CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 73 **Date: MAY 7, 2004**

CHANGE REQUEST 2646

I. SUMMARY OF CHANGES: The manual instruction for Pub 100-08, Chapter 7 was issued on April 9, 2004 via CR 3030. The business requirements to support the manual instruction were not communicated and are being submitted via this change request.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 10, 2004
***IMPLEMENTATION DATE: June 10, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

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

***III. FUNDING:**
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 73	Date: May 7, 2004	Change Request 2646

SUBJECT: **Program Integrity Management Reporting System (PIMR) Section 7.2 of the Program Integrity Manual (PIM)**

I. GENERAL INFORMATION

A. Background:

Section 7.2 of the PIM provides instructions for implementing PIMR for Fiscal Intermediaries (FIs), carriers, and DMERCs.

The PIMR system changes reporting requirements for medical review (MR) formerly in Publication 100-08 (Program Integrity Manual) Chapter 7 (MR and BI Reports) Sections 1, 5, and 6-10. Before Publication 100-08, the requirements were in Publication 13 (Intermediary Manual) Part 2 §2301 and Part 3 §3939, and Publication 14 (Carrier Manual) Part 3 §§7504.2, 7535-7537, and 14021.

This system will improve the management of cost, savings, and workload data relative to the MR unit. The PIMR System will replace: The Report of Benefit Savings (RBS); The MR System 1 (MRS-1); The Focused MR (FMR) Report; and The Medicare Focused MR Status Report (MFSR) once it becomes fully operational.

The relevant FMR and MFSR data will be collected through PIMR. Mainly, this data relates to how problems are resolved. Certain aspects of the FMR and MFSR systems will not be continued; for instance, we will not obtain through PIMR data on procedure and diagnostic codes that define aberrancies. However, we will obtain the data (i.e., how aberrancies are resolved) we are currently obtaining on aberrancies on each provider type and provider subtype. CMS will obtain that information through interfaces with the standard processing systems. CMS will obtain PIMR data that it cannot extract from existing systems through manual reporting by contractor staff. Those reports will be due monthly within 15 calendar days following the end of the month (See section 2.5 [interactive modules] and 2.8.2.5 [Postpayment report] and 2.8.2.6 [Edit Descriptions]). Contractor data centers will transfer most of the data requested directly from contractor standard systems to the CMS Central Office computer within 15 calendar days following the end of each month.

B. Policy: Requirements in this section were formerly in Publication 100-08 (Program Integrity Manual), Chapter 7 (MR and BI Reports), Sections 1, 5, and 6-10. Previous to that, they were in Publication 13 (Intermediary Manual) Part 2 §2301 and Part 3 §3939, and Publication 14 (Carrier Manual) Part 3 §§7504.2, 7535-7537, and 14021.

These instructions are reporting instructions; they are not instructions for how to perform MR or benefit integrity activities, or requirements for performing those activities.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Description	Responsibility
2.7.1	By April 1, 2003, contractors using VIPS and MCS shall insure that standard system maintainers correctly implement in PIMR codes dependent on local contractor definitions and used by the standard system modules that this CR requires and making certain that data submissions required by this CR are correct. The HPBSS standard system and associated carriers are waived from implementing this CR due to their upcoming transition to the MCS system.	Contractor Staff of carriers using VIPS and MCS
2.7.2	By April 1, 2003, contractors using FISS shall insure that standard system maintainers correctly implement codes dependent on local contractor definitions and used by the standard system modules that phase 1 requires and making certain that data submissions that phase 1 requires are correct. For phase 1, PIMR must report the information indicated below from the prepayment section (section 1) and denial section (section 2) of the CR. For the prepayment section, PIMR must provide units, claims, line items, billed dollars, denied claims, and denied line items by activity type, provider type, and bill/subtype. From the denial section, PIMR must include reason code and denied claims by activity type, provider type, and bill/subtype. At this time, we will not require PIMR to include information on savings (i.e., allowed dollars, denied dollars, and eligible dollars) or by edit codes. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Contractor Staff of FIs using FISS
2.7.3	By July 1, 2003, contractors using FISS shall insure that standard system maintainers correctly implement codes dependent on local contractor definitions and used by the standard system modules that phase 2 requires and make certain that data submissions that phase 2 requires are correct. For phase 2, PIMR must report all other referral information (section 3: Reason	Contractor Staff of FIs using FISS

Requirement #	Description	Responsibility
	code and number of referrals by activity type provider type, and bill/subtype) and claims information (section 4: claims received, line items received, billed dollars received, claims paid, line items paid, dollars paid, and claims available for MR by provider type and bill/subtype) to that required in phase 1. At this time, we will not require the system to include information on savings or by edits.	
2.7.4	Contractors using FISS shall insure that their PIMR reporting meets phase 3 requirements by April 1, 2004. Phase 3 must include savings information for sections 1 and 4, i.e., items P11, P14, P15, and P18 from section 1; and D9 from section 2. At this time, we will not require the system to include information by edits or dollars "$ referrals accepted (item P22). The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system. Further clarification of reversals (item P18): Reversals are the result of a process in which the provider appeals an MR claims payment decision and a formal review and decision process is conducted. Include in reversals reductions in MR savings that result from: · Reconsiderations of a medical review decision, · Reopening of a medical review decision, · Appeals of a medical review decision, · Fair hearings on a medical review decision, · Administrative Law Judge decisions on a medical review decision, · Quality reviews of medical review decisions, and · Mass adjustments that are based on medical review policy. If any part of this clarification increases the April 2004 release hour estimate for the CR, that part of the requirement shall be removed from the requirements for the April 2004 release.	Contractor Staff of FIs using FISS
2.7.5	Contractors using FISS shall insure that they begin reporting phase 4 data by September 1, 2004; Standard System Maintainers are responsible for developing standard system modifications that meet phase 4	Contractor Staff of FIs using FISS

Requirement #	Description	Responsibility
	requirements. In phase 4, contractors shall begin to report all PIMR prepayment data including edit detail and savings. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	
2.7.6	Contractors shall manually enter the data for the period, October 2003 through the date of issuance of these business requirements, for the postpayment module (section 2.8.2.5) and the edit module (section 2.8.2.6) into the PIMR system within 90 calendar days following the issuance of these business requirements.	Contractor Staff
2.7.7	Data Centers shall submit the files described in sections 2.8.2.1 through 2.8.2.4) within 15 calendar days following the end of the month. The APASS and associated FIs are waived from implementing until they transition to the FISS system. The HPBSS standard system and associated carriers are waived from implementing this CR due to their upcoming transition to the MCS system. However, those associated FIs implement this requirement upon transitioning to the FISS or MCS systems.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.8	Contractors shall manually enter the data for the postpayment module (section 2.8.2.5) and the edit module (section 2.8.2.6) into the PIMR system within 15 calendar days following the end of the month beginning with the report for April 1, 2004, i.e., first entries are due May 15, 2004.	Contractor Staff
2.7.9	If a claim has different types of review applied to different lines on the claim, count the line for each type of review. For instance if a claim contains two lines, one subjected to automated review and one subjected to manual complex review, report one line for manual complex and one for automated. Do not report two lines as routine manual review. Applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.10	Report all activities performed during a month for that month, this includes reporting on a postpayment review activity (see Section 2.8.2.5) that did not start during the month but was completed during the month, e.g., a contractor requested medical documentation in a	Staff of all contractors using FISS, MCS, and VIPS systems

Requirement #	Description	Responsibility
	previous month but they did not receive and review the documentation until the current month. Applies to prepayment and postpayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	
2.7.11	Include in the report for the month all initial claims processing results for claims on which the contractor has made a payment decision (i.e., pay, deny, or reject). Include in the count all adjustment claims that you did not subject to medical review when you initially processed them. Do not include re-review of denials except for re-openings (i.e., both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff might need to re-process). The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.12	Do not duplicate Correct Coding Initiative (CCI) edits with local edits. This applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.13	Count claims multiple times if line items on the claims fall into multiple activity types. For instance, if a claim contains some line items that are subjected to manual complex review and others that are subjected to manual routine review, the claim is included in the claim count for both activity types (i.e., the action codes indicate manual complex review and manual routine review. See "Activity Types" section below for further definitions). For counts of claims without reference to activity types into which different line items on the claim might fall, e.g., claim count by bill type, count each claim only once. This requirement applies to prepayment and postpayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.14	Count a claim multiple times if each edit the contractor	Staff of all

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	applies to the claim is performed on a different line item. For example, count the claim multiple times if line item 1 is subjected to manual complex probe review (21201) and line item 2 is subjected to manual routine review (21002). To continue this example, the claim may not be counted twice if line item 1 is subjected to manual complex review and subjected to manual routine review, and no other line item on the claim is subjected to a manual complex review or manual routine review. This requirement applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	contractors using FISS, MCS, and VIPS systems
2.7.15	Count line items only once per activity type even if there are multiple services for the line item. Report on level of activity, not the number of services provided. Number of services will not be reported in PIMR. That information will be obtained from the National Claims History file, the CMS repository for claims records, or summary databases such as HCFA Customer Information System (HCIS) or Part B Extract and Statistical System (BESS). Applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.16	If a claim has multiple reviews due to multiple line items on a claim, contractors shall count the line item once for each review and the claim once for each line item review. This requirement applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.17	If the contractor applies two different activity types of review for the same item or items, e.g., a line item that is subject to prepayment review and postpayment review, count the line item and claim once regardless of the number of activity types. CMS expects this situation to occur infrequently. If a line item receives a complex review prepayment, we do not expect it to be subjected to postpayment review except in rare cases in which new information became available on the claim,	Staff of all contractors using FISS, MCS, and VIPS systems

Requirement #	Description	Responsibility
	such as a complaint or an indication of potential fraud resulting from data analysis. For prepayment review, do not report more than one type of review activity per line per claim cycle. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	
2.7.18	Do not edit line items twice (i.e., in two different claim cycles). Catch problems with a line item with the first edit. The APASS and associated FIs are waived from implementing this requirement on 4/1/02 due to their upcoming transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.19	Count the workload and costs for medical review of claims, line items, and services on bills that are denied or reduced after MR has been completed – after the claim is finalized (i.e., pay, deny, or reject). For example, if a claim is denied post Common Working File (CWF) for any other reason, even though it may have had MR activities prior to denying, include that claim in PIMR reporting under claims available for MR. Another example: if an MR edit/audit denies or suspends a claim prior to going to CWF, that counts as a claim available for MR and, if after working the edits or audits the claim denies post CWF, it also counts as a claim available for MR. Include the costs and workload for claims that meet the conditions of those examples in the PIMR report. This requirement applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.20	Do not count the re-review of a claim that has been previously fully or partially denied (other than re-openings (i.e., both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff might need to re-process) and adjustments that you did not medically review during your initial review of the claim.) as a review. That is because, once you deny a line item, the provider must appeal the denial if he/she disagrees; the provider may not resubmit the	Staff of all contractors using FISS, MCS, and VIPS systems

Requirement #	Description	Responsibility
	line item as a new claim. Applies to prepayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	
2.7.21	Do not report claims paid under waiver separately. Include the costs, workload, and savings for reviews of claims paid under waiver in the statistics for claims not paid under waiver. Applies to prepayment and postpayment review. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, system
2.7.22	Contractors shall access their error data sets at the CMS data center each month within 5 working days of submitting data, work with their data centers to correct the submission, and resubmit the entire file to the CMS data center before the fifteenth of the following month. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	Staff of all contractors using FISS, MCS, and VIPS systems
2.7.23	Data centers shall work with their contractors to correct the submission that contain errors and resubmit the entire correct file to the CMS data center. The APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	FISS, VMS, and MCS Data Centers
2.7.24	By July 1, 2003, VIPS contractors shall begin reporting PIMR data for each review only once. This requirement clarifies requirement 2.7.10 that requires the reporting of all activities performed during a month for that month, and requirement 2.7.11 that requires, for prepayment, that contractors shall include in the report for the month all initial claims processing results for claims on which the contractor has made a payment decision (i.e., pay, deny, or reject). Those requirements say that an activity should be reported only once, preferably after the contractor has completed all claims processing activities for the claim.	Contractors using VIPS standard systems
2.7.25	By January 5, 2004, contractors shall insure that standard system maintainers correctly implement PIMR codes dependent on local contractor definitions	Contractors using FISS, MCS, and VIPS standard

Requirement #	Description	Responsibility
	and used by the standard system modules that this CR requires and make certain that data submissions required by PIMR are correct. APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs implement this requirement upon transitioning to the FISS system.	systems
2.7.26	By January 5, 2004, contractors shall insure that standard system maintainers correctly implement PIMR codes dependent on local contractor definitions and used by the standard system modules that this CR requires and make certain that changes to data submissions required by the MR section of the FY 2004 BPR are correct. APASS and associated FIs are waived from implementing until they transition to the FISS system. However, those associated FIs shall implement this requirement upon transitioning to the FISS system.	Contractors using FISS, MCS, and VIPS standard systems
2.7.27	Contracts	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: May 10, 2004 **Implementation Date:** June 10, 2004 **Pre-Implementation Contact(s):** John Stewart (410) 786-1189 JStewart@cms.hhs.gov **Post-Implementation Contact(s):** John Stewart (410) 786-1189 JStewart@cms.hhs.gov	**These instructions shall be implemented within your current operating budget.**