatory for revised policies	The date on which a revision of the policy went into effect or became effective. Also includes optional descriptive text indicating what the effective date refers to: -for services performed on or after this date -for claims received on or after this date.	Date (mm/dd/yyyy)
Revision Ending Date	Optional	Mandatory (System will auto-fill)	The date on which a revision of the policy is no longer effective (i.e., subsequent Revision Effective Date entered or policy retired).	Automatic Fill-in
LMRP Abstract	Mandatory	Mandatory	Prior to 2/1/03: Characterize or define the service and explain how it operates or is performed. Use this filed to enhance the policy subject. All new/revised LMRPs entered into the database after 2/1/03: Enter here a brief explanation of the LMRP.	Memo
Indications and Limitations of Coverage and/or Medical Necessity	Optional	Mandatory	The general indications for which a service is covered and/or considered reasonable and necessary. Also, the limitations such as least costly alternative reductions.	Memo
CPT/HCPCS Section	Optional	Mandatory	The CPT/HCPCS section (Heading Levels 1 and 2) that applies to the policy.	Memo
Benefit Category	Mandatory	Mandatory	The benefit category that applies to the policy.	Picklist (Select one or more)
Coverage Topic	Mandatory	Mandatory	The coverage topics (from the 82	Picklist

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			topics that are currently listed in the www.medicare.gov Your Medicare Coverage Database) that apply to the policy.	(Select one or more)
Type of Bill Code	Mandatory (for FIs and RHHIs)	Mandatory (for FIs and RHHIs)	The related type of bill codes for the service. Type of Bill Code applies only to FIs and RHHIs.	Picklist (Select one or more)
Revenue Codes	Mandatory (for FIs and RHHIs)	Mandatory (for FIs and RHHIs)	The related revenue code (Version I) for the service.	Code List (Enter one or more)
CPT/HCPCS Codes	Mandatory (for FIs, Carriers, and DMERCs)	Mandatory (for FIs, Carriers, and DMERCs)	The related CPT/HCPCS codes and any appropriate modifiers for the service. Contractors may list NOC codes in this field.	Code List (Enter one or more)
Does the "CPT 30% Rule" apply?	Mandatory	Mandatory	The short descriptor should be displayed for a CPT code if more than 30% of the CPT section codes are used in the LMRP. Otherwise, the long CPT descriptors should be displayed. Possible options for this field include Yes, No, and Undefined.	Radio button (Y/N/ Undefined)
Not Otherwise Classified (NOC)	Optional	Optional	The NOC code and the classified codes associated with the text. This field will be eliminated in the future. Contractors should list NOC codes in the "CPT/HCPCS Codes" field instead.	Code List (Enter one or more)
ICD-9-CM Codes that Support Medical Necessity	Mandatory (for FIs, Carriers, and RHHIs)	Mandatory (for FIs, Carriers, and RHHIs)	The ICD-9-CM codes for which the service is general covered, and/or considered medically necessary. A policy can be associated with one or many diagnosis codes.	Code List (Enter one or more; may enter ranges)
Diagnoses that Support Medical Necessity	Optional	Optional	In the absence of ICD-9-CM codes, the medical diagnoses that supports the medical necessity for the service.	Memo
ICD-9-CM Codes that	Optional	Optional	The ICD-9-CM codes that do not support the medical necessity of the	Code List (Enter one or

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
DO NOT Support Medical Necessity			service.	more; may enter ranges)
Diagnoses that DO NOT Support Medical Necessity	Optional	Optional	In the absence of ICD-9-CM codes, the medical diagnoses that do not support medical necessity of the service.	Memo
Reasons for Denials	Optional	Mandatory	The specific situations under which a service will **always** be denied. Also, list the reasons for denial such as investigational, cosmetic, routine screening, dental, program exclusion, otherwise not covered, or never reasonable and necessary.	Memo
Noncovered ICD-9-CM Codes	Optional	Optional	The ICD-9-CM codes that are never covered.	Code List (Enter one or more; may enter ranges)
Noncovered Diagnoses	Optional	Optional	The medical diagnoses that are not covered.	Memo
Coding Guidelines	Optional	Optional	The relationships between codes. Define how services are billed. Include information about the units of service, place of service, HCPCS modifiers, etc. An example of an appropriate coding technique is "use CPT xxxxx to bill this service rather than yyyyy."	Memo
Documentation Requirements	Optional	Optional	Specific information from the medical records or other pertinent information that would be required to justify the service.	Memo
Appendices	Optional	Optional	A text narrative of appendices for the LMRP that is searchable. Future enhancements will allow attachment of forms, graphics, and tables.	Memo
Footnotes	Optional	Optional	This field contains the footnotes for	Memo

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			the LMRP.	
Utilization Guidelines	Optional	Optional	The information concerning the typical or expected utilization for the service.	Memo
Other Comments	Optional	Optional	Other information not included in other fields.	Memo
Sources of Information and Basis for Decision	Optional	Mandatory for new policies	The information sources, pertinent references (other than national policy) and other clinical or scientific evidence reviewed in the development of this policy. Cite, for example: Agency for Health Care Policy and Research (AHCPR) guidelines, position papers released by specialty societies or other sources used during the development of this policy. Also, include the basis for the coverage decision and references that may apply.	Memo
Advisory Committee Meeting Notes	Optional	Optional	The meeting date on which the policy was discussed with the advisory committee and/or any notes from the meeting.	Memo
Start Date of Comment Period	Optional	Optional	The date this version of the LMRP was released for comment.	Date (mm/dd/yyyy)
End Date of Comment Period	Optional	Optional	The date the comment period ended.	Date (mm/dd/yyyy)
Start Date of Notice Period	Optional	Mandatory	The date the medical community was notified of this version of the LMRP.	Date (mm/dd/yyyy)
Revision History Number	Optional	Mandatory (for revisions)	The revision number (unique identifier created by a Contractor).	Memo
Revision History Explanation	Optional	Mandatory (for revisions)	An explanation of the revisions made to the policy.	Memo
Disclaimer Specialty Name	Optional	Optional	The system will auto-fill the following text when the LMRP is viewed or printed: "This policy does not reflect the sole opinion of the	Memo

Field Name	Mandatory During Conversion? (7/24/2002 – 5/1/2003)	Mandatory After Conversion? (5/1/2003 - Forward)	Field Description	Type of Field
			contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with representatives from [fill in appropriate specialty name]."	
Notes	Optional	Not Applicable after the Transition	This field is for Fu Associates data entry users to enter questions that they had while entering the LMRP so that contractors can focus on these areas in their review process. Data entry users will also have the capability to include codes that were not accepted in previous field because they are invalid.	Memo

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

EXHIBITS

Exhibit 7 - Sample Letter for On-Site Reviews - (Rev.)

DATE:

PROVIDER NAME: CONTRACTOR NAME:

PROVIDER ADDRESS: CONTRACTOR ADDRESS:

OPENING

Dear _____:

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

REASON FOR REVIEW

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

HOW THE OVERPAYMENT WAS DETERMINED

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

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

WHY YOU ARE RESPONSIBLE

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

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

WHAT YOU SHOULD DO

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

Intermediary's Address

IF YOU DO NOT REFUND WITHIN 30 DAYS:

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

However, if you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods.

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

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

APPEAL RIGHTS:

For Part A services, you may appeal denials for which you are determined to be liable under §1879 of the Act, or for which the beneficiary is determined to be liable but refuses to exercise his/her appeal rights. If you disagree with these determinations, you must request a reconsideration within 60 days of the date of this letter. Refer to the appeals procedure in your Provider Manual Section _____.

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

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

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

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

Sincerely,

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

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

- Beneficiary Name: John Smith
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/08/97 - 12/08/97
- Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/97
- Reason for Denial: MRI's are not considered reasonable and medically necessary for the diagnosis of xxxx.
- Why the Provider is Responsible: We believe you knew or should have known that the services were not reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1997, outlined Local Medical Review Policy which indicated that MRI's were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
- Overpayment: $900.00
- Beneficiary Name: Mary Smith
- HI Claim Number: 000-00-0000B
- Service Dates: 10/01/97 - 10/31/97
- Services Denied and Dates: Physical therapy evaluation and re-evaluation on 10/03/97 and 10/26/97.
- Reason for Denial: The two physical therapy visits are not reasonable and medically necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation.
- Why you are Responsible: In a letter dated 07/30/97 you were notified that such therapy evaluation and re-evaluation were not considered reasonable and necessary. Therefore, you are responsible for the overpayment.
- Overpayment: $ 200.00
- Beneficiary Name: Tom Jones

- HI Claim Number: 000-00-0000A
- Service Dates: 12/10/97 - 12/31/97
- Services Denied and Dates: 10 physical therapy visits from 12/10/97 - 12/31/97
- Reason for Denial: No plan of care signed by a physician.
- Why you are responsible: We find you responsible for the overpayment because regulations at 42 CFR, and manual instructions at §xxxx, clearly require a plan of care signed by a physician for therapy visits.
- Overpayment: $1,200.00

7.*2* - Exhibit-Sample Letter--Request For Medical Records - (Rev.)

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

DATE:

PROVIDER NAME: **INTERMEDIARY NAME:**
PROVIDER ADDRESS: **INTERMEDIARY ADDRESS:**
PROVIDER NUMBER:
OPENING:

Dear XXXXX:

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

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

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

- Form HCFA-485*;*
- Form HCFA-486, or equivalent information, if applicable;

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

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

Intermediary Name, Address, and Contact Person

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

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

Following our review, we will inform you in writing of our findings. We will provide you with a listing of the claims that were reviewed and our determinations with regard to those claims (i.e., full or partial denials and payable claims), the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, the amount of the overpayment or underpayment, and interest accrual on unpaid balances. We will provide you with an explanation of your right to submit a rebuttal statement under 42 CFR 405.370-375 if we determine that you have been overpaid, and your options for repaying any overpayments, or our refund of any underpayments. We will provide you with an explanation of how any overpayment was determined, including the sampling methodology used to project the amount of the overpayment. We will also provide you with a full explanation of your appeal

rights, including appeal of the sampling methodology used to determine the overpayment, estimation of the overpayment, coverage decisions, limitation on liability decisions under §1879 of the Act, and our determination as to whether you are without fault under §1870 of the Act.

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

Sincerely,

Enclosure: Listing of Sample Claims Requiring Medical Documentation

7.*3* - Exhibit: Part A Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments - (Rev.)

DATE:

PROVIDER NAME: **INTERMEDIARY NAME:**
PROVIDER ADDRESS: **INTERMEDIARY ADDRESS:**
PROVIDER NUMBER:
OPENING:

Dear XXXXXX:

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

REASON FOR REVIEW

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

HOW THE OVERPAYMENT WAS DETERMINED

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

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

TOTAL OVERPAYMENTS

(List the aggregate overpayments)

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

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

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

WHY YOU ARE RESPONSIBLE

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

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

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

WHAT YOU SHOULD DO

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

INTEREST

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

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

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

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

FI Name, Address, Telephone #, and Fax #

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

If you choose not to submit a rebuttal statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do "). Whether or not you submit a rebuttal statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal statement are not

initial determinations as defined in 42 CFR 405.704, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you must request a reconsideration within 60 days of the date you receive this letter (receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual § _____ for further details.)

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

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

Sincerely,

Enclosures

7.*3*.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the Results, and Request Repayment of Overpayments - (Rev.)

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

A. Beneficiary Name: John Smith

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

2. Service Dates: 12/01/96 - 01/15/97

3. Services Denied and Dates: 45 Inpatient SNF Days, 12/1/96 - 1/15/97

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

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

6. Overpayment: $2,000.00

B. Beneficiary Name: Mary Smith

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

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

3. Services Denied and Dates: 31 Inpatient SNF Days, 01/01/97 - 01/31/97

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

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

6. Overpayment: $200.00

7.*4* - Exhibit: Part B Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments - (Rev.)

SAMPLE LETTER--MEDICARE PART B

DATE:

PROVIDER NAME: **INTERMEDIARY NAME:**
PROVIDER ADDRESS: **INTERMEDIARY ADDRESS:**
PROVIDER NUMBER:

OPENING:

Dear XXXXX:

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

REASON FOR REVIEW

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

HOW THE OVERPAYMENT WAS DETERMINED

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

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

TOTAL OVERPAYMENTS

(List the aggregate overpayments)

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

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

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

WHY YOU ARE RESPONSIBLE

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

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

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

WHAT YOU SHOULD DO

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

INTEREST

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods. Medicare charges interest on its outstanding Part B debts in accordance with §1833(j) of the Act and 42 CFR 405.378.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

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

debt to the Department of Treasury for offset against any monies payable to you by the federal government.

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

FI Name, Address, Telephone #, and Fax #

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

If you choose not to submit a rebuttal statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do"). Whether or not you submit a rebuttal statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal statement are not initial determinations as defined in 42 CFR 405.803, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the attachment. If you disagree with this determination, you must request a review (**if the amount in controversy is $100 or less, or a Hearing Officer hearing if the amount in controversy is greater than $100**) within 6 months of the date of this letter. You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and overpayment recovery. (See 42 CFR 405.801, et seq. and 42 CFR 405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual Section _____ for further details.)

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

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

Sincerely,

Enclosures

7.*4*.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the Results, and Request Repayment of Overpayments - (Rev.)

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

A. Beneficiary Name: John Smith

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

2. Service Dates: 12/08/96 - 12/08/96

3. Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/96

4. Reason for Denial: MRIs are not considered medically reasonable and necessary for the diagnosis of xxxx (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. You knew or should have known that the services were not medically reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1996, outlined Local Medical Review Policy which indicated that MRIs were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: $900.00

B. Beneficiary Name: Mary Smith

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

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

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

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

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

6. Overpayment: $200.00

Exhibit 8 – *Reserved for Future Use*

Exhibit 9 - Projection Methodologies and Instructions for Reviews of Home Health Agencies *for Claims Not Paid Under PPS* - (Rev.)

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

A - Reimbursement Methods for Home Health Agencies (HHAs)

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

HHAs are reimbursed as follows:

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

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

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

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

- The sample may be chosen from a frame including claims with a particular or many disciplines;
- For each discipline, MR determines the total number of visits and number of visits denied by re-adjudication;
- *The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, § 3.10.1.5 – Consultation with a Statistical Expert; Chapter 3, §3.10.1.6 – Use of Other Sampling Methodologies; and Chapter 3, §3.10.5.1 – The Point Estimate on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert.*
- Multiply the proportion obtained above by the total number of Medicare visits in the frame. This will determine the projected total number of visits to be denied for the period and the adjusted Medicare visits;
- If the adjustment occurs prior to the submission of the cost report, the projected denied visits will be multiplied by the provider's interim payment rate per visit to determine the overpayment amount by discipline subject to collection. The FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options;
- Upon submission of the cost report, total visits on the cost report will not change. The cost per visit computation will remain the same. Only the Medicare visits and the total cost of Medicare services will be reduced. The charges that are applicable to these adjusted costs must also be determined. Both of these adjusted totals are needed to settle the cost report. For cost report periods beginning prior to 10/1/97, HHA cost reports are settled on the lesser of reasonable cost or customary charges. Under the BBA, for cost report periods beginning on or after 10/1/97, the methodology for settling HHA cost reports has changed. Medical Review staff must complete worksheets 1-7 and notify Audit and Reimbursement staff of all necessary adjustments so that the amount can properly be reflected in the cost report.

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

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

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

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

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

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

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

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

C - Procedures for Other Patient Services

The following procedures apply to other patient services:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If the adjustment occurs prior to the submission of the cost report, the FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and

- Upon submission of the cost report, as in the case for disciplines 1 through 6, medical review staff must complete worksheets 1 - 7 identified in §5.3.7B above, and provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

D - Coordination Between Medical Review and Audit and Reimbursement Staff

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

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections on denied HHA services must be made for each discipline and revenue center, as instructed above;
- When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs;
- Information from the completed Worksheets 1 - 7 identified in §5.3.7B above, must be routed to the FI/RHHI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs; and
- Upon completion of the review, furnish the audit and reimbursement staff with the information listed in PIM Chapter 3 §5.3.1.

The audit and reimbursement staff will:

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

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

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

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

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

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

- Radiology;
- Laboratory;
- IV Therapy;
- Oxygen Therapy;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;
- Electrocardiology;
- Medical Supplies;
- Drugs Charged; and
- Other

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

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

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;

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

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

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

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

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

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

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

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

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

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

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

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

B - Coordination Between Medical Review and Audit and Reimbursement Staff

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

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied SNF services must be made by each individual ancillary cost center, as instructed above;
- Denied charges must be segregated between Part A and Part B as the SNF Medicare cost report is set up to apportion costs and make separate settlements for Part A and Part B;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 8 - 17 (PIM chapter 3, §5.3.8 above), must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, MR furnishes the audit and reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

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

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

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

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

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

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

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

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- *The lower limit of a one-sided 90% confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, Sections 3.10.1.5, 3.10.1.6, and 3.10.5.1 on alternative scientific*

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

- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the costs report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete Worksheets 24 - 30, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

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

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

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

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

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

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

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

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

B - Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CORFs.

Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

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

The audit and reimbursement staff will:

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

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

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

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

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

When making this determination, the following should be used:

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

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

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

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- *The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in [Chapter 3, Sections 14.1.5, 14.1.6, and 14.5.1] on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;*
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete worksheets 18 - 23, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

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

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

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

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

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

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

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

B - Coordination Between Medical Review and Audit and Reimbursement Staff

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

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

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and

- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

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

Identification Section

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

Payment and Utilization Section

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

Carrier Review Conducted Section

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

Contacts Made	Number of Cases Reviewed	Reason
Provider		
SNF		
Hospital		
Beneficiary		

Documentation of §1879 of the Act Determinations Section

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

Documentation of §1870 of the Act Determinations Section

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

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

A - Notice to Beneficiaries

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

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

B - Notice to Others

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

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

- Pay the first claim submitted by the supplier and immediately give notice of the exclusion; and

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

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

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

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

The determinations which follow a §1862(a)(1) denial may require a decision if the beneficiary or provider knew or could have known that a service would not be covered by Medicare because it would be considered medically unnecessary. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. The beneficiary is liable if it is determined the beneficiary knew, or could reasonably have been expected to know (e.g. utilization review notice from a SNF) that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability (i.e., makes payment to a provider even though a non-covered service is involved) if neither the beneficiary nor the provider knew, or could reasonably be expected to have known, that the services were not covered. Waiver of liability exists when both the beneficiary and the provider did not and could not reasonably have been expected to know that payment would not be made for services.

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

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

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

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

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

A - Documentation of §1879 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary/provider (i.e., demand letters) should include all §1879 determinations as to knowledge of noncoverage, both favorable and unfavorable. Document the §1879 determination in the CMR summary report.

B - Section 1879 of the Act Determinations and Overpayments

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

14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment - (Rev. 3, 11-22-00)

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

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

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

A - Documentation of §1870 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or provider (i.e., demand letters) should include all §1870 refund determinations. Also, document the §1870 determination in the CMR summary report.

B - Section 1870 of the Act Determinations and Overpayments

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

C - Section 1870 of the Act Determinations and Extrapolations

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

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

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

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

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

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

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

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

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

Exhibit 14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews (Rev. 17, 12-12-01)

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

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

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

Contractors must use these sample documents when offering consent settlements. Within these sample documents are instructions that must not be inserted in correspondence going to providers. These instructions are printed in **bold**, italics and bordered by brackets. Fill-ins

indicated by a blank line and sentences printed simply in bold are not instructions to the carrier and are to be part of the correspondence going to the provider.

Dear Doctor:

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

On _____, [**Fill-in date of initial request for records prior to conducting audit**.] you received our request for records to conduct an audit of your practice. The purpose of this letter and attachments is to describe the steps involved in the audit process, to highlight problems in your billing and practice patterns identified as a result of our audit, to notify you of the potential overpayment calculated as a result of our audit, and to outline three options available to you.

Our normal full-scale audit process entails the review of records *using statistical sampling for overpayment estimation.* However, in the interest of economy and expediency for both you and the Medicare program, as a first step, we elected to perform a limited audit. We reviewed claims and medical records for services rendered to [**Fill-in the number of beneficiaries making up the sample. Fifteen (15) is the minimum number, you may elect to use a larger sample size.**] beneficiaries over a period of time, from_____to_____. While_____beneficiaries [**A minimum of 15, you may select a larger sample size**] were randomly selected for our sample from a larger universe of beneficiaries for whom you provided services, it is not *done based on our instructions for conducting statistical sampling for overpayment estimation*.

You were chosen for an audit because_____ [**Fill-in the reason for the audit. The reason may be exceeding peer norms or a call from a beneficiary. For example, if the provider exceeded peer norms the contractor might want to use the following language: "You were chosen for an audit because our records indicate you exceeded the average utilization rates of your peers by_____% for the same time period. Your specialty is listed as_____. The peer group consisted of_____ who billed for the same procedure(s)."**] We selected the _____[**NOTE: a minimum of 15, you may select a larger sample size**] beneficiaries by identifying the procedure codes where your billing exceeded the norm for your peers. Included in the universe are only those beneficiaries for whom you rendered and billed at least one of these procedure codes that was paid by Medicare during the review period. From this universe of beneficiaries, a computer is used to randomly select the beneficiaries to be included in the sample. All claims for the procedure codes at issue that were rendered to the sampled beneficiaries and paid within the _____ time period were audited. [**Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As worded, all claims would have to actually been paid within the time period. Whichever method is used,**

you must be consistent.] The list of sampled beneficiaries, dates of service, and procedure codes is contained in the attachment to this letter.

The [**a minimum of 15, carriers may select a larger sample size**] beneficiaries included in our audit resulted in claims being paid by Medicare between_____. [**See note in preceding paragraph. The same type of rewording could be required here.**] These claims and their corresponding medical records were audited, resulting in a potential overpayment of $_____including an actual overpayment of $_____for the_____[**a minimum of 15, carriers may select a larger sample size**] beneficiaries. Item 3 under "Audit Results" explains how we calculated the potential overpayment. Please review the attached documents containing the audit results and options along with an explanation of the Extended Repayment Plan.

We must have your response to this letter within sixty (60) days from the date of this letter,_____ If we do not receive a response from you by_____ , Option 3 will be chosen for you by default (see attached discussion of audit results). Be advised that by signing this letter your legal options may be affected. *Please also be advised that repayment of the overpayment specified herein in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.* You may wish to have legal counsel review this letter before signing it. If you have any questions, please contact me at_____.

Sincerely,

Attachments

A - Consent Settlement Attachment 1 Audit Results

IDENTIFYING INFORMATION

List the following information in the heading of the attachment:

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

SCOPE OF AUDIT

This audit covers services that were paid by Medicare from_____to_____. [**Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims.**

As worded, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.]

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

ISSUES/DETERMINATIONS

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

[**This area lists the problem areas noted in 1.B. above, such as exceeding peer norms and medical necessity/documentation concerns. Additionally, each of the sampled beneficiaries, dates of services, procedure codes, and the Medical Director's determination on each denied service is noted here. Attach newsletters discussing medical policy and documentation requirements for the problem areas found during the audit.]**

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

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

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

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

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

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

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

CALCULATIONS

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

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

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

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

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

OPTIONS

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

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

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

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

Option One - Acceptance of Potential Projected Overpayment

You agree to refund the entire potential overpayment amount (which includes the actual overpayment for the sample beneficiaries) of $_____and do not wish to submit additional medical documentation.

The potential overpayment amount may be paid by check written to_____. Any balance not paid within thirty (30) days of the date you select this option will be subject to offset, whereby future Medicare payments made to you will be withheld and applied to the potential overpayment.

You may apply for an Extended Repayment Plan (ERP) to extend the time over which the potential overpayment must be paid. Please refer to Attachment 5 for an explanation of the ERP. As explained in Item 5 below, interest will be assessed on any balance outstanding thirty (30) days from the date of your selection of this option. Your selection of this option must be received within thirty (30) days of the date of this letter, which is _____.

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

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

Option Two Acceptance of Capped Potential Projected Overpayment

You agree to repay the potential projected overpayment, after providing additional medical documentation relevant to the____ [**A minimum of 15, you may select a larger sample size**] beneficiaries involved in our sample which was in existence at the time the services were rendered.

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

- All services in contention could be determined to be appropriate and allowed as originally processed, and the question of any potential overpayment would be eliminated; or

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

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

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

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

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

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

Option Three Election to Proceed to *Statistical Sampling for Overpayment Estimation*

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

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

If you elect (or accept by default) Option 3, it is important that you understand the following information concerning our actions and your responsibilities with regard to the actual overpayments found for the claims involved in the limited audit:

The potential projected overpayment referred to in this correspondence is based on a sample of _____[**a minimum of 15, you may select a larger sample size**] beneficiaries. We audited claims and medical documentation for the_____[**a minimum of 15, you may select a larger sample size**] beneficiaries in the sample to arrive at an actual overpayment for these claims. The actual overpayment amount was then projected to the universe of procedure codes to develop the potential projected overpayment. (See Item 3. above for the actual overpayment amount and the potential projected overpayment amount.)

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

ASSESSMENT OF INTEREST

We wish to make you aware, should you elect Option One, that interest will be assessed on any balance outstanding thirty (30) days from the date of your signed selection, or, if you choose Option Two, thirty (30) days from the date of the letter notifying you of a final potential overpayment, if any. Should you choose Option 3, interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final overpayment determination. We must assess interest as provided in 42 CFR §405.376. Interest will accrue on the unpaid balance for each thirty (30) day period (or portion thereof) that repayment is delayed. The current interest rate is _____ %.

LIMITATION OF LIABILITY

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

as not reasonable or necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member and those disallowed as custodial services.

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

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

GENERAL

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

Your decision regarding this matter must be in writing and received by this office within sixty (60) days from the date of this letter. If your decision is not received by the above-mentioned date, Option 3, Election to Proceed to *statistical sampling for overpayment estimation*, will be selected for you by default.

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

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

Name:

Title:

Address:

Telephone number:

Consent Settlement Attachment 2: Acceptance of Potential Projected Overpayment

OPTION ONE - ACCEPTANCE OF POTENTIAL PROJECTED OVERPAYMENT

I, **(Name of Provider)**_____:

- have read the results of the audit findings in the letter dated **(Date of letter)**_____.
- understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding ___$**(Dollar amount)** to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.
- understand that if the settlement amount is not paid in full within thirty (30) days from the date I sign this agreement, the unpaid balance is subject to offset. I may apply for an Extended Repayment Plan and if approved, may make payments over an approved period of time.
- understand that interest on the amount accrues from the date I sign this consent agreement, but that this interest will be waived if repayment is made within thirty (30) days from the date I sign this consent agreement.
- understand that claims paid to me from **(From Date)** to **(To Date)** will not be audited in the future. [**Reword this statement to reflect service dates if service dates were used in the audit to select claims instead of dates of payment**.] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.
- *understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.*

I, _**(Name of Provider)**_____, agree by settling this:

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

Provider signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Carrier Representative Signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Overpayment instructions will be provided upon Medicare's receipt of the signed option agreement.

Please do not enclose a check with the option form.

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

CONSENT SETTLEMENT ATTACHMENT 3 OPTION TWO - ACCEPTANCE OF CAPPED POTENTIAL PROJECTED OVERPAYMENT

Option Two - Acceptance of Capped Potential Projected Overpayment

I,_____:

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

- understand that claims paid to me from _____ to_____will not be audited in the future. [**Reword this statement to reflect services dates if service dates were used in the audit to select claims instead of dates of payment**.] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.
- *understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.*

I,_____, agree by settling this:

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

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

Provider signature:_____

Date signed:_____

Printed or typed name:_____

Title of signatory:_____

Carrier Representative Signature:_____

Date signed:_____

Printed or typed name:_____

Title of signatory:_____

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

CONSENT SETTLEMENT ATTACHMENT 4: OPTION THREE - ELECTION TO PROCEED TO *STATISTICAL SAMPLING FOR OVERPAMENT ESTIMATION*

Option Three - Election to Proceed to *statistical sampling for overpayment estimation*

I,_____:

- have read the results of the audit findings in the letter dated _____.
- elect to proceed to your full-scale audit process, involving *use of statistical sampling for overpayment estimation* for the same universe of procedure codes and time period as the limited audit, as explained in the letter. I understand the full-scale audit process is the normal audit process, and that the limited audit was offered to me only in the interest of economy and expediency. Upon selection of Option Three, I understand that the offer of a consent settlement as stated in Options One and Two is withdrawn.
- understand that I and/or my office staff will be required to submit medical documentation for all services at issue in the *statistical sampling for overpayment estimation*, upon request by the carrier.
- understand that all applicable appeals rights, including any right to a hearing officer hearing, an administrative law judge hearing, or court review are available to me. I also retain any rights available under §1879 and/or 1870 of the Social Security Act, as appropriate.
- understand that the claims from the above-referenced limited audit will not be selected for inclusion in the *statistical sampling for overpayment estimation*; the *statistical sampling for overpayment estimation* will be a new and independent audit.
- understand that the overpayment identified for claims in the limited audit will be pursued on an individual basis, and that this overpayment will be subtracted from any overpayment resulting from the *statistical sampling for overpayment estimation*; that I will be provided with appeal rights regarding the overpayment amount on the claims in the limited audit at a later date; and that any interest on the overpayment amount on the claims in the limited audit will be calculated from the date of this later notice with appeal rights.
- *understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.*

Provider signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Carrier Representative Signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

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

CONSENT SETTLEMENT ATTACHMENT 5: EXTENDED REPAYMENT PLAN (ERP)

It has been determined by an audit that there is a potential overpayment amount due to Medicare. It is expected that you will remit the entire amount in one payment within thirty (30) days of the date you sign Consent Agreement Option One (Acceptance of Potential Projected Overpayment) or, if you select Consent Agreement Option Two (Acceptance of Capped Potential Projected Overpayment), the date of the final potential overpayment determination, or, if you select Option Three (Election to Proceed to *statistical sampling for overpayment estimation*), the date of the final overpayment determination. However, if you are unable to repay the amount within that time, we are authorized to consider repayment in installments based on validated financial hardship. **[Installments are based on the amount of the overpayment as stated in *Financial Management, Chapter 4, §§20, 30*.]** Installments can range from 2-6 months based on the amount of overpayment. Be aware that if repayment is not made within thirty (30) days, interest will be due. For Option One, interest accrues from the date you sign Consent Agreement Option One or, if you select Consent Agreement Option Two, interest accrues from the date of the final potential overpayment determination, or if you elect Option Three, interest accrues from the date of the final overpayment determination (See 42 CFR 405.37*8*.). Interest will be waived if repayment is made within thirty (30) days of the applicable date cited above for the option chosen. The current rate of interest is _____ percent. If you wish to claim financial hardship, contact _____ to obtain the financial statement of debtor form (*CMS*-379). This form must be completed and returned with your request for approval of an installment schedule. If compliance with the above is not acceptable to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.

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

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

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

[DATE]

[NAME AND ADDRESS OF PROVIDER]

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

Dear [PROVIDER]:

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

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

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

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

[NAME]

[TITLE]

[AGENCY]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

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

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

Sincerely,

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

B: Notice Prior to Suspension:

[DATE]

[NAME AND ADDRESS OF PROVIDER]

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

Dear [PROVIDER]:

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

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

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

Pursuant to 42 CFR 405.372(b)(2), you have the right to submit a rebuttal statement in writing *within fifteen (15) days* addressing why the suspension should not be initiated or should be removed. You may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be initiated or should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER]

[FAX NUMBER]

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

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

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

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

Sincerely,

[NAME]

[TITLE]

[AGENCY]

[MAILING ADDRESS]

[CITY, STATE, ZIP]

[TELEPHONE NUMBER][FAX NUMBER]

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

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

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

Heading	Description of Information to Include
Summary of Original Allegations/Complaint	Date complaint was received; who made complaints; how actions were taken to corroborate information

Source	(pulled bills and payment information, contacted complainant); overpayment identified by complaint.
Citations	Code of Federal Regulation; Manual Provisions
Identify the Amount of the Actual Overpayment Established	Detail claim information related to allegation; i.e., number of claims submitted/paid; amount paid/ procedure codes involved; pertinent profile information.
Estimated Additional Overpayment/Scope of Alleged Fraud	Be specific on how this estimated amount was determined, i.e., billing for specialized procedure and the total number of these procedures that were billed; therefore, if all were false, the overpayment would be $_____ dollars.
Billing Information (Last 3 Years)	(Report Data For Questions Procedures and Total Billings)19__ 19__ 19__ • Total covered charges-Part A; • Total non-covered charges; • Total DRG payments; • Total Admissions; and, • Total Medicare admissions. • National pass-through costs, SNF or HHAs - Under reasonable cost payment (last 3 years): • Total costs; • Total allowable costs; • Total Medicare payment; • Total patient days; and • Total Medicare patient days.
Medicare Coverage/Intermediary Payment Guidelines Summarized	Be specific as to the Medicare coverage issue involved. Define necessary medical terms and describe the necessary medical procedures in layman's terms. Procedure code description.
Identify Copies of All Correspondence, Newsletters, Publications	Briefly summarize all newsletters, publications, and/or correspondence related to the issue at hand. Attach a copy of each.
Additional Development	• Summarize the information received through

	interviews that corroborate the original complaint. Attach interview reports and copies of Medicare claims used to arrive at this summary. • Summarize new allegations identified. Attach interview reports and copies of Medicare claims used to arrive at this summary. • Summarize the information obtained that appears to refute the original allegation or new allegations identified.
Background Information on Subject	Date of birth; any known disabilities; schools attended; State licenses; number of employees and names; previous investigation by contractor; previous complaint history; all other pertinent information.
Telephone Number(s)	
Specialty	
EIN/SSN	(Include **ALL** tax identification numbers)
Provider Number(s)	Date Issued; Related Numbers; and, Application (If required)
Details of Past Complaints (If Identified Above)	Summarize complaint history, including the details of actions taken and all other pertinent information.
Detailed Correspondence History with Subject	• Summarize all direct correspondence with subject regarding the allegation at hand (if contacted) and/or all other correspondence related to allegation(s) at hand. • Alert OI to any congressional or press interest, or any public relations problem.
Other Agencies Involved	• If a referral has been made to any other agency, such as the licensing board of a State or a State Medicaid agency, show when it was done and who that material was directed

to. Attach any correspondence sent to those agencies; and

- If aware of any other agency investigating the subject, include that information.

Other Pertinent Information

- Is this provider/facility a member of a chain within and/or outside the area? If so, identify the chain and all other facilities it owns or manages in the area;
- List all related organizations. Specify whether they were identified by the provider or uncovered through audit;
- What is the subject's filing history? Were the bills denied? Why? Were the denials appealed? Who requested an appeal, and through what mechanism was the appeal requested? What was the outcome of the appeal? Were determinations made by a Hearing Officer and/or an Administrative Law Judge;
- Was a review of services done on the areas where this subject exceeded the norm of his peers? For example, if the complaint was for non-rendered lab work, did the subject exceed the norm in that area? List the areas as items that may need to be investigated; and
- List other items known that would assist the OIG in evaluating this case.

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

List of Attachments

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

Retain a copy of the summary in the case file.

Exhibit 17 – *Reserved for Future Use* - (Rev.)

Exhibit 18 – *Reserved for Future Use* - (Rev.)

Exhibit 19 – *Reserved for Future Use* - (Rev.)

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

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

Associated Hospital Services of Maine

Connecticut	Maine	Massachusetts
New Hampshire	Rhode Island	Vermont

Palmetto Government Benefits Administration

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

Blue Cross of California

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

United Government Services

Michigan	Minnesota	New Jersey	New York
Puerto Rico	Virgin Islands	Wisconsin	

Wellmark, Inc

Colorado	Delaware	District of Columbia	Iowa
Kansas	Maryland	Missouri	Montana
Nebraska	North Dakota	Pennsylvania	South Dakota
Utah	Virginia	West Virginia	Wyoming

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

Street Address	Mailing Address	States
BOSTON: Room 1405 JFK Federal Bldg. Boston, MA 02203 (617) 565-2660	HHS, OS, OIG, OI P.O. Box 8767 Boston, MA 02114	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
NEW YORK Room 3900 B Federal Building New York, NY 10278 (212) 264-1691	HHS, OS, OIG, OI P.O. Box 3209 Church St. Station New York, NY 10008	New Jersey New York Puerto Rico Virgin Islands
PHILADELPHIA Room 4430 3535 Market Street Philadelphia, PA 19104 (215) 596-6796	HHS, OS, OIG, OI P.O. Box 8049 Philadelphia, PA 19101	Delaware Pennsylvania West Virginia Maryland Except: - Prince Georges County - Montgomery County Virginia Except: - Fairfax County - Arlington County - City of Alexandria - City of Falls Church
ATLANTA Room 1404 101 Marietta Tower	HHS, OS, OIG, OI P.O. Box 2288 Atlanta, GA 30301	Alabama Florida Georgia

Atlanta, GA 30323 (404) 331-2131/2556		Kentucky Mississippi North Carolina South Carolina Tennessee
CHICAGO 23rd Floor 105 West Adams St. Chicago, IL 60603 (312) 353- 2740	HHS, OS, OIG, OI 23rd Floor 105 West Adams Street Chicago, IL 60603	Illinois Indiana Michigan Minnesota Ohio Wisconsin Missouri Iowa
DALLAS Room 4E1B 1100 commerce St. Dallas, TX 75242 (214) 767-8406	HHS, OS, OIG, OI Room 4E1B 1100 Commerce St. Dallas, TX 75242	Arkansas Louisiana New Mexico Oklahoma Texas
DENVER Room 327 1961 Stout Street Federal Office Bldg. Denver, CO 80294-3546 (303) 844-5621	HHS, OS, OIG, OI 1961 Stout Street Denver, CO 80294-3546	Colorado Kansas Montana Nebraska North Dakota South Dakota Wyoming</> Utah
SAN FRANCISCO Room 174 50 U.N. Plaza San Francisco, CA 94102 (415) 556-8880	HHS, OS, OIG, OI P.O. Box 42516 San Francisco, CA 94142-2516	Arizona California Guam Hawaii Nevada Samoa
SEATTLE SUB OFFICE Room 209, RX-81 2201 Sixth Avenue Seattle, WA 98121 (206) 442-0547	HHS, OS, OIG, OI P.O. Box 61220 Seattle, WA 98121	Alaska Idaho Oregon Washington
WASHINGTON, D.C. Field Office Room 5193 Cohen Bldg. 330 Independence Av. SW	HHS, OS, OIG, OI Room 5193 Cohen Bldg. 330 Independence Av SW Washington, DC	District of Columbia Maryland Counties: - Prince Georges - Montgomery Counties - Virginia Counties Virginia Cities

Washington, DC 20201 - Alexandria
20201 - Falls Church
(202) 619-1900

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

Acronym	Meaning
ABG	Arterial Blood Gas
ABN	Advanced Beneficiary Notice
AC	*Affiliated Contractor*
ADL	Activities of Daily Living
ADMC	Advance Determination of Medicare Coverage
AIDE	Home Health Aide
AKA	Also Known As
ALJ	Administrative Law Judge
AMA	American Medical Association
AoA	Administration on Aging
ASC	Ambulatory Surgical Center
AUSA	Assistant United States Attorney
BESS	Part B Extract Summary System
BI	Benefit Integrity
CAC	Carrier Advisory Committee
CBR	Cost Benefit Ratio
CFO	Chief Financial Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMD	Contractor Medical Director
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalties Law
CMR	Comprehensive Medical Review
CMS	*Centers for Medicare & Medicaid Services*
CO	Central Office
COB	Coordination of Benefits

CORF	Comprehensive Outpatient Rehabilitation Facility
CPE	Contractor Performance Evaluation
CPT	Current Procedural Terminology
CWF	Common working File
DAP	DMERC Advisory Panel
DBA	Doing Business As
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, and Orthotic Supplier
DMERC	Durable Medical Equipment Regional Carrier
DOJ	Department of Justice
DRG	Diagnosis Related Groups
DX	Diagnosis
EMC	Electronic Media Claims
EOMB	Explanation of Medicare Benefits
EPO	Epoetin
ESRD	End Stage Renal Dialysis
FBI	Federal Bureau of Investigation
FHIBA	Federal Health Insurance Benefits Accounts
FI	Fiscal Intermediary
FID	Fraud Investigation Database
FMR	Focused Medical Review
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GPRA	Government Performance Results Act
GTL	*Government Task Leader*
HCFA	Health Care Financing Administration
HCIS	*Healthcare* Customer Information System
HCPCS	*Healthcare* Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
HI	Health Insurance
HICN	Health Insurance Claim Number

HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HO	Hearings Officer
ICN/DCN	Internal Control Number/Document Control Number
IER	Interim Expenditure Report
IRP	Incentive Reward Program
IRS	Internal Revenue Service
LMRP	Local Medical Review Policy
MCM	Medicare Carrier Manual
MFCU	Medicaid Fraud Control Unit
MFIS	Medicare Fraud Information Specialist
MFSR	Medicare Focused Medical Review Status
MIM	Medicare Intermediary Manual
MIP	Medicare Integrity Program
MIP-PET	Medicare Integrity Program-Provider Education and Training
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSS	Medical social Services
N/A	Not Applicable
NCP	National Coverage Policy
NMFA	National Medicare Fraud Alert
NOU	Notice of Utilization
NPR	National Performance Review
NSC	National Supplier Clearinghouse
OCIG	*Office of Counsel to the Inspector General*
OCSQ	Office of Clinical Standards and Quality
OIFO	Office of Investigations Field Office
OIG	Office of Inspector General
OIGOAS	Office of Inspector General Office of Audit Services
OIG/OI	Office of Inspector General Office of Investigations
OP	Outpatient
OPT	Outpatient Physical Therapy
OT	Occupational Therapy

PAL	Provider Audit List
PI	Program Integrity
PIM	Program Integrity Manual
PIN	Provider Identification Number
PIP	Periodic Interim Payments
PM	Program Memorandum
PM-PET	Program Management-Provider Education and Training
POC	Plan of Care
PPAC	Practicing Physicians Advisory Council
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PSC	*Program Safeguard Contractor*
PS&R	Provider Statistical and Reimbursement
PT	Physical Therapy
PTS	Provider Tracking system
QA	Quality Assurance
QIO	*Quality Improvement Organization*
RBS	Report of Benefit Savings
RCCO	Regional Chief Counsel's Office
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RMFA	Restricted Medicare Fraud alert
RMRP	Regional Medical Review Policy
RO	Regional Office
ROM	Range of Motion
RRB	Railroad Retirement Board
RT	Record Type
RVU	Relative Value Unit
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SLP	Speech-Language Pathology
SMI	Supplementary Medical Insurance
SME	*Subject Matter Expert*
SN	Skilled Nursing

SNF	Skilled Nursing Facility
SOC	Start of Care
SSA	Social Security Administration
SSAFO	Social Security Administration Field Office
ST	Speech Therapy
SUR	State Utilization Review Units
the Act	the Social Security Act
TOB	Type of Bill
TPN	Total Parenteral Nutrition
UPIN	Unique Physician Identification Number

Exhibit 25 – *Procedures and Forms for Obtaining Protected Health Information*

Office of the Director

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

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

MEMORANDUM -Sent via Electronic Mail

DATE: April 11, 2003

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

FROM: Guy A. Lewis
Director

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

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

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

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

New medical privacy rules (located at 45 C.F .R., Parts 160 and 164) take effect on Monday, Apri114, 2003. These rules will affect all Assistant United States Attorneys (AUSAs) who obtain medical information in the course of their work.

In order to assist AUSAs, the Executive Office for United States Attorneys (EOUSA) and the Civil and Criminal Divisions of the Department of Justice have prepared form materials which can be used to obtain medical records in law enforcement and health oversight investigations. Attached is a WordPerfect document titled "Updated Process, Model Letters, and Forms to Request Protected Health Information Pursuant to the HIPAA Privacy Regulation." This document includes (1) a description of the process for obtaining Centers for Medicare and Medicaid Services (CMS) data after Apri114, 2003; (2) a form letter to be used in requesting information from CMS contractors; (3) a form letter to be used in requesting protected health information from entities other than CMS contractors (including federal agencies in affirmative civil and criminal health care fraud cases; and (4) potential paragraphs to be inserted in letters, subpoenas, or other forms of legal process requesting production of protected health information.

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

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

If you have any questions regarding implementation of the privacy regulations, you may contact one of the people listed below:
Dan Anderson (Affirmative Civil)
Civil Division
(202) 616-2451

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

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

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

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

3

Sherri Keene (Civil DefensiveIFTCA)
Civil Division
(202) 616-4272

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

Attachments

cc: All United States Attorneys' Secretaries

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

Table of Contents

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

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

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

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

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

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

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

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

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

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

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

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

USE DEPARTMENT OF JUSTICE LETTERHEAD

[DATE]

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

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

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

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

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

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

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

Dear [insert name]:

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

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

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

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

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

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

Sincerely,

[name, title, and office of DOJ official]

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

[DATE]

Re: Request for production of protected health information

Dear [insert name]:

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

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

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

Sincerely,

[name, title, office of DOJ official]

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

HEALTH OVERSIGHT

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

REQUIRED BY LAW[3]

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

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

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

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

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

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

WHISTLEBLOWERS/VICTIMS OF WORKPLACE CRIME

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

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

OR

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

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

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

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

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

OR

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

OR

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

OR

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

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

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

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

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

OR

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

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

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

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

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

OR

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

OR, EITHER

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

OR

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

Locate and Identify

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

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

Decedents

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

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

Correctional institutions and other law enforcement custodial situations

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

Judicial/Administrative

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

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

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

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

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

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

No objections were filed, or

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

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

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

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

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

Minimum Necessary

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

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

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

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

Insert Only When Suspension of Notification to Individual is Desired

The protected health information concerning the patients

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

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

OR

(ii) which is disclosed in response to the accompanying

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

PATIENT AUTHORIZATIONS

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

NOTE:

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

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

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:	***PATIENT:***	***RELEASE TO:***
[Name of person or class of persons authorized to make disclosure]	*NAME:* *BIRTH DATE:*	*Representatives of the United States Attorney's Office or Department of Justice*

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

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

2. Billing records

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

[Include case name or identify administrative claim]

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

EXPIRATION:

Check one:

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

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

__ This Authorization shall be effective until _____.

OTHER CONDITIONS:

__x__ A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x__ Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

_____

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

_____ _____

MONTH/DAY/YEAR *PRINT OR TYPE NAME*

**Provide basis of Authorization:*_____
.

PATIENT AUTHORIZATION TO RELEASE PSYCHOTHERAPY INFORMATION

TO:	***PATIENT:***	***RELEASE TO:***
[Name of person or class of persons authorized to make disclosure]	*NAME:* *BIRTH DATE:*	*Representatives of the United States Attorney's Office or Department of Justice*

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

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

2. Billing records.

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

[Include case name or identify administrative claim]

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

EXPIRATION:

Check one:

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

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

___ The Authorization shall be effective until _____.

__ *This Authorization shall be effective until _____.*

OTHER CONDITIONS:

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

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

SIGNATURE OF PATIENT:

_____

OR PERSON AUTHORIZED TO SIGN FOR PATIENT:*_____

_____ _____

MONTH/DAY/YEAR *PRINT OR TYPE NAME*

**Provide basis of Authorization:*_____.

EXHIBIT 26 - DOJ Report (Excel Spreadsheet)--(Rev. 16, 11-28-01)

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

Exhibit 27 - National Medicare Fraud Alert -- (Rev. 32, 10-25-02)

National Medicare Fraud Alert Template

Date

Distribution of this Fraud Alert is Limited to the Following Audience: CMS Regional Offices, All Medicare Carrier and Intermediary benefit integrity units, Program Safeguard Contractors, Medicare Integrity Program (MIP) Units, Peer Review Organizations, Medicaid Fraud Control Units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Insurance Division

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION:

FID CASE (S):

STATUS:

CONTACT:

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

CMS NMFA 2002-01

Exhibit 28 - Restricted Medicare Fraud Alert -- (Rev. 32, 10-25-02)

RESTRICTED MEDICARE FRAUD ALERT TEMPLATE

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this alert. Distribution is Limited to the Following Audience:CMS Regional Offices, Medicare Carrier and Intermediary benefit integrity units, Program Safeguard Contractors and Medicare Integrity Program Units, Peer Review Organizations, Medicaid Fraud Control Units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspector Offices, and the Internal Revenue Service.

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION:

FID CASE (S):

STATUS:

CONTACT:

NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT PURSUANT TO EXEMPTION (b)(2), (b)(5) AND (b)(7)(E) OF THE FOIA. ITS CONTENTS SHOULD NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN APPROVAL OF THE BENEFITS INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.
THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS RMFA 2002-01

Exhibit 29 - Description of Items Contained on Form CMS-485 (Rev. 23, 03-18-02)

The following items are contained on the Form CMS-485:

No	Data Element	Description:
1	Patient's HICN	The HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.
2	SOC Date	The HHA enters the month, day, year on which covered home health services began, i.e., MMDDYYYY (03012000). The SOC date is the first Medicare billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health may be suspended and later resumed under the same SOC date in accordance with the HHA's internal procedures.

3	Certification Period	a. For Dates of Service before the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period. EXAMPLE: Initial certification "From" date 03012000; Initial certification "To" date 05012000; Re-certification "From" date 05012000; Re-certification "To" date 07012000. b. For Dates of Service on or after the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY, that identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed, 60 days. EXAMPLE: Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001. NOTE: Services delivered on 11292000 are covered in the initial certification episode.
4	Medical Record No	This is the patient's medical record number that is assigned by the HHA and is an ***optional*** item. If not applicable, the agency enters "N/A."
5	Provider No.	This is the 6-digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).
6	Patient's Name and	The HHA enters the patient's last name, first

	Address	name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code.
7	Provider's Name, Address and Telephone No	The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code and telephone number.
8	Date of Birth	The patient's date of birth (month, day, year) in numbers, i.e., MMDDYYYY (04031920) is entered.
9	Sex	The patient's sex is checked in the appropriate box.
10	Medications: Dose, Frequency, Route	The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed. Drugs, which cannot be listed on the plan of care due to lack of space, are listed on an addendum.

- The letter "N" is used after the medication(s) that are "new" orders.
- The letter "C" is used after the medication(s) that are "change" orders either in dose, frequency or route of administration.
- "New" medications are those that the patient has not taken recently, i.e., within the last 30 days.
- "Change" are medications which include dosage, frequency or route of administration changes within the last 60 days.

11	Principal Diagnosis, ICD-9-CM Code and Date of Onset, Exacerbation	The principal diagnosis is the diagnosis most related to the current POC. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered. In certain cases, ICD-9-CM calls for more than one code to report a condition; this requirement, termed "multiple coding of

diagnoses," often involves both a disease and one of its manifestations. The ICD-9-CM manual clearly shows the instances where manifestation coding is required. These codes must appear in their proper sequence as the first secondary diagnosis. ICD-9-CM sequencing requirements for manifestation codes are indicated in two ways in the ICD-9-CM manual. First, manifestation codes are indicated in the index to diseases where two codes are listed after a specific condition, with the second code in brackets. Second, manifestation codes are indicated in the tabular list where codes appear in italicized letters. Codes italicized in the tabular list can never appear in the primary diagnosis field, and must be preceded by the code for the underlying condition. Every italicized code in the tabular list is accompanied by instructions to report the code for the etiology first.

Using the ICD-9-CM coding guidelines, the HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. Prior to the effective date of HH PPS, V codes are acceptable as primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. After the implementation of HH PPS, the primary diagnosis must match on the POC, the OASIS, and the UB-92. In addition, V codes are NOT acceptable as primary or first secondary diagnoses, but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code.

EXAMPLES: (Prior to the effective date of HH PPS): 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture.

2) Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the

proposed services.

EXAMPLES: (After the effective date of HH PPS): 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Her past medical history includes controlled HTN but the patient currently has chronic urinary tract infection (on medication) that the nurse will monitor for treatment effectiveness. Admission to home care is for rehabilitation following the hip fracture and surgery. The physician orders the agency to provide PT for gait training and exercise 3 times per week for four weeks. The HHA uses 781.2, abnormality of gait as the primary diagnosis and 599.0, urinary tract infection, site not specified; additional code to identify organism, if known; and V57.1, physical therapy.

Discussion: The treatment is directed at rehabilitation following the hip fracture and surgery. OASIS instructs home care agencies to code the relevant medical diagnosis when a V code for rehabilitation therapy (followed by a symptom code for abnormality of gait) would normally be assigned. Although the hip fracture is the medical diagnosis relevant to the surgery, and would be equally acceptable under OASIS logic, we chose abnormality of gait because it more accurately describes her current condition and need for therapy (i.e., technically, she no longer has a hip fracture, which was resolved by the hospital surgical treatment) and because the physician specified gait training. If the plan of care called for the nurse or physical therapist to also carry out wound care, then the V-code for attention to surgical dressings and sutures (V59.3) would be added.

2) Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Even though V55.3 is more specific to the nature of the proposed service, the HHA must use code 153.2 as the primary diagnosis and may use V55.3 as a second secondary diagnosis or in field 21.

Reporting the Principle Diagnosis on the POC must comply with the OASIS reporting restrictions, agencies should report the medical diagnosis relevant to the surgery for M0230/M0240 when V-codes for post-operative wound care would otherwise be used. Agencies should reserve injury and poisoning ICD-9 codes (categories 800-995) for injuries from accidents or violence. Surgical complications codes are available from ICD-9, however, they should not be used inappropriately to fill the gap left by the OASIS restrictions. The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an

exacerbation of a secondary diagnosis requiring intensive services different than those on the established POC.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

12	Surgical Procedure, Date, ICD-9-CM Code	The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.52, Partial Hip Replacement, 060998).

If a surgical procedure was not performed or is not relevant to the POC, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

13	Other Pertinent Diagnoses: Dates of Onset/Exacerbation ICD-9-CM Code	Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established, or which developed subsequently, or that affect the treatment of care. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC. It is expected that these diagnoses include not only conditions active with the patient, but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnosis that are of mere historical interest and without impact of patient progress or outcome.

These diagnoses can be changed to reflect changes in the patient's condition. However, they must match the diagnoses listed on the OASIS and the UB-92, and conform with the ICD-9-CM coding guidelines.

In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. However, there may be exceptions to this rule, dictated by ICD-9-CM coding sequencing requirements. For example, if a principle diagnosis exists which dictates the utilization of a specific secondary diagnosis, then the agency should list this secondary diagnosis first in the list of "other pertinent diagnoses". If there are

more than four pertinent secondary diagnoses, use an addendum to list them. Enter N/A if there are no pertinent diagnoses.

The date reflects either the date of onset if it is a new diagnosis or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

14	DME and Supplies	All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that it is billing to Medicare that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies, which would vary by patient. Therefore, the non-routine supplies would be listed.

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the RHHI can request a breakdown of kit components.

RHHIs should reference the HIM 11, §206.4 for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

15	Safety Measures	The physician's instructions for safety measures are listed.
16	Nutritional Requirements	The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item or under medications if more space is needed.
17	Allergies	Medications to which the patient is allergic

		are listed. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.
18A	Functional Limitations	All items that describe the patient's current limitations as assessed by the physician and the agency are indicated.
18B	Activities Permitted	The activity(ies) that the physician allows and/or for which physician orders are present are indicated.

If "Other" is checked under Item 18A or 18B, a narrative explanation is required.

19	Mental Status	The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, the patient's condition is specified here.
20	Prognosis	A check is placed in the box, which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent.

NOTE: The number or letter adjacent to the blocks in Items 18 though 20 correspond to the codes for EMC transmission only.

21	Orders for Discipline and Treatments (Specify Amount, Frequency, Duration)	The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: SN, PT, ST, OT, MSS, or AIDE.

Orders must include all disciplines and treatments, even if they are not billable to Medicare. In general, the narrative explanation for applicable treatment codes is acceptable as the order when that narrative is sufficiently descriptive of the services to be furnished. However, additional explanation is required in this item to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Additional explanation is also required where the physician has ordered specific treatment, medications or supplies. When aide services are needed to furnish personal care, an order for "personal care" is sufficient. See example of orders below.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

A range of visits may be reflected in the frequency (e.g., 2 to 4 visits per week). When a range is used, consider the upper limit of the range the specific frequency. An agency may use ranges if acceptable to the physician without regard to diagnosis or other limits.

Example of Physician's Orders: Certification period is from 03012000 - 05012000:

OT - Eval., Activities of Daily Living (ADL) training, fine motor coordination 3x/wk x 6wks

ST - Eval., speech articulation disorder treatment 3x/wk x 4wks

SN - Skilled observation and assessment of C/P and neuro status instruct meds and diet/hydration 3x/wk x 2wks

MSS - Assessment of emotional and social factors 1x/mo x 2mos

AIDE - Assist with personal care, catheter care 3x/wk x 9wks

Specific services rendered by physical, speech and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

EXAMPLE: PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2wks.

PRN visits may be ordered on a plan of treatment only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the plan of care. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature nor the frequency of the service is specified.

EXAMPLE: Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.

22	Goals/Rehabilitation Potential/Discharge Plans	This reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.

Examples of realistic goals:

- Independence in transfers and ambulating with walker;
- Healing of leg ulcer(s);
- Maintain patency of Foley catheter. Decrease risk of urinary infection;
- Achieve optimal level of cardiovascular status. Medication and diet compliance; and
- Ability to demonstrate correct insulin preparation/administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond. The words "Fair," or "Poor" alone, are not acceptable. Instead, descriptors must be added:

EXAMPLE: Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

23	Nurse's Signature and Date of Verbal Start of Care	This verifies for surveyors, CMS' representatives, and the RHHI that a registered nurse, qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker), or any health professional responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient. This date **may** precede the SOC date in Item 2 and may precede the "From" date in Item 3.

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who

receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. The HHA enters N/A if the physician has signed and dated Form CMS-485 on or before the SOC or re-certification date, or has submitted a written order to start, modify, or continue care on a document other than Form CMS-485.

24	Physician's Name and Address	The agency prints the physician's name and address. The attending physician is the physician who established the plan of treatment and who certifies and re-certifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the addendum only. The physician must be qualified to sign the certification and plan of care in accordance with 42 CFR 424 Subpart B. Physicians who have significant ownership interest in, or a significant financial or contractual relationship with an HHA may not establish or review a plan of treatment or certify or re-certify the need for home health services.
25	Date HHA Received Signed Plan of Care	The date the agency received the signed POC from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27 DATE is completed.
26	Physician Certification	This statement serves to verify that the physician has reviewed the POC and certifies to the need for the services.
27	Attending Physician's Signature and Date	The attending physician signs and dates the plan of care/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require

		verification of an original signature. HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, State surveyor, or other authorized personnel or in the event of a system breakdown.

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POC under Item 25.

28	Penalty Statement	This statement specifies the penalties imposed for misrepresentation, falsification or concealment of essential information on the Form CMS-485.

Exhibit 30 - Treatment Codes (Rev. 23, 03-18-02)

A -- Skilled Nursing

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

A1 *	Skilled Observation and Assessment (Inc. V.S., Response to Med., etc)	Includes all skilled observation and assessment of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)
A2	Foley Insertion	Insertion and/or removal of the Foley catheter by nurse.

A3	Bladder Instillation	Instilling medications into the bladder.
A4*	Open Wound Care/Dressing	Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) on an addendum, when necessary. See A28 for observation uncomplicated surgical incision.
A5*	Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss, etc.)	Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance on an addendum when necessary. Use this code only if the decubitus being treated presents the following characteristics: 1 -- Partial tissue loss with signs of infection such as foul odor or purulent drainage; 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone. For care of decubitus not meeting this definition, see A29.
A6*	Venipuncture	The HHA specifies the test and frequency to be performed under physician's orders.
A7*	Restorative Nursing	Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g., routine range of motion exercises).
A8	Post Cataract Care	Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.4.A.)
A9	Bowel/Bladder Training	Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified. (See MIM §3114.4.E.1.)
A10	Chest Physio (Including postural drainage)	Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.

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

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

		achieve their purpose, and to promote the beneficiary's recovery and medical safety.
A32*	Teaching and Training (other) (spec. under Orders)	Specify under physician orders.

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

B -- Physical Therapy (PT)

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

B1	Evaluation	Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).
B2	Therapeutic Exercise	Exercises designed to restore function. Specific exercise techniques (e.g., Proprioceptive Neuromuscular Facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques, which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion.
B3	Transfer Training	To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques.
B4	Establish or Upgrade Home Program	To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as

		an adjunct to PT programs.
B5	Gait Training	Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.).
B6	Pulmonary Physical Therapy	Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction.
B7	Ultra Sound	Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.
B8	Electro Therapy	Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, Transcutaneous Electrical Nerve Stimulation (TENS), Functional Electrical Stimulation (FES), biofeedback, High Voltage Galvanic Stimulation (HVGS), etc.).
B9	Prosthetic Training	Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.
B10	Fabrication Temporary Devices	Includes fabrication of temporary prostheses, braces, splints, and slings.
B11	Muscle Re-education	Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.
B12	Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.

B13	Reserved	
B14	Reserved	
B15	Other (Spec. Under Orders)	Includes all PT services not identified above. Specific therapy services are identified under physician's orders (Form CMS-485, Item 21).

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

C -- Speech Therapy (ST)

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

C1	Evaluation	Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
C2	Voice Disorders Treatments	Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.
C3	Speech Articulation Disorders Treatments	Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements – usually referred to as apraxia/dyspraxia.
C4	Dysphagia Treatments	Includes procedures designed to facilitate and restore a functional swallow.
C5	Language Disorders Treatments	Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression,

		and/or arithmetical processes.
C6	Aural Rehabilitation	Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.
C7	Reserved	
C8	Non-oral Communications	Includes any procedures designed to establish a non-oral or augmentive communication system.
C9*	Other (Spec. Under Orders)	Speech therapy services not included above. Specify service to be rendered under physician's orders (Form CMS-485, Item 21).

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

D -- Occupational Therapy

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

D1	Evaluation	Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.
D2	Independent Living/Daily Living Skills (ADL Training)	Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.
D3	Muscle Re-education	Includes therapy designed to restore function lost due to disease or surgical intervention.
D4	Reserved	

D5	Perceptual Motor Training	Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities, which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.
D6	Fine Motor Coordination	Refers to the skills and the performance in fine motor and dexterity activities.
D7	Neurodevelop-mental Treatment	Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses, which are coordinated at subcortical and cortical levels.
D8	Sensory Treatment	Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.
D9	Orthotics Splinting	Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.
D10	Adaptive Equipment (Fabrication and Training)	Refers to the provision of special devices that increase independent functions.
D11*	Other	Occupational therapy services not quantified above.

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

E -- Medical Social Services (MSS)

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

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

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

F -- Home Health Aide

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

F1	Tub/Shower Bath	Assistance with tub or shower bathing.
F2	Partial/Complete Bed Bath	Bathing or assisting the patient with bed bath.
F3	Reserved	
F4	Personal Care	Includes shaving of patient or shampooing the hair.
F5	Reserved	
F6	Catheter Care	Care of catheter site and/or irrigations under nursing supervision.
F7	Reserved	
F8	Assist with Ambulation	Assisting the patient with ambulation as determined necessary by the nurse care plan.
F9	Reserved	
F10	Exercises	Assisting the patient with exercises in accordance with the plan of care.
F11	Prepare Meal	May be furnished by the aide during a visit for personal care.
F12	Grocery Shop	May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.
F13	Wash Clothes	This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.
F14	Housekeeping	Household services incidental to care and which do not substantially increase the time spent by the home health aide.
F15*	Other (Specify Under Orders)	Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Form CMS-485, Item 21.

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

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

View Form CMS-485 **(PDF, 10 KB)**

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

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

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

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

HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM

DATE:

From: (Your Name)_____ Organization:
_____

Address:_____ City:_____ State:_____

Zip:_____

Phone: (With Area Code) Fax # E-Mail (If Applicable)

Beneficiary Name: Medicare #: Medicaid #:
Date of Birth:

Address: Phone #: (With Area Code)

City: State: Zip:

Name of Complainant (If Different From Beneficiary):

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

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

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

Date(s) of Service:

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

Provider Number:

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

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

Non-rendered Services Section:

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

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

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

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

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

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

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

_____ _____

Signature *Date*

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

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

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

STRUCTURE OF ARGUS.DBF

All Character fields are to be LEFT JUSTIFIED.

Leading Zeroes and Blanks are to be OMITTED.

All Numeric fields are to be RIGHT JUSTIFIED.

All dates must be in the form YYMMDD.

Field #	Name	HUBC Field#	HUBC Name	Type	Length	Description
1	Carrier	7	Processing Carrier	Character	5	ID of Carrier who processed claim
2	HICN	3	CLAIM NUMBER	Character	12	Claim Number
3	SURNAME	4A	BEN NAME-SURNAME	Character	6	First six positions of Beneficiary's last name
4	F_INITIA	4B	BEN NAME-FIRST INITIAL	Character	1	First initial of Beneficiary's first name
5	DCN	23	DOCUMENT CONTROL NUM	Character	5	Carrier assigned claim control number

6	*PAID_DT*	*26*	*DATE CLAIM PAID/DENIED*	*Numeric*	*6*	*Date claim paid/Denied*
7	*RENDERIN*	*79*	*PROVIDER NUMBER*	*Character*	*10*	*Carrier assigned ID number for the physician performing services*
8	*REFERRIN*	*24*	*REFERRING PHYSICIAN*	*Character*	*14*	*Carrier assigned ID number for the referring, prescribing or ordering physician*
9	*TYPE_SER*	*59*	*TYPE OF SERVICE*	*Character*	*1*	*Represents the type of service as specified by HCFA 0-Whole Blood or Packed Red Cells 1-Medical Care 2-Surgery 3-Consultation 4-Diagnostic X-Ray 5-Diagnostic Laboratory 6-Radiation Therapy 7-Anesthesia 8-Assistance at Surgery 9-Other Medical Service A-Used DME B-High risk Mammography C-Low risk Mammography F-Ambulatory surgical Center (Facility Usage) G-Immunosuppressive drugs received within 12 months of a Medicare covered transplant I-Install purchase DME L – Renal supplier in home M-Monthly Capitation Payment (Dialysis) N-Kidney Donor P-Lump Sum purchase of DME R-Rental of DME T-Psychological*

						Therapy U-Occupational V-Pneumococcal Vaccine W-Physical Therapy Y-Second opinion on Elective Surgery Z-Third opinion on Elective Surgery
10	*PROC_CD*	*68*	*HCPCS PROC CODE*	*Character*	*5*	*HCPCS code used to process claim*
11	*PROC_CD1*	*69A*	*PROC CODE MODIFIER 1*	*Character*	*2*	*Procedure*
12	*PROC_CD2*	*69B*	*PROC CODE MODIFIER 2*	*Character*	*2*	*Code modifier 1 and 2 used to process the claim*
13	*PLACE_SE*	*76*	*PLACE OF SERVICE*	*Character*	*2*	*Field denotes the place of service. 11-Office 12-Home 21-Inpatient Hospital 22-Outpatient Hospital 23-Emergency Room Hospital 24-Ambulatory Surgical Center 25-Birthing Center 26-Military Treatment Facility 31-Skilled Nursing Facility 32-Nursing Facility 33-Custodial Care Facility 34-Hospice 41-Ambulance - Land 42-Ambulance - Air 51-Inpatient Psychiatric Facility 52-Psychiatric Facility Partial Hospitalization 53-Community Mental Health Center 54-Intermediate Care Facility/Mental Retarded 55-Residential Substance*

						Abuse Treatment Facility 56-Psychiatric Residential Treatment Center 61-Comprehensive Inpatient Rehabilitation Facility 62-Comprehensive Outpatient Rehabilitation Facility 65-End Stage Renal Disease Treatment *71-State or local Public Health Clinic 72-Rural Health Clinic 81-Independent Laboratory 99-Other Skilled Facility*
14	*NUMB_SER*	*80*	*NUMBER OF SERVICES*	*Numeric*	*3*	*Total number of services processed for this line item*
15	*UNITS_SE*	*66*	*UNITS*	*Numeric*	*3*	*Total units associated with services needing unit reporting such as miles, anesthesia, time units, volume of oxygen or blood*
16	*FROM_DT*	*77*	*FIRST EXPENSE DATE*	*Numeric*	*6*	*Beginning date of service*
17	*TO_DATE*	*78*	*LAST EXPENSE DATE*	*Numeric*	*6*	*Ending date of service*
18	*EOMB_COD*	*81*	*EOMB ACTION CODE*	*Character*	*2*	*Codes used on EOMB and reported in MCM §7012*
19	*SUBM_CHA*	*70*	*SUBMITTED CHARGE*	*Numeric*	*7*	*Total submitted charge for this line item*
20	*ALLW_CHA*	*71*	*ALLOWED CHARGE*	*Numeric*	*7*	*Total allowed charge for this line item*

21	*PD_PATIE*	*91*	*REIMBURSEMENT PATIENT*	*Numeric*	*7*	*Amount of payment being made to patient*
22	*PD_PROV*	*92*	*REIMBURSEMENT PROVIDER*	*Numeric*	*7*	*Amount of payment being made to provider*
23	*DEDUCT*	*93*	*CASH DEDUCTIBLE APPLIED*	*Numeric*	*3*	*Charged to beneficiary*
24	*PMT_DNL*	*18*	*PAYMENT, DENIAL CODE*	*Character*	*1*	*Code for payment denial. Shows who payment was made to or if claim was denied. 0-Denied 1-Physician/Supplier 2-Beneficiary 3-Both physician, supplier and beneficiary 4-Hospital (hospital based physicians) 5-Both hospital and beneficiary 6-Group Practice Prepayment Plan 7-Other entries (e.g. Employer, union) 8-Federally funded entities 9-PA services A-Beneficiary under limitation of liability B-Physician/Supplier under limitation of liability X-MSP cost avoided Y-IRS/SSA data match project MSP cost avoided*
25	*PHYS-IDENT*	*5*	*UPIN-REFERRING*	*Character*	*6*	*UPIN (Unique Physician Identification Number of Referring PHYS)*
26	*SUPP-IDENT*	*100*	*UPIN-SUPPLIER*	*Character*	*6*	*UPIN (of Physician Supplier Actually Performing/Providing the Service)*
27	*DIAGNOSIS*	*45A*	*DIAG CODE*	*Character*	*5*	*Diagnosis Code*

			PRIMARY			*Primary*
28	*DIAGSEC*	*45B*	*DIAG CODE 1ST SECONDARY*	*Character*	*5*	*Diagnosis Code First Secondary*
29	*DIAG2SEC*	*45C*	*DIAG CODE 2ND SECONDARY*	*Character*	*5*	*Diagnosis Code Second-Secondary.*

Exhibit 35 – Memorandum of Understanding (MOU) with Law Enforcement

DEPARTMENT OF JUSTICE ACCESS TO MEDICARE CONTRACTOR INFORMATION

Combating Medicare fraud is a goal shared by the Department of Justice (DOJ), Department of Health and Human Services Office of the Inspector General (OIG), and the Health Care Financing (HCFA). Investigating and prosecuting such cases typically requires access to information and documents from Medicare contractors. To ensure that law enforcement's need for this information is met consistent with Medicare contractors' other responsibilities, DOJ, OIG, and HCFA agree to the following procedures:

1. *DOJ can request in writing information and documents related to an ongoing civil or criminal health care fraud investigation or prosecution directly from a Medicare contractor. DOJ includes personnel at the Federal Bureau of Investigation (FBI), United States Attorneys Offices, and the Department of Justice in Washington, D.C., including but not limited to the Criminal Division and Civil Division.*

2. *When DOJ requests information from a Medicare contractor, it must notify the Regional OIG in writing.*

   OIG approval is not necessary for DOJ requests for information from a Medicare contractor. OIG notification is intended to prevent duplication in investigative efforts.

3. *HCFA approval is not necessary before a Medicare contractor can provide information requested to DOJ.*

4. *It is presumed that a Medicare contractor will furnish DOJ officials with information and documents related to a civil or criminal health care fraud investigation or prosecution in a timely fashion. However, if a Medicare contractor objects to the request on the basis that it is unduly burdensome in terms of the volume of information requested, the timing of the request, or the format in which DOJ seeks the information, the Medicare contractor may take the following steps:*

   a. *Contact the requesting DOJ official to explain the basis of the objection. All parties agree to make good faith efforts to reach a resolution that accommodates DOJ's legitimate law enforcement needs and the Medicare contractor's budgetary constraints or other needs.*

Legitimate requests include but are not limited to requests for the following documents:

(1) information contained on claim forms and other records maintained on individual providers or suppliers;

(2) billing procedure updates and other Medicare publications furnished to providers or suppliers;

(3) contractor correspondence to and from providers/suppliers;

(4) billing history of beneficiaries;

(5) analysis performed by Fraud and Abuse Units;

(6) data analysis routinely done by Medicare contractors such as utilization reviews.

DOJ recognizes that general data analysis is typically the prerogative of the Medicare contractor and HCFA and, therefore, agrees to limit requests for data analysis not otherwise performed by the Medicare contractor. HCFA recognizes that OIG and DOJ may have legitimate law enforcement needs for data analysis in ongoing investigations and proceedings. Where DOJ requests data analysis not otherwise performed by the contractor, DOJ should discuss the request with the Medicare contractor to explain the need for such analysis and to determine whether there is an alternative format for a contractor to provide the information.

b. Where the FBI has sought the information, the FBI may involve in the resolution a representative of the United States Attorney's Office, DOJ's Criminal Division or Civil Division.

c. If the Medicare contractor and the requesting DOJ official cannot reach an accommodation, then they may seek the intervention of HCFA's Associate Regional Administrator. It is anticipated that such an appeal will be a rare occurrence prevented by reasonable requests and timely and comprehensive responses.

5. Periodic meetings between DOJ, OIG, HCFA regional officials, and the Medicare contractors should be held at the local levels. Similar meetings between DOJ, OIG, and HCFA should be held at the national levels. Such meetings offer an opportunity to discuss trends in fraudulent practices; to devise possible solutions to stopping ongoing fraud; to report the status of DOJ health care fraud cases—consistent with DOJ's enforcement needs and limitations on permissible disclosure of such information; to resolve problems, if any, concerning requests for information; and generally, to foster cooperation among law enforcement, HCFA, and Medicare contractors.

6. DOJ, OIG, and HCFA agree to conduct training to familiarize their respective personnel on the activities and needs of the others.

7. *DOJ will handle the information and documents obtained from Medicare contractors consistent with existing statutory and regulatory provisions protecting confidentiality of patient records including, but not limited to, the Privacy Act of 1974.*

8. *Contractors requiring further instructions or clarification regarding any aspect of this policy, including the application of any statute or regulation, may contact the appropriate Associate Regional Administrator.*

This policy will be revisited six months from the date of its adoption.

/s/
GERALD M. STERN
Special Counsel for Health Care Fraud
Department of Justice

/s/
JUNE GIBBS BROWN
Inspector General
Department of Health and Human Services

/s/
BRUCE VLADECK
Administrator
Health Care Financing Administration

4/29/94
DATE

36 - Overview of the CERT Process

(Rev. 67,02-27-04)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all ACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the ACs' claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the AC or full PSC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate AC or full PSC for follow-up. ACs/full PSCs then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Exhibit 36.1 - CERT File Descriptions For Part A Contractors and Standard Systems

(Rev. 67,02-27-04)

Claims Universe File Format

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

DATA ELEMENT DETAIL

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

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

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill,*** *1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: *Universe Date*

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

Claims Universe File				
Claims Universe Claim Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Internal Control Number	X(23)	7	29	Spaces
Beneficiary HICN	X(12)	30	41	Spaces
Provider Number	X(9)	42	50	Spaces
Type of Bill	X(3)	51	53	Spaces
Claim From Date	X (8)	54	61	Spaces
Claim Through Date	X (8)	62	69	Spaces
Condition Code 1	X (2)	70	71	Spaces
Condition Code 2	X (2)	72	73	Spaces
Condition Code 3	X (2)	74	75	Spaces
Condition Code 4	X (2)	76	77	Spaces
Condition Code 5	X (2)	78	79	Spaces
Condition Code 6	X (2)	80	81	Spaces
Condition Code 7	X (2)	82	83	Spaces
Condition Code 8	X (2)	84	85	Spaces
Condition Code 9	X (2)	86	87	Spaces
Condition Code 10	X (2)	88	89	Spaces
Condition Code 11	X (2)	90	91	Spaces
Condition Code 12	X (2)	92	93	Spaces
Condition Code 13	X (2)	94	95	Spaces
Condition Code 14	X (2)	96	97	Spaces
Condition Code 15	X (2)	98	99	Spaces
Condition Code 16	X (2)	100	101	Spaces
Condition Code 17	X (2)	102	103	Spaces
Condition Code 18	X (2)	104	105	Spaces
Condition Code 19	X (2)	106	107	Spaces
Condition Code 20	X (2)	108	109	Spaces
Condition Code 21	X (2)	110	111	Spaces
Condition Code 22	X (2)	112	113	Spaces
Condition Code 23	X (2)	114	115	Spaces
Condition Code 24	X (2)	116	117	Spaces
Condition Code 25	X (2)	118	119	Spaces
Condition Code 26	X (2)	120	121	Spaces
Condition Code 27	X (2)	122	123	Spaces
Condition Code 28	X (2)	124	125	Spaces
Condition Code 29	X (2)	126	127	Spaces
Condition Code 30	X (2)	128	129	Spaces
PPS Indicator Code	X(1)	130	130	Spaces
Revenue Code Count	S9(3)	131	133	Zero
Revenue Code group:				

Claims Universe File				
Claims Universe Claim Record				
Field Name	*Picture*	*From*	*Thru*	*Initialization*
The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)				
		From *and* ***Thru*** *values relate to the 1st line item*		
Revenue Center Code	*X(4)*	*134*	*137*	*Spaces*
HCPCS	*X(5)*	*138*	*142*	*Spaces*

DATA ELEMENT DETAIL

Claim Header Fields

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

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

Data Element: ***Internal Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*
Validation: *N/A*
Remarks: *Do not include hyphens or spaces*
Requirement: *Required*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*
Validation: *N/A*
Remarks: *Do not include hyphens or spaces*
Requirement: *Required*

Data Element: ***Provider Number***
Definition: *First nine characters of number assigned by the Standard System to identify the billing/pricing provider or supplier*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Type of Bill***

Definition: ***Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code***

Validation: *Must be a valid bill type*

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)

7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be alphanumeric
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim From Date***
Definition: ***The first day on the billing statement covering services rendered to the beneficiary***
Validation: *Must be a valid date*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim Through Date***
Definition: ***The last day on the billing statement covering services rendered to the beneficiary***
Validation: *Must be a valid date*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Condition Code 1***
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16

Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30

Definition: *The code that indicates a condition relating to an institutional claim that may effect payer processing*

Validation: *Must be a valid code as defined in the Intermediary Manual Part 3, Chapter IX - Processing - Reports - Records, Section 3871: MAGNETIC TAPE PROCESSING OF BILLS -- CODING STRUCTURES*

Remarks: *N/A*

Requirement: *Required if claim has a condition code*

Data Element: ***PPS Indicator Code alias Claim PPS Indicator Code***

Definition: *The code indicating whether (1) the claim is Prospective Payment System (PPS), (2) Unknown or (0) not PPS.*

Validation: *0 = Not PPS*
1 = PPS
2 = Unknown

Remarks: *N/A*

Requirement: *Required*

Data Element: ***Revenue Code Count***

Definition: *Number indicating number of revenue code lines on the claim. Include line 1 in the count*

Validation: *Must be a number 01 – 450*

Remarks: *N/A*

Requirement: *Required*

Claim Line Item Fields

Data Element: ***Revenue Code***

Definition: *Code assigned to each cost center for which a charge is billed*

Validation: *Must be a valid National Uniform Billing Committee (NUBC) approved code*

Remarks: *Include an entry for revenue code '0001'*

Requirement: *Required*

Data Element: ***HCPCS***

Definition: *Healthcare common procedure coding system (HCPCS) is a collection of codes that represent procedures, supplies, products, and services that may be provided*

to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels or groups

Validation: *Must be a valid code*
Remarks: *N/A*
Requirement: *Blank or code*

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	***X(5)***	***1***	***5***	***Spaces***
Record Type	***X(1)***	***6***	***6***	***'3'***
Number of Claims	***S9(9)***	***7***	***15***	***Zeroes***

DATA ELEMENT DETAIL

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

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

Data Element: ***Number of Claims***
Definition: *Number of claim records on this file*
Validation: *Must be equal to the number of claims records on the file*
Remarks: *Do not count header or trailer records*
Requirement: *Required*

Sampled Claims Transaction File Format

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

DATA ELEMENT DETAIL

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

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

Data Element: ***Contractor Type***
Definition: ***Type of Medicare contractor(s) included in the file***
Validation: ***Must be 'A' or 'R'***
Where the Type of Bill, 1st position = 3, Claim Type should be 'R'.
Where the Type of Bill, 1st/2nd positions = 81 or 82, Claim Type should be 'R'.
All others will be Claim Type 'A'.
Remarks: ***A = FI only***
R = RHHI only or both FI and RHHI
Requirement: Required

Sampled Claims Transaction File
Sampled Claims Transaction File Detailed Record

Field Name	***Picture***	***From***	***Thru***
Contractor ID	*X(5)*	*1*	*5*
Record Type	*X(1)*	*6*	*6*
Claim Control Number	*X(23)*	*7*	*29*
Beneficiary HICN	*X(12)*	*30*	*41*

DATA ELEMENT DETAIL

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

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

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

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

Sampled Claims Transaction File Format

Sampled Claims Transaction File				
Sampled Claims Transaction File Trailer Record (one record per file)				
Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	***X(5)***	***1***	***5***	***Spaces***
Record Type	***X(1)***	***6***	***6***	***'1'***
Contractor Type	***X(1)***	***7***	***7***	***Spaces***
Number of records	***S9(9)***	***8***	***16***	***0***

DATA ELEMENT DETAIL

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

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

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: ***Number of Records Included***
Definition: *Number of records in the transaction file.*
Validation: *Must be greater than 0 and equal to the number of records on the file.*
Remarks: *Header and trailer records are not included in the file*
Requirement: *Required*

Sampled Claims Resolution File Format

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

DATA ELEMENT DETAIL

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

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

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Number	9(1)	7	7	Zero
Claim Type	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Original Claim Control Number	X(23)	10	32	Spaces
Internal Control Number	X(23)	33	55	Spaces
Beneficiary HICN	X(12)	56	67	Spaces
Beneficiary Name	X(30)	68	97	Spaces
Beneficiary Date of Birth	X(8)	98	105	Spaces
Beneficiary Gender	X(1)	106	106	Spaces
Billing Provider Number	X(9)	107	115	Spaces
Attending Physician Number	X(15)	116	130	Spaces
Claim Paid Amount	9(7)v99	131	139	Zeroes
Claim ANSI Reason Code 1	X(8)	140	147	Spaces
Claim ANSI Reason Code 2	X(8)	148	155	Spaces
Claim ANSI Reason Code 3	X(8)	156	163	Spaces
Claim ANSI Reason Code 4	X(8)	164	171	Spaces
Claim ANSI Reason Code 5	X(8)	172	179	Spaces
Claim ANSI Reason Code 6	X(8)	180	187	Spaces
Claim ANSI Reason Code 7	X(8)	188	195	Spaces
Statement covers From Date	X(8)	196	203	Spaces
Statement covers Thru Date	X(8)	204	211	Spaces
Claim Entry Date	X(8)	212	219	Spaces
Claim Adjudicated Date	X(8)	220	227	Spaces
Condition Code 1	X(2)	228	229	Spaces
Condition Code 2	X(2)	230	231	Spaces
Condition Code 3	X(2)	232	233	Spaces
Condition Code 4	X(2)	234	235	Spaces
Condition Code 5	X(2)	236	237	Spaces
Condition Code 6	X(2)	238	239	Spaces
Condition Code 7	X(2)	240	241	Spaces
Condition Code 8	X(2)	242	243	Spaces
Condition Code 9	X(2)	244	245	Spaces
Condition Code 10	X(2)	246	247	Spaces
Condition Code 11	X(2)	248	249	Spaces
Condition Code 12	X(2)	250	251	Spaces
Condition Code 13	X(2)	252	253	Spaces
Condition Code 14	X(2)	254	255	Spaces
Condition Code 15	X(2)	256	257	Spaces
Condition Code 16	X(2)	258	259	Spaces
Condition Code 17	X(2)	260	261	Spaces
Condition Code 18	X(2)	262	263	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Condition Code 19	*X(2)*	*264*	*265*	*Spaces*
Condition Code 20	*X(2)*	*266*	*267*	*Spaces*
Condition Code 21	*X(2)*	*268*	*269*	*Spaces*
Condition Code 22	*X(2)*	*270*	*271*	*Spaces*
Condition Code 23	*X(2)*	*272*	*273*	*Spaces*
Condition Code 24	*X(2)*	*274*	*275*	*Spaces*
Condition Code 25	*X(2)*	*276*	*277*	*Spaces*
Condition Code 26	*X(2)*	*278*	*279*	*Spaces*
Condition Code 27	*X(2)*	*280*	*281*	*Spaces*
Condition Code 28	*X(2)*	*282*	*283*	*Spaces*
Condition Code 29	*X(2)*	*284*	*285*	*Spaces*
Condition Code 30	*X(2)*	*286*	*287*	*Spaces*
Type of Bill	*X(3)*	*288*	*290*	*Spaces*
Diagnosis Code 1	*X(5)*	*291*	*295*	*Spaces*
Diagnosis Code 2	*X(5)*	*296*	*300*	*Spaces*
Diagnosis Code 3	*X(5)*	*301*	*305*	*Spaces*
Diagnosis Code 4	*X(5)*	*306*	*310*	*Spaces*
Diagnosis Code 5	*X(5)*	*311*	*315*	*Spaces*
Diagnosis Code 6	*X(5)*	*316*	*320*	*Spaces*
Diagnosis Code 7	*X(5)*	*321*	*325*	*Spaces*
Diagnosis Code 8	*X(5)*	*326*	*330*	*Spaces*
Diagnosis Code 9	*X(5)*	*331*	*335*	*Spaces*
ICD9-CM Procedure Code 1	*X(4)*	*336*	*339*	*Spaces*
ICD9-CM Procedure Code 2	*X(4)*	*340*	*343*	*Spaces*
ICD9-CM Procedure Code 3	*X(4)*	*344*	*347*	*Spaces*
ICD9-CM Procedure Code 4	*X(4)*	*348*	*351*	*Spaces*
ICD9-CM Procedure Code 5	*X(4)*	*352*	*355*	*Spaces*
ICD9-CM Procedure Code 6	*X(4)*	*356*	*359*	*Spaces*
ICD9-CM Procedure Code 7	*X(4)*	*360*	*363*	*Spaces*
ICD9-CM Procedure Code 8	*X(4)*	*364*	*367*	*Spaces*
ICD9-CM Procedure Code 9	*X(4)*	*368*	*371*	*Spaces*
ICD9-CM Procedure Code 10	*X(4)*	*372*	*375*	*Spaces*
Claim Demonstration Identification Number	*9(2)*	*376*	*377*	*Zeroes*
PPS Indicator	*X(1)*	*378*	*378*	*Spaces*
Total Line Item Count	*9(3)*	*379*	*381*	*Zeroes*
Record Line Item Count	*9(3)*	*382*	*384*	*Zeroes*
Line Item group: *The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to 150 times for the Record (depending on Record Line Item Count)*				

From *and* ***Thru*** *values relate to the 1st line item.*

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	Picture	From	Thru	Initialization

Field Name	Picture	From	Thru	Initialization
Revenue center code	X(4)	385	388	Spaces
SNF-RUG-III code	X(3)	389	391	Spaces
APC adjustment code	X(5)	392	396	Spaces
HCPCS Procedure Code	X(5)	397	401	Spaces
HCPCS Modifier 1	X(2)	402	403	Spaces
HCPCS Modifier 2	X(2)	404	405	Spaces
HCPCS Modifier 3	X(2)	406	407	Spaces
HCPCS Modifier 4	X(2)	408	409	Spaces
HCPCS Modifier 5	X(2)	410	411	Spaces
Line Item Date	X(8)	412	419	Spaces
Submitted Charge	9(7)v99	420	428	Zeroes
Medicare Initial Allowed Charge	9(7)v99	429	437	Zeroes
ANSI Reason Code 1	X(8)	438	445	Spaces
ANSI Reason Code 2	X(8)	446	453	Spaces
ANSI Reason Code 3	X(8)	454	461	Spaces
ANSI Reason Code 4	X(8)	462	469	Spaces
ANSI Reason Code 5	X(8)	470	477	Spaces
ANSI Reason Code 6	X(8)	478	485	Spaces
ANSI Reason Code 7	X(8)	486	493	Spaces
ANSI Reason Code 8	X(8)	494	501	Spaces
ANSI Reason Code 9	X(8)	502	509	Spaces
ANSI Reason Code 10	X(8)	510	517	Spaces
ANSI Reason Code 11	X(8)	518	525	Spaces
ANSI Reason Code 12	X(8)	526	533	Spaces
ANSI Reason Code 13	X(8)	534	541	Spaces
ANSI Reason Code 14	X(8)	542	549	Spaces
Manual Medical Review Indicator	X(1)	550	550	Spaces
Resolution Code	X(5)	551	555	Spaces
Final Allowed Charge	9(7)v99	556	564	Zeroes
Filler	X(25)	565	589	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

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

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

Data Element: ***Record Number***
Definition: *The sequence number of the record. A claim may have up to three records*
Validation: *Must be between 1 and 3*
Remarks: *None*
Requirement: *Required*

Data Element: ***Claim Type***
Definition: *Type of claim*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = Part A*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: ***Mode of Entry Indicator***
Definition: *Code that indicates if the claim is paper, EMC, or unknown*
Validation: *Must be 'E', 'P', or 'U'*
Remarks *E = EMC*
P = Paper
U= Unknown
Use the same criteria to determine EMC, paper, or unknown as that used for workload reporting
Requirement: *Required*

Data Element: ***Original Claim Control Number***
Definition: *The Claim Control Number assigned to the claim in the universe file. This will be the number assigned by the Standard System to provide a crosswalk to pull all claims associated with the sample claim if a crosswalk is used for the claim.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Internal Control Number***
Definition: *Number currently assigned by the Standard System to uniquely identify the claim*
Validation: *N/A*
Remarks: *This number may be different from the Original Claim Control Number if the standard system has assigned a new Claims Control Number to an adjustment to the claims requested. The number assigned to the adjustment or the original claim control number if no adjustment has been made.*
Requirement: *Required*

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

Data Element: ***Beneficiary Name***
Definition: *Name of the beneficiary*
Validation: *N/A*
Remarks: *First, middle initial, and last names must be strung together to form a formatted name (e.g. John E Doe). If there are more than 30 characters, truncate the last name*
Requirement: *Required*

Data Element: ***Beneficiary Date of Birth***

Definition: *Birth date of the beneficiary*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary Gender***
Definition: *Gender of the beneficiary*
Validation: *'M' = Male, 'F' = Female, or 'U' = Unknown*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Billing Provider Number***
Definition: *First nine characters of number assigned by the Standard System to identify the billing/pricing provider or supplier*
Validation: *Must be present if claim contains the same billing/pricing provider number on all lines*
Remarks: *N/A*
Requirement: *Required for all claims containing the same billing/pricing provider on all lines*

Data Element: ***Attending Physician Number***
Definition: *The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.*
Validation: *N/A*
Remarks: *Left justify*
Requirement: *Required*

Data Element: ***Claim Paid Amount***
Definition: *Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier and represents what CMS paid to the institutional provider, physician, or supplier, i.e., The net amount paid after co-insurance and deductibles.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim ANSI Reason Code 1***
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6
Claim ANSI Reason Code 7
Definition: *Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code.*
Remarks: *Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code*
Requirement: *Report all ANSI reason codes on the bill*

Data Element: ***Statement Covers From Date***
Definition: *The beginning date of the statement*
Validation: *Must be a valid date*

Remarks: Format must be CCYYMMDD

Requirement: Required

Data Element: ***Statement Covers Thru Date***
Definition: *The ending date of the statement*

Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

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

Data Element: ***Claim Adjudicated Date***
Definition: *Date claim completed adjudication, i.e., process date*
Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

Data Element: ***Condition Code 1***
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30
Definition: *The code that indicates a condition relating to an institutional claim that may effect payer processing*
Validation: *Must be a valid code as defined in the Intermediary Manual Part 3, Chapter IX - Processing - Reports - Records, Section 3871: MAGNETIC TAPE PROCESSING OF BILLS -- CODING STRUCTURES*
Remarks: *N/A*
Requirement: *Required if there is a condition code for the bill.*

Data Element: ***Type of Bill***
Definition: ***Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code***
Validation: *Must be a valid bill type*

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

For facility type code 1 thru 6, and 9
1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7
1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)

3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be between 0 and 9

Remarks: *N/A*
Requirement: *Required*

Data Element: ***Diagnosis Code 1***
Diagnosis Code 2
Diagnosis Code 3
Diagnosis Code 4
Diagnosis Code 5
Diagnosis Code 6
Diagnosis Code 7
Diagnosis Code 8
Diagnosis Code 9
Definition: *Code identifying a diagnosed medical condition resulting in one or more items of service*
Validation: *Must be a valid ICD-9-CM diagnosis code*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***ICD9-CM Procedure Code 1***
ICD9-CM Procedure Code 2
ICD9-CM Procedure Code 3
ICD9-CM Procedure Code 4
ICD9-CM Procedure Code 5
ICD9-CM Procedure Code 6
ICD9-CM Procedure Code 7
ICD9-CM Procedure Code 8
ICD9-CM Procedure Code 9
ICD9-CM Procedure Code 10
Definition: *Code identifying a service*
Validation: *Must be a valid ICD-9-CM procedure code*
Remarks: *N/A*
Requirement: *Required if on bill*

Data Element: ***Claim Demonstration Identification Number***
Definition: *The number assigned to identify a demonstration project.*
Validation: *Must be numeric or zeroes*
Remarks: *N/A*
Requirement: *Required only if carried on claim record*

Data Element: ***PPS Indicator***
Definition: *The code indicating whether (1) the claim is Prospective Payment System (PPS) or (0) not PPS.*
Validation: *0 = Not PPS*
1 = PPS
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Total Line Item Count***
Definition: *Number indicating number of service lines on the claim*
Validation: *Must be a number 001 - 450*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Line Item Count***
Definition: *Number indicating number of service lines on this record*
Validation: *Must be a number 001 - 150*
Remarks: *N/A*
Requirement: *Required*

Claim Line Item Fields

Data Element: ***Revenue Center Code***
Definition: *Code assigned to each cost center for which a charge is billed*
Validation: *Must be a valid NUBC-approved code*
Remarks: *Include an entry for revenue code '0001'*
Requirement: *Required*

Data Element: ***SNF RUG-III Code***
Definition: *Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required for SNF inpatient bills*

Data Element: ***APC Adjustment Code***
Definition: *The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code.*

The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.

Validation: *N/A*
Remarks: *Left justify the APC Adjustment Code*
Requirement: *Required*

Data Element: ***HCPCS Procedure Code***
Definition: *The HCPCS/CPT-4 code that describes the service*
Validation: *Must be a valid HCPCS/CPT-4 code*
Remarks: *N/A*
Requirement: *Required if present on bill*

Data Element: ***HCPCS Modifier 1***
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4

HCPCS Modifier 5

Definition: *Codes identifying special circumstances related to the service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required if available*

Element: *Line Item Date*
Definition: *The date the service was initiated*
Validation: *Must be a valid date.*
Remarks: *Format is CCYYMMDD*
Requirement: *Required if on bill and included in the standard system*

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

Data Element: ***Medicare Initial Allowed Charge***
Definition: *Amount Medicare allowed for the service or equipment before any reduction or denial*
Validation: *Must be a numeric value if the standard system can calculate the value, blanks if the standard system cannot calculate the value.*
Remarks: *N/A*
Requirement: *Required if the standard system can calculate the value. Enter blanks if the standard system cannot calculate the value*

Data Element: ***ANSI Reason Code 1***
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 14
Definition: *Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid ANSI ASC claim adjustment codes and applicable group codes*
Remarks: *Format is GGRRRRRR where:*
GG is the group code and RRRRRR is the adjustment reason code
Requirement: *Report all ANSI Reason Codes included on the bill.*

Data Element: ***Complex Manual Medical Review Indicator***
Definition: *Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from*

a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: *Must be 'Y' or 'N'*
Remarks: *Set to 'Y' if service was subjected to complex manual medical review, else 'N'*
Requirement: *Required*

Data Element: ***Resolution Code***
Definition: *Code indicating how the contractor resolved the line.*

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

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

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

Validation: *Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC' or 'REO', 'DENAM', 'REDAM'*
Remarks:
APP = Approved as a valid submission
APPMR = Approved manually routine
APPMC = Approved manually complex
DENMR = Denied manually routine
DENMC = Denied manually complex
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable
REDMR = Reduced manually routine
REDMC = Reduced manually complex
REO = Reduced for non-medical review reasons
DENAM = Denied after automated medical review
REDAM = Reduced after medical review
Requirement: *Required*

Data Element: ***Final Allowed Charge***
Definition: *Final amount paid to the provider for this service or equipment plus patient responsibility.*
Validation: *N/A*
Remarks: *N/A*

Requirement: *Required*

Data Element: ***Filler***
Definition: *Additional space -- use to be determined*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

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

DATA ELEMENT DETAIL

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

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

Data Element: ***Number of Claims***
Definition: *Number of sampled claim resolution records (not number of claims - there may be one to three records per claim) on this file (do not count header or trailer record)*
Validation: *Must be equal to the number of sampled claims resolution records on the file*
Remarks: *N/A*
Requirement: *Required*

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

DATA ELEMENT DETAIL

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

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

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

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

Provider Address File				
Provider Address Detail Record				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'2'*
Sequence Number	*X(1)*	*7*	*7*	*Spaces*
Provider Number	*X(15)*	*8*	*22*	*Spaces*
Provider Name	*X(25)*	*23*	*47*	*Spaces*
Provider Address 1	*X(25)*	*48*	*72*	*Spaces*
Provider Address 2	*X(25)*	*73*	*97*	*Spaces*
Provider City	*X(15)*	*98*	*112*	*Spaces*
Provider State Code	*X(2)*	*113*	*114*	*Spaces*
Provider Zip Code	*X(9)*	*115*	*123*	*Spaces*
Provider Phone Number	*X(10)*	*124*	*133*	*Spaces*
Provider FAX Number	*X(10)*	*134*	*143*	*Spaces*
Provider Type	*X(1)*	*144*	*144*	*Spaces*
Filler	*X(25)*	*145*	*169*	*Spaces*

DATA ELEMENT DETAIL

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

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

Data Element: ***Sequence Number***
Definition: *Number occurrence number of addresses when there are multiple addresses for a provider.*
Validation: *Must be between 1 and 3*
Remarks: *Enter 1 if there is only one address for a provider*
Requirement: *Required*

Data Element: ***Provider Number***
Definition: *Number assigned by the standard system to identify the billing/pricing provider or submitted on the claim to identify the attending physician*
Validation: *N/A*
Remarks: *Left justify*
Requirement: *Required*

Data Element: ***Provider Name***
Definition: *Provider's name*
Validation: *N/A*
Remarks: *This is the payee name of the billing/pricing provider or attending physician Must be formatted into a name for mailing (e. g., Roger A Smith M.D. or Medical Associates, Inc.)*
Requirement: *Required*

Data Element: ***Provider Address 1***
Definition: *First line of provider's address*
Validation: *N/A*
Remarks: *This is the address1of the billing/pricing provider or attending physician*

Requirement: *Required*

Data Element: ***Provider Address 2***
Definition: *Second line of provider's address*
Validation: *N/A*
Remarks: *This is the address2 of the billing/pricing provider or attending physician*
Requirement: *Required if available*

Data Element: ***Provider City***
Definition: *Provider's city name*
Validation: *N/A*
Remarks: *This is the city of the billing/pricing provider or attending physician*
Requirement: *Required if available*

Data Element: ***Provider State Code***
Definition: *Provider's state code*
Validation: *Must be a valid state code*
Remarks: *This is the state of the billing/pricing provider or the attending physician*
Requirement: *Required if available*

Data Element: ***Provider Zip Code***
Definition: *Provider's zip code*
Validation: *Must be a valid postal zip code*
Remarks: *This is the payee zip code of the billing/pricing provider or attending physician Provide 9-digit zip code if available, otherwise provide 5-digit zip code*
Requirement: *Required if available*

Data Element: ***Provider Phone Number***
Definition: *Provider's phone number*
Validation: *Must be a valid phone number*
Remarks: *This is the phone number of the billing/pricing or attending physician. It will not be requested until the Spring of 2002*
Requirement: *Required*

Data Element: ***Provider Fax Number***
Definition: *Provider's fax number*
Validation: *Must be a valid fax number*
Remarks: *This is the fax number of the billing/pricing provider or attending physician*
Requirement: *Provide this information if available*

Data Element: ***Provider Type***
Definition: *1=Billing 2=Attending*
Validation: *Must be a 1 or a 2*
Remarks: *This field indicates whether the provider (whose name, address, and phone number are included in the record) billed the service or referred the beneficiary to the billing provider*
Requirement: *Required*

Data Element: ***Filler***
Definition: *Additional space -- use to be determined*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Provider Address File				
Provider Address Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3 '*
Number of Records	*S9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

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

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

Data Element: ***Number of Records***
Definition: *Number of provider address records on this file (do not count header or trailer record)*
Validation: *Must be equal to the number of provider address records on the file*
Remarks: *N/A*
Requirement: *Required*

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system claims history file. It should not include header or trailer records

Exhibit 36.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 67, 02-27-04)

File Formats *Error! Bookmark not defined.*

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

DATA ELEMENT DETAIL

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

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

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

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

Claims Universe File				
Claims Universe Claim Record				
Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	2"
Claim Control Number	X(15)	7	21	Spaces
Beneficiary HICN	X(12)	22	33	Spaces
Billing Provider	X(15)	34	48	Spaces
Line Item Count	S9(2)	49	50	Zeroes
Line Item group: **The following group of Fields occurs from 1 to 52 Times (depending on Line Item Count).**				
	From and Thru values relate to the 1st line item			
Performing Provider Number	X(15)	51	65	Spaces
Performing Provider Specialty	X(2)	66	67	Spaces
HCPCS Procedure Code	X(5)	68	72	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

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

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

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

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

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

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

Claim Line Item Fields

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

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

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

Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	***X(5)***	***1***	***5***	***Spaces***
Record Type	***X(1)***	***6***	***6***	***'2'***
Claim Type	***X(1)***	***7***	***7***	***Space***
Assignment Indicator	***X(1)***	***8***	***8***	***Space***
Mode of Entry Indicator	***X(1)***	***9***	***9***	***Space***
Original Claim Control Number	***X(15)***	***10***	***24***	***Spaces***
Claim Control Number	***X(15)***	***25***	***39***	***Spaces***
Beneficiary HICN	***X(12)***	***40***	***51***	***Spaces***
Beneficiary Name	***X(30)***	***52***	***81***	***Spaces***
Beneficiary Date Of Birth	***X(8)***	***82***	***89***	***Spaces***
Billing Provider Number	***X(15)***	***90***	***104***	***Spaces***
Referring Provider Number	***X(15)***	***105***	***119***	***Spaces***
Paid Amount	***9(7)v99***	***120***	***128***	***Zeroes***
Claim ANSI Reason Code 1	***X(8)***	***129***	***136***	***Spaces***
Claim ANSI Reason Code 2	***X(8)***	***137***	***144***	***Spaces***
Claim ANSI Reason Code 3	***X(8)***	***145***	***152***	***Spaces***
Claim Entry Date	***X(8)***	***153***	***160***	***Spaces***
Claim Adjudicated Date	***X(8)***	***161***	***168***	***Spaces***
Line Item Count	***9(2)***	***169***	***170***	***Zeroes***
Line Item group:				
The following group of fields occurs from 1 to 52 times (depending on Line Item Count).				
	From and Thru values relate to the 1st line item			
Performing Provider Number	***X(15)***	***171***	***185***	***Spaces***
Performing Provider Specialty	***X(2)***	***186***	***187***	***Spaces***
HCPCS Procedure Code	***X(5)***	***188***	***192***	***Spaces***
HCPCS Modifier 1	***X(2)***	***193***	***194***	***Spaces***
HCPCS Modifier 2	***X(2)***	***195***	***196***	***Spaces***
HCPCS Modifier 3	***X(2)***	***197***	***198***	***Spaces***
HCPCS Modifier 4	***X(2)***	***199***	***200***	***Spaces***
Number of Services	***999v9***	***201***	***204***	***Zeroes***
Service From Date	***X(8)***	***205***	***212***	***Spaces***
Service To Date	***X(8)***	***213***	***220***	***Spaces***
Place of Service	***X(2)***	***221***	***222***	***Spaces***
Type of Service	***X(1)***	***223***	***223***	***Spaces***
Diagnosis Code	***X(5)***	***224***	***228***	***Spaces***
CMN Control Number	***X(15)***	***229***	***243***	***Spaces***
Submitted Charge	***9(7)v99***	***244***	***252***	***Zeroes***
Medicare Initial Allowed Charge	***9(7)v99***	***253***	***261***	***Zeroes***
ANSI Reason Code 1	***X(8)***	***262***	***269***	***Spaces***
ANSI Reason Code 2	***X(8)***	***270***	***277***	***Spaces***
ANSI Reason Code 3	***X(8)***	***278***	***285***	***Spaces***
ANSI Reason Code 4	***X(8)***	***286***	***293***	***Spaces***
ANSI Reason Code 5	***X(8)***	***294***	***301***	***Spaces***

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

DATA ELEMENT DETAIL

Claim Header Fields

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

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

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

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

Data Element: *Mode of Entry Indicator*
Definition: ***Code that indicates if the claim is paper or EMC***
Validation: ***Must be 'E' or 'P'***
Remarks: ***E = EMC***
P = Paper
Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: Required

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

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

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

Data Element: *Beneficiary Name*
Definition: ***Name of the beneficiary***
Validation: ***N/A***
Remarks: ***First, middle and last names must be strung together to form a formatted name (e.g., John E Doe)***
Requirement: Required

Data Element: *Beneficiary Date of Birth*
Definition: ***Date on which beneficiary was born.***
Validation: ***Must be a valid date***
Remarks: ***Month, day and year on which the beneficiary was born***
Requirement: Required

Data Element: *Billing Provider Number*
Definition: ***Number assigned by the standard system to identify the billing/pricing provider or supplier.***
Validation: ***Must be present if claim contains the same billing/pricing provider number on all lines***
Remarks: ***N/A***
Requirement: Required for all claims, assigned and non-assigned, containing the same billing/pricing provider on all lines

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

Data Element: *Paid Amount*
Definition: ***Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.***
Validation: ***N/A***
Remarks: ***N/A***
Requirement: Required.

Data Element: *Claim ANSI Reason Code 1*
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Definition: ***Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed***
Validation: ***Must be valid ANSI ASC claim adjustment codes and applicable group codes***
Remarks: ***Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code***
Requirement: ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.

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

Data Element: *Claim Adjudicated Date*
Definition: ***Date claim completed adjudication***
Validation: ***Must be a valid date. Format must be CCYYMMDD***
Remarks: ***This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made***
Requirement: Required
Data Element: Line Item Count
Definition: ***Number indicating number of service lines on the claim***
Validation: ***Must be a number 01 – 52***
Remarks: ***N/A***
Requirement: Required

Claim Line Item Fields

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

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

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

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

Data Element: *HCPCS Modifier 1*
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
Definition: ***Codes identifying special circumstances related to the service***
Validation: ***N/A***
Remarks: ***N/A***
Requirement: Required if available

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

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

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

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

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

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

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

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

Data Element: *Medicare Initial Allowed Charge*
Definition: ***Amount Medicare allowed for the service or equipment before any reduction or denial***
Validation: ***N/A***
Remarks: ***This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.***
Requirement: ***Required***

Data Element: *ANSI Reason Code 1*
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
Definition: ***Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed***
Validation: ***Must be valid ANSI ASC claim adjustment codes and applicable group codes***

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

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

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

Data Element: *Resolution Code*
Definition: ***Code indicating how the contractor resolved the line.***

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

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

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

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

Remarks:

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

Requirement: ***Required.***

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

DATA ELEMENT DETAIL

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

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

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

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

Provider Address File
Provider Address Detail Record

Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	***X(5)***	***1***	***5***	***Spaces***
Record Type	***X(1)***	***6***	***6***	***"2"***
Provider Number	***X(15)***	***7***	***21***	***Spaces***
Provider Name	***X(25)***	***22***	***46***	***Spaces***
Provider Address 1	***X(25)***	***47***	***71***	***Spaces***
Provider Address 2	***X(25)***	***72***	***96***	***Spaces***
Provider City	***X(15)***	***97***	***111***	***Spaces***
Provider State Code	***X(2)***	***112***	***113***	***Spaces***
Provider Zip Code	***X(9)***	***114***	***122***	***Spaces***
Provider Phone Number	***X(10)***	***123***	***132***	***Spaces***
Provider Fax Number	***X(10)***	***133***	***142***	***Spaces***
Provider Type	***X(1)***	***143***	***143***	***Spaces***
Filler	***X(25)***	***144***	***168***	***Spaces***

DATA ELEMENT DETAIL

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

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

Data Element: *Provider Number*
Definition: ***Number assigned by the standard system to identify the billing/pricing provider or supplier or referring provider***
Validation: ***N/A***
Remarks: ***N/A***
Requirement: ***Required***

Data Element: *Provider Name*
Definition: ***Provider's name***
Validation: ***N/A***
Remarks: ***This is the name of the billing/pricing provider or referring provider must be formatted into a name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).***
Requirement: ***Required***

Data Element: *Provider Address 1*
Definition: ***1st line of provider's address***
Validation: ***N/A***
Remarks: ***This is the payee address1of the billing/pricing provider or referring provider***
Requirement: ***Required***

Data Element: *Provider Address 2*
Definition: ***2nd line of provider's address***
Validation: ***N/A***
Remarks: ***This is the address2 of the billing/pricing provider or referring provider***
Requirement: ***Required if available***

Data Element: *Provider City*
Definition: ***Provider's city name***
Validation: ***N/A***
Remarks: ***This is the city of the billing/pricing provider or referring provider***
Requirement: ***Required***

Data Element: *Provider State Code*
Definition: ***Provider's billing state code***
Validation: ***Must be a valid state code***
Remarks: ***This is the state of the billing/pricing provider or referring provider***
Requirement: ***Required***

Data Element: *Provider Zip Code*
Definition: ***Provider's billing zip code***
Validation: ***Must be a valid postal zip code***
Remarks: ***This is the zip code of the billing/pricing provider or referring provider. Provide 9-digit zip code if available, otherwise provide 5-digit zip code***
Requirement: ***Required***

Data Element: *Provider Phone Number*
Definition: ***Provider's telephone number***
Validation: ***Must be a valid telephone number***
Remarks: ***This is the phone number of the billing/pricing provider or referring provider***
Requirement: ***None***

Data Element: *Provider Fax Number*
Definition: ***Provider's fax number***
Validation: ***Must be a valid fax number***
Remarks: ***This is the fax number of the billing/pricing provider or referring provider***
Requirement: ***None***

Data Element: *Provider Type*
Definition: ***1=billing/pricing provider 2= referring provider***
Validation: ***Must be a valid provider type***
Remarks: ***This field indicates whether the information provided on the record is for the billing/pricing provider or referring provider***
Requirement: ***Required***

Data Element: *Filler*
Definition: ***Additional space TBD***
Validation: ***N/A***
Remarks: ***N/A***
Requirement:

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

DATA ELEMENT DETAIL

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

Requirement: Required

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

Data Element: *Number of Records*
Definition: ***Number of provider address records on this file (do not count header or trailer record)***
Validation: ***Must be equal to the number of provider address records on the file***
Remarks: ***N/A***
Requirement: Required

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system's claims history file. It should not include header or trailer records.

Exhibit 36.3 - Language for Inclusion in Provider Letter

Rev. 67, 02-27-04)

In order to improve the processing and medical decision making involved with payment of Medicare claims, CMS began a new program effective August 2000. This program is called CERT and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (AdvanceMed of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. AdvanceMed's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that the contractor decisions regarding the claims were accurate and based on sound policy. CMS will use the AdvanceMed findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by AdvanceMed. On a monthly basis, AdvanceMed will request a small sample of claims, approximately 200 from each contractor, as the claims are entered into their system. AdvanceMed will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., questions of medical necessity or inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How are providers and suppliers of sampled claims impacted by CERT?

You may be asked during AdvanceMed's review to provide more information such as medical records or certificates of medical necessity so that AdvanceMed can verify that billing was proper and that claims processing procedures were appropriate. You will be advised what documentation is need and the name of your contact.

General questions regarding the CERT initiative may be directed to the CERT Program, at (804) 264-1778. Otherwise, providers and suppliers will be contacted ONLY if their claim(s) is selected and AdvanceMed requires additional information.

Exhibit 36.4 - Monthly CERT Error Review Report (Rev. 67, 02-27-04)

AC FEEDBACK

Contractor Name: ***X (79)***
Contractor Number: ***99999***
Sample ID: XXXXXXXX

Sample Month: ***MM/YYYY***
Report Generated: ***MM/DD/YYYY***

HICN: XXXXXXXXXXXX
ICN: XXXXXXXXXXXXXXXXXXXXXXX

Claim Adjustment Date: XX/XX/XXXX
Adjusted ICN: XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Line Nbr	Carrier Decision (A/D)	Disagreement Code	Original HCPCS	Adjusted HCPCS	Amt of O/P in Question	Final Allowed Amount
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						

Exhibit 36.5 - CERT Quarterly Error Reconciliation Report **(Rev. 67, 02-27-04)**

Contractor Name: ***X (79)***
Contractor Number: ***99999***
Sample ID: XXXXXXXX

Sample Month: ***MM/YYYY***
Report Generated: ***MM/DD/YYYY***

HICN: XXXXXXXXXXXX
ICN: XXXXXXXXXXXXXXXXXXXXXXX

Claim Adjustment Date: XX/XX/XXXX
Adjusted ICN: XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Line Nbr	Carrier Decision (A/D)	Disagreement Code	Original HCPCS	Adjusted HCPCS	Amt of O/P in Question	Final Allowed Amount	CERT Response to AC Rebuttal (A/D)	CMS Panel Decision (A/D)
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								

MISCELLANEOUS CHARTS THAT I HAVE REMOVED

The transmission name for the Sampled Claims Transaction Files are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTTRN
A00020	P#CER.#NCHPSC.A00020.CERTTRN
A00030	P#CER.#NCHPSC.A00030.CERTTRN
A00040	P#CER.#NCHPSC.A00040.CERTTRN
A00090	P#CER.#NCHPSC.A00090.CERTTRN
A00101	P#CER.#NCHPSC.A00101.CERTTRN
A00130	P#CER.#NCHPSC.A00130.CERTTRN
A00131	P#CER.#NCHPSC.A00131.CERTTRN
A00140	P#CER.#NCHPSC.A00140.CERTTRN
A00150	P#CER.#NCHPSC.A00150.CERTTRN
A00160	P#CER.#NCHPSC.A00160.CERTTRN
A00180	P#CER.#NCHPSC.A00180.CERTTRN
A00181	P#CER.#NCHPSC.A00181.CERTTRN
A00190	P#CER.#NCHPSC.A00190.CERTTRN
A00230	P#CER.#NCHPSC.A00230.CERTTRN
A00250	P#CER.#NCHPSC.A00250.CERTTRN
A00260	P#CER.#NCHPSC.A00260.CERTTRN
A00270	P#CER.#NCHPSC.A00270.CERTTRN
A00308	P#CER.#NCHPSC.A00308.CERTTRN
A00310	P#CER.#NCHPSC.A00310.CERTTRN
A00320	P#CER.#NCHPSC.A00320.CERTTRN
A00332	P#CER.#NCHPSC.A00332.CERTTRN
A00340	P#CER.#NCHPSC.A00340.CERTTRN
A00350	P#CER.#NCHPSC.A00350.CERTTRN
A00363	P#CER.#NCHPSC.A00363.CERTTRN
A00370	P#CER.#NCHPSC.A00370.CERTTRN
A00380	P#CER.#NCHPSC.A00380.CERTTRN
A00400	P#CER.#NCHPSC.A00400.CERTTRN
A00410	P#CER.#NCHPSC.A00410.CERTTRN
A00430	P#CER.#NCHPSC.A00430.CERTTRN
A00450	P#CER.#NCHPSC.A00450.CERTTRN
A00452	P#CER.#NCHPSC.A00452.CERTTRN
A00453	P#CER.#NCHPSC.A00453.CERTTRN
A00460	P#CER.#NCHPSC.A00460.CERTTRN
A50333	P#CER.#NCHPSC.A50333.CERTTRN
A52280	P#CER.#NCHPSC.A52280.CERTTRN
A57400	P#CER.#NCHPSC.A57400.CERTTRN
A57401	P#CER.#NCHPSC.A57401.CERTTRN

AC Number	*Holding File*
635	*P#CER.#NCHPSC.D00635.CERTTRAN*

AC Number	Holding File
811	P#CER.#NCHPSC.D00811.CERTTRAN
885	P#CER.#NCHPSC.D00885.CERTTRAN
5655	P#CER.#NCHPSC.D05655.CERTTRAN
10555	P#CER.#NCHPSC.D10555.CERTTRAN
510	P#CER.#NCHPSC.B00510.CERTTRAN
520	P#CER.#NCHPSC.B00520.CERTTRAN
528	P#CER.#NCHPSC.B00528.CERTTRAN
570	P#CER.#NCHPSC.B00570.CERTTRAN
580	P#CER.#NCHPSC.B00580.CERTTRAN
621	P#CER.#NCHPSC.B00621.CERTTRAN
623	P#CER.#NCHPSC.B00623.CERTTRAN
630	P#CER.#NCHPSC.B00630.CERTTRAN
640	P#CER.#NCHPSC.B00640.CERTTRAN
650	P#CER.#NCHPSC.B00650.CERTTRAN
655	P#CER.#NCHPSC.B00655.CERTTRAN
660	P#CER.#NCHPSC.B00660.CERTTRAN
700	P#CER.#NCHPSC.B00700.CERTTRAN
740	P#CER.#NCHPSC.B00740.CERTTRAN
780	P#CER.#NCHPSC.B00780.CERTTRAN
781	P#CER.#NCHPSC.B00781.CERTTRAN
801	P#CER.#NCHPSC.B00801.CERTTRAN
803	P#CER.#NCHPSC.B00803.CERTTRAN
805	P#CER.#NCHPSC.B00805.CERTTRAN
820	P#CER.#NCHPSC.B00820.CERTTRAN
824	P#CER.#NCHPSC.B00824.CERTTRAN
825	P#CER.#NCHPSC.B00825.CERTTRAN
865	P#CER.#NCHPSC.B00865.CERTTRAN
880	P#CER.#NCHPSC.B00880.CERTTRAN
889	P#CER.#NCHPSC.B00889.CERTTRAN
900	P#CER.#NCHPSC.B00900.CERTTRAN
901	P#CER.#NCHPSC.B00901.CERTTRAN
973	P#CER.#NCHPSC.B00973.CERTTRAN
974	P#CER.#NCHPSC.B00974.CERTTRAN
2050	P#CER.#NCHPSC.B02050.CERTTRAN
5130	P#CER.#NCHPSC.B05130.CERTTRAN
5440	P#CER.#NCHPSC.B05440.CERTTRAN
5535	P#CER.#NCHPSC.B05535.CERTTRAN
14330	P#CER.#NCHPSC.B14330.CERTTRAN
16360	P#CER.#NCHPSC.B16360.CERTTRAN
16510	P#CER.#NCHPSC.B16510.CERTTRAN
21200	P#CER.#NCHPSC.B21200.CERTTRAN
31140	P#CER.#NCHPSC.B31140.CERTTRAN

Within 5 working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

The target data set names for the current Sampled Claim Resolution Files are listed below:

AC Number	***Target File***
635	*P#CER.#NCHPSC.D00635.CERTRSLN*
811	*P#CER.#NCHPSC.D00811.CERTRSLN*
885	*P#CER.#NCHPSC.D00885.CERTRSLN*
655	*P#CER.#NCHPSC.D05655.CERTRSLN*
10555	*P#CER.#NCHPSC.D10555.CERTRSLN*
510	*P#CER.#NCHPSC.B00510.CERTRSLN*
520	*P#CER.#NCHPSC.B00520.CERTRSLN*
528	*P#CER.#NCHPSC.B00528.CERTRSLN*
570	*P#CER.#NCHPSC.B00570.CERTRSLN*
580	*P#CER.#NCHPSC.B00580.CERTRSLN*
621	*P#CER.#NCHPSC.B00621.CERTRSLN*
623	*P#CER.#NCHPSC.B00623.CERTRSLN*
630	*P#CER.#NCHPSC.B00630.CERTRSLN*
640	*P#CER.#NCHPSC.B00640.CERTRSLN*
650	*P#CER.#NCHPSC.B00650.CERTRSLN*
655	*P#CER.#NCHPSC.B00655.CERTRSLN*
660	*P#CER.#NCHPSC.B00660.CERTRSLN*
700	*P#CER.#NCHPSC.B00700.CERTRSLN*
740	*P#CER.#NCHPSC.B00740.CERTRSLN*
780	*P#CER.#NCHPSC.B00780.CERTRSLN*
781	*P#CER.#NCHPSC.B00781.CERTRSLN*
801	*P#CER.#NCHPSC.B00801.CERTRSLN*
803	*P#CER.#NCHPSC.B00803.CERTRSLN*
805	*P#CER.#NCHPSC.B00805.CERTRSLN*
820	*P#CER.#NCHPSC.B00820.CERTRSLN*
824	*P#CER.#NCHPSC.B00824.CERTRSLN*
825	*P#CER.#NCHPSC.B00825.CERTRSLN*
865	*P#CER.#NCHPSC.B00865.CERTRSLN*
880	*P#CER.#NCHPSC.B00880.CERTRSLN*
889	*P#CER.#NCHPSC.B00889.CERTRSLN*
900	*P#CER.#NCHPSC.B00900.CERTRSLN*
901	*P#CER.#NCHPSC.B00901.CERTRSLN*
973	*P#CER.#NCHPSC.B00973.CERTRSLN*
974	*P#CER.#NCHPSC.B00974.CERTRSLN*
2050	*P#CER.#NCHPSC.B02050.CERTRSLN*

5130	*P#CER.#NCHPSC.B05130.CERTRSLN*
5440	*P#CER.#NCHPSC.B05440.CERTRSLN*
5535	*P#CER.#NCHPSC.B05535.CERTRSLN*
14330	*P#CER.#NCHPSC.B14330.CERTRSLN*
16360	*P#CER.#NCHPSC.B16360.CERTRSLN*
16510	*P#CER.#NCHPSC.B16510.CERTRSLN*
21200	*P#CER.#NCHPSC.B21200.CERTRSLN*
31140	*P#CER.#NCHPSC.B31140.CERTRSLN*

The target data set names for the current Provider Address Files are listed below:

AC Number	***Target File***
635	*P#CER.#NCHPSC.D00635.CERTPROV*
811	*P#CER.#NCHPSC.D00811.CERTPROV*
885	*P#CER.#NCHPSC.D00885.CERTPROV*
5655	*P#CER.#NCHPSC.D05655.CERTPROV*
10555	*P#CER.#NCHPSC.D10555.CERTPROV*
510	*P#CER.#NCHPSC.B00510.CERTPROV*
520	*P#CER.#NCHPSC.B00520.CERTPROV*
528	*P#CER.#NCHPSC.B00528.CERTPROV*
570	*P#CER.#NCHPSC.B00570.CERTPROV*
580	*P#CER.#NCHPSC.B00580.CERTPROV*
621	*P#CER.#NCHPSC.B00621.CERTPROV*
623	*P#CER.#NCHPSC.B00623.CERTPROV*
630	*P#CER.#NCHPSC.B00630.CERTPROV*
640	*P#CER.#NCHPSC.B00640.CERTPROV*
650	*P#CER.#NCHPSC.B00650.CERTPROV*
655	*P#CER.#NCHPSC.B00655.CERTPROV*
660	*P#CER.#NCHPSC.B00660.CERTPROV*
700	*P#CER.#NCHPSC.B00700.CERTPROV*
740	*P#CER.#NCHPSC.B00740.CERTPROV*
780	*P#CER.#NCHPSC.B00780.CERTPROV*
781	*P#CER.#NCHPSC.B00781.CERTPROV*
801	*P#CER.#NCHPSC.B00801.CERTPROV*
803	*P#CER.#NCHPSC.B00803.CERTPROV*
805	*P#CER.#NCHPSC.B00805.CERTPROV*
820	*P#CER.#NCHPSC.B00820.CERTPROV*
824	*P#CER.#NCHPSC.B00824.CERTPROV*
825	*P#CER.#NCHPSC.B00825.CERTPROV*
865	*P#CER.#NCHPSC.B00865.CERTPROV*
880	*P#CER.#NCHPSC.B00880.CERTPROV*
889	*P#CER.#NCHPSC.B00889.CERTPROV*
900	*P#CER.#NCHPSC.B00900.CERTPROV*
901	*P#CER.#NCHPSC.B00901.CERTPROV*

973	*P#CER.#NCHPSC.B00973.CERTPROV*
974	*P#CER.#NCHPSC.B00974.CERTPROV*
2050	*P#CER.#NCHPSC.B02050.CERTPROV*
5130	*P#CER.#NCHPSC.B05130.CERTPROV*
5440	*P#CER.#NCHPSC.B05440.CERTPROV*
5535	*P#CER.#NCHPSC.B05535.CERTPROV*
14330	*P#CER.#NCHPSC.B14330.CERTPROV*
16360	*P#CER.#NCHPSC.B16360.CERTPROV*
16510	*P#CER.#NCHPSC.B16510.CERTPROV*
21200	*P#CER.#NCHPSC.B21200.CERTPROV*
31140	*P#CER.#NCHPSC.B31140.CERTPROV*

The target data set names for the current Claims History Replica Files are listed below:

AC Number	***Target File***
635	*P#CER.#NCHPSC.D00635.CERTRPLI*
811	*P#CER.#NCHPSC.D00811.CERTRPLI*
885	*P#CER.#NCHPSC.D00885.CERTRPLI*
5655	*P#CER.#NCHPSC.D05655.CERTRPLI*
10555	*P#CER.#NCHPSC.D10555.CERTRPLI*
510	*P#CER.#NCHPSC.B00510.CERTRPLI*
520	*P#CER.#NCHPSC.B00520.CERTRPLI*
528	*P#CER.#NCHPSC.B00528.CERTRPLI*
570	*P#CER.#NCHPSC.B00570.CERTRPLI*
580	*P#CER.#NCHPSC.B00580.CERTRPLI*
621	*P#CER.#NCHPSC.B00621.CERTRPLI*
623	*P#CER.#NCHPSC.B00623.CERTRPLI*
630	*P#CER.#NCHPSC.B00630.CERTRPLI*
640	*P#CER.#NCHPSC.B00640.CERTRPLI*
650	*P#CER.#NCHPSC.B00650.CERTRPLI*
655	*P#CER.#NCHPSC.B00655.CERTRPLI*
660	*P#CER.#NCHPSC.B00660.CERTRPLI*
700	*P#CER.#NCHPSC.B00700.CERTRPLI*
740	*P#CER.#NCHPSC.B00740.CERTRPLI*
780	*P#CER.#NCHPSC.B00780.CERTRPLI*
781	*P#CER.#NCHPSC.B00781.CERTRPLI*
801	*P#CER.#NCHPSC.B00801.CERTRPLI*
803	*P#CER.#NCHPSC.B00803.CERTRPLI*
805	*P#CER.#NCHPSC.B00805.CERTRPLI*
820	*P#CER.#NCHPSC.B00820.CERTRPLI*
824	*P#CER.#NCHPSC.B00824.CERTRPLI*
825	*P#CER.#NCHPSC.B00825.CERTRPLI*
865	*P#CER.#NCHPSC.B00865.CERTRPLI*

880	*P#CER.#NCHPSC.B00880.CERTRPLI*
889	*P#CER.#NCHPSC.B00889.CERTRPLI*
900	*P#CER.#NCHPSC.B00900.CERTRPLI*
901	*P#CER.#NCHPSC.B00901.CERTRPLI*
973	*P#CER.#NCHPSC.B00973.CERTRPLI*
974	*P#CER.#NCHPSC.B00974.CERTRPLI*
2050	*P#CER.#NCHPSC.B02050.CERTRPLI*
5130	*P#CER.#NCHPSC.B05130.CERTRPLI*
5440	*P#CER.#NCHPSC.B05440.CERTRPLI*
5535	*P#CER.#NCHPSC.B05535.CERTRPLI*
14330	*P#CER.#NCHPSC.B14330.CERTRPLI*
16360	*P#CER.#NCHPSC.B16360.CERTRPLI*
16510	*P#CER.#NCHPSC.B16510.CERTRPLI*
21200	*P#CER.#NCHPSC.B21200.CERTRPLI*
31140	*P#CER.#NCHPSC.B31140.CERTRPLI*

Target data set names for the sampled claim resolution files are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRSLN
A00020	P#CER.#NCHPSC.A00020.CERTRSLN
A00030	P#CER.#NCHPSC.A00030.CERTRSLN
A00040	P#CER.#NCHPSC.A00040.CERTRSLN
A00090	P#CER.#NCHPSC.A00090.CERTRSLN
A00101	P#CER.#NCHPSC.A00101.CERTRSLN
A00130	P#CER.#NCHPSC.A00130.CERTRSLN
A00131	P#CER.#NCHPSC.A00131.CERTRSLN
A00140	P#CER.#NCHPSC.A00140.CERTRSLN
A00150	P#CER.#NCHPSC.A00150.CERTRSLN
A00160	P#CER.#NCHPSC.A00160.CERTRSLN
A00180	P#CER.#NCHPSC.A00180.CERTRSLN
A00181	P#CER.#NCHPSC.A00181.CERTRSLN
A00190	P#CER.#NCHPSC.A00190.CERTRSLN
A00230	P#CER.#NCHPSC.A00230.CERTRSLN
A00250	P#CER.#NCHPSC.A00250.CERTRSLN
A00260	P#CER.#NCHPSC.A00260.CERTRSLN
A00270	P#CER.#NCHPSC.A00270.CERTRSLN
A00308	P#CER.#NCHPSC.A00308.CERTRSLN
A00310	P#CER.#NCHPSC.A00310.CERTRSLN
A00320	P#CER.#NCHPSC.A00320.CERTRSLN
A00332	P#CER.#NCHPSC.A00332.CERTRSLN
A00340	P#CER.#NCHPSC.A00340.CERTRSLN
A00350	P#CER.#NCHPSC.A00350.CERTRSLN
A00363	P#CER.#NCHPSC.A00363.CERTRSLN
A00370	P#CER.#NCHPSC.A00370.CERTRSLN
A00380	P#CER.#NCHPSC.A00380.CERTRSLN
A00400	P#CER.#NCHPSC.A00400.CERTRSLN
A00410	P#CER.#NCHPSC.A00410.CERTRSLN
A00430	P#CER.#NCHPSC.A00430.CERTRSLN
A00450	P#CER.#NCHPSC.A00450.CERTRSLN
A00452	P#CER.#NCHPSC.A00452.CERTRSLN
A00453	P#CER.#NCHPSC.A00453.CERTRSLN
A00460	P#CER.#NCHPSC.A00460.CERTRSLN
A50333	P#CER.#NCHPSC.A50333.CERTRSLN
A52280	P#CER.#NCHPSC.A52280.CERTRSLN
A57400	P#CER.#NCHPSC.A57400.CERTRSLN
A57401	P#CER.#NCHPSC.A57401.CERTRSLN

P#CER.#NCHPSC.A**.CERTPROV. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the provider address files are listed below:***

AC Number	*Holding File*

AC Number	Holding File
A00010	**P#CER.#NCHPSC.A00010.CERTPROV**
A00020	**P#CER.#NCHPSC.A00020.CERTPROV**
A00030	**P#CER.#NCHPSC.A00030.CERTPROV**
A00040	**P#CER.#NCHPSC.A00040.CERTPROV**
A00090	**P#CER.#NCHPSC.A00090.CERTPROV**
A00101	**P#CER.#NCHPSC.A00101.CERTPROV**
A00130	**P#CER.#NCHPSC.A00130.CERTPROV**
A00131	**P#CER.#NCHPSC.A00131.CERTPROV**
A00140	**P#CER.#NCHPSC.A00140.CERTPROV**
A00150	**P#CER.#NCHPSC.A00150.CERTPROV**
A00160	**P#CER.#NCHPSC.A00160.CERTPROV**
A00180	**P#CER.#NCHPSC.A00180.CERTPROV**
A00181	**P#CER.#NCHPSC.A00181.CERTPROV**
A00190	**P#CER.#NCHPSC.A00190.CERTPROV**
A00230	**P#CER.#NCHPSC.A00230.CERTPROV**
A00250	**P#CER.#NCHPSC.A00250.CERTPROV**
A00260	**P#CER.#NCHPSC.A00260.CERTPROV**
A00270	**P#CER.#NCHPSC.A00270.CERTPROV**
A00308	**P#CER.#NCHPSC.A00308.CERTPROV**
A00310	**P#CER.#NCHPSC.A00310.CERTPROV**
A00320	**P#CER.#NCHPSC.A00320.CERTPROV**
A00332	**P#CER.#NCHPSC.A00332.CERTPROV**
A00340	**P#CER.#NCHPSC.A00340.CERTPROV**
A00350	**P#CER.#NCHPSC.A00350.CERTPROV**
A00363	**P#CER.#NCHPSC.A00363.CERTPROV**
A00370	**P#CER.#NCHPSC.A00370.CERTPROV**
A00380	**P#CER.#NCHPSC.A00380.CERTPROV**
A00400	**P#CER.#NCHPSC.A00400.CERTPROV**
A00410	**P#CER.#NCHPSC.A00410.CERTPROV**
A00430	**P#CER.#NCHPSC.A00430.CERTPROV**
A00450	**P#CER.#NCHPSC.A00450.CERTPROV**
A00452	**P#CER.#NCHPSC.A00452.CERTPROV**
A00453	**P#CER.#NCHPSC.A00453.CERTPROV**
A00460	**P#CER.#NCHPSC.A00460.CERTPROV**
A50333	**P#CER.#NCHPSC.A50333.CERTPROV**
A52280	**P#CER.#NCHPSC.A52280.CERTPROV**
A57400	**P#CER.#NCHPSC.A57400.CERTPROV**
A57401	**P#CER.#NCHPSC.A57401.CERTPROV**

P#CER.#NCHPSC.A**.CERTRPLI. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the claims history replica file are listed below:***

AC Number	Holding File
A00010	**P#CER.#NCHPSC.A00010.CERTRPLI**

AC Number	Holding File
A00020	**P#CER.#NCHPSC.A00020.CERTRPLI**
A00030	**P#CER.#NCHPSC.A00030.CERTRPLI**
A00040	**P#CER.#NCHPSC.A00040.CERTRPLI**
A00090	**P#CER.#NCHPSC.A00090.CERTRPLI**
A00101	**P#CER.#NCHPSC.A00101.CERTRPLI**
A00130	**P#CER.#NCHPSC.A00130.CERTRPLI**
A00131	**P#CER.#NCHPSC.A00131.CERTRPLI**
A00140	**P#CER.#NCHPSC.A00140.CERTRPLI**
A00150	**P#CER.#NCHPSC.A00150.CERTRPLI**
A00160	**P#CER.#NCHPSC.A00160.CERTRPLI**
A00180	**P#CER.#NCHPSC.A00180.CERTRPLI**
A00181	**P#CER.#NCHPSC.A00181.CERTRPLI**
A00190	**P#CER.#NCHPSC.A00190.CERTRPLI**
A00230	**P#CER.#NCHPSC.A00230.CERTRPLI**
A00250	**P#CER.#NCHPSC.A00250.CERTRPLI**
A00260	**P#CER.#NCHPSC.A00260.CERTRPLI**
A00270	**P#CER.#NCHPSC.A00270.CERTRPLI**
A00308	**P#CER.#NCHPSC.A00308.CERTRPLI**
A00310	**P#CER.#NCHPSC.A00310.CERTRPLI**
A00320	**P#CER.#NCHPSC.A00320.CERTRPLI**
A00332	**P#CER.#NCHPSC.A00332.CERTRPLI**
A00340	**P#CER.#NCHPSC.A00340.CERTRPLI**
A00350	**P#CER.#NCHPSC.A00350.CERTRPLI**
A00363	**P#CER.#NCHPSC.A00363.CERTRPLI**
A00370	**P#CER.#NCHPSC.A00370.CERTRPLI**
A00380	**P#CER.#NCHPSC.A00380.CERTRPLI**
A00400	**P#CER.#NCHPSC.A00400.CERTRPLI**
A00410	**P#CER.#NCHPSC.A00410.CERTRPLI**
A00430	**P#CER.#NCHPSC.A00430.CERTRPLI**
A00450	**P#CER.#NCHPSC.A00450.CERTRPLI**
A00452	**P#CER.#NCHPSC.A00452.CERTRPLI**
A00453	**P#CER.#NCHPSC.A00453.CERTRPLI**
A00460	**P#CER.#NCHPSC.A00460.CERTRPLI**
A50333	**P#CER.#NCHPSC.A50333.CERTRPLI**
A52280	**P#CER.#NCHPSC.A52280.CERTRPLI**
A57400	**P#CER.#NCHPSC.A57400.CERTRPLI**
A57401	**P#CER.#NCHPSC.A57401.CERTRPLI**

Assumptions and Constraints

- ***Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.***

- *Files must be transmitted to the CERT operations center via CONNECT:Direct.*

- *CMS or the CERT contractor will provide Medicare contractors with dataset names for all files that will be transmitted to the CERT operations center.*

- *The CERT contractor will provide the Medicare contractors with the dataset names with which the sampled claims transaction file will be transmitted.*

- *Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted.*

- *Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor to support CERT implementation and will provide updates within 60 calendar days before each expected implementation of a change in the data dictionary. .*

Below are details on how those requirements must be implemented.

1. *Coordinate with the CERT contractor to provide the requested information in an electronic format for claims identified in the sample.*

   The CERT contractor will make all requests for information or data through letters, e-mail, or via the Network Data Mover (NDM) to the CERT point of contact of each Medicare contractor. Instructions for responding to requests via the NDM will be provided after a test of the process with the DMERCs has been completed. Medicare contractors are required to provide responses in electronic format as described in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Responses provided in electronic form must be made within five working days of a request.

2. *Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims processed during the day.*

   *FI and RHHI data centers and contractors should use the file formats from Attachment 1 for this section. Use CONNECT:Direct to transmit the files. The target filename for transmission to the CERT test environment in the CMSDC is D#CER.#NCHPSC.A*****.CERTUNV. Target file names for transmission to the CERT production environment in the CMSDC is P#CER.#NCHPSC.A*****.CERTUNV. The Medicare contractor data center must replace the "*****" in each file name with the contractor ID number of the contractor for which the file is being submitted.*

   Carrier and DMERC data centers and contractors should use the file formats from the Attachment 2 for this transmission. Use CONNECT:Direct to transmit the files. Target filenames for transmission to the CERT test environment in the CMSDC are listed below:

Claims Universe File	*D#CER.#NCHPSC.B*****CERTUNV*
Sampled Claims Resolution File	*D#CER.#NCHPSC.B*****.CERTRSLN*
Provider Address File	*D#CER.#NCHPSC.B*****CERTPROV*
Claims History Replica File	*D#CER.#NCHPSC.B****CERTRPLI*
Sampled Claims Transaction File	*D#CER.#NCHPSC.B****.CERTTRAN*

Target file names for transmission to the CERT production environment in the CMSDC are listed below:

Claims Universe File	*P#CER.#NCHPSC.B*****.CERTUNV*
Sampled Claims Resolution File	*P#CER.#NCHPSC.B*****.CERTRSLN*
Provider Address File	*P#CER.#NCHPSC.B*****.CERTPROV*
Claims History Replica File	*P#CER.#NCHPSC.B*****.CERTRPLI*
Sampled Claims Transaction File	*P#CER.#NCHPSC.B*****.CERTTRAN*

*Each Medicare contractor in Phases 1, 2, and 3 of CERT has identified a CMSDC NDM User ID they will use to transmit the files. Notify the CERT contractor at the address included in the **"How to Contact and Make Submissions to the CERT Operations Center"** section above of any NDM user ID changes or additions. Medicare contractors in Phases after 3 must provide CMSDC User IDs to the CERT operations center at least 30 calendar days before their first sample is due.*

3. *On a periodic basis, generally monthly, the CERT contractor will make a request via the NDM for the Medicare contractor to return a sampled claims resolution file, claims history replica file, and provider address file for every claim in listed in the sampled claims transaction file that has completed adjudication by the Medicare contractor. The contents of the sampled claims transaction file will consist of all claims that recently were selected in the sample for the first time and any claims remaining from prior requests that had not completed the adjudication process by the Medicare contractor at the time of the previous request.*

4. *Provide the CERT contractor with the Sample Claims Resolution file, claims history replica file, and provider address file within five working days of a CERT request.*

   Within five working days of a CERT request, provide for every claim listed in the sampled claims transaction file that has undergone payment adjudication (i.e., denial, reduction, return, payment approval, etc) all sampled claims resolution files, all claims history replica files, and a single provider address file in the formats contained in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Note that more than one sampled claims resolution file and claims history replica file may be provided under circumstances where the Claim Control Number has changed since its original assignment and claim activity has occurred. Standard systems are expected to provide a look up list, where necessary, to associate the last Claim Control Number submitted to the CERT contractor from the standard system with new Claim Control Numbers assigned to the claim subsequent to that submission. If there are clams adjustments that have not been adjudicated when the sample claims transaction file is receive, those adjustments do not need to be included in a sample claims resolution file.

   Included in the requirements for the sampled claims resolution file is a requirement to report the manual medical review indicator for each line on the sampled claim. We have defined this item as follows:

   Data Element: ***Complex Manual Medical Review Indicator***

   Definition: *Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow*

complex review to be done without requesting additional documentation, count the review as complex. For instance, if relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: *Must be 'Y' or 'N' or blank*
Remarks: *Set to 'Y' if service was subjected to complex manual medical review, 'N' if the service was subjected to routine manual medical review, and leave it blank if the service was subjected to automated review.*
Requirement: Not required

A line level MR indicator field is included on the standard system claim records. Providing a Value for the MR indicator on the standard system claim record will allow CERT to distinguish among automated MR, complex MR, and routine MR. Contractors that ***do not*** *enter MR indicators on the review line in question, will not have the opportunity to dispute that line of service.*

The contractor must enter the necessary data to allow the standard processing intermediary shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. We expect contractors to manually put this indicator on the claim. Contractors must enter the following indicators on the claim to document the type of review that they performed (automated, routine, or complex):

Situation	***Payment Decision Contractor***	***Enters***
Contractor receives documentation and performs complex manual medical review on one or more specific lines of service for that claim.	***-Approved*** ***-Denied*** ***-Reduced***	***Y*** *in the detail level (line level) complex manual medical review indicator for each line of complex manual medical review. Leave the claim level manual review indicator blank.*
Contractor performs routine manual medical review on one or more specific lines of service for that claim.	***-Approved*** ***-Denied*** ***-Reduced***	*N in the detail level (line level) routine manual medical review indicator for each line of routine manual medical review. Leave the claim level manual review indicator blank.*

Contractor does not perform complex or routine manual medical review. The system performs automated medical review on any line of service.	***-Approved*** ***-Denied*** *-Reduced*	***Leave claim and line level manual medical review indicators blank.***

By July 1, 2003, the manual medical review indicator for FIs and RHHIs was implemented. The following requirements went into effect at that time.

A. Contractors must insure that standard system maintainers correctly implement standard system modifications that automatically place the appropriate manual medical review indicator on each line in the sample claims resolution file.

B. If manual review is not performed on the line the manual medical review indicator must be blank. If manual review is performed on a line, the manual medical review indicator must be either a "Y" or an "N."

C. The manual medical review indicator must be "Y" for all lines for which the Medicare contractor has received medical records. When the contractor asks for medical records but the provider does not send every one of the notes that the contractor requested, put a "Y" for the lines corresponding to missing notes.

D. Contractor staff must manually enter information needed to decide if medical records were obtained for lines where that information cannot be obtained from the system claims processing modules.

The medical review indicator was automated for carriers and DMERCs at the beginning of Phases I-III.

Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.

This requirement applies only when the routine processing cycle does not run. For example, if the Medicare contractor routinely processes claims every other day, zero count records do not have to be submitted for days on which processing is not routinely done. To ensure the CERT contractor knows when to expect records, CMS requests that the Medicare contractor send a copy of their processing schedule, if they do not process claims every day, to the CERT contractor ten working days before they are required to begin sending processed records or ten working days after receipt of this PM, whichever is later. Send the list to the address listed in the " ***How to Contact and Make Submissions to the CERT Operations Center"*** *section above.*

Files must be transmitted to the CERT operations center via CONNECT:Direct. Following are the target dataset names for all files that will be transmitted to the CERT operations center.

A manual monthly process is in place to upload the sampled claims transaction file containing the data for all Medicare contractors to the mainframe. A batch job is

executed to separate the sampled claim transaction file into smaller files based on Medicare contractor. The files are placed into the function send mode of the NDM process. The files are then transmitted to each Medicare contractor data center (schedule to be determined).

The format for the transmission name for the sampled claims transaction files is P#CER.#NCHPSC.A**.CERTTRN for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTTRN for FIs, and P#CER.#NCHPSC.D*****.CERTTRN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.***

Within five working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

The format for the data set name for the sampled claims resolution files is P#CER.#NCHPSC.A**.CERTRSLN for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTRSLN for FIs, and P#CER.#NCHPSC.D*****.CERTRSLN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.***

Target data set names for the provider address files are in the format: P#CER.#NCHPSC. A**.CERTPROV for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTPROV for FIs, and P#CER.#NCHPSC.D*****.CERTPROV for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.***

Target data set names for the claims history replica file is in the format: P#CER.#NCHPSC. A**.CERTRPLI for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTRPLI for FIs, and P#CER.#NCHPSC.D*****.CERTRPLI for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.***

The CERT contractor will retrieve the target files on the 6th workday after transmission of the Sampled Claims Transaction Files. The files will be processed through a screening module on the mainframe and then transferred to the CERT database. If a file is not received by COB of the 5th day, it will be processed in the following month's sample.

Transmittal of the Sampled Claims Transactions File will be handled via the NDM and may include an e-mail notification to the Medicare contractor concerning any deviations from established schedules and other information as appropriate. Medicare contractors must provide the CERT contractor with an e-mail address for requests. At least 30 calendar days before the due date for implementation of CERT, send the address to the CERT operations center at the address listed in the " ***How to Contact and Make Submissions to the CERT Operations Center"*** *section.*

Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted within 24 hours (one business day) of notification.

Requests for retransmissions will be made to the CERT point of contact via telephone. Retransmissions must be made in one of the following formats included in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs) as appropriate:

Claims universe file
Sampled claims resolution file,
Claims history replica file, and/or
Provider address file

NDM retransmissions to the data sets described above. If you transmission fails, please call the CERT operations center for instructions.

Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor before implementation of CERT or when it becomes available and will provide updates as necessary.

The data dictionary must be provided within ten working days after receipt of this PM or within 10 days of the data dictionary becoming available, whichever is later. Send it in Microsoft Word 97 format to the CERT operations center at the address provided in the ***"How to Contact and Make Submissions to the CERT Operations Center"*** *section. Updates must be provided to the CERT contractor at least 60 calendar days before a change is implemented in the standard system that will affect the data transmitted in files for CERT.*

Exhibit 36.6 – CERT PSC Contractor Feedback Data Entry Screen Version 1.01 (Rev. 67, 02-27-04)

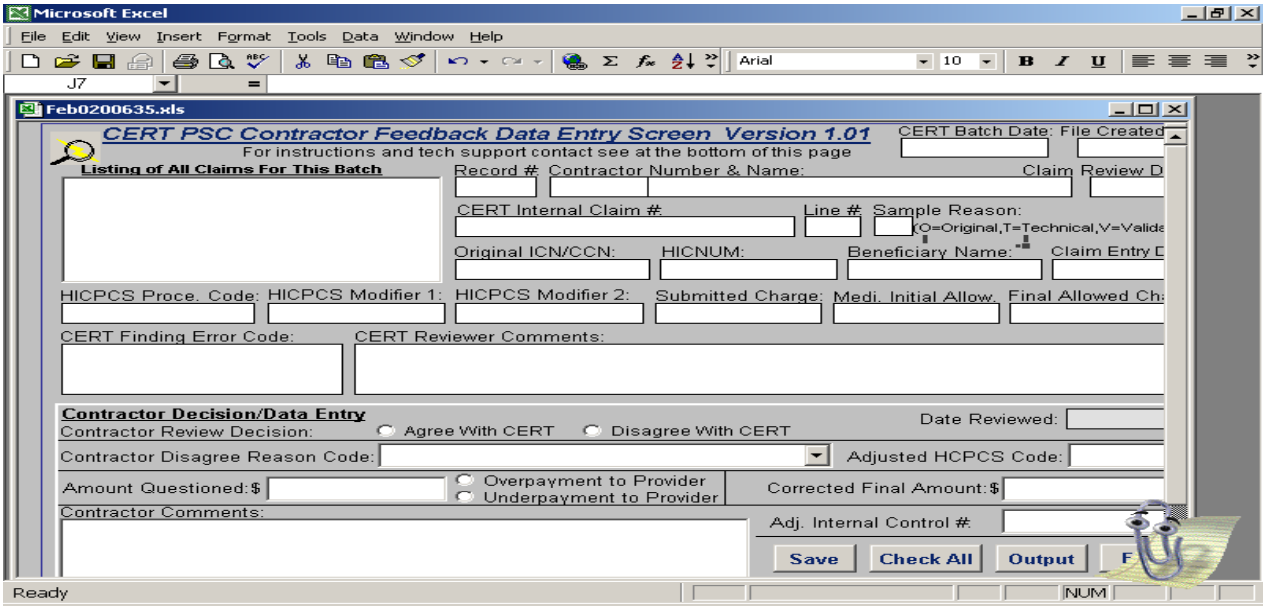

Figure 1: CERT PSC Contractor Feedback Data Entry Screen

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the CCRP, even where your staff have previously conducted routine or complex MR.

The CMS will conduct a routine quality assurance review of the CERT program including review of claims with error and non-error findings.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

Exhibit 36.7 - Data Items Included on CERT Reports (Rev. 67, 02-27-04)

The COCP will receive the following for each line submitted to the CCRP:

Relevant information from the medical record for the disagreed upon line of service,
Explanations from the CERT PSC and the AC of their decisions, and
Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The COCP will make a decision based upon all information presented to them.

To insure that regional offices (ROs) have an opportunity to be involved in the CCRP, the COCP will invite the participation of RO clinicians in the process.

The COCP at a minimum will consist of four individuals. There will be physician representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PIG). There will be at least one registered nurse on this panel. The COCP will request the participation of consortia staff; requests will be made at least one month before participation is expected. The panel may request the assistance of complex medical review experts, coding experts, or clinical specialists. A list of all participants must accompany the final report from the panel.

Members of panels will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CMS will provide final results from the COCP reviews to you in the CERT Quarterly Error Reconciliation Report (see attachment 5 for the report format); CMS will include in this report only those lines the COCP has confirmed to be in error after the COCP has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. You will pay to the billing providers amounts that you have denied in error and the CERT PSC has identified as such. The CMS does not require collection or payment for errors in coding that do not affect the amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact you identified.

On an annual basis, the COCP will conduct random reviews of the decisions on requests submitted to the CCRP. The QA findings shall be sent to the CERT PSC, AC, and applicable parties (i.e., RO or CO).

Exhibit 37 - FEDERAL AGREEMENT (OFFICE OF THE INSPECTOR GENERAL) FOR RELEASE OF DATA WITH INDIVIDUAL IDENTIFIERS

Release of _____ data.

I, _____, representing the Office of the Inspector General, will observe the following in the use of the Centers for Medicare & Medicaid Services (CMS) files released to me.

1. *The files will be used only for purposes authorized by the Inspector General Act of 1978 or other applicable law.*

2. *CMS will be notified of files extracted or derived from these files that are released to other organizations or individuals in identifiable form for other than law enforcement purposes.*

3. *_____ will be designated as custodian of these files and will be responsible for establishment and maintenance of security arrangements to prevent unauthorized use. If the custodianship is transferred within the organization, CMS will be notified.*

4. *No listings or information from individual records, with identifiers will be published or otherwise released outside of those deemed appropriate by OIG to perform the legal scope of OIG duties and responsibilities.*

5. *The OIG needs to retain these files for up to 10 years. CMS will contact the OIG representative at the end of 5 years to confirm either that data will be destroyed or that OIG has a continuing need for the data. CMS will document its tracking system to indicate OIG's need for retention or destruction.*

_____

(Representative of OIG--Typed and Signed) *(Date)*

_____

(Custodian of Files, if different--Typed and Signed) *(Date)*

_____

(CMS Representative--Typed and Signed) *(Date)*