CMS Manual System

Pub. 100 20 – One Time Notification

Transmittal 56   Date: **February 6, 2004**

CHANGE REQUEST 3113

I.   SUMMARY OF CHANGES:

This is a One Time Notification for Program Integrity Management Reporting (PIMR) System – Part A Phase 4

The new PIMR system changes reporting requirements for MR and fraud that are in CMS Publication 10-8 (Program Integrity Manual), Chapter 7 (MR and BI Reports), §§ 1, 2, 5, and 6-10. Formerly the requirements were in Publication 13 (Intermediary Manual), Part 2, §2301, and Part 3, §3939. They were also included in Publication 14 (Carriers Manual), Part 3, §§7504.2, 7535-7537, and 14021.

This change request requires that shared systems make changes to allow collection of information for PIMR Part A Phase 4.

NEW/REVISED MATERIAL - EFFECTIVE DATE: FISS July 1, 2004
                        IMPLEMENTATION DATE: July 6, 2004

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated)

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

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	One-Time Notification

One-Time Notification

Pub. 100-20	Transmittal: 56	Date: February 6, 2004	Change Request 3113

**SUBJECT: Program Integrity Management Reporting (PIMR) System for Part A –
            Phase 4**

I - GENERAL INFORMATION:

**A. Background: This One Time Notification (OTN) provides instructions for
implementing PIMR for fiscal intermediaries (FI) for Phase 4.**

The new PIMR system changes reporting requirements for medical review (MR) and fraud
are in Pub. 100-8 (Program Integrity Manual), Chapter 7 (MR and BI Reports) §§1, 5, and 6-
10. Formerly the requirements were in Pub. 13 (Intermediary Manual), Part 2 §2301 and
Part 3 §3939, and Pub. 14 (Carriers Manual), Part 3 §§7504.2, 7535-7537, and 14021.

The CMS' Program Integrity Group has developed a new system for improving the
management of cost, savings, and workload data relative to the MR unit and Benefit Integrity
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).

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

The PIMR data required for the new system that CMS cannot extract from existing systems
will be collected from contractors monthly within 15 calendar days following the end of the
month. Contractor data centers will transfer most of the data requested directly from
contractor shared systems to central office computer within 15 calendar days following the
end of each month.

Final reporting requirements that shared systems and other sources must meet are provided
below. This OTN implements Phase 4 of PIMR for Part A. Requirements for phase 1-3 and
the attachments to which this OTN refers were provided in the Program Integrity Manual
section 7.2

Interface Identification

The PIMR system will require summarized data from other CMS databases on a monthly
basis. The databases include the Contractor Shared Systems, Contractor Reporting of
Operational and Workload Data (CROWD), Contractor Administrative Cost and Financial
Management System (CAFM), Fraud Investigation Database (FID), the CMS complaint
reporting system, and the CMS overpayment reporting system. The CMS will use a Data
Transfer Utility to map and transfer the data. Mapping will be the responsibility of CMS.

B. Policy: Necessary changes in the Program Integrity Manual (PIM) will be forthcoming. These instructions are *reporting* instructions; **they are not instructions for how to perform MR or benefit integrity activities, or requirements for performing those activities.**

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
3113.1	In time for contractors to begin reporting data for Phase 4 of PIMR by July 1, 2004, Shared System Maintainers shall develop shared system modifications to meet Phase 4 of PIMR. In Phase 4 of PIMR, contractors shall begin to report all PIMR denial reasons data (items D1- D9 of the attachment) and prepay MR data (items P01-P18 of the attachment) except referral items (P19-P22 of the attachment) by edit code. Edit code is item P04 of the prepayment dataset and item D4 of the denial reasons dataset. The APASS maintainer and associated FIs are waived from implementing Phase 4 of PIMR until they transition to the FISS system. However, those associated FIs and the associated FIs' data centers shall implement this requirement upon transitioning to the FISS system.	FISS Shared System Maintainer
3113.2	Contractors using FISS shall insure that they begin reporting phase 4 data by July 1, 2004. In Phase 4 of PIMR, contractors shall begin to report all PIMR prepayment data except referral items (P19-P22) and denial data by edit code: item P04 of the prepay dataset and item D4 of the denial reason dataset. The APASS maintainer and associated FIs and the associated FIs' data centers are waived from implementing Phase 4 of PIMR until they transition to the FISS system. However, those associated FIs shall implement this requirement upon transitioning to the FISS system.	Contractor Staff of FIs using FISS

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Instructions

X-Ref Requirement #	Instructions

C. Interfaces:

C.1 OTHER SYSTEMS

The PIMR system will require summarized data from other CMS databases on a monthly basis. The databases include the Contractor Shared Systems, CROWD, CAFM, (FID, the CMS complaint reporting system, and the CMS overpayment reporting system. The CMS will use a Data Transfer Utility to map and transfer the data. Mapping will be the responsibility of CMS.

C.2 INTERACTIVE MODULES

Some of the required modules have manual interfaces in addition to a batch data transfer capability. They are the postpayment module (PIM section 7.2.8.2.5 through 7.2.8.2.4) and the edit description module (PIM section 7.2.8.2.6).

C.3 EDITS CMS APPLIED TO PIMR DATA

The CMS applies two types of edits to PIMR data:

1. Totals by activity type, provider type, and provider subtype for each monthly submissions are compared to the totals for the previous month. If a threshold of difference is exceeded, the file is rejected.

2. Submitted data is checked for formats and ranges specified in PIM sections 7.2.8.2.1 through 7.2.8.2.4. If data does not match, the file is rejected.

Specific problems with each file are noted and the files are made available to data centers for correction. Rejected files should be corrected before the 15th of the month following the month of submission.

C.4 CORRECTING A SUBMISSION

Errors in submissions are listed in the following datasets:

> P#PMR.#PIMR.CXXXXX.CVTPPAY.REPORT;
> P#PMR.#PIMR.CXXXXX. CVTCLM. REPORT;
> P#PMR.#PIMR.CXXXXX. CVTDNL. REPORT; and
> P#PMR.#PIMR.CXXXXX. CVTOTR. REPORT;

The "XXXXX" in the above data files is the contractor number. Contractors must access their data sets at the CMS data center each month, work with their data centers to correct the submission, and resubmit the entire file to the CMS data center.

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

E. Dependencies: The new PIMR system changes reporting requirements for MR and fraud in Pub.100-8 Chapter 7, (MR and BI Reports), §§1, 2, 5, and 6-10. Formerly, the requirements were in Pub. 13 (Intermediary Manual), Part 2 §2301 and Part 3 §3939, and Pub. 14 (Carriers Manual), Part 3 §§7504.2, 7535-7537, and 14021.

F. Testing Considerations: None

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date: July 6, 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.**

Attachment

:

ATTACHMENT

Contractor/Shared System Interface and Manual Data Requirements

Sections 1 through 4 identify the data elements contractor shared systems are required to collect and transfer to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

1.0 Prepay MR Data

The following table provides a definition of the Prepay MR data required by the PIMR system from the contractor shared systems.

Note: The ideal interface is a flat file exported from the shared system. The format and order of the file is defined in the table below.

PK = Primary Key

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
P01	Contractor Number CTRR_NUM	A unique number by contract type assigned to each contractor for CROWD reporting.	CHAR(5), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P02	Year/Month YR_MO_TXT	A code, which specifies the year and month for the data, reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P03	Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N = Automated National Edit, 21001 I = Automated CCI Edit, 21002 = Manual Routine Review, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the shared system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review Left justify activity types less than six positions.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P04	Edit Code EDIT_CD	A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply. For Part A, enter '99999' for edit code until phase 4 is implemented.	CHAR(5), PK	PMR_PPAY_RVW
P05	Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician).	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P06	Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery).	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P07	Units UNIT_CNT	The number of units that vary by activity. Activity types 21001L, 21001N, and 21001I include number of edits associated with that activity used during the reporting period. All other Activity Types refer to the number of reviews associated with that activity during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
P08	Claims CLAIM_CNT	The number of claims a specific activity type reviews during the reporting period. This item does not apply to 21001N, 21001L, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
P09	Line Items LINE_ITM_CNT	The number of individual lines a specific activity type reviews during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
P10	Billed Dollars BILD_AMT	The actual charges submitted by providers, suppliers, or beneficiaries during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW
P11	Allowed Dollars	The amount of the charges that are approved	NUMERIC(13)	PMR_PPAY_RVW

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
	ALWB_AMT	for payment on claims prior to medical review. This does not apply to activity types 21001L, 21001N, and 21001I.		
P12	Denied Claims DND_CLM_CNT	The number claims denied or reduced by each activity type during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
P13	Denied Line Items (Part B) DND_LINE_ITM_CNT	The number of line items denied or reduced by each activity type during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
P14	Denied Dollars DND_AMT	The amount of charges that were billed by the provider, supplier, or beneficiary and subsequently denied or reduced after MR.	NUMERIC(13)	PMR_PPAY_RVW
P15	Eligible Dollars ELGLL_AMT	The amount of charges that were billed by the provider, supplier, or beneficiary and are eligible for payment on valid claims after MR .	NUMERIC(13)	PMR_PPAY_RVW
P16	Reversed Claims RVRS_CLM_CNT	The number of claims that were reversed during this period from claims that had been denied or reduced during this or prior periods	NUMERIC(10)	PMR_PPAY_RVW
P17	Reversed Line Items RVRS_LINE_ITM_CNT	The number of line items (Part B) that were reversed during this period from line items that had been denied or reduced during this or prior periods.	NUMERIC(10)	PMR_PPAY_RVW
P18	Reversed Dollars RVRS_AMT	The amount of dollars that were reversed during this period from dollars that had been denied or reduced during this or prior periods.	NUMERIC(13)	PMR_PPAY_RVW
P19	# Referrals RFRL_CNT	The number of claims(s) , issues, or providers referred to the BI unit or PSC during the reporting period. This does not apply to Activity Types 21001L, 21001N, and 21001L.	NUMERIC(10)	PMR_FRD_RFRL
P20	$ Referrals RFRL_AMT	The dollar amount referred to the BI unit or PSC broken down by Provider Type and Bill/Subtype. This does not apply to Activity Types 21001L, 21001N, and 21001I.	NUMERIC(13)	PMR_FRD_RFRL
P21	# Referrals Accepted ACPT_CNT	The number of referrals accepted by the BI unit or PSC during the reporting period. This data only applies to Activity Types 21002, 21220, and 21221.	NUMERIC(10)	PMR_FRD_RFRL
P22	$ Referrals Accepted ACPT_AMT	The dollar amount of referrals accepted by the BI unit or PSC during the reporting period. This data only applies to Activity Types 21002, 21220, and 21221.	NUMERIC(13)	PMR_FRD_RFRL

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

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

2.0 Denial Reasons

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

Note: The ideal interface is a flat file exported from the shared system. The format and order of the file is defined in the table below.

PK = Primary Key

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
D1	Contractor Number CTRR_NUM	A unique number by contract type assigned to each contractor for CROWD reporting.	CHAR(5), PK	PMR_PPAY_DNL
D2	Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_DNL
D3	Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N = Automated National Edit, 21001 I = Automated CCI Edit, 21002 = Manual Routine Review, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the shared system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review Left justify activity types less than six positions.	CHAR(6), PK	PMR_PPAY_DNL
D4	Edit Code EDIT_CD	A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221.. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of "99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_DNL
D5	Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in Attachment 3.	CHAR(6), PK	PMR_PPAY_DNL
D6	Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and bill types include procedure codes. Bill/subtype codes are defined in Attachment 3.	CHAR(6), PK	PMR_PPAY_DNL
D7	Reason Code RSN_CD	A unique 6 character code that applies to either Reasons for Denials. Reason Codes include 100001 = Documentation does not . support service, 100002 = Investigation/experimental, 100003 = Items/services excluded, 100004 = Requested information not . received, 100005 = Services not billed under the . appropriate revenue . procedure code, 100006 = Services not documented in . record, 100007 = Services not medically . reasonable and necessary, 100008 = Skilled Nursing Facility . demand bills, 100009 = Daily nursing visits are not . intermittent/part time,	CHAR(6), PK	PMR_PPAY_DNL

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
		100010 = Specific visits did not include personal care services,		
		100011 = Home Health demand bills, 100012 = Ability to leave home unrestricted,		
		100013 = Physicians order not timely, 100014 = Service not ordered/not included I treatment plan, 100015 = Services not included in plan of care, 100016 = No physician certification, 100017 = Incomplete physician order, 100018 = No individual treatment plan		
		100019 = Other.		
D8	Denied Claims DNL_CLM_CNT	The number claims denied or reduced by each activity type and denial reason code during the reporting period.	NUMERIC(10)	PMR_PPAY_ DNL
D9	Denied Dollars DNL_AMT	The amount of charges that were billed by the provider, supplier, or beneficiary and subsequently denied or reduced after MR. Report by Activity type and denial reason code.	NUMERIC(13)	PMR_PPAY_ DNL

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

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

4.0 Claims Processing Data

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

Note: The ideal interface is a flat file exported from the shared system. The format and order of the file is defined in the table below.

PK = Primary Key

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
C1	Contractor Number CTRR_NUM	A unique number by contract type assigned to each contractor for CROWD reporting.	CHAR(5), PK	PMR_CLM_ PRCS
C2	Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_CLM_ PRCS
C3	Activity Type ACTY_TYPE_CD	A unique 6 character code. Code as "999999" for all Part B claims. Left justify activity types of less than six positions.	CHAR(6), PK	PMR_CLM_ PRCS
C4	Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_CLM_ PRCS
C5	Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3. Code as "999999 " for all Part B.	CHAR(6), PK	PMR_CLM_ PRCS
C6	Claims Received CLM_RCV_CNT	The number of claims received from providers/suppliers/beneficiaries for claims processing within the report.	NUMERIC(10)	PMR_CLM_ PRCS
C7	Line Items Received LINE_ITM_RCV_C NT	The number of line items received from providers/suppliers/beneficiaries for claims processing within the reporting period.	NUMERIC(10)	PMR_CLM_ PRCS
C8	Billed Dollars Received BILD_RCV_AMT	The amount in dollars of claims received from providers/suppliers/beneficiaries for claims processing within the report period.	NUMERIC(13)	PMR_CLM_ PRCS
C9	Claims Paid CLM_PD_CNT	The number of claims reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_ PRCS
C10	Line Items Paid LINE_ITM_PD_CN T	The number of line items reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_ PRCS
C11	Dollars Paid PD_AMT	The amount in dollars reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(13)	PMR_CLM_ PRCS
C12	Claims Available for MR CLM_AVL_CNT	The number of claims considered valid by contractor's claims processing function. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data, or claims that are not subject to MR by the contractor .	NUMERIC(10)	PMR_CLM_ PRCS

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

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