Program Memorandum Carriers

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

Transmittal B-02-077 **Date: NOVEMBER 1, 2002**

CHANGE REQUEST 2307

SUBJECT: Program Integrity Management Reporting (PIMR) System for Part B

I. GENERAL INFORMATION

A. Background:

This Program Memorandum (PM) provides instructions for implementing changes to PIMR specified in this CR for Carriers.

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

CMS's 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 continue to obtain the data (i.e., how aberrancies are resolved) on aberrancies on each provider type and provider subtype. CMS will obtain that information through interfaces with the standard systems.

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 standard systems to the CMS Central Office computer within 15 calendar days following the end of each month.

Final reporting requirements that standard systems and other sources must meet are provided below. Specific reporting requirements for data that contractors must manually enter are in the fifth section of those requirements.

Interface Identification

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

B. Policy:

Requirements in CMS Publication 100-8 (Program Integrity Manual), Chapter 7 (MR and BI Reports), §§1, 5, and 6-10 were formerly in CMS Publication 13 (Intermediary Manual), Part 2, §2301 and Part 3, §3939. These requirements were also in CMS Publication 14 (Carriers Manual) Part 3, §§7504.2, 7535-7537, and 14021.

Necessary changes in the Medicare Carriers Manual (MCM), Medicare Intermediary Manual (MIM), or 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.**

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1	In time for contractors to begin reporting data required by this CR by April 1, 2003, Standard System Maintainers are responsible for developing standard system modifications that meet all requirements in this CR.	Standard System Main-tainers
2	By April 1, 2003, Contractor Data Centers are responsible for implementing, operating, and maintaining the standard system modules provided by standard system maintainers; sending to CMS on a monthly basis reports that this CR requires; and correcting errors in their submissions that the PIMR system identifies.	Contractor Data Centers
3	By April 1, 2003, contractors must 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.	Contractor Staff
4	Contractors must manually enter the data for the Edit Description module (Section 6) into the PIMR system within 15 calendar days following the end of the month beginning January 8, 2001.	Contractor staff
5	Data Centers must submit the files described in Attachment 2 (sections 1-4) within 15 calendar days following the end of the month.	Data Center
6	Contractors must manually enter the data for the postpayment module (section 5) into the PIMR system within 15 calendar days following the end of the month beginning January 8, 2001.	Contractor staff
7	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 routine and one for automated. Do not report two lines as routine manual review. Applies to prepayment review.	System maintainers, Contractor staff, and Data Centers

8	You must report all activities performed during a month for that month, this includes reporting on a postpayment review activity (see Section 5 of Attachment 2) that did not start during a month but was completed during the month, i.e., an overpayment was requested or received. Applies to prepayment and postpayment review.	All
9	For prepayment, you must 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 (as defined in Attachment 1).	All
10	You must not duplicate Correct Coding Initiative (CCI) edits with local edits. Applies to prepayment review.	All
11	You must 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. Applies to prepayment and postpayment review.	All
12	You must count a claim multiple times if each edit you apply 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. Applies to prepayment review.	All

13	You must count line items only once per activity type even if there are multiple services for the line item. You must report on level of activity, not the number of services provided. Number of services will not be reported in PIMR. That information will be obtained from the National Claims History file, the 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.	
14	If a claim has multiple reviews due to multiple line items on a claim, you must count the line item once for each review and the claim once for each line item review. Applies to prepayment review.	All
15	If you apply 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, 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.	All
16	Do not edit line items twice (i.e., in two different claim cycles). Catch problems with a line item with the first edit.	All
17	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. Applies to prepayment review.	All

18	You must not count the re-review of a claim that has been previously fully or partially denied (other than re-openings as defined in Attachment 1 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 line item as a new claim. Applies to prepayment review.	All
19	You must 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.	All
20	Contractors must access their error data sets at the CMS data center each month within five 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 15th of the following month.	Contractor staff
21	Data centers must work with their contractors to correct the submission that contain errors and resubmit the entire correct file to the CMS data center.	Data Centers

See Attachment 2 for standard system (sections 1 through 4) and contractors (see sections 5 and 6) interfaces.

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:

C.1 OTHER SYSTEMS

The PIMR system will require summarized data from other CMS databases on a monthly basis. The databases include the Contractor Standard Systems, Contractor Reporting of Operational and Workload Data (CROWD), Contractor Administrative Cost and Financial Management System (CAFM), Fraud Investigative Database (FID), the CMS complaint reporting system, and the CMS overpayment reporting system. 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 (section 5 of attachment 2) and the edit description module (section 6 of attachment 2).

C.3 EDITS CMS APPLIED TO PIMR DATA

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 the CR. If data does not match the CR, 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.XXXXXX.PREPAY.EDTDATA;
P#PMR.#PIMR.XXXXXX.CLAIMS.EDTDATA;
P#PMR.#PIMR.XXXXXX.DENIAL.EDTDATA; and
P#PMR.#PIMR.XXXXXX.OTHERR.EDTDATA.

The "XXXXXX" 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: None

E. Dependencies:

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

F. Testing Considerations: None

IV. ATTACHMENT(S)

Attachment 1: Definitions

Attachment 2: Contractor/Standard System Interface and Manual Data Requirements

Attachment 3: Provider Type

Attachment 4: Crosswalk Between Medicare Summary Notice Message PIMR Denial Reason Codes

Attachment 5: Crosswalk Between Data Items and Definitions
5a: Crosswalk between data items and definitions
5b: Crosswalk between definitions and data items

Attachment 6: National Edits

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Implementation Date: 04/01/03 for Phase 1 Discard Date: 10/01/04 Post-Implementation Contact: **John Stewart, OFM/PIG/DMS, Jstewart@cms.hhs.gov**	Funding: Implement within existing budget. Pre-Implementation Contact: **John Stewart, OFM/PIG/DMS, Jstewart@cms.hhs.gov**

Attachment 1: Definitions

General Data Definitions (See Attachment 5b for a crosswalk between definitions and data items)

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

Definition 1 - MR: For the purposes of Program Integrity Management Reporting (PIMR) system, MR is defined as review of claims that occurs when review staff:

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

or

2) Investigate complaints to determine whether a corrective action was effective (e.g., an educational contact resulted in changed behavior), or identify situations that require prepayment edits or the development of a local MR policy (LMRP).

MR requires the application of clinical judgement either as part of a review, in writing policies, or in the development of guidelines and processing instructions. For local edits, that input must be from the contractor staff. For national edits, input from the contractor medical/clinical staff is not necessary.

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

Generally, a line cannot result in MR workload or savings if it is not referred to MR. A line that potentially involves both MR and claims processing work should suspend to a claims processing reviewer, and that reviewer should refer the line to MR only if the claims processing reviewer cannot make a decision based on guidelines available to that reviewer.

- Do NOT consider the review as MR if it requires:
  1. Pricing Only;
  2. Coding Only; or
  3. Pricing and Coding only.

- Consider the review as MR if:
  1. Pricing is based on Medical review determination;
  2. Coding is based on Medical review determination; or
  3. Coding and Pricing are based on Medical review determination.

- If the review always results in the same conclusion when the same characteristics exist and all characteristics are enumerated or if it is a one-step routine decision, it should NOT be defined as Routine Medical review.

  For example: “Always pay code J3490 when accompanied with the note Zantac," consider this claims processing review. If you must make the decision based upon the diagnosis that accompanies the claim, consider it MR.

- If an automated claims processing edit has already made a decision to pay, and the claim only suspends for pricing, consider the review automated claims processing and do not count it for MR workload or costs.

Definition 2 – Part B only: When this document refers to "Part B only", it means the requirement applies only to carriers and DMERCs.

Definition 3 - Units: Reporting units may be reviews, claims, services, referrals, etc. Units are defined for each item. Units are usually reviews. Where they are not, the instructions clearly indicate the units contractors are to report.

Definition 4 - Coding Decisions: Where used in this PM, the term "coding decisions" generally refers to MR decisions. For example, coding decisions include each of the following:

> A contractor reviews product information for a Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) item, finds that the wrong code has been billed based upon the review of diagnoses codes and narrative information included on the claim/bill, changes the code to the correct code, and completes the claim.
>
> In the situation described above, the contractor denies the claim line with the wrong code and uses the message that the supplier has incorrectly coded the item.
>
> A local DMEPOS rebundling edit automatically denies a Column II code billed on the same date of service as a Column I code.
>
> The contractor determines that a service billed as a bilateral X-ray is a single view X-ray and indicates a down code to a single view X-ray in the remittance advice.

Include only coding decisions that require the application of clinical judgement as part of a review, in writing policies, or in the development of guidelines and processing instructions. For decisions based on local edits, that input must be from the contractor staff. For decisions based on national edits, input from the contractor medical/clinical staff is not necessary.

Definition 5 - Effort Data: Effort is the number of claims, line items, reviews, etc. to be reported.

> **Definition 5a - Cost** - Dollars extracted from the Contractor Administrative and Financial Management (CAFM) system directly associated with each of the activities types described in later sections. Round to the nearest dollar.
>
> **Definition 5b - FTE** - Full-time-equivalent (FTE) personnel counts extracted from CAFM directly associated with the direct personnel cost of each of the activity types described in later sections.

Definition 6 - Workload Data: Workload is the number of full-time-equivalents required to perform a task.

> ***Definition 6a* - Units** - The number of workload units vary by activity types. Units may include the counts of edits, MRs, special studies, fraud cases, and data analysis. Where a unit is not specified, the unit desired is the number of reviews.
>
> ***Definition 6b* - Total No. of Claims** - Number of claims a specific activity reviews during the reporting period.

***Definition 6c* - No. of Line Items** - Number of individual lines a specific activity reviews during the reporting period.

***Definition 6d* - Billed Dollars** - The actual charges submitted by providers or suppliers during the reporting period. Round to the nearest dollar.

***Definition 6e* -Allowed Dollars** -The amount of the charges that are approved for payment on claims prior to MR. Round to the nearest dollar.

Definition 7 - Denial Data: Denials are our measure of savings in both dollars and workload units.

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

Definition 7a – Technical Denial: A technical denial for PIMR purposes, is defined as a denial that results because the claim cannot be read by the processing system or a payment decision cannot be made because sufficient information is not included on the claim. Examples of unreadable claims are ones that do not include a Health Insurance Claim Number or provider number. Examples of claims with insufficient information are claims that do not include a billed amount or procedure code.

***Definition 7b* - No. Denied Claims** - Number of claims denied or reduced by each activity during the reporting period.

***Definition 7c* - No. Denied Line Items** - Number of line items denied or reduced by each activity during the reporting period.

***Definition 7d* - Denied Dollars** - The portion of the Medicare-approved amount (initial charges allowed) subsequently denied or reduced after MR. Include dollars saved through cutbacks or down codes that result from MR in this amount. Round to the nearest dollar. Standard systems are required to develop procedures to determine this amount by line item for each activity code and edit.

***Definition 7e* - Eligible Dollars** - Amount of charges initially billed by the provider, supplier or beneficiary and eligible for payment on valid claims after MR. Count dollars eligible for MR even if they are subsequently denied by CWF processing. Round to the nearest dollar.

***Definition 7f* - Reversed Claims** - Number of claims reversed during this period from claims denied or reduced during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

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

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

Definition 7g **- Reversed Line Items -** Number of line items reversed during this period from or reduced during this or a prior period. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

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

Definition 7h **- Reversed Dollars** - Amount of dollars reversed during this period from dollars denied or reduced during this or a prior period. Round to the nearest dollar. We recognize that reversals always occur postpayment. The contractor is not required to match a reversal to the period in which the payment denial occurred.

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

Definition 7i **- Denial Reasons** - Categories explaining why a claim was denied or reduced, or why an edit was developed. A listing is included in the reporting specifications. Current reason codes are used where possible; some existing reason codes may have to be mapped to the new codes for reporting purposes.

We summarized denial reasons for reporting at a very high level. That level gives us sufficient information to meet our current needs. We also attempted to stay at a high enough level of summary that contractors can easily comply with our requirements without having to revise their denial reason codes. Use the codes for both prepayment and postpayment reporting. To assist in assigning codes, Attachment 4 contains a crosswalk between denial reason codes and the Medicare Summary Notice (MSN) codes used for remittance notices.

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

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100001 = Documentation does not support service,
100002 = Investigational/experimental
100003 = Items/services excluded from Medicare coverage,
100004 = Requested information not received,
100005 = Services not billed under the appropriate revenue or procedure code (include denials due to unbundling in this category),
100006 = Services not documented in record,
100007 = Services not medically reasonable and necessary,
100008 = Skilled Nursing Facility demand bills,
100009 = Daily nursing visits are not intermittent/part time,
100010 = Specific visits did not include personal care services,
100011 = Home Health demand bills,
100012 = Ability to leave home unrestricted,
100013 = Physician's order not timely,
100014 = Service not ordered/not included in treatment plan,
100015 = Services not included in plan of care,
100016 = No physician certification (e.g., Home Health), and
100017 = Incomplete physician order, and
100018 = No individual treatment plan
100019 = Other.

Where a denial is due to multiple reasons, use the code for the reason that was most responsible for the denial.

Definition 7j **- Overpayment Assessments Dollars** -. Amount in dollars from those that were paid in error and should be collected from the **provider, supplier or beneficiary**. Report extrapolated dollars. Round to the nearest dollar.

Definition 7k **- Overpayment Assessments Claims** - This item applies to postpayment reporting. Number of claims from those that were paid in error and should be collected from the provider, supplier , or beneficiary. Report number of claims from the sample that were in error.

Definition 7l **- Overpayment Collected Dollars** - Amount in dollars from those paid in error and collected from the provider, supplier , or beneficiary during the reporting period. Round to the nearest dollar. Where collected dollars attributable to MR cannot be distinguished from collected dollars attributable to other activities, allocate collected dollars based on cumulative overpayments assessed and not collected in each category.

Definition 7m **- Overpayment Collected Claims** - Number of claims from those paid in error and collected from the provider, supplier , or beneficiary during the reporting period. Round to the nearest dollar. Collected overpayments do not have to be linked to the specific claims from which they resulted. Include interest in amounts reported.

Definition 8 - Referral Data: Referrals are the number of issues or cases transferred between entities internal (e.g., the MR unit to professional relations) or external (e.g., the MR unit to a state licensing agency) to the contractor. Accumulate referral data by claim. The benefit integrity unit (BI unit) or Program Safeguard Contractor (PSC) may have to supply CMS with some data on the outcome of referrals, i.e., accepted and referred to OIG. A referral does not include such activities as a medical reviewer calling a provider to clarify or correct a billing error. MR units do not have to report on referrals made by BI unit or PSC. A referral occurs only when one entity refers a provider or case to an entity other than a provider. In most instances, referrals occur postpayment; however, they may occur prepayment. Report referrals in the section (i.e., prepayment or postpayment) to which they apply.

Definition 8a **- $ Referred to BI Unit or PSC** - Dollar amount (i.e., questioned dollars) referred to the BI unit or PSC. These are referrals within the contractor's organization. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. The dollar value of all fraud related referrals made by the contractor should be included in this count.

Definition 8b **- # Referred to BI unit or PSC** - Number of referrals made to the BI unit or PSC at the contractor. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. Report the number of referrals, not the number of claims; line items; or providers. These are referrals within the contractor's organization. All fraud related referrals made by the contractor should be included in this count.

Definition 8c **- # Referrals Accepted** - Number of referrals accepted by the BI unit or PSC. These are referrals within the contractor's organization. A referral may be an individual claim; a number of claims or line items; one or more providers; an issue; or a problem. Report the number of referrals, not the number of claims; line items; or providers.

Definition 8d **- $ Referrals Accepted** - Dollar amount (i.e., questioned dollars) of referrals accepted by the BI unit or PSC. These are referrals within the contractor's organization.

***Definition 8e.1* - Other Referrals** - Include actions, such as a referral for provider education based on MR, if you determine that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization.

Generally, if the work of the person or unit to which you refer a claim line is charged to the same MR line as your work is charged, do not count the referral as an "Other referral." If the work of the person or unit to which you make the referral is not charged to the MR line as your, count it as an "Other referral."

For example: A referral for continuation of PCA should not be considered other referral. Count each prepayment PCA as a manual review.

***Definition 8e.2* - Other Referral Reason Codes -** These are unique 6 character codes that apply to Other Referrals or Actions. Reason codes include:

200001 = Develop Local MR Policy,
200002 = Overpayment recovery - Overpayment recovery occurs when a contractor assesses an overpayment and refers an account for overpayment recovery. Overpayment recovery does not have to have occurred for this code to be used. An example of prepayment overpayment recovery is the denial of a claim previously paid when a contractor determines that a submitted claim results in a provider exceeding five surgeries in one day and there is a multiple surgery indicator of 2 for the claim. For postpayment reporting, enter this code and overpayment amount, where applicable. If this code is used, an amount for overpayments assessed should be entered for either the prepayment section 1 or in the postpayment report,
200003 = Requirement of a corrective action plan (e.g., clarifications of coding guidelines),
200004 = Suspension of Payment,
200005 = Education (e.g., referral to the Medical Director for a follow-up call),
200006 = Development of denial rationales (clarification as of 01/17/01) This code is used when a claim is referred for the development of internal comments for a claim denial. This code should be used when a contractor is developing a rational for denial of new benefit types prepayment or for denial of claims with payment problems that the contractor has newly identified postpayment,
200007 = Individual provider training (e.g., formal training, a structure course given for an individual provider),
200008 = Provider bulletin issued,
200009 = Provider seminar/workshop,
200010 = Additional or provider specific MR,
200011 = Comprehensive MR,
200012 = Focusing MR because of percent increase in a measure of provider activity,
200013 = Continuous prepay MR (e.g., requiring that a percentage of or all claims from a provider that meet a given criteria; be reviewed regardless of whether they fail any other edit, and someone other than the staff who makes the decision implements the action),
200014 = Referral to a BI unit or PSC,
200015 = Develop an edit,
200016 = Other,
210017 = Data analysis, and
210018 = Special studies.

This field may be blank if there were no referrals for reasons other than fraud.

Definition 8e.3 - Dollars Referred to Other - Dollar amount (i.e., questioned dollars) referred as a result of actions, such as a referral for provider education based on MR, if you determine that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization.

***Definition 9* - General Reporting Levels**

Depending on the situation, the data elements defined above are reported by several different categories or levels of detail. These levels include: Contractor Number, Year/Month, Provider Type, Bill/Subtype, Edit Code, and Activity Type. The levels are defined below.

***Definition 9a* - Contractor Number** - A unique number CMS assigned to each contractor for Contractor Reporting of Operational and Workload Data (CROWD) reporting purposes. You must report for each contract number served by the standard system. Zero fill this field to the left where necessary.

***Definition 9b* - Year/Month** - The fiscal year and month in which the data is reported. The format is YYYY/MM. For example, the first month (i.e., October, 1998) of fiscal year 1999 is 199901. **Note that the date for the example is not a calendar date.**

***Definition 9c* - Provider Type** - Provider types are defined in Attachment 3. For Part B, code as "Physician" if the study addresses both physicians and suppliers. Zero fill this field to the left where necessary.

***Definition 9d* - Bill/Subtype** - Bill Types will be used in the future for Part A, and Subtypes are for Part B. These are the second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and bill types may be based on procedure codes. Procedure code modifiers are not used to identify bill type or bill subtype. In deciding on the bill types for Part B, base the decision on the specialty of the performing (i.e., rendering) provider if there is a billing number for that provider. Otherwise, use the specialty of the rendering provider if there is no performing provider billing number. (See Attachment 3). Zero fill this field to the left where necessary.

***Definition 9e* - Edit Code** - Locally developed edits are edits for which the contractor developed some or all of the logic. These do not include Correct Coding Initiative (CCI) or National edits unless the contractor modified the edit to include other logic; report a modified CCI, or National edit as a local edit only and do not include it in the CCI or national categories. The data for locally developed edits must be reported for each individual edit by edit code. Data at the automated edit level applies only to specific prepayment activity types. That decision reflects the current needs of CMS, i.e., to identify the effectiveness and costs of manual edits. We do not need the same level of detail on national edits as we do on local edits. If additional needs arise in the future, we will either revise PIMR (if the requirement is long term) or make a special request (immediate and short term needs).

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

An edit code is described in the manual entry database based on procedure code, diagnosis code, and specialty. A narrative description of each code is also entered as part of the description. The description includes a description of criteria applied by the edit. The lists of procedure codes and diagnosis codes may be given in the form of ranges of codes. The edit code should correspond

to an action code where possible. In the case of procedure code/diagnosis code pair edits, ranges may be used to describe the edits.

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

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

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

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

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

Zero fill this field to the left where necessary.

Other names contractors use for edit codes are: "medical policy screen number," "UR screen number," and "UR edit number."

***Definition 9f* - Activity Type** - A set of MR activities performed by the Medicare contractor. There are essentially five different categories of activities: Prepayment MRs, Other Prepayment Reviews, Postpayment MRs, Claims Processing, and Other Activities. They are defined below:

Definition 9f.1 - Prepayment MR

These reviews occur prior to payment decisions. A Manual Prepay MR is a manual review of claim data or supporting documentation, when necessary, by health professionals or trained MR staff. They include manual reviews that result from automated edits (not automated reviews) fully or partially suspending claims for MR. These are reviews that result in human review whether reviewed initially by automated MR edits or not. If a claim suspends for manual review for reasons other than failing a MR automated edit, report it in the automated edit category.

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

***Definition 9f.1a* - Automated Edits:** An automated edit is one that never suspends for human intervention. It is an edit that pays or denies claims, i.e., processes the claim to completion without stopping for resolution. See PIM Chapter 3 section 5.1 for further discussion of automated prepayment review.

Some automated edits automatically request documentation from a provider without human intervention. If such an edit requests documentation and none is received, consider the review automated. If documentation is received and medical review is performed, consider the review complex manual.

Determine if a claim falls into the automated edit category on a claim by claim basis. Report the number of denials that result from automated edits where this element is required. Note that PIMR does not ask for reports on automated edit payments; it asks only for reports on automated edit denials.

Fully automated MR edits result in a claim or line item being paid or denied without manual review. It is implemented with systems edits that compare two or more data fields on the claim or other file (e.g., history file). For example, automated edits can be established to compare the procedure code to diagnosis code or the procedure code to a patient's sex. In those instances where prepayment review is automated, the contractor may specify, thorough their local medical review policy, the circumstance under which they will deny the service. When a national coverage policy or local MR policy clearly indicates that under certain circumstances a service is never covered, contractors may also automatically deny the services under those circumstance without stopping the claim for manual review, even if documentation is attached.

An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system and is denied in whole or in part because the service(s) is non-covered or not coded correctly; that means that an automated review is reported in PIMR only when it denies a part or all of a line item. The data referred to here is any resulting data that does not become associated with a manual MR. Specific data elements are transferred for the reporting period categorized as one of the following edit types:

***Definition 9f.1a.1* - Locally Developed** - edits for which the contractor developed some or all of the logic. This does not include CCI or National edits unless the contractor has modified the edit to include other logic. The data for locally developed edits must be reported for each individual edit by edit code.

***Definition 9f.1a.2* - National** - fully automated MR edits that CMS creates and the contractors do not modify. They are exactly the same for all FIs; they allow no deviations whatsoever. Basically, these edits encompass all

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

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

Examples of national automated edits include:

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

The OCE module triggers an edit that sets a reason code for medical review.

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

Edits that auto-deny for assistants at surgery.

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

See Attachment 6 for further discussion of national edits based upon program documents as of February 25, 2002.

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

Activity code 21001N, national automated edits, includes all edits specifically required by CMS except CCI. National automated edits never suspend for manual review. All criteria in them may be applied via computer.

Definition 9f.1a.3 - CCI - Correct Coding Initiative (CCI) edits that some contractors may operate as partially automated MR edits (ones that sometimes suspend for manual review) and that are developed under the Correct Coding Initiative and are provided to the contractor. CMS considers CCI edits fully automated even if a contractor operates them as partially automated. The data reported for CCI edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by CCI edits will be required for "CCI edits."

Definition 9f.1b - Manual Edits

Definition 9f.1b.1 - Manual Routine Reviews - Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. This includes a review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include extensive review of medical records. A review is considered routine if a medical record is requested from a provider and not received. Routine reviews refer to routine MRs conducted on a continuing basis and target all claims that meet an established or pre-existing set of criteria. Include prior authorization reviews in this category. Include in this category adjustments for which you 1) did not request medical records and 2) did no medical review previous to the adjustment.

Definition 9f.1b.2 - Manual Complex Reviews - Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. Manual Complex Reviews are complex MRs conducted on a continuing basis and targeted at all claims that meet an established or pre-existing set of criteria. 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. Only clinician reviewers may perform complex review (i.e., review that involves extensive evaluation of medical records) for the purpose of making a coverage or coding determination. Include in this category adjustments for which you 1) did request medical records and 2) did no medical review previous to the adjustment. Include DMERC Advanced Determinations of Medicare Coverage (ADMC) reviews in this category.

Definition 9f.1b.3 - Prepay Complex Probe Reviews - Error validation reviews, also known as "probe" reviews. See PIM chapter 3, section 2 for more information about probe reviews.

Definition 9f.1b.4 **- Prepay Complex Provider Specific Reviews** - This is Complex Manual Prepay Review that determines if a provider or a group of providers are providing non-covered or medically unnecessary services. They are not probe reviews

Definition 9f.1b.5 **- Prepay Complex Service Specific Reviews -** This is Complex Manual Prepay Review that determines if a service or a group of services are providing non-covered or medically unnecessary services. They are not probe reviews. Include DMERC Advanced Determinations of Medicare Coverage (ADMC) reviews in this category.

Definition 9f.1b.6 **- Re-openings -** This is Complex or Routine review that is done as a result of re-review of the automated review of a previously denied or partially denied claim. Do not count more than one re-opening per claim.

Definition 9f.1c - Other Prepayment Reviews

There are other prepay reviews that are not a result of partially automated or manual edits suspending claims for manual review. Those reviews are the result of special requests.

PIMR will not require specific review activities such as Directed OIG Reviews or Directed Law Enforcement Reviews. Review requirements will be set by other Program Instructions or, as in the case with the examples, by requests from agencies outside of CMS. PIMR instructions indicate only what contractors are required to report.

The following provides a definition of each review:

Definition 9f.1c.1 **- Court Ordered MRs** - A Court Ordered MR is a review that is required by a judicial order as evidenced by a subpoena or writ and not requested by law enforcement, the OIG, a PRO, the BI unit, or the PSC.

Definition 9f.1c.2 **- Directed BI unit or PSC Reviews** - Prepay reviews directed by or directly supporting the BI unit or PSC. These are reviews that the MR unit did not start or that the BI unit or PSC requested after the MR unit started the review.

Definition 9f.1c.3 **- Directed Law Enforcement Reviews** - Prepay reviews directed by or directly supporting law enforcement. These are reviews that the MR unit did not start or that law enforcement requested after the MR unit started the review.

Definition 9f.1c.4 **- Directed OIG Reviews** - Prepay reviews directed by or directly supporting, the HHS Office of the Inspector General. These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review. Include CFO audit activities in this category.

Definition 9f.1c.5 **- Directed PRO** - Prepay reviews directed by or directly supporting the Peer Review Organization. These are reviews that the MR unit did not start or that the PRO requested after the MR unit started the review.

Definition 9f.1c6 - Third Party Liability (TPL) or Demand Bill Claim Review - Demand bills are bills submitted by the SNF at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request. See the PIM Chapter 6.1.1B for additional detail.

Definition 9f.2 - Postpayment MRs

Postpayment reviews occur after a decision to pay is made. They include:

Postpayment Routine Manual Review (see definition below);

Postpayment Complex Provider Specific Reviews (see definition below);

Postpayment Complex Service Specific Reviews (see definition below);

Postpayment Complex Probe Reviews (see definition below);

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

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

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

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

Definition 9f.2a - Postpayment Routine Manual Review -

For routine manual postpayment review, the claim reviewer reviews a claim or any attachment submitted by the provider. This includes a review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review of medical records by a clinician. If review of medical records is performed by a non-clinician, report it as routine review. A review is considered routine if, after routine manual medical review, a medical record is requested from a provider and not received. Routine reviews refer to routine MRs that target all claims that meet an established criteria. Include prior authorization reviews in this category.

Definition 9f.2b - Postpayment Complex Manual 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. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. Manual Complex Reviews

are complex MRs that targeted at all claims that meet an established set of criteria. 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 relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Complex MR is a process that includes the review of medical records and other documentation to determine if a provider or a group of providers are providing non-covered or medically unnecessary services; or, if a specific service or a group of services is non-covered or medically unnecessary. Complex MRs are usually targeted at providers or services that have demonstrated aberrant billing or practice patterns. They also serve as the basis for overpayment assessment and projection. You may perform Complex MRs at the contractor's facility or at a provider's or supplier's facility. Location does not determine if the review is complex. Include all Progressive Corrective Action (PCA) postpayment reviews in complex postpayment MRs. There are three types of complex postpayment review:

Definition 9f.2b.1 Postpayment **Complex Provider Specific Reviews** -

This is Complex Manual Postpay Review that determines if a provider or a group of providers are providing non-covered or medically unnecessary services. This is not a probe review.

Definition 9f.2b.2 - Postpayment **Complex Service Specific Reviews** -

This is Complex Manual Postpay Review that determines if a specific service or a group of services is non-covered or medically unnecessary. This is not a probe review.

Definition 9f.2b.3 - Postpayment **Complex Probe Reviews** - Error validation reviews, also known as "probe" reviews (see PIM chapter 3, section 2 for more information about probe reviews

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

Definition 9f.2c **- Directed Reviews** - Postpay reviews directed by or directly supporting a unit outside of the Medical Review Unit. These are reviews that the MR unit did not start or that the outside unit requested after the MR unit started the review. The different types of directed reviews are described below.

Definition 9f.2c.1 **- Directed BI unit or PSC Reviews** - Postpay reviews directed by or directly supporting the BI unit or PSC. These are reviews that the MR unit did not start or that the BI unit or PSC requested after the MR unit started the review.

Definition 9f.2c.2 **- Directed CMS CFO Reviews** - Postpay reviews directed by or directly supporting the CFO Audit. These are reviews that the MR unit did not start or that CMS or OIG requested to support the CFO audit after the MR unit started the review.

Definition 9f.2c.3 **- Directed OIG Reviews** - Postpay reviews directed by or directly supporting the Department of Health and Human Services Office of the Inspector General (DHHS OIG). These are reviews that the MR unit did not start or that the OIG requested after the MR unit started the review. Include CFO audit activities in this category.

Definition 9f.2c.4 **- Directed Law Enforcement Reviews** - Postpay reviews directed by or directly supporting law enforcement other than the DHHS OIG. These are reviews that the MR unit did not start or that law enforcement other than the DHHS OIG requested after the MR unit started the review.

Definition 9f.2c.5 **- Directed ORT or Wedge Reviews** - Postpay reviews performed under Operation Restore Trust (ORT) or reviews that support joint agency/State MR activities. These are reviews that the MR unit did not start or that ORT requested after the MR unit started the review.

Definition 9f.2c.6 **- Directed PRO** - Postpay reviews directed by or directly supporting the Peer Review Organization (PRO). These are reviews that the MR unit did not start or that the RO requested after the MR unit started the review.

Definition 10 - Claims Processing

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

Definition 10a **- Claims Received** - The number of provider/supplier/beneficiary requests for payment received within a given period that undergo review in accordance with CMS regulations and manual instructions. The claims are paid, denied ((clarification 01/17/01) or reduced), or suspended.

Definition 10b **- Claims Paid** - Claims reviewed and adjudicated that meet the claims payment and MR criteria for payment for the reporting period.

Definition 10c **- Claims Available for MR** - Claims considered valid by the contractor's claims processing function, i.e., claims that would have been paid if they had not gone to MR. 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.

Definition 10d - Line Items Paid - Line items reviewed and adjudicated that meet the claims payment and MR criteria for payment for the reporting period.

Definition 11 - Other Activities

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

Definition 11a **- Data Analysis** - Data Analysis is defined as the review of claims information and other related data sources to

identify patterns of over utilization or abuse by claim characteristics individually or in the aggregate.

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

(1) ***Definition 11a.1* - Detection analysis** - This analysis is conducted for the purpose of identifying where PI problems exist. It includes the following activities:

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

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

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

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

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

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

- Participation on CMS PI data analysis workgroups.

(2) ***Definition 11a.2* - Effectiveness analysis** -- This analysis is conducted for the purpose of evaluating the effectiveness of contractor actions to correct PI problems once the problems have been verified. It includes the following activities:

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

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

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

***Definition 11b* - Special Studies** - Special Studies are defined as activities or projects with unique identifications designed to develop and demonstrate a new approach to fraud, abuse, or waste protection. Special studies include data collections, analyses, and surveys at the request of CMS Central Office or ROs that are classified in other categories for PIMR reporting.

***Definition 11c* - Edit Development** - Edit development is the effort necessary to create a computerized logic test developed with the assistance of health professionals that compares the data elements on a Medicare claim for the purposes of (1) making a coverage or local coding determination or (2) suspending a claim so such determinations can be made by health professionals or trained MR staff prior to payment of the claim. Use the term edit instead of "screen or audit."

***Definition 11d* - Contractor Policy Development** - Contractor Policy Development involves determining that a local MR policy (LMRP) is needed, using or adapting an existing LMRP or model policy, or developing an LMRP using medical consultants, input from professional organizations, and information from medical literature to address aberrant utilization under benefit category for an item/service.

Definition 12 - Miscellaneous Postpayment Definitions

Definition 12a - Review ID

This is a number PIMR automatically assigns as records enter the system. Contractors should leave this field blank. PIMR uses the number to uniquely identify each study.

Definition 12b - Claims Reviewed

This is number of claims reviewed as part of a postpayment review. This is the number of claims not the number of line items or providers. This figure will give CMS and idea of the amount of effort required to request medical records for a study and a claims level estimate of the number of lines per record when combined with the number of line items entered in a lines reviewed field (S8).

Definition 12c - Review date

The beginning date of the postpayment review, i.e., the date that medical records are requested for the study.

Definition 12d - Updated by

The PIMR user ID of the person who last updated the record for the study.

Definition 12e - Case Code

The contractor supplies and tracks this number. It could be the control number the contractor uses in their case tracking system or a number assigned by the MR staff to manually track reviews. The purpose of the number is to make it easy for contractors to find studies in the PIMR system and update them as the contractor obtains additional information, e.g., results of appeals or overpayment collections, on the study.

INTERACTIVE MODULES

The following modules require that contractor staff manually enter data into the PIMR system. The data must be entered monthly within 15 days of the end of the month. The requirements in Attachment 2 sections 1-4 are submitted by contractor data centers.

EDITS CMS APPLIES TO PIMR DATA

CMS applies two types of edits to PIMR data:

1. Totals by activity type, provider type, and provider subtype for each monthly submission 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 the CR. If data does not match the CR, 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 within five working days of the submission date.

HOW TO CORRECT A SUBMISSION

Errors in submissions are listed in the following datasets:

P#PMR.#PIMR.XXXXXX.PREPAY.EDTDATA
P#PMR.#PIMR.XXXXXX.CLAIMS.EDTDATA
P#PMR.#PIMR.XXXXXX.DENIAL.EDTDATA
P#PMR.#PIMR.XXXXXX.OTHERR.EDTDATA

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

RESPONSIBILITIES OF MAINTAINERS, DATA CENTERS, AND CONTRACTORS

Responsibility for PIMR is divided among standard system maintainers, contractors, and data centers as follows:

Standard System Maintainers are responsible for developing standard system modifications that meet PIMR requirements for sections 1-4 of Attachment 2 and providing them to contractor data centers.

Contractor Data Centers are responsible for implementing, operating, and maintaining the standard system modules provided by standard system maintainers; sending to CMS on a monthly basis reports that sections 1-4 of Attachment 2 require; and correcting errors in their submissions that the PIMR system identifies.

Contractors are responsible for data entering the information that the interactive PIMR modules, i.e., the postpayment and edit modules, require; insuring that standard system maintainers correctly implement codes dependent on local contractor definitions and used by the standard system modules (sections 1-4 of Attachment 2), entering manual data (sections 5B and 6b of Attachment 2), and making certain that data submissions are correct.

ATTACHMENT 2

Contractor/Standard System Interface and Manual Data Requirements

Sections 1 through 4 identify the data elements contractor standard 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. See Attachment 5a for a cross walk between data items and definitions.

1.0 Prepay MR Data

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

Note: The ideal interface is a flat file exported from the standard 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, 21201 = Prepay Complex Probe Review 21201R=Re-opening 21202 = Prepay Complex Provider Specific Review 21203 = Prepay Complex Service Specific Review 21010 = TPL or Demand Bill Claim 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, 21201, 21202, and 21203. 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). Provider Type codes are defined in Attachment 3.	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). Subtypes and Bill types include Procedure codes. Bill/subtype codes are defined in Attachment 3.	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	NUMERIC(10)	PMR_PPAY_RVW

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
		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.		
P08	Claims CLAIM_CNT	The number of claims a specific activity type reviews during the reporting period. This item does not apply to 21001N 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 ALWB_AMT	The amount of the charges that are approved for payment on claims prior to medical review. This does not apply to activity types 21001L, 21001N, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW
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 and 21001N.	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 21201, 21202, and 21203.	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 21201, 21202, and 21203.	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 standard systems.

Note: The ideal interface is a flat file exported from the standard 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,** **21201 = Prepay Complex Probe Review** 21201R = Re-opening **21202 = Prepay Complex Provider Specific Review** **21203 = Prepay Complex Service Spedific Review** **21010 = TPL or Demand Bill Claim 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 21201, 21202, and 21203. 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). 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, 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,**	**CHAR(6), PK**	**PMR_PPAY_DNL**

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
		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)

3.0 Other Referrals

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

Note: The ideal interface is a flat file exported from the standard 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
O1	**Contractor Number CTRR_NUM**	**A unique number by contract type assigned to each contractor for CROWD reporting.**	**CHAR(5), PK**	**PMR_OTH_RFRL**
O2	**Year/Month YR_MO_TXT**	**A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)**	**CHAR(6), PK**	**PMR_OTH_RFRL**
O3	**Activity Type ACTY_TYPE_CD**	**A unique 6 character code associated with each of the following activities:** **21002 = Manual Routine Review,** **21201 = Prepay Complex Probe Review** 21201R=Re-opening **21202 = Prepay Complex Provider Specific Review** **21203 = Prepay Complex Service Specific Review** **21007 = Data Analysis, and** **210018 = Special Studies.** **Left justify activity types less than six positions.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
O4	**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_OTH_RFRL**
O5	**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_OTH_RFRL**
O6	**Reason Code RSN_CD**	**A unique 6 character code that applies to Other Referrals or Actions. Reason Codes include 200001 = Develop Local MR Policy, 200002 = Overpayment recovery, 200003 = Requirement of a corrective action plan, 200004 = Suspension of Payment, and 200005 = Education, 200006 = Development of denial rationales, 200007 = Individual provider training, 200008 = Provider bulletin issued, 200009 = Provider seminar/workshop, 200010 = Additional or provider specific MR, 200011 = Comprehensive MR, 200012 = Focusing MR % increased, 200013 = Continuous Prepay MR, 200014 = Referral to a BI unit or PSC, 200015 = Develop an edit, and 200016 = Other, 210017 = Data Analysis, and 210018 = Special Studies.. If there are multiple reasons for the referral, report only the reason that is most responsible for the referral.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
O7	**Other Referrals RFRL_CNT**	**The number of referrals include, such as a referral for provider education based on MR, where it has been determined that the provider or supplier needs further claim submission education, either individually or in a group setting. Referrals are categorized by the Reason Codes above. They are broken down by Provider Type, Bill/Subtype, and “Other Referral Reason Code. This only applies to activity types 21002 21201, 21202, and 21203.**	**NUMERIC(10)**	**PMR_OTH_RFRL**

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.
Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Reason Code (RSN_CD)

4.0 Claims Processing Data

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

Note: The ideal interface is a flat file exported from the standard 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_CN T**	**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_CNT**	**The number of line items reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.**	**NUMERIC(10)**	**PMR_CLM_ PRCS**
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

5.0 Postpay MR Data

Section 5A is a table that provides a definition of the Postpay MR data required by the PIMR system and that may be obtained from the contractor standard systems. Section 5B is a module that allows contractors to manually enter postpayment data into the system.

5A <u>FILE LAYOUT FOR DATASET TRANSMISSION:</u> These specifications are provided for standard systems maintainers that wish to develop modules to transfer post payment data directly to PIMR from the standard system. Standard systems are not required to develop such modules

Initially, enter the data for this module when a study is completed, i.e., when an overpayment is identified. Updates to the initial report for overpayment collection and reversals must be made manually using the interactive module provide in PIMR. Updates can be done as they occur (enter cumulative amounts) or they may be made once an activity is completed, i.e., the overpayment is collected or the time limit for appeals expires.

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

PK = Primary Key

Item Number	Destination Table	PIMR Logical and Physical Name	Definition	Physical Design
S1	PMR Postpay Review PMR_PSPY_RVW	Contractor Number CTRR_NUM	A unique identification number CMS has assigned to the Medicare contractor for CROWD reporting purposes.	CHAR(5), PK
S2	PMR Postpay Review PMR_PSPY_RVW	Year/Month YR_MO_TXT	The year and month to which the data applies.	CHAR(6), PK
S3	PMR Postpay Review PMR_PSPY_RVW	Provider Type PROV_TYPE_CD	A unique identifier for each provider type. Provider types and codes are defined in Attachment 3. For Part B, code as "Physician" if the study addresses both physicians and suppliers.	CHAR(6), PK
S4	PMR Postpay Review PMR_PSPY_RVW	Bill/Sub Type BILL_TYPE_CD	A unique identifier to be used for Part A Postpayment reporting. It is based on Bill Type (Part A) . For Part B postpayment reporting code as "999999."	CHAR(6), PK
S5	PMR Postpay Review PMR_PSPY_RVW	Activity Type Code ACTY_TYPE_CD	A unique identification code associated with the Postpay Review activity. This code is used to track workload, denials, and referrals resulting from each activity. Left justify activity types less than six positions. 21030 = Routine Manual Postpay 21031 = Complex Manual Provider-Specific Postpay Review 21032 = Complex Manual Service-Specific Postpay Review 21205 = Postpay Complex Probe Review	CHAR(6), PK
S6	PMR Postpay Review PMR_PSPY_RVW	Review Identifier RVW_NUM	A number to differentiate reviews under each Contractor and Postpay activity. The PIMR System will automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractors should leave this field blank.	CHAR(6), PK
S7	PMR Postpay Review PMR_PSPY_RVW	Claims CLM_CNT	The total number of claims reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype. Enter a 1 to indicate a postpayment review that involved only one claim.	NUMERIC(10)
S8	PMR Postpay Review PMR_PSPY_RVW	Line Items LINE_ITM_CNT	The total number of line items reviewed during each Postpay review by Activity Type, Provider Type, and Bill/Subtype.	NUMERIC(10)
S9	PMR Postpay Review PMR_PSPY_RVW	Billed Dollars BILD_AMT	The dollar amount charged by the provider, supplier or beneficiary under review for each Postpayment review by Activity Type, Provider Type, and Bill/Subtype. This is the actual amount billed for the claims in the sample not an estimate of the amount billed for the universe.	NUMERIC(13)
S10	PMR Postpay Review PMR_PSPY_RVW	Allowed Dollars ALWB_AMT	The actual amount of charges in the sample approved for payment on claims before the	NUMERIC(13)

Item Number	Destination Table	PIMR Logical and Physical Name	Definition	Physical Design
			Postpay review for each Postpay review by Activity, Provider Type, and Bill/Subtype. This is the actual amount allowed for the claims in the sample not an estimate of the amount allowed for the universe.	
S11	PMR Postpay Review PMR_PSPY_RVW	Denied Claims DNL_LINE_ITEM_CNT	The actual number of claims that were denied or reduced for each Postpay review by Activity, Provider Type, and Bill/Subtype.	T
S12	PMR Postpay Review PMR_PSPY_RVW	Denied Line Items DNL_LINE_ITEM_CNT	The number of line items in the sample that were denied or reduced for each Postpay review by Activity, Provider Type, and Bill/Subtype. This is the actual number of lines denied for the claims in the sample not an estimate of the number of lines denied for the universe.	NUMERIC(10)
S13	PMR Postpay Review PMR_PSPY_RVW	Denied Dollars DNL_AMT	The estimated dollar amount that was denied or reduced for each Postpay review by Activity, Provider Type, and Bill/Subtype. If dollars are not estimated for the universe enter actual dollars denied.	NUMERIC(13)
S14	PMR Postpay Review PMR_PSPY_RVW	Eligible Dollars ELGBL_AMT	The actual amount of the charges in the sample that were billed by the provider that are still eligible for payment after the review for each Postpay review by Activity, Provider Type, and Bill/Subtype. This is the actual amount for the claims in the sample not an estimate of the amount for the universe.	NUMERIC(13)
S15	PMR Postpay Review PMR_PSPY_RVW	Reversed Claims RVRS_CLM_CNT	The number of claims initially denied or reduced postpayment but reversed as a result of appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype. Update and accumulated this field as reversals occur. This is the actual number for the claims for the sample not an estimate of the number for the universe.	NUMERIC(10)
S16	PMR Postpay Review PMR_PSPY_RVW	Reversed Line Items RVRS_LINE_ITM_CNT	The number of line items initially denied or reduced postpayment but reversed as a result of appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype. Update and accumulated this field as reversals occur. This is the actual number for the lines for the sample not an estimate of the number for the universe.	NUMERIC(10)
S17	PMR Postpay Review PMR_PSPY_RVW	Reversed Dollars RVRS_AMT	The amount in dollars initially denied or reduced postpayment but reversed as a result of appeals and/or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype. Update and accumulate this field as reversals occur. This is an estimate of the dollars for the universe.	NUMERIC(13)
S18	PMR Postpay Review PMR_PSPY_RVW	Overpayment Assessed Dollars OVPY_ASMT_AMT	The estimated amount in dollars originally paid in error but identified for collection from the provider, supplier , or beneficiary because of each Postpay review by Activity, Provider Type, and Bill/Subtype. For Part B, report only one figure for each activity type. Code provider type and sub type "999999" for these reports.	NUMERIC(13)
S19	PMR Postpay Review PMR_PSPY_RVW	Overpayment Collected Dollars OVPY_COL_AMT	The amount in dollars originally paid in error but collected from the provider, supplier , or beneficiary because of each Postpay review by Activity, Provider Type, and Bill/Subtype. Include interest collected in this amount.. Contractors may cumulate this field each month or report the total once the total has been collected or the debt written off. This is an estimate of the dollars for the universe.	NUMERIC(13)
S20	PMR Postpay Review PMR_PSPY_RVW	Review Date RVW_DT	The beginning date of each Postpay review as entered into the system. Enter as YYYY-MM-DD.	DATE (10)

Item Number	Destination Table	PIMR Logical and Physical Name	Definition	Physical Design
S21	PMR Postpay Review PMR_PSPY_RVW	Reason Code RSN_CD	A unique identification code by denial reason for each Postpay review that results in a denial. If there are multiple reason codes, enter the one that is the main reason for the denial. See Attachment 4 for a cross walk with MSNs. Enter 999999 if you did not deny in whole or part as a result of review or the outcome was in favor of the provider. See reasons below: 100001 = Documentation does not support service, 100002 = Investigational/experimental 100003 = Items/services excluded from Medicare coverage, 100004 = Requested information not received, 100005 = Services not billed under the appropriate revenue or procedure code (include denials due to unbundling in this category), 100006 = Services not documented in record, 100007 = Services not medically reasonable and necessary, 100008 = Skilled Nursing Facility demand bills, 100009 = Daily nursing visits are not intermittent/part time, 100010 = Specific visits did not include personal care services, 100011 = Home Health demand bills, 100012 = Ability to leave home unrestricted, 100013 = Physician's order not timely, 100014 = Service not ordered/not included in treatment plan, 100015 = Services not included in plan of care, 100016 = No physician certification (e.g., Home Health), 100017 = Incomplete physician order, and 100018 = No individual treatment plan 100019 = Other.	CHAR(6)
S22	PMR Postpay Review PMR_PSPY_RVW	Other Referral Reason OTH_RFRL_RSN_CD	A unique identification code by "other referrals" from each Postpay review that results in a referral other than a fraud referral. Enter 999999 if you did not refer as a result of review. See reasons below: 200001 = Develop Local MR Policy, 200002= Overpayment recovery 200003 = Requirement of a corrective action plan 200004 = Suspension of Payment, 200005 = Education 200006 = Development of denial rationales 200007 = Individual provider training 200008 = Provider bulletin issued, 200009 = Provider seminar/workshop, 200010 = Additional or provider specific MR, 200011 = Comprehensive MR, 200012 = Focusing MR 200013 = Continuous prepay MR 200014 = Referral to a BI unit or PSC, 200015 = Develop an edit, and 200016 = Other. If there are multiple other referral reasons, report the one expected to do the most to correct the problem.	CHAR(6)
S23	PMR Postpay Review PMR_PSPY_RVW	Number Referred to Fraud FRD_RFRL_CNT	The number of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, PSC, or the law enforcement authorities. This item should be a 1 or a 0.	NUMERIC(10)
S24	PMR Postpay Review PMR_PSPY_RVW	Dollars Referred to Fraud FRD_RFRL_AMT	The actual dollar amount of referrals as a result of the Postpay Review where a claim is suspected to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities.	NUMERIC(13)
S25	PMR Postpay Review PMR_PSPY_RVW	Number Referred to Other OTH_RFRL_CNT	The number of referrals other than fraud referrals that were referred to another activity as a result of the Postpay Review. This item should be a 1 or a 0.	NUMERIC(10)

Item Number	Destination Table	PIMR Logical and Physical Name	Definition	Physical Design
S26	**PMR Postpay Review PMR_PSPY_RVW**	**Dollar Referred to Other OTH_RFRL_AMT**	**The dollar amount of referrals other than fraud referrals that were referred to another Activity as a result of the Postpay Review. Report the actual dollars referred.** (clarification as of 01/17/01) **This may be either allowed or paid, whichever is actually referred.**	**NUMERIC(13)**
S27	**PMR Postpay Review PMR_PSPY_RVW**	**Number Accepted ACPT_CNT**	**The number of referrals accepted by the BI unit, PSC, or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities. This item should be a 1 or a 0.**	**NUMERIC(10)**
S28	**PMR Postpay Review PMR_PSPY_RVW**	**Dollars Accepted ACPT_AMT**	**The dollar amount of referrals accepted by the BI unit , PSC, or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities.**	**NUMERIC(13)**
S29	**PMR Postpay Review PMR_PSPY_RVW**	**Updated By UPDT_BY_TXT**	**The User Identification of the last person who updated the record.** Enter the CMS Data Center ID of the person updating the report.	**CHAR(8)**
S30	**PMR Postpay Review PMR_PSPY_RVW**	**Contractor Case Code CTRR_CASE_CD**	**A locally developed unique identifier used by Medicare contractors to identify postpay cases**	**CHAR(14)**

Level of Detail:

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

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

5B DESCRIPTION OF THE MANUAL POSTPAY MODULE

The following table provides a definitions for the Postpay MR data required by the PIMR module. The data may be entered into the PIMR interactively by contractors. The item number in this table shows a reference to section 5A of Attachment 2.

Initially, enter the data for this module when a study is completed, i.e., when an overpayment is identified. Updates to the initial report for overpayment collection and reversals must be made manually using the interactive module provide in PIMR. Updates can be done as they occur (enter cumulative amounts) or they may be made once an activity is completed, i.e., the overpayment is collected or the time limit for appeals expires.

ITEM NUMBER	Item name for the Interactive Module	Definition	Section 5 Name
S1	**Item does not appear on screen**	**A unique identification number CMS has assigned to the Medicare contractor for CROWD reporting purposes.**	**Contractor Number CTRR_NUM**
S2	**No field name on screen - month/year selected before user gets to screen; appears in upper right corner of screen**	**The year and month to which the data applies.**	**Year/Month YR_MO_TXT**

ITEM NUMBER	Item name for the Interactive Module	Definition	Section 5 Name
S3	**Provider Type**	**A unique identifier for each provider type. Provider types and codes are defined in Attachment 3. For Part B, code as "Physician" if the study addresses both physicians and suppliers.**	**Provider Type PROV_TYPE_CD**
S4	**Provider Sub Type**	**A unique identifier to be used for Part A Postpayment reporting. It is based on Bill Type (Part A) . For Part B postpayment reporting, code as "999999."**	**Provider Sub Type BILL_TYPE_CD**
S5	**Select an Activity to enter data for:**	**A unique identification code associated with the Postpay Review activity. This code is used to track workload, denials, and referrals resulting from each activity. Right justify activity types less than six positions.** **21030 = Routine Manual Postpay** **21031 = Complex Manual Provider-Specific Postpay Review** **21032 = Complex Manual Service-Specific Postpay Review** **21205 = Postpay Complex Probe Review**	**Activity Type Code ACTY_TYPE_CD**
S6	**Review No**	**A number to differentiate reviews under each Contractor and Postpay activity. The PIMR System will automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractors should leave this field blank.**	**Review Identifier RVW_NUM**
S7	**Claims**	**The actual total number of claims reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype. Enter a 1 to indicate a postpayment review that involved only one claim.**	**Claims CLM_CNT**
S8	**TO BE ADDED**	**The actual total number of line items reviewed during each Postpay review by Activity Type, Provider Type, and Bill/Subtype.**	**Line Items LINE_ITM_CNT**
S9	**Billed Dollars**	**The actual dollar amount charged by the provider or supplier under review for each Postpayment review by Activity Type, Provider Type, and Bill/Subtype.**	**Billed Dollars BILD_AMT**
S10	**Allowed Dollars**	**The actual amount of charges approved for payment on claims before the Postpay review for each Postpay review by Activity, Provider Type, and Bill/Subtype.**	**Allowed Dollars ALWB_AMT**
S11	**Overpayment Claims**	**The actual number of claims that were denied** or reduced **for each Postpay review by Activity, Provider Type, and Bill/Subtype.**	**Denied Claims DNL_LINE_ITEM_CNT**
S12	**Overpayment Line Items**	**The actual number of line items that were denied** or reduced **for each Postpay review by Activity, Provider Type, and Bill/Subtype.**	**Denied Line Items DNL_LINE_ITEM_CNT**
S13	**TO BE ADDED**	**The estimated dollar amount that was denied or reduced for each Postpay review by Activity, Provider Type, and Bill/Subtype. Enter actual amount if you do not extrapolate to the universe.**	**Denied Dollars DNL_AMT**
S14	**TO BE ADDED**	**The amount of the charges that were billed by the provider that are still eligible for payment after the review for each Postpay review by Activity, Provider Type, and Bill/Subtype.**	**Eligible Dollars ELGBL_AMT**
S15	**Reversed Claims**	**The number of claims initially denied** or reduced **postpayment but reversed as a result of appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype.**	**Reversed Claims RVRS_CLM_CNT**

ITEM NUMBER	Item name for the Interactive Module	Definition	Section 5 Name
		Update and accumulated this field as reversals occur.	
S16	Reversed Line Items	The actual number of line items initially denied or reduced postpayment but reversed as a result of appeals or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype. Update and accumulated this field as reversals occur.	Reversed Line Items RVRS_LINE_ITM_CNT
S17	Reversed Dollars	The actual amount in dollars initially denied or reduced postpayment but reversed as a result of appeals and/or other reconsiderations. Report by Activity, Provider Type, and Bill/Subtype. Update and accumulate this field as reversals occur.	Reversed Dollars RVRS_AMT
S18	Overpayment $s Assessed	The amount in dollars originally paid in error but identified for collection from the provider, supplier , or beneficiary because of each Postpay review by Activity, Provider Type, and Bill/Subtype. Net overpayments and underpayments. For Part B, report only one figure for each activity type. Code provider type and sub type "999999" for these reports.	Overpayment Assessed Dollars OVPY_ASMT_AMT
S19	Overpayment $s Collected	The amount in dollars originally paid in error but collected from the provider, supplier , or beneficiary because of each Postpay review by Activity, Provider Type, and Bill/Subtype. Include interest collected in this amount.. Contractors may cumulate this field each month or report the total once the total has been collected or the debt written off.	Overpayment Collected Dollars OVPY_COL_AMT
S20	Review Date	The beginning date of each Postpay review as entered into the system. Enter as YYYY-MM-DD.	Review Date RVW_DT
S21	Overpayment Reason	A unique identification code by denial reason for each Postpay review that results in a denial. If there are multiple reason codes, enter the one that is the main reason for the denial. See Attachment 4 for a cross walk with MSNs.	Reason Code RSN_CD
S22	Other Referral Reason	A unique identification code by "other referrals" from each Postpay review that results in a referral other than a fraud referral. See reasons below: 200001 = Develop Local MR Policy, 200002= Overpayment recovery 200003 = Requirement of a corrective action plan 200004 = Suspension of Payment, 200005 = Education 200006 = Development of denial rationales 200007 = Individual provider training 200008 = Provider bulletin issued, 200009 = Provider seminar/workshop, 200010 = Additional or provider specific MR, 200011 = Comprehensive MR, 200012 = Focusing MR 200013 = Continuous prepay MR 200014 = Referral to a BI unit or PSC, 200015 = Develop an edit, and 200016 = Other.	Other Referral Reason OTH_RFRL_RSN_CD
S23	Number Referrals	The number of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities. This item should be a 1 or a 0.	Number Referred to Fraud FRD_RFRL_CNT

ITEM NUMBER	Item name for the Interactive Module	Definition	Section 5 Name
S24	**Referred $s**	**The dollar amount of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities.**	**Dollars Referred to Fraud FRD_RFRL_AMT**
S25	**TO BE ADDED**	**The number of referrals other than fraud referrals that were referred to another activity as a result of the Postpay Review. This item should be a 1 or a 0.**	**Number Referred to Other OTH_RFRL_CNT**
S26	**TO BE ADDED**	**The dollar amount of referrals other than fraud referrals that were referred to another Activity as a result of the Postpay Review. Report the actual dollars referred. Either this may be the allowed or paid, whichever is actually referred.**	**Dollar Referred to Other OTH_RFRL_AMT**
S27	**Accepted Referrals**	**The number of referrals accepted by the BI unit, PSC, or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities.**	**Number Accepted ACPT_CNT**
S28	**Accepted $s**	**The dollar amount of referrals accepted by the BI unit, PSC, or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the issue, claims(s) or provider is referred to the BI unit, a PSC, or the law enforcement authorities.**	**Dollars Accepted ACPT_AMT**
S29	**Last Updated By**	**The User Identification of the last person who updated the record.** Enter the CMS Data Center ID of the person updating the report.	**Updated By UPDT_BY_TXT**
S30	**TO BE ADDED**	**A locally developed unique identifier used by Medicare contractors to identify postpay cases**	**Contractor Case Code CTRR_CASE_CD**
S31	**On**	**The date on which the last person who updated the record did so**	
S32	**Contractor Name appears in the top middle of the screen (the field name does not appear on screen). Name is put in by PIMR system based on contractor number.**	**Corporate name of the contractor submitting the report. This information is supplied by the PIMR system based upon contractor number (item S1).**	

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

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

6. INTERACTIVE EDIT DESCRIPTION MODULE

The edit description module is an interactive PIMR module. The standard system does not collect this data, contractor MR staff manually enter the data into the system. The requirements for this module are described below.

Make an entry in this module for each MR edit you currently have in your claims processing system. Once you enter information on an edit, you do not need to enter information on the edit again during the life of the edit. You must revise information on an edit if there are changes to the edit. An edit should not and cannot be removed from the system by a user.

Instructions and definitions for entering each item on the screen are provided below (separate definitions for most items are not included in the definitions (see Attachment 1) provided thus far in the document since these items are unique to the edit module. Where any of the definitions (see Attachment 1) given above apply, they are referenced in the item description):

E1. CONTRACTOR - This is your corporate name. **Do not enter data in this field.** CMS CO loads the information into the system when your contract is signed.

E2 EDIT CODE -- Enter up to five characters to uniquely identify the edit. You may use a combination of letters and numbers to identify the edits. Right justify the code and left fill it with 0s , e.g., enter edit code 45 as '00045.' Edit codes of 00001-00030 have already been assigned to CMS Mandated/Optional edits. Edit codes you assign should begin with 00031.

E3. DESCRIPTION -- Provide a description of the edit. The description should reflect the purpose of the edit and the unacceptable billing practice for which the edit tests. For example, the description for an edit to detect unnecessary EKGs might read: 'Allow a maximum of one EKG every 30 days.' The description should be no longer than two lines, i.e., 200 characters including blanks. For Part A, use the standard or external description of the edits.

E4. EDIT STATUS -- Use the following definitions to complete this item.

ACTIVE -- You planned to apply the edit to one or more claims during the current quarter

INACTIVE -- You did not plan to apply the edit to at least one claim during the current quarter. Edits should not be considered inactive until all use of the code is terminated, e.g., all controls of a Part A edit are terminated or all criteria associated with a particular Part B edit code are terminated.

E5. POLICY No. -- Enter up to four identifiers you assigned to policies that justify and/or explain the edit. Leave this field blank if you have no local medical review policies that support the edit.

E6. LEVEL OF AUTOMATION: Mark the box that best describes the extent to which the edit is computerized. Use the following definitions to determine into which category the edit fits:

MANUAL -- An MR edit that always suspends for human review (see definition 9f.1b for more detail).

PARTIALLY -- An MR edit that is somewhat automated but may result in suspension of claims for manual review (see definition 9f.1a for more detail).

FULLY -- An MR edit that never results in a claim suspending for manual review (see definition 9f.1a for more detail).

E7. TYPE OF EDIT (MARK ALL THAT APPLY): Indicate what class of Medicare requirements you use the edit to test. Use the following definitions to classify the edits:

BENEFIT CATEGORY -- An edit used to determine if a service fits one of the benefit categories described in Title XVIII of the Social Security Act and Medicare program manuals,

STATUTORY EXCLUSION -- An edit used to determine if the Act excludes a service.

MEDICAL NECESSITY -- An edit used to determine if a service is reasonable and necessary within the meaning of §1862(a)(1) of the Act for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. This determination includes decisions you make concerning whether a provider who bills a service that appears to be covered has inaccurately or untruthfully billed that service.

LOCAL CODING -- An edit that decides whether a service meets the requirements listed in the local coding guidelines. Local coding guidelines are stated in the section of the local MR policy that describes the relationships between codes and defines how providers should bill services. It includes a description of non-physician rebundling rules as well as information about how and when to report units of service, place of service, Health Care Common Procedure Coding System (HCPCS) modifiers, etc. This determination includes decisions you make concerning whether a provider who bills a service that appears to be correctly coded has inaccurately or untruthfully billed that service.

E8. SPECIALTY CODE -- Enter the specialty identification for which the item/service is allowed to occur the number of times specified in 'PER.'

E9. REASON CODE -- If there is an expected outcome from the edit, enter it here. The outcome could be a denial (use the codes from definition 7i) or a referral (use the codes from definition 8e.2).

CRITERIA -- For items E10 through E18, indicate the tests the edit applies to each claim that passes through it. If the specified test is not a criteria of the edit, leave blank.

E10. PER -- In the space before 'PER' enter (a) the number of times the item/service is allowed to occur or (b) the dollars in thousands (include a dollar sign) per number of days, number of locations, a given specialty, number of miles, number of dollars, or per provider (conditional upon a given HCPCS code not appearing on the claim).

E11. DAYS -- Enter the number of days during which the item/service is allowed to occur the number of times specified in 'PER.'

E12. LOCATION -- Enter the number of locations at which the item/service is allowed to occur the number of times specified in 'PER.'

E13. ASC -- If the edit is applied to providers that performed the submitted service in an ambulatory surgical center (ASC); enter 1 otherwise leave it 0.

E14. MILES -- Enter the number of miles at or below which the item/service is allowed to occur the number of times specified in 'PER.'

E15. DOLLARS -- Enter the number of dollars for which the item/service is allowed to occur the number of times specified in 'PER.'

E16. PROC, UNLESS _____ CODE -- Enter the HCPCS code that determines that the edit does not apply per provider.

E17. DIAGNOSIS -- Enter up to ten diagnosis codes for which the item/service is allowed to occur the number of times specified in 'PER.'

E18. HCPCS -- Enter up to ten HCPCS codes for which the edit checks.

THE REQUIREMENTS FOR CAFM, CROWD, FID, AN OVERPAYMENT REPORTING SYSTEM, AND A COMPLAINT REPORTING SYSTEM ARE INCLUDED IN THIS CR FOR INFORMATION PURPOSES ONLY

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

(CAFM Interface)

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

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_EFRT PMR_EDIT_DVPT
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_EFFORT PMR_EDIT_DVLPMT
Activity Type ACTY_TYPE_CD	A unique 6-character code associated with each MR activity to allow reporting by Activity. Activities include: 21001 = Prepay Automated 21002 = Prepay Routine Review, 21007 = Data Analysis 21010 = TPL or demand bills 21030 = Postpay Routine Manual Review 21031 = Postpay Complex Provider Specific Review 21032 = Postpay Complex Service Specific Review 21100 = PSC Support Services 21201 = Prepay Complex Probe Review 21202 = Prepay Complex Provider Specific Review 21203 = Prepay Complex Service Specific Review 21205 = Postpay Complex Probe Specific Review 21206 = Policy Recon/Revision 21207 = MR workload management 21208 = New Policy Development 21209 = Prepay Complex Service Specific Review **Left justify activity types less than six positions.**	CHAR(6), PK	PMR_EFRT PMR_EDIT_DVPT (DVPT_STUS_CD for activities 21026S and 21026T only)
Cost CST_AMT	The dollars reported as the direct cost from CAFM associated with each Activity Type Code.	NUMERIC(13)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
FTE FTE_CNT	The full-time-equivalent personnel from CAFM associated with the direct personnel cost of each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
Units UNIT_CNT EDIT_CNT	The number of workload units that vary by each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)

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

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

(FID Interface)

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

1.0 Fraud Case Data

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

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

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_FRD_CASE	CASE CONTRACTOR	Contractor Identifier CNTRCTR_ID	Use CASE_ID to map case related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, which specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE	ACTION	Action Date ACTN_DT *Note: Action Date and Action Taken should be a key in the FID ACTION table if data is to be captured by each action.*	If ACTN_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE	PRVDR	Provider Type Text PRVDR_TYPE_ TXT	Use CASE_ID to map case to Contractor by CNTRCTR_ID and to Provider Type by PRVDR_TYPE_TXT
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE	BILL_TYPE	Bill Type Identifier BILL_TYPE_ID	Use CASE_ID to map case related data to a Bill Type by BILL_TYPE_ID.
Fraud Source Code FRD_SRC_CD	A unique code that identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal Sources. Beneficiary Integrity - Non IRP and MR Referrals fall under 100004.	CHAR(6), PK	PMR_FRD_CASE	ALGTN_SRC	Allegation Source Text ALGTN_SRC_T XT	Use CASE_ID to map case related data to a fraud source by ALGTN_SRC_TXT.
Fraud Status FRD_STUS_CD	A unique 1 character code that identifies fraud status. Fraud status codes include A = Active, C = Closed, N = Not Applicable. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1) PK	PMR_FRD_CASE	ACTN	Action Text ACTN_TXT	Set FRD_STUS_CD to "A" for all cases that are identified as Opened in ACTN_TXT for all ACTN_DT's within the Year/Month period. Set FRD_STUS_CD to "C" for all cases that are identified as Closed in ACTN_TXT for all ACTN_DT's within the Year/Month period.
Number Cases CASE_CNT	The number of fraud cases broken down by each combination of the keys above for the reporting period.	NUMERIC(1 0)	PMR_FRD_CASE	FID _CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT for ACTN_DT within the YEAR_Month_TXT.
# of Referrals RFRL_CNT	The number of cases referred to the OIG during the reporting period.	NUMERIC(1 0)	PMR_FRD_CASE	FID_CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T

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

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

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

2.0 Payment Suspension Data

The following table provides a definition of the payment suspension data required by the PIMR system from the FID system. The data will be extracted from the FID Database by CMS.

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

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_SPSN	SUSPNSN_ CNTRCTR	Contractor Identifier CNTRCTR_ID	Use SUSPNSN_ID to map suspension related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN	SUSPNSN	Effective Date EFCTV_DT	If EFCTV_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_ CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_SPSN	SUSPNSN	Provider Type Text PRVDR_TYPE_T XT	Each suspension record includes PRVDR_TYPE_TXT to allow filtering of data.
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Definitions and codes are currently under currently under review.	CHAR(6), PK	PMR_SPSN	SUSPNSN	BILL_TYPE_ID	Each suspension record includes BILL_TYPE_ID to allow filtering of data.
Suspension Type SPSN_TYPE_CD	A unique code, which identifies the type of suspension for the data set. Suspension types include BI = Benefit Integrity and MR = MR.	CHAR(2), PK	PMR_SPSN	SUSPNSN	Suspension Type Text SUSPNSN_TYPE_ CD	Map each FID suspension type to either BI or MR.
Suspended Providers SPSN_PROV_CNT	The number of providers that received Payment Suspensions during the reporting period. Payment Suspensions are defined as the withholding of payment by an intermediary or carrier from a provider or supplier of an approved Medicare Payment amount before a determination of the amount of the overpayment exits.	NUMERIC(10)	PMR_SPSN	SUSPNSN	SUM(Suspension Identifier) SUM(SUSPNSN_I D)	SUM(SUSPNSN_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Claims SPSN_CLAIM_CNT	The number of suspended claims associated with suspended providers for the reporting period.	NUMERIC(10)	PMR_SPSN	SUSPNSN	CLM_SUBMSN_C NT	SUM(CLM_SUBMSN _CNT) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Dollars SPSN_AMT	The amount in dollars associated with suspended providers for the reporting period. Enter amount that would be paid if not suspended.	NUMERIC(13)	PMR_SPSN	SUSPNSN	Suspension Amount SUSPNSN_AMT	SUM(SUSPNSN_AMT) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.

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

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

(OVERPAYMENT REPORTING SYSTEM INTERFACE)

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

1.0 MR Overpayment Data

The following table provides a definition of the MR overpayment data required by the PIMR system from the OVERPAYMENT REPORTING SYSTEM system.

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_PSPY_RVW
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PSPY_RVW
Activity Type ACTY_TYPE_CD	A unique code associated with each MR activity to allow reporting by Activity. Activities include: 21020 = Postpay Directed BI unit or PSC Review, 21021 = Postpay CMS CFO Review, 21022 = Postpay Directed OIG Review, 21023 = Postpay Directed Law Enforcement Review, 21024 = Postpay Directed by PRO, 21205 Postpay Directed ORT, 21027 = Court Ordered MR. **Left justify activity types less than six positions.**	CHAR(6), PK	PMR_PSPY_RVW
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	VARCHAR(6), PK	PMR_PSPY_RVW
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	VARCHAR(6), PK	PMR_PSPY_RVW
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims from that were paid in error and should be collected from the provider and supplier during the reporting period. Report the number of claims in samples that were identified as containing an overpayment.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars from that were paid in error and should be collected from the provider and supplier during the reporting period. Report the estimated amount to be collected and not the actual amount error in the sample from which the overpayment was estimated.	NUMERIC(13)	PMR_PSPY_RVW
Overpayment Collected Claims OVPY_COL_CNT	Number of claims from that were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars from that were paid in error and have been collected from the provider and supplier during the reporting period. Include interest in amounts reported.	NUMERIC(13)	PMR_PSPY_RVW

Level of Detail:

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

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

2.0 Fraud Case Overpayment Data

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

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Fraud Status Code FRD_STUS_CD	A unique code that identifies status of fraud cases. Fraud status codes include A = Active and C = Closed. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1), PK	PMR_FRD_CASE
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims associated with fraud cases that involved claims paid in error and that should be collected from the provider and supplier during the reporting period. Report the number of claims in samples identified as containing an overpayment.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars associated with fraud cases from that were paid in error and should be collected from the provider and supplier during the reporting period. Report the estimated amount to be collected and not the actual amount error in the sample from which the overpayment was estimated.	NUMERIC(13)	PMR_FRD_CASE
Overpayment Collected Claims OVPY_COL_CNT	Number of claims associated with fraud cases from that were paid in error and have been collected from the provider and supplier during the reporting period. Report the number of claims in samples for which an overpayment was collected.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars associated with fraud cases from that were paid in error and have been collected from the provider and supplier during the reporting period. Report the actual amount collected. Include interest in amounts reported.	NUMERIC(13)	PMR_FRD_CASE

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

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

3.0 Payment Suspension Overpayment Data

The following table provides a definition of the overpayment data associated with payment suspensions required by the PIMR system from the OVERPAYMENT REPORTING SYSTEM system. The data will be extracted from the OVERPAYMENT REPORTING SYSTEM Database by CMS.

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_SPSN
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_SPSN
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	VARCHAR(6), PK	PMR_SPSN
Suspension Type SPSN_TYPE_CD	A unique code that identifies the type of suspensions for the data set. Suspension types include BI = Benefit Integrity and MR = MR.	CHAR(2), PK	PMR_SPSN
Recovered Dollars OVPY_COL_AMT	Amount in dollars associated with suspended providers from that were paid in error and have been collected from the provider and supplier during the reporting period. Recovered dollars are the actual dollars recovered after issuing a demand letter and lifting the payment suspension. It is not the dollars suspended.	NUMERIC(13)	PMR_SPSN

Level of Detail:

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

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

(CROWD INTERFACE)

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

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints and 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	The number of complaints received from Law Enforcement during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

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

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

NEEDED FROM A COMPLAINT REPORTING SYSTEM

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

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

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type assigned to each contractor for CROWD reporting.**	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and Bill types include Procedure codes. Bill/subtype codes defined in Attachment 3.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes from complaint reporting system include 100002 = COMPLAINT REPORTING SYSTEM Complaints and 100004 = Other	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	The number of complaints received during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

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

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

ATTACHMENT 3

FI PROVIDER TYPE

PROVIDER CODE	PROVIDER DESCRIPTION
0	PART B PROVIDER
1	HOSPITAL
2	SKILLED NURSING FACILITY (SNF)
3	HOME HEALTH ASSOCIATION (HHA)
4	CHRISTIAN SCIENCE (CS) HOSPITAL
5	CS EXTENDED CARE
6	INTERMEDIATE CARE
7	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY
8	SPECIAL FACILITY OR AMBULATORY SURGICAL CENTER SURGERY
9	RESERVED

Provider code is the fifth digit of the six-digit provider type code below. This chart is provided as a clarification of the structure of provider type code.

Provider Types for Part B
(Use These Codes for Reporting Provider Type)

Provider Type Code	Part Code	Description
000001	B	PHYSICIAN
000002	B	NON-PHYSICIAN

Bill Types for Part B
(Use the second column for reporting Bill/Subtype)

Provider Type Code	Bill Type Code	Code Range	Description
000001	000001	00100-01999	ANESTHESIA
000001	000002	10040-69999	SURGERY
000001	000003	70010-79999	RADIOLOGY
000001	000004	80049-89399	PATHOLOGY
000001	000005	90281-98939	MEDICAL EXCEPT ANESTHESIA
000001	000006	99141-99199	MED EXCEPT ANESTHESIA
000001	000007	99201-99499	EVALUATION & MANGE
000001	000008	A0000-A0999	TRANSPORTATION SERVICE
000001	000009	A2000-A2999	CHIROPRACTIC
000001	000010	A4000-A8999	DMEPOS – SURGICAL SUPPLIES
000001	000011	B4000-B9999	DMEPOS - ENTERAL AND PARENTERAL
000001	000012	E0100-E2101	DMEPOS – MEDICAL EQUIPMENT
000001	000013	G0000-G9999	MED EXCEPT ANESTHESIA
000001	000014	H5000-H6000	MED EXCEPT ANESTHESIA
000001	000015	K0000-K9999	DMEPOS – DME
000001	000016	L0100-L9999	DMEPOS – ORTHOTICS
000001	000017	M0000-M0799	MED EXCEPT ANESTHESIA
000001	000018	M0900-M0999	ESRD
000001	000019	P2000-P9999	PATHOLOGY
000001	000020	V0000-V5399	MED EXCEPT ANESTHESIA (INCLUDES CORRECTIVE LENSES)
000001	000021	ALL OTHERS	OTHER
000001	999999		FOR PART B POST PAY AND CLAIMS REPORTING
000002	000001	00100-01999	ANESTHESIA
000002	000002	10040-69999	SURGERY
000002	000003	70010-79999	RADIOLOGY
000002	000004	80049-89399	PATHOLOGY
000002	000005	90281-98939	MEDICAL EXCEPT ANESTHESIA
000002	000006	99141-99199	MED EXCEPT ANESTHESIA
000002	000007	99201-99499	EVALUATION & MANGE
000002	000008	A0000-A0999	TRANSPORTATION SERVICE
000002	000009	A2000-A2999	CHIROPRACTIC
000002	000010	A4000-A8999	DMEPOS - SURGICAL SUPPLIES
000002	000011	B4000-B9999	DMEPOS - ENTERAL AND PARENTERAL
000002	000012	E0100-E2101	DMEPOS – MEDICAL EQUIPMENT
000002	000013	G0000-G9999	MED EXCEPT ANESTHESIA

Provider Type Code	Bill Type Code	Code Range	Description
000002	000014	H5000-H6000	MED EXCEPT ANESTHESIA
000002	000015	K0000-K9999	DMEPOS – DME
000002	000016	L0100-L9999	DMEPOS – ORTHOTICS
000002	000017	M0000-M0799	MED EXCEPT ANESTHESIA
000002	000018	M0900-M0999	ESRD
000002	000019	P2000-P9999	PATHOLOGY
000002	000020	V0000-V5399	MED EXCEPT ANESTHESIA (INCLUDES CORRECTIVE LENSES)
000002	000021	ALL OTHERS	OTHER
000002	999999		FOR PART B POST PAY AND CLAIMS REPORTING

Attachment 4

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
1.1	Air ambulance is not covered since you were not taken to the airport by ambulance.	100003
1.2	Payment is denied because the ambulance company is not approved by Medicare.	100003
1.3	Ambulance service to a funeral home is not covered.	100003
1.4	Transportation in a vehicle other than an ambulance is not covered.	100003
1.5	Transportation to a facility to be closer to home or family is not covered.	100003
1.6	This service is included in the allowance for the ambulance transportation.	100003
1.7	Ambulance services to or from a doctor's office are not covered.	100003
1.8	This service is denied because you refused to be transported.	100003
1.9	Payment for ambulance services does not include mileage when you were not in the ambulance.	100003
1.10	Payment for transportation is allowed only to the closest facility that can provide the necessary care.	100007
1.11	The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.	100007
2.1	The first three pints of blood used in each year are not covered.	100003
2.2	Charges for replaced blood are not covered.	100003
3.1	This service is covered only when recent x-rays support the need for the service.	100003
4.1	This charge is more than Medicare pays for maintenance treatment of renal disease.	NOT PI
4.2	This service is covered up to (insert appropriate number) months after transplant and release from the hospital.	100003
4.3	Prescriptions for immunosuppressive drugs are limited to a 30-day supply.	100003
4.4	Only one supplier per month may be paid for these supplies/services.	100003
4.5	Medicare pays the professional part of this charge to the hospital.	100003
4.6	Payment has been reduced by the number of days you were not in the usual place of treatment.	100019
4.7	Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.	NOT PI
4.8	This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.	NOT PI
4.9	Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.	100003
4.10	No more than ($) can be paid for these supplies each month. (NOTE: Insert appropriate dollar amount.)	NOT PI
4.11	The amount listed in the "You May Be Billed" column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the approved amount.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
5.1	Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.	NOT PI
5.2	The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.	NOT PI
5.3	Our records show that the date of death was before the date of service.	100003
5.4	If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.	NOT PI
5.5	Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.	NOT PI
5.6	The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.	NOT PI
6.1	This drug is covered only when Medicare pays for the transplant.	100003
6.2	Drugs not specifically classified as effective by the Food and Drug Administration are not covered.	100007
6.3	Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.	100007
6.4	Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.	100007
7.1	This is a duplicate of a charge already submitted.	NOT PI
7.2	This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.	NOT PI
8.1	Your supplier is responsible for the servicing and repair of your rented equipment.	100003
8.2	To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.	100016
8.3	This equipment is not covered because its primary use is not for medical purposes.	100007
8.4	Payment cannot be made for equipment that is the same or similar to equipment already being used.	100007
8.5	Rented equipment that is no longer needed or used is not covered.	100007
8.6	A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.	NOT PI
8.7	This equipment is covered only if rented.	100003
8.8	This equipment is covered only if purchased.	100003
8.9	Payment has been reduced by the amount already paid for the rental of this equipment.	NOT PI
8.10	Payment is included in the approved amount for other equipment.	100003
8.11	The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
8.12	The approved charge is based on the amount of oxygen prescribed by the doctor.	100017
8.13	Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.	NOT PI
8.14	Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6-month period after the end of the 15th paid rental month.	NOT PI
8.15	Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.	NOT PI
8.16	The approved amount includes payment for all covered stationary oxygen equipment, contents and accessory items for an entire rental month.	100003
8.17	Payment for this item is included in the monthly rental payment amount.	NOT PI
8.18	Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.	100016
8.19	Sales tax is included in the approved amount for this item.	NOT PI
8.20	Medicare does not pay for this equipment or item.	100003
8.21	This item cannot be paid without a new, revised or renewed certificate of medical necessity.	100016
8.22	No further payment can be made because the cost of repairs has equaled the purchase price of this item.	100003
8.23	No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 6 months.	100003
8.24	The claim does not show that you own or are purchasing the equipment requiring these parts or supplies.	100003
8.25	Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.	100003
8.26	Payment is reduced by 25 percent beginning the 4th month of rental.	100003
8.27	Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.	100003
8.28	Maintenance, servicing, replacement or repair of this item is not covered.	100003
8.29	Payment is allowed only for the seat lift mechanism, not the entire chair.	100003
8.30	This item is not covered because the doctor did not complete the certificate of medical necessity.	100016
8.31	Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.	100003
8.32	This item can only be rented for two months. If the item is still needed, it must be purchased.	100003
8.33	This is the next to last payment for this item.	100003
8.34	This is the last payment for this item.	100003
8.35	This item is not covered when oxygen is not being used.	100003
8.36	Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.	100016

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
8.37	An oxygen recertification form was sent to the physician.	NOT PI
8.38	This item must be rented for 2 months prior to purchasing it.	100003
8.39	This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.	100003
8.40	We have previously paid for the purchase of this item.	100003
8.41	Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.	100003
8.42	Standby equipment is not covered.	100003
8.43	Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.	100017
8.44	Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.	100001
8.45	Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.	NOT PI
8.46	Payment is included in the allowance for another item or service provided at the same time.	100003
8.47	Supplies or accessories used with noncovered equipment are not covered.	100003
8.48	Payment for this drug is denied because the need for the equipment has not been established.	100007
8.49	This allowance has been reduced because part of this item was paid on another claim.	NOT PI
8.50	Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay.	100003
9.1	The information we requested was not received.	100004
9.2	This item or service was denied because information required to make payment was missing.	100001
9.3	Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)	NOT PI
9.4	This item or service was denied because information required to make payment was incorrect.	100005
9.5	Our records show your doctor did not order this supply or amount of supplies.	100014
9.6	Please ask your provider to resubmit this claim with a breakdown of the charges or services.	NOT PI
9.7	We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate)	NOT PI
9.8	The hospital has been asked to submit additional information, you should not be billed at this time.	NOT PI
10.1	Shoes are only covered as part of a leg brace.	100003

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
11.1	Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them. (NOTE: Use for Carriers, Intermediaries, RRB, United Mine Workers)	NOT PI
11.2	This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.	NOT PI
11.3	Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.	NOT PI
11.4	Our records show that you are enrolled in a health maintenance organization. Your claim was sent to them for processing.	NOT PI
11.5	This claim will need to be submitted to (another carrier, a durable medical equipment regional carrier (DMERC), Medicaid agency.)	NOT PI
11.6	We have asked your provider to resubmit this claim to the proper carrier (intermediary). That carrier (intermediary) is (name and address of carrier, intermediary or durable medical equipment regional carrier, etc.)	NOT PI
12.1	Hearing aids are not covered.	100003
13.1	No qualifying hospital stay dates were shown for this Skilled Nursing Facility stay.	100003
13.2	Skilled Nursing Facility benefits are only available after a hospital stay of at least 3 days.	100003
13.3	Information provided does not support the need for skilled nursing facility care.	100007
13.4	Information provided does not support the need for continued care in a skilled nursing facility.	100007
13.5	You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.	100003
13.6	Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days. (NOTE: This message is used only in connection with hospital stays that occurred prior to October 1, 1997.)	100003
14.1	The laboratory is not approved for this type of test.	100003
14.2	Medicare approved less for this individual test because it can be done as part of a complete group of tests.	100003
14.3	Services or items not approved by the Food and Drug Administration are not covered.	100003
14.4	Payment denied because the claim did not show who performed the test and/or the amount charged.	100001
14.5	Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.	100001
14.6	This test must be billed by the laboratory that did the work.	NOT PI
14.7	This service is paid at 100 percent of the Medicare approved amount. (NOTE: Mandated message -This message must appear on all service lines paid at 100 percent of the Medicare approved amount.)	NOT PI
14.8	Payment cannot be made because the physician has a financial relationship with the laboratory.	NOT PI
14.9	Medicare cannot pay for this service for the diagnosis shown on the claim.	100007
14.10	Medicare does not allow a separate payment for EKG readings.	100003

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
14.11	A travel allowance is paid only when a covered specimen collection fee is billed.	100003
14.12	Payment for transportation can only be made if an X-ray or EKG is performed.	100003
14.13	The laboratory was not approved for this test on the date it was performed.	100003
15.1	The information provided does not support the need for this many services or items.	100007
15.2	The information provided does not support the need for this equipment.	100007
15.3	The information provided does not support the need for the special features of this equipment.	100007
15.4	The information provided does not support the need for this service or item.	100007
15.5	The information provided does not support the need for similar services by more than one doctor during the same time period.	100007
15.6	The information provided does not support the need for this many services or items within this period of time.	100007
15.7	The information provided does not support the need for more than one visit a day.	100007
15.8	The information provided does not support the level of service as shown on the claim.	100007
15.9	The Peer Review Organization did not approve this service.	100007
15.10	Medicare does not pay for more than one assistant surgeon for this procedure.	100003
15.11	Medicare does not pay for an assistant surgeon for this procedure/surgery.	100003
15.12	Medicare does not pay for two surgeons for this procedure.	100003
15.13	Medicare does not pay for team surgeons for this procedure.	100003
15.14	Medicare does not pay for acupuncture.	100003
15.15	Payment has been reduced because information provided does not support the need for this item as billed.	100007
15.16	Your claim was reviewed by our Medical Staff. (NOTE: Add-on to other messages as appropriate.)	NOT PI
15.17	We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate)	NOT PI
16.1	This service cannot be approved because the date on the claim shows it was billed before it was provided.	100001
16.2	This service cannot be paid when provided in this location/facility.	100007
16.3	The claim did not show that this service or item was prescribed by your doctor.	100017
16.4	This service requires prior approval by the Peer Review Organization.	100007
16.5	This service cannot be approved without a treatment plan by a physical or occupational therapist.	100018
16.6	This item or service cannot be paid unless the provider accepts assignment.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
16.7	Your provider must complete and submit your claim.	NOT PI
16.8	Payment is included in another service received on the same day.	100003
16.9	This allowance has been reduced by the amount previously paid for a related procedure.	100003
16.10	Medicare does not pay for this item or service.	100003
16.11	Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10 percent reduction.)	NOT PI
16.12	Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction when no deductible has been applied.)	NOT PI
16.13	The code(s) your provider used is/are not valid for the date of service billed.	100005
16.14	The attached check replaces your previous check (#) dated .	NOT PI
16.15	The attached check replaces your previous check. (NOTE: Use only if prior check information is not accessible by the system.)	NOT PI
16.16	As requested, this is a duplicate copy of your Medicare Summary Notice.	NOT PI
16.17	Medicare does not pay for these services when they are not given in conjunction with total parenteral nutrition.	100003
16.18	Service provided prior to the onset date of certified parenteral/enteral nutrition therapy is not covered.	100003
16.19	The approved amount of this parenteral/enteral nutrition supply is based on a less extensive level of care for the nature of the diagnosis stated.	100005
16.20	The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.	100007
16.21	The procedure code was changed to reflect the actual service rendered.	100005
16.22	Medicare does not pay for services when no charge is indicated.	NOT PI
16.23	This check is for the excess amount you paid toward a prior overpayment.	NOT PI
16.24	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.	100003
16.25	Medicare does not pay for this much equipment, or this many services or supplies.	100009
16.26	Medicare does not pay for services or items related to a procedure that has not been approved or billed.	100003
16.27	This service is not covered since our records show you were in the hospital at this time.	100003
16.28	Medicare does not pay for services or equipment that you have not received.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
16.29	Payment is included in another service you have received.	100003
16.30	Services billed separately on this claim have been combined under this procedure.	100003
16.31	You are responsible to pay the primary physician the agreed monthly charge.	NOT PI
16.32	Medicare does not pay separately for this service.	100003
16.33	Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)	NOT PI
16.34	You should not be billed for this service. You do not have to pay this amount. (NOTE: Add-on to other messages, or use individually as appropriate.)	NOT PI
16.35	You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)	NOT PI
16.36	If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)	NOT PI
16.37	Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)	NOT PI
16.38	Charges are not incurred for leave of absence days.	NOT PI
16.39	Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.	100003
16.40	Only one inpatient service per day is allowed.	100003
16.41	Payment is being denied because you refused to request reimbursement under your Medicare benefits.	NOT PI
16.42	The provider's determination of noncoverage is correct.	100003
16.43	This service cannot be approved without a treatment plan and supervision of a doctor.	100018
16.44	Routine care is not covered.	100003
16.45	You cannot be billed separately for this item or service. You do not have to pay this amount.	100003
16.46	Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.	NOT PI
16.47	When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider.	NOT PI
17.1	Services performed by a private duty nurse are not covered.	100003
17.2	This anesthesia service must be billed by a doctor.	100003
17.3	This service was denied because you did not receive it under the direct supervision of a doctor.	100003
17.4	Services performed by an audiologist are not covered except for diagnostic procedures.	100003
17.5	Your provider's employer must file this claim and agree to accept assignment.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
17.6	Full payment was not made for this service because the yearly limit has been met.	100003
17.7	This service must be performed by a licensed clinical social worker.	100003
17.8	Payment was denied because the maximum benefit allowance has been reached.	100003
17.9	Medicare (Part A / Part B) pays for this service. The provider must bill the correct Medicare contractor. (NOTE: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)	NOT PI
17.10	The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.	100003
17.11	This item or service cannot be paid as billed.	100005
17.12	This service is not covered when provided by an independent therapist.	100003
17.13	Medicare approves up to ($) a year for services billed by a physical or occupational therapist. (NOTE: Insert appropriate dollar amount.)	100003
17.14	Charges for maintenance therapy are not covered.	100007
17.15	This service cannot be paid unless certified by your physician every ( ) days. (NOTE: Insert appropriate number of days.)	100016
17.16	The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.	100003
18.1	Routine examinations and related services are not covered.	100003
18.2	This immunization and/or preventive care is not covered.	100003
18.3	Screening mammography is not covered for women under 35 years of age.	100003
18.4	This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)	100003
18.5	Medicare will pay for another screening mammogram in (12, 24) months. (NOTE: Insert appropriate number of months.)	100003
18.6	A screening mammography is covered only once for women age 35 - 39.	100003
18.7	Screening pap smears are covered only once every 36 months unless high risk factors are present.	100003
18.8	Screening mammograms are covered for women 40 - 49 years of age without high risk factors only once every 24 months.	100003
18.9	Screening mammograms are covered for women 40 - 49 years of age with high risk factors only once every 12 months.	100003
18.10	Screening mammograms are covered for women 50 - 64 years of age once every 12 months.	100003
18.11	Screening mammograms are covered for women 65 years of age and older only once every 24 months.	100003
18.12	Screening mammograms are covered annually for woman 40 years of age and older.	100003
18.13	This service is not covered for beneficiaries under 50 years of age.	100003
18.14	Service is being denied because it has not been (12,24,48) months since your last (test/procedure) of this kind.	100003

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
18.15	Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.	100003
18.16	This service is being denied because payment has already been made for a similar procedure within a set timeframe.	100003
18.17	Medicare pays for screening Pap smear and/or screening pelvic examination only once every 3 years unless high risk factors are present.	100003
18.18	Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.	100003
19.1	Services of a hospital-based specialist are not covered unless there is an agreement between the hospital and the specialist.	100003
19.2	Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider's office.	100003
19.3	Only one hospital visit or consultation per provider is allowed per day.	100003
20.1	You have used all of your benefit days for this period.	100003
20.2	You have reached your limit of 190 days of psychiatric hospital services.	100003
20.3	You have reached your limit of 60 lifetime reserve days.	100003
20.4	( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)	100003
20.5	These services cannot be paid because your benefits are exhausted at this time.	100003
20.6	Days used has been reduced by the primary group insurer's payment.	100003
20.7	You have ____ day(s) remaining of your 190-day psychiatric limit.	100003
20.8	Days used are being subtracted from your total (inpatient or skilled nursing facility) benefits for this benefit period.	100003
20.9	Services after mm/dd/yy cannot be paid because your benefits were exhausted.	100003
21.1	Services performed by an immediate relative or a member of the same household are not covered.	100003
21.2	The provider of this service is not eligible to receive Medicare payments.	100003
21.3	This provider was not covered by Medicare when you received this service.	100003
21.4	Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.	100003
21.5	Services needed as a result of war are not covered.	100003
21.6	This item or service is not covered when performed, referred, or ordered by this provider.	100003
21.7	This service should be included on your inpatient bill.	100003
21.8	Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.	100003
21.9	Payment cannot be made for unauthorized service outside the managed care plan.	100003
21.10	A surgical assistant is not covered for this place and/or date of service.	100003

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
21.11	This service was not covered by Medicare at the time you received it.	100003
21.12	This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.	100003
21.13	This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.	100003
21.14	Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.	100002
21.15	Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.	100002
21.16	Medicare does not pay for this investigational device.	100003
21.17	Your provider submitted noncovered charges for which you are responsible.	100003
21.18	This item or service is not covered when performed or ordered by this provider.	100003
21.19	This provider decided to drop out of Medicare. No payment can be made for this service, you are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.	100003
21.20	The provider decided to drop-out of Medicare. No payment can be made for this service, you are responsible for this charge.	100003
22.1	Your claim was separated for processing. The remaining services may appear on a separate notice.	NOT PI
23.1	The cost of care before and after the surgery or procedure is included in the approved amount for that service.	100003
23.2	Cosmetic surgery and related services are not covered.	100003
23.3	Medicare does not pay for surgical supports except primary dressings for skin grafts.	100003
23.4	A separate charge is not allowed because this service is part of the major surgical procedure.	100003
23.5	Payment has been reduced because a different doctor took care of you before and/or after the surgery.	100003
23.6	This surgery was reduced because it was performed with another surgery on the same day.	100003
23.7	Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.	100003
23.8	This service is not payable because it is part of the total maternity care charge.	100003
23.9	Payment has been reduced because the charges billed did not include post-operative care.	100003
23.10	Payment has been reduced because this procedure was terminated before anesthesia was started.	100003
23.11	Payment cannot be made because the surgery was canceled or postponed.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
23.12	Payment has been reduced because the surgery was canceled after you were prepared for surgery.	NOT PI
23.13	Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.	NOT PI
23.14	The assistant surgeon must file a separate claim for this service.	NOT PI
23.15	The approved amount is less because the payment is divided between two doctors. (NOTE: Use for global reductions.)	NOT PI
23.16	An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.	100003
24.1	Protect your Medicare number as you would a credit card number.	NOT PI
24.2	Beware of telemarketers or advertisements offering free or discounted Medicare items and services.	NOT PI
24.3	Beware of door-to-door solicitors offering free or discounted Medicare items or services.	NOT PI
24.4	Only your physician can order medical equipment for you.	100014
24.5	Always review your Medicare Summary Notice for correct information about the items or services you received.	NOT PI
24.6	Do not sell your Medicare number or Medicare Summary Notice.	NOT PI
24.7	Do not accept free medical equipment you don't need.	NOT PI
24.8	Beware of advertisements that read, "This item is approved by Medicare", or "No out-of-pocket expenses."	NOT PI
24.9	Be informed - Read your Medicare Summary Notice.	NOT PI
24.10	Always read the front and back of your Medicare Summary Notice.	NOT PI
24.11	Beware of Medicare scams, such as offers of free milk or cheese for your Medicare number.	NOT PI
24.12	Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.	NOT PI
24.13	Be sure you understand anything you are asked to sign.	NOT PI
24.14	Be sure any equipment or services you received were ordered by your doctor.	100014
25.1	This claim was denied because it was filed after the time limit.	NOT PI
25.2	You can be billed only 20 percent of the charges that would have been approved.	NOT PI
26.1	Eye refractions are not covered.	100003
26.2	Eyeglasses or contact lenses are covered only after cataract surgery or if the natural lens of your eye is missing.	100003
26.3	Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.	100003
26.4	This service is not covered when performed by this provider.	100003

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
26.5	This service is covered only in conjunction with cataract surgery.	100003
26.6	Payment was reduced because the service was terminated early.	100003
27.1	This service is not covered because you are enrolled in a hospice.	100003
27.2	Medicare will not pay for inpatient respite care when it exceeds five (5) consecutive days at a time.	100003
27.3	The physician certification requesting hospice services was not received timely.	100013
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	100007
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.	100003
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate.	100007
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	100019
27.8	The documentation submitted does not support that your illness is terminal.	100007
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	100007
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	100007
27.11	The provider has billed in error for the routine home care items or services received.	100019
28.1	Because you have Medicaid, your provider must agree to accept assignment.	NOT PI
29.1	Secondary payment cannot be made because the primary insurer information was either missing or incomplete.	NOT PI
29.2	No payment was made because your primary insurer's payment satisfied the provider's bill.	NOT PI
29.3	Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.	NOT PI
29.4	In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).	NOT PI
29.5	Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.6	Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.	NOT PI
29.7	Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
	records show that you were informed of this rule.	
29.8	This claim is denied because the service(s) may be covered by the worker"s compensation plan. Ask your provider to submit a claim to that plan.	NOT PI
29.9	Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.	NOT PI
29.10	These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.	NOT PI
29.11	Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.12	Our records show that these services may be covered under the Black Lung Program. Contact the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.13	Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.14	Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
29.15	Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
29.16	Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)	NOT PI
29.17	Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
29.18	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)	NOT PI
29.19	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)	NOT PI
29.20	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare-approved amount. Do not print on denied service lines.)	NOT PI
29.21	The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)	NOT PI
29.22	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See Note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)	NOT PI
29.23	No payment can be made because payment was already made by either workers' compensation or the Federal Black Lung Program.	NOT PI
29.24	No payment can be made because payment was already made by another government entity.	NOT PI
29.25	Medicare paid all covered services not paid by other insurer.	NOT PI
29.26	The primary payer is . (NOTE: Add-on to messages as appropriate and/or as your system permits.)	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
29.27	Your primary group's payment satisfied Medicare deductible and coinsurance.	NOT PI
29.28	Your responsibility on this claim has been reduced by the amount paid by your primary insurer.	NOT PI
29.29	Your provider is allowed to collect a total of ($) on this claim. Your primary insurer paid ($) and Medicare paid ($). You are responsible for the unpaid portion of ($).	NOT PI
29.30	($) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.	NOT PI
29.31	Resubmit this claim with the missing or correct information.	NOT PI
29.32	Medicare's secondary payment is ($). This is the difference between Medicare's limiting charge amount of ($) and the primary insurer's paid amount of ($).	NOT PI
30.1	The approved amount is based on a special payment method.	NOT PI
30.2	The facility fee allowance is greater than the billed amount.	NOT PI
30.3	Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by CMS.)	NOT PI
30.4	A change in payment methods has resulted in a reduced or zero payment for this procedure.	NOT PI
31.1	This is a correction to a previously processed claim and/or deductible record.	NOT PI
31.2	A payment adjustment was made based on a telephone review.	NOT PI
31.3	This notice is being sent to you as the result of a reopening request.	NOT PI
31.4	This notice is being sent to you as the result of a fair hearing request.	NOT PI
31.5	If you do not agree with the Medicare-approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.	NOT PI
31.6	A payment adjustment was made based on a Peer Review Organization request.	100007
31.7	This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.	NOT PI
31.8	This claim was adjusted to reflect the correct provider.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
31.9	This claim was adjusted because there was an error in billing.	NOT PI
31.10	This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.	NOT PI
31.11	The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)	NOT PI
31.12	The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($).	NOT PI
31.13	The Medicare paid amount has been reduced by ($) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)	NOT PI
31.14	This payment is the result of an Administrative Law Judge's decision.	NOT PI
31.15	An adjustment was made based on a review decision.	NOT PI
31.16	An adjustment was made based on a reconsideration.	NOT PI
32.1	($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)	NOT PI
33.1	The ambulatory surgical center must bill for this service.	NOT PI
34.1	Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent co-insurance on Medicare-approved services. The remaining ($) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned claims generating payment to the beneficiary.)	NOT PI
34.2	The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)	NOT PI
34.3	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.) (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.8.)	NOT PI
34.4	We are paying you ($) because the amount you paid the provider was more than you may be billed for Medicare-approved charges.	NOT PI
34.5	The amount owed you is ($). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information Box	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
	the address or phone number in the Customer Service Information Box.	
34.6	Your check includes ____ which was withheld on a prior claim.	NOT PI
34.7	This check includes an amount less than $1.00 which was withheld on a prior claim. (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.6.)	NOT PI
34.8	The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
35.1	This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (NOTE: Add if possible : Your private insurer(s) is/are .)	NOT PI
35.2	We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (NOTE: Add if possible: Your Medigap insurer is .)	NOT PI
35.3	A copy of this notice will not be forwarded to your Medigap insurer because the information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.	NOT PI
35.4	A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.	NOT PI
35.5	We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.	NOT PI
35.6	Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.	NOT PI
35.7	Please do not submit this notice to them. (NOTE: Add-on to other messages as appropriate.)	NOT PI
36.1	Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.	NOT PI
36.2	It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: 1) A copy of this notice, 2) Your provider's bill and, 3) A receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.	100007

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
36.3	Your provider has been notified that you are due a refund if you paid for this service. If you do not receive a refund from the provider within 30 days from your receipt of this notice, please write our office and include a copy of this notice. Your provider has the right to appeal this decision, which may change your right to a refund.	NOT PI
36.4	This payment refunds the full amount you paid to your provider for the services previously processed and denied. You are entitled to this refund because your provider did not tell you in writing before providing the service(s) that Medicare would not pay for the denied service (s). In the future, you will have to pay for this service when it is denied.	NOT PI
36.5	This payment refunds the full amount you are entitled to for services previously processed and reduced. You are entitled to this refund because your provider did not tell you in writing before providing the service (s) that Medicare would approve it at a lower amount. In the future, you will have to pay for the service as billed when it is reduced.	NOT PI
36.6	Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. Future services of this type provided to you will be your responsibility.	NOT PI
37.1	This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)	NOT PI
37.2	($) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)	NOT PI
37.3	( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)	NOT PI
37.4	( ) was applied to your inpatient coinsurance.	NOT PI
37.5	( ) was applied to your skilled nursing facility coinsurance.	NOT PI
37.6	( ) was applied to your blood deductible.	NOT PI
37.7	Part B cash deductible does not apply to these services.	NOT PI
37.8	Coinsurance amount includes outpatient mental health treatment limitation.	NOT PI
37.9	You have now met ($) of your ($) Part B deductible for (year).	NOT PI
37.10	You have now met ($) of your ($) Part A deductible for this benefit period.	NOT PI
37.11	You have met the Part B deductible for (year).	NOT PI
37.12	You have met the Part A deductible for this benefit period.	NOT PI
37.13	You have met the blood deductible for (year).	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
37.14	You have met ( ) pint(s) of your blood deductible for (year).	NOT PI
38.1	If you think Medicare was billed for something you did not receive, please call our Fraud Hotline, (phone number of Fraud Hotline).	NOT PI
38.2	If you were offered free items or services but Medicare was billed, please call our Fraud Hotline, (phone number of Fraud Hotline)	NOT PI
38.3	If you change your address, please contact (contractor's name) by calling (contractor's phone) and the Social Security Administration by calling 1-800-772-1213.	NOT PI
39 -- 9.3	Please ask your provider to submit a new complete claim to us. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 9.7	We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 15.16	Your claim was reviewed by our Medicare staff. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 15.17	We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 16.34	You should not be billed for this item or service. You do not have to pay this amount. (NOTE: Add-on to other messages, or use individually as appropriate.)	NOT PI
39 -- 16.35	You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 16.36	If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)	NOT PI
39 -- 16.37	Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)	NOT PI
39 -- 16.45	You cannot be billed separately for this item or service. You do not have to pay this amount.	NOT PI
39 -- 25.20	You can be billed only 20 percent of the charges that would have been approved. (NOTE: Add-on to 25.1 for assigned claims.)	NOT PI
39 -- 29.26	The primary payer is . (NOTE: Add-on to other messages as appropriate.)	100004
39 -- 29.31	Resubmit this claim with the missing or correct information.	NOT PI
39 -- 35.701	Please do not submit this notice to them. (NOTE: Add-on to other messages as appropriate.)	NOT PI
40 -- 14.7	This service is paid at 100 percent of the Medicare approved amount. (NOTE: Mandated message -This message must appear on all service lines paid at 100 percent of the Medicare approved amount.)	NOT PI
40 -- 16.11	Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10 percent reduction.)	NOT PI
40 -- 16.12	Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
40 -- 16.33	Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)	NOT PI
40 -- 20.40	( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)	NOT PI
40 -- 29.14	Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is the amount Medicare would pay if services were not covered by a third party insurer.)	NOT PI
40 -- 29.15	Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
40 -- 29.16	Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)	NOT PI
40 -- 29.17	Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)	NOT PI
40 -- 29.18	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
40 -- 29.19	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)	NOT PI
40 -- 29.20	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)	NOT PI
40 -- 29.21	The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)	NOT PI
40 -- 29.22	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)	NOT PI
40 -- 30.3	Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all assigned service line for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount of the limiting charge is exceeded is less than the threshold estimated by CMS.)	NOT PI
40 -- 31.11	The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)	NOT PI
40 -- 31.12	The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($). (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
	applies.)	
40 -- 31.13	The Medicare paid amount has been reduced by ($) previously paid for this claim. (NOTE: Mandated message - This messages should printed claim level on all adjustments for which a partial payment was previously made.)	NOT PI
40 -- 32.1	($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)	NOT PI
40 -- 34.1	Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining ($) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned split pay claims.)	NOT PI
40 -- 34.2	The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)	NOT PI
40 -- 34.3	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 -- 34.30	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 -- 34.8	The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 -- 37.1	This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)	NOT PI
40 -- 37.2	($) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
40 -- 37.3	( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.) Print the following messages in the "Deductible Section of all MSNs.	NOT PI
40 -- 37.9	You have now met ($) of your ($) Part B deductible for (year).	NOT PI
40 -- 37.10	You have now met ($) of your ($) Part A deductible for this benefit period.	NOT PI
40 -- 37.11	You have met the Part B deductible for (year).	NOT PI
40 -- 37.12	You have met the Part A deductible for this benefit period.	NOT PI
40 -- 37.13	You have met the blood deductible for (year).	NOT PI
40 -- 37.14	You have met ( ) pints of your blood deductible.	NOT PI
41.1	Medicare will pay for this service only when it is provided in addition to other services.	100003
41.2	This service must be performed by a nurse with the required psychiatric nurse credentials.	100003
41.3	The medical information did not support the need for continued services.	100007
41.4	This item is not considered by Medicare to be appropriate for home use.	100007
41.5	Medicare does not pay for comfort or convenience items.	100003
41.6	This item was not furnished under a plan of care established by your physician.	100015
41.7	This item is not considered by Medicare to be a prosthetic and/or orthotic device.	100003
41.8	Based on the information provided, your illness or injury did not prevent you from leaving your home unaided.	100012
41.9	Services exceeded those ordered by your physician.	100014
41.10	Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.	100003
41.11	Doctors orders were incomplete.	100017
41.12	The Provider has billed in error for items/services according to the medical record.	100019
41.13	The Provider has billed for services/items not documented in your record.	100006
41.14	This service/item was billed incorrectly.	100005
41.15	The information shows that you can do your own personal care.	100007
41.16	To receive Medicare payment, you must have a signed doctor's order before you receive the services.	100014
60.1	In partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.	NOT PI

CROSSWALK BETWEEN MEDICARE SUMMARY NOTICE MESSAGES AND PIMR DENIAL REASON CODES

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
60.2	The total Medicare approved amount for your hospital service is _______. Is the Part A Medicare amount for hospital services and ________ is the Part B Medicare amount for physician services (of which Medicare pays 80 percent). You are responsible for any deductible and coinsurance amounts represented.	NOT PI
60.3	Medicare has paid _______ for hospital and physician services. Your Part A deductible is _________. Your Part A coinsurance is __________. Your Part B coinsurance is ________.	NOT PI
60.4	This claim is being processed under a demonstration project.	NOT PI

ATTACHMENT 5A

CROSSWALK BETWEEN DATA ITEMS AND DEFINITIONS

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINITION ID	RELATED DATA ITEM
P01	Contractor Number	F09A	D01, O01, C01, S01
P02	Year/Month	F09B	D02, O02, C02, S02
P03	Activity Type	F09F	D03, O03, C03, S05
P04	Edit Code	F09F	D04, E01
P05	Provider Type	F09C	D05, O04, C04, S03
P06	Bill/Subtype	F09D	D06, O05, C05, S04
P07	Units	F03 F06A	
P08	Claims	F06B F10A	C06
P09	Line Items	F06C	C07, S08
P10	Billed Dollars	F06D	C08, S09
P11	Allowed Dollars	F06E	S10, C11
P12	Denied Claims	F07B	S11, D08
P13	Denied Line Items (Part B)	F07C	S12
P14	Denied Dollars	F07D	S13, D09

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
P15	Eligible Dollars	F07E	S14
P16	Reversed Claims	F07F	S15
P17	Reversed Line Items	F07G	S16
P18	Reversed Dollars	F07H	S17
P19	# Referrals	F08B	S23
P20	$Referrals	F08A	S24
P21	# Referrals Accepted	F08C	S27
P22	$ Referrals Accepted	F08D	S28
D01	Contractor Number	F09A	P01, O01, C01, S01
D02	Year/Month	F09B	P02 O02, C02, S02
D03	Activity Type	F09F	P03, O03, C03, S05
D04	Edit Code	F09F	P04, E01
D05	Provider Type	F09C	P05, O04, C04, S03
D06	Bill/Subtype	F09D	P06, O05, C05, S04
D07	Reason Code	F07I	
D08	Denied Claims	F07B	P12, S11
D09	Denied Dollars	F07D	P14, S13

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINITION ID	RELATED DATA ITEM
O01	Contractor Number	F09A	P01, D01, C01, S01
O02	Year/Month	F09B	P02, D02, C02, S02
O03	Activity Type	F09F	P03, D03, C03, S05
O04	Provider Type	F09C	P05, D05, C04, S03
O05	Bill/Subtype	F09D	P06, D06, C05, S04
O06	Reason Code	F08E.2	S22
O07	Other Referrals	F08E.1	S25

C01	Contractor Number	F09A	P01, D01 O01, S01
C02	Year/Month	F09B	P02, D02, O02, S02
C03	Activity Type	F09F	P03, D03, O03, S05

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
			S05
C04	Provider Type	F09C	P05, D05, O04, S03
C05	Bill/Subtype	F09D	P06, D06, O05, S04
C06	Claims Received	F06B, F10A	P08
C07	Line Items Received	F06C	
C08	Billed Dollars Received	F06D	P10, S09
C09	Claims Paid	F10B	
C10	Line Items Paid	F10D	
C11	Allowed Dollars	F06E	P11, S10
C12	Claims Available for MR	F10C	
S01	Contractor Number	F09A	P01, D01 O01, C01
S02	Year/Month	F09B	P02, D02, O02, C02
S03	Provider Type	F09C	P05, D05, O04, C04
S04	Bill/Sub Type	F09C	P06, D06, O05, C04
S05	Activity Type Code	F09F	
S06	Review Identifier	F12A	
S07	Claims	F12B	

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINITION ID	RELATED DATA ITEM
S08	Line Items	F06C	P09, C07
S09	Billed Dollars	F06D	P10, C08
S10	Allowed Dollars	F06E	P11, S10
S11	Denied Claims	F07B	P12 D08
S12	Denied Line Items	F07C	P13
S13	Denied Dollars	F07D	P14 D09
S14	Eligible Dollars	F07E	P15
S15	Reversed Claims	F07F	P16
S16	Reversed Line Items	F07G	P17
S17	Reversed Dollars	F07H	P18
S18	Overpayment Assessed Dollars	F07J	
S19	Overpayment Collected Dollars	F07L	
S20	Review Date	F12C	
S21	Reason Code	F7I	
S22	Other Referral Reason	F08E.2	O06
S23	Number Referred to Fraud	F08B	P19
S24	Dollars Referred to Fraud	F08A	P20
S25	Number Referred to Other	F08E.1	O07
S26	Dollars Referred to Other	F08E.3	
S27	Number Accepted	F08C	P21
S28	Dollars Accepted	F08D	P22
S29	Updated By	F12D	
S30	Contractor Case Code	F12E	
S31	On (date updated)	See postpay	
S32	Contractor Name	See postpay	E2
E1	Edit code	F09	
E2	Contractor		S32
E3	Description		
E4	Edit Status		
E5	Policy No.		
E6	Level of Automation		
E7	Type of Edit		

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
E8	Specialty Code		
E9	Reason Code		
E10	CRITERIA: PER		
E11	CRITERIA: DAYS		
E12	CRITERIA: LOCATION		
E13	CRITERIA: ASC		
E14	CRITERIA: MILES		
E15	CRITERIA: DOLLARS		
E16	CRITERIA: PROC, UNLESS __ CODE		
E17	DIAGNOSIS		
E18	HCPCS		

HDR = HEADER

ATTACHMENT 5B

CROSSWALK BETWEEN DEFINITIONS AND DATA ITEMS

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
F01	Definition 01 - MR:	ALL	ALL
F02	Definition 02 - Part A Adjustments	ALL	ALL
F03	Definition 03 - Units:	F06A	P07
F04	Definition 04 - Coding Decisions:	ALL	ALL
F05	Definition 05 - Effort Data.	HDR	HDR
F05A	Definition 05a – Cost		CAFM
F05B	Definition 05b – FTE		CAFM
F06	Definition 06 - Workload Data	HDR	HDR
F06A	Definition 06a – Units	F03	P07
F06B	Definition 06b - Total No. of Claims	F10A	P08, C06
F06C	Definition 06c - No. of Line Items		P09, C07, S08
F06D	Definition 06d - Billed Dollars		P10, C08, S09
F06E	Definition 06e -Allowed Dollars		P11, S10, C11
F07	Definition 07 - Denial Data	HDR	HDR
F07A	Definition 07a - A technical denial		
F07B	Definition 07b - No. Denied Claims		P12, S11, D08
F07C	Definition 07c - No. Denied Line Items		P13, S12
F07D	Definition 07d - Denied Dollars		P14, S13, D09
F07E	Definition 07e - Eligible Dollars		P15, S14
F07F	Definition 07f - Reversed Claims		P16, S15
F07G	Definition 07g - Reversed Line Items		P17, S16
F07H	Definition 07h - Reversed Dollars		P18, S17
F07I	Definition 07i - Denial Reasons		D07
F07J	Definition 7j - Overpayment Assessments Dollars		S18
F07K	Definition 07k - Overpayment Assessments Claims		NA
F07L	Definition 07l - Overpayment Collected Dollars		S19
F07M	Definition 07m - Overpayment Collected Claims		NA
F08	Definition 08 - Referral Data	HDR	HDR
F08A	Definition 08a - $ Referred to BI unit or PSC		P20, S24
F08B	Definition 08b - # Referred to BI unit or PSC		P19, S23
F08C	Definition 08c - # Referrals Accepted		P21, S27
F08D	Definition 08d - $ Referrals Accepted		P22, S28
F08E.1	Definition 08e.1 - Other Referrals		O07, S25
F08E.2	Definition 08e.2 - Referral Reason Code		O06, S22
F08E.3	Definition 08e.3 - Dollars Referred to Other		S26
F09	Definition 09 - General Reporting Levels	HDR	HDR

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
F09A	Definition 09a - Contractor Number		P01, D01, O01, C01, S01
F09B	Definition 09b - Year/Month -		P02, D02, O02, C02, S02
F09C	Definition 09c - Provider Type		P05, D05, O04, C04, S03
F09D	Definition 09d - Bill/Subtype		P06, D06, O05, C04, S04
F09E	Definition 09e - Edit Code		P04, D04
F09F	Definition 09f - Activity Type		P03, D03, O03, C03, S05
F09F.1	Definition 09f.1 - Prepayment MR	F09F	
F09F.1A	Definition 09f.1a - Automated Edits	F09F	
F09F.1A.1	Definition 09f.1a.1 - Locally Developed	F09F	
F09F.1A.2	Definition 09f.1a.2 – National	F09F	
F09F.1A.3	Definition 09f.1a.3 – COTS	F09F	
F09F.1B	Definition 09f.1b - Manual Edits	F09F	
F09F.1B.1	Definition 09f.1b.1 - *Manual Routine Reviews*	F09F	
F09F.1B.2	Definition 09f.1b.2 - *Manual Complex Review*	F09F	
F09F.1B.3	Definition 09f.1b.3 - *Prepay Complex Probe Review*	F09F	
F09F.1B.4	Definition 09f.1b.4 - *Prepay Complex Provider Specific Review*	F09F	
F09F.1B.5	Definition 09f.1b.5 - *Prepay Complex Service Specific Review*	F09F	
F09F.1C	Definition 09f.1c - Other Prepayment Reviews	F09F	
F09F.1C.1	Definition 09f.1c.1 - Court Ordered MRs	F09F	
F09F.1C.2	Definition 09f.1c.2 - Directed BI unit or PSC Reviews	F09F	
F09F.1C.3	Definition 09f.1c.3 - Directed Law Enforcement Reviews	F09F	
F09F.1C.4	Definition 09f.1c.4 - Directed OIG Reviews	F09F	
F09F.1C.5	Definition 09f.1c.5 - Directed PRO	F09F	
F09F.1C.65	Definition 09f.1c.5 - TPL or Demand Bills	F09F	
F09F.2	Definition 09f.2 - Postpayment MRs	F09F	
F09F.2.A	Definition 09f.2a - Routine Manual Postpayment Reviews	F09F	
F09F.2.B	Definition 09f.2b - Complex Manual Postpayment Reviews	F09F	
F09F.2.B.1	Definition 09f.2b.1 - Complex Manual Provider- Specific Postpayment Reviews	F09F	
F09F.2.B.2	Definition 09f.2b.2 - Complex Manual Service- Specific Postpayment Reviews	F09F	
F09F.2.B.3	Definition 09f.2b.3 - Complex Manual Probe Postpayment Reviews	F09F	

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
F09F.2C	Directed Reviews		
F09F.2C.1	Definition 09f.2c.1 - Directed BI unit or PSC Reviews	F09F	
F09F.2C.2	Definition 09f.2c.2 - Directed CMS CFO Reviews	F09F	
F09F.2C.3	Definition 09f.2c.3 - Directed OIG Reviews	F09F	
F09F.2C.4	Definition 09f.2c.4 - Directed Law Enforcement Reviews	F09F	
F09F.2C.5	Definition 09f.2c.5 - Directed ORT or Wedge Reviews	F09F	
F09F.2C.6	Definition 09f.2c.6 - Directed PRO	F09F	
F10	Definition 10 - Claims Data	HDR	HDR
F10A	Definition 10a – Claims Reviewed	F06B	C06 P08
F10B	Definition 10b – Claims Paid		C09
F10C	Definition 10c – Claims Available for MR		C12
F10D	Definition 10d - Line items paid		C10
F11	Definition 11 - Other Activities	HDR	HDR
F11A	Definition 11a - Data Analysis	HDR	HDR
F11A.1	Definition 11a.1 - Detection analysis		CAFM
F11A.2	Definition 11a.2 - Effectiveness analysis		CAFM
F11B	Definition 11b - Special Studies		CAFM
F11C	Definition 11c - Edit Development		CAFM
F11D	Definition 11d - Contractor Policy Development		CAFM
F12	Definition 12 - Postpayment	HDR	HDR
F12A	Definition 12a – Review ID	S06	
F12B	Definition 12b – Claims reviewed	S07	
F12C	Definition 12c – Review date	S20	
F12D	Definition 12d - Updated by	S29	
F12E	Definition 12e - Case Code	S30	

ATTACHMENT 6

NATIONAL EDITS

National edits are defined in the Coverage Issues Manual (CIM) when it contains specific requirements defined as HCPCS or ICD9-CM codes and in the annual update of the fee schedules (e.g. CRs A-01-162 (Clinical labs), A-01-10 (Part B), B-01-78 (Parenteral and enteral), AB-01-178 (DME), A-01-165 (Ambulance), and A-01-135 (SNF).

Coverage Issues Manual (CIM)

As an aid, the national edits defined in the CIM as of February 25, 2002, are described below. The following sections of the CIM contained requirements for national codes; they are further described in the information found in the following the list. Please check the most current version of the CIM for up-to-date information on national edits.

35-16 VITRECTOMY
35-30.1 STEM CELL TRANSPLANTATION
35-41 DIATHERMY TREATMENT
35-82 PANCREAS TRANSPLANTS
35-85 IMPLANTATION OF AUTOMATIC DEFIBRILLATORS
35-91 LAPAROSCOPIC CHOLECYSTECTOMY
35-100 PHOTODYNAMIC THERAPY
45-30 PHOTOSENSITIVE DRUGS
50-20 DIAGNOSTIC PAP SMEARS
50-20.1 SCREENING PAP SMEARS AND PELVIC EXAMINATIONS FOR EARLY
50-34 OBSOLETE OR UNRELIABLE DIAGNOSTIC TESTS
50-55 PROSTATE CANCER SCREENING TESTS-COVERED
55-50 B. SCREENING DIGITAL RECTAL EXAMINATIONS
60-11 HOME BLOOD GLUCOSE MONITORS
60-16. PNEUMATIC COMPRESSION DEVICES