Medicare Program Integrity Manual

Chapter 7 - MR Reports

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(Rev. 71, 04-09-04)

*7.*1 - Medicare Focused Medical Review Status Report (MFSR)

(Rev. 71, 04-09-04)

MFSR is a management report that allows *CMS* to monitor the services being targeted for investigation and correction by carriers and the success of corrective actions being employed to address those areas. Carriers can determine to focus efforts on specific services for a number of reasons as explained in the PIM Chapter 2, Section *2.*2. The MFSR collects the following kinds of information:

- Identification of aberrant providers selected to target for corrective action in a given fiscal year (FY);
- Sources of data which contributed to identification and selection;
- Cause of problem;
- Corrective action; and
- Outcomes of corrective action.

For a given FY, carriers report on the identified areas of abuse 3 times (i.e., the initial submission, the follow-up submission, and the final submission). Follow-up information indicates whether corrective actions taken were effective in resolving the areas of abuse.

Carriers are required to submit the initial FY MFSR 1 month following the end of the FY. They update the MFSR at 12 months following the FY. A final MFSR update must be submitted 24 months following the end of the FY.

*7.*2 - Program Integrity Management Reports (PIMR)

(Rev. 71, 04-09-04)

7.2.1 - Background

(Rev. 71, 04-09-04)

This section provides instructions for implementing PIMR for fiscal intermediaries (FIs), carriers, and DMERCs.

The PIMR system changes reporting requirements for medical review (MR) formerly in Publication 83 (Program Integrity Manual) Chapter 7 (MR and BI Reports) sections 1, 5, and 6-10. Before Publication 83, the requirements were in Publication 13 (Intermediary Manual) Part 2 §2301 and Part 3

§3939, and Publication 14 (Carriers Manual) Part 3 §§7504.2, 7535-7537, and 14021.

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

The relevant FMR and MFSR data will be collected through PIMR. Mainly, this data relates to how problems are resolved. Certain aspects of the FMR and MFSR systems will not be continued; for instance, we will not obtain through PIMR data on procedure and diagnostic codes that define aberrancies. However, we will obtain the data (i.e., how aberrancies are resolved) we are currently obtaining on aberrancies on each provider type and provider subtype. The CMS will obtain that information through interfaces with the standard processing systems. The CMS will obtain PIMR data that it cannot extract from existing systems through manual reporting by contractor staff. Those reports will be due monthly within 15 calendar days following the end of the month (See section 2.5 [interactive modules] and 2.8.2.5.2 [Postpayment report] and 2.8.2.6 [Edit Descriptions]). Contractor data centers will transfer most of the data requested directly from contractor standard systems to the central office computer within 15 calendar days following the end of each month.

7.2.2 - Interface
(Rev. 71, 04-09-04)

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 II), 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.

7.2.3 - Policy
(Rev. 71, 04-09-04)

Requirements in this section were formerly in Publication 83 (Program Integrity Manual), Chapter 7 (MR and BI Reports), sections 1, 5, and 6-10. Previous to that, they were in Publication 13 (Intermediary Manual) Part 2 §2301 and Part 3 §3939, and Publication 14 (Carriers Manual) Part 3 §§7504.2, 7535-7537, and 14021.

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

7.2.4 - Interactive Modules

(Rev. 71, 04-09-04)

Some of the required modules have manual interfaces in addition to a batch data transfer capability. They are the postpayment module described in section 2.8.2.5.2 and the edit description module described in section 2.8.2.6.

7. 2.5 - Edits CMS Applies To Report Submissions

(Rev. 71, 04-09-04)

The 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.

7. 2.6 - Correcting A Submission

(Rev. 71, 04-09-04)

Errors in submissions are listed in the following datasets:

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

The "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.

7.2.7 - Reporting Requirements

(Rev. 71, 04-09-04)

See attached Business requirements in Pub. 100-08 Medicare Program Integrity Manual. See section 2.8.11 for a suggested hierarchy of how maintainers should assign activity types when multiple activity types occur for the same claim line.

7.2.8 - Exhibits

(Rev. 71, 04-09-04)

7.2.8.1 - Definitions

(Rev. 71, 04-09-04)

General data definitions. (See section 7.2.8.5.2 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 judgment 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 judgment 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, section 2.8.4 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 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 section 2.8.3. 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 section 2.8.3). 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 section 2.8.6 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** - 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 CCI 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. Re-openings include both additional documentation requests that contractors decide to process

and denials returned from the formal appeals process that contractor MR staff might need to re-process)

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.

The 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. The 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 a non-clinician performs review of medical records, 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

The 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, up coding reports, over utilization 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, up coding reports, over utilization 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 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.

7.2.8.2 - Contractor/Standard System Interfaces and Manual Data Requirements

(Rev. 71, 04-09-04)

Sections 2.8.2.1 through 2.8.2.4 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.

7.2.8.2.1 - Prepayment Reporting Based on Line Counts

(Rev. 71, 04-09-04)

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, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the standard system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review Left justify activity types less than six positions.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P04	Edit Code EDIT_CD	A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply. For Part A, enter '99999' for edit code until phase 4 is implemented.	CHAR(5), PK	PMR_PPAY_RVW
P05	Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician).	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P06	Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery).	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
P07	Units UNIT_CNT	The number of units that vary by activity. Activity types 21001L, 21001N, and 21001I include number of edits associated with that activity used during the reporting period. All other Activity Types refer to the number of reviews associated with that activity during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
P08	Claims CLAIM_CNT	The number of claims a specific activity type reviews during the reporting period. This item does not apply to 21001N, 21001L, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
P09	Line Items LINE_ITM_CNT	The number of individual lines a specific activity type reviews during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
P10	Billed Dollars BILD_AMT	The actual charges submitted by providers, suppliers, or beneficiaries during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
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, 21001N, and 21001L.	NUMERIC(10)	PMR_FRD_RFRL
P20	$ Referrals RFRL_AMT	The dollar amount referred to the BI unit or PSC broken down by Provider Type and Bill/Subtype. This does not apply to Activity Types 21001L, 21001N, and 21001I.	NUMERIC(13)	PMR_FRD_RFRL
P21	# Referrals Accepted ACPT_CNT	The number of referrals accepted by the BI unit or PSC during the reporting period. This data only applies to Activity Types 21002, 21220, and 21221.	NUMERIC(10)	PMR_FRD_RFRL
P22	$ Referrals Accepted ACPT_AMT	The dollar amount of referrals accepted by the BI unit or PSC during the reporting period. This data only applies to Activity Types 21002, 21220, and 21221.	NUMERIC(13)	PMR_FRD_RFRL

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

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

7.2.8.2.2 - Reporting of Denials

(Rev. 71, 04-09-04)

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	A unique number by contract type	CHAR(5), PK	PMR_PPAY

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
	CTRR_NUM	assigned to each contractor for CROWD reporting.		DNL
D2	Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_ DNL
D3	Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N = Automated National Edit, 21001 I = Automated CCI Edit, 21002 = Manual Routine Review, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the standard system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review Left justify activity types less than six positions.	CHAR(6), PK	PMR_PPAY_ DNL
D4	Edit Code EDIT_CD	A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221.. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of "99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_ DNL
D5	Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in section 2.8.3.	CHAR(6), PK	PMR_PPAY_ DNL
D6	Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and bill types include procedure codes. Bill/subtype codes are defined in section 2.8.3.	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,	CHAR(6), PK	PMR_PPAY_ DNL

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

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

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

7.2.8.2.3 - Report of Other Referrals

(Rev. 71, 04-09-04)

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 code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N = Automated National Edit, 21001 I = Automated CCI Edit, 21002 = Manual Routine Review, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the standard system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review 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 section 2.8.3.	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 section 2.8.3.	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)

7.2.8.2.4 - Reporting Based on Claims Counts

(Rev. 71, 04-09-04)

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 section 2.8.3.	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 section 2.8.3. 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_CNT	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

7.2.8.2.5 - Postpayment Report

(Rev. 71, 04-09-04)

Section 2.8.2.5.1 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.

7.2.8.2.5.1 - File Layout For Dataset Transmission

(Rev. 71, 04-09-04)

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 section 2.8.3. 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	CHAR(6), PK

			PIMR System will automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractors should leave this field blank.	
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	The estimated amount in dollars originally paid in error but identified for collection	NUMERIC(13)

		OVPY_ASMT_AMT	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.	
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 section 7.2.8.4 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,	CHAR(6)

			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.	
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)

7.2.8.2.5.2 - Description of the Manual Postpay Module

(Rev. 71, 04-09-04)

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 7.2.8.4.1, a crosswalk between data items and definitions.

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 Name
S01	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
S02	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
S03	Provider Type	A unique identifier for each provider type. Provider types and codes are defined in section 2.8.3. For Part B, code as "Physician" if the study addresses both physicians and suppliers.	Provider Type PROV_TYPE_CD
S04	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
S05	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
S06	Review No	A number to differentiate reviews under each Contractor and Postpay activity. The PIMR System will	Review Identifier RVW_NUM

ITEM NUMBER	Item name for the Interactive Module	Definition	Section Name
		automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractors should leave this field blank.	
S07	**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**
S08	**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**
S09	**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. Update and accumulated this field as reversals occur.**	**Reversed Claims RVRS_CLM_CNT**
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**	**Overpayment Assessed Dollars**

ITEM NUMBER	Item name for the Interactive Module	Definition	Section Name
		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.	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 section 7.2.8.4 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
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	Dollar Referred to Other

ITEM NUMBER	Item name for the Interactive Module	Definition	Section Name
		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.	**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)

7.2.8.2.6 - Edit Descriptions

(Rev. 71, 04-09-04)

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 edit module items are not included in the definitions section of this chapter (section 7.2.8.1) since these items are unique to the edit module. Where any of the definitions for edit module items are in section 7.2.8.1, they are referenced in the edit module item description below.

Attribute Name	Definition	Data Type
E01 CONTRACTOR NUMBER	A unique number CMS assigned to each contractor for CROWD reporting purposes. You must report for each contract number served by the shared system. Zero fill this field to the left where necessary.	CHAR(5)
E02 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.'	CHAR(5)
E19 RECORD TYPE	A code used to distinguish record format type in the contractor edit file. Codes include 0 = Edit Code, 1 = LMRP, 2 = Specialty/Provider Type Code, 3 = Revenue Code, 4= Occurrence Code, 5 = Condition Code, 6 = Value Code, 7= Edit Procedure Code, 8 = Edit Diagnosis Code, 9 = Reason Code (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(1)
E03 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 three lines, i.e., 255 characters including blanks. For Part A, use the standard or external description of the edits.	CHAR(255)
E04 EDIT STATUS	Use the following definitions to complete this item. ACTIVE -- You <u>planned</u> to apply the edit to one or more claims during the current quarter. Active = '1'. INACTIVE -- You <u>did not plan</u> 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. Inactive = '0'.	CHAR(1)
E05 POLICY NO	Enter an unlimited number of identifiers assigned to policies that justify and/or explain the edit. Leave these fields blank if you have no local medical review policies that support the edit.	CHAR(12)
E06 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:	CHAR(1)

Attribute Name	Definition	Data Type
	MANUAL -- An MR edit that always suspends for human review (see definition 9f.1b for more detail). Manual = '0'. 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). Partially = '1'. FULLY -- An MR edit that never results in a claim suspending for manual review (see definition 9f.1a for more detail). Fully = '2'.	
E07 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 (the Act) and Medicare program manuals. Benefit Category = '0'. STATUTORY EXCLUSION -- An edit used to determine if the Act excludes a service. Statutory Exclusion = '1'. 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. Medical Necessity = '2' 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. Local Coding = '3'	CHAR(4)
E08 SPECIALTY/ PROVIDER TYPE CODE	Enter all specialty (Part B) or provider type (Part A) identifications for which the item/service is allowed to occur. Right justify codes that are less than five characters long.	CHAR(5)
E09 REASON CODE	If there is an expected outcome from the edit, enter all reason codes for this item. The outcome could be a denial (use the codes from definition 7i) or a referral (use the codes from	CHAR(6)

Attribute Name	Definition	Data Type
	definition 8e.2).	
E10 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/Provider Type, number of miles, number of dollars, or provider (conditional upon a given procedure code not appearing on the claim). If there are multiple criteria that require a "PER," enter "99999."	NUMERIC (5)
E11 TIME PERIOD UNITS	Enter the type of period during which the item/service is allowed to occur the number of times specified in 'PER Daily = '0', Weekly = '1', Monthly = '2', Quarterly = '3', Yearly = '4' Lifetime = '5'	NUMERIC(1)
E12 POS	Enter the place of service code at which the item/service is allowed to occur the number of times specified in 'PER.' If there are multiple criteria that require a "POS," enter "99" in the POS field.	CHAR(2)
E20 TIME PERIOD OCCURRENCE	Enter the number of occurrences allowed during the time period units specified in 'PER'. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(4)
E13 ASC	If the edit is applied to providers that performed the submitted service in an ambulatory surgical center (ASC); enter 1, otherwise enter 0.	CHAR(1)
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.' If there are multiple criteria that require "miles," enter "multiple" in the blank	CHAR(8)
E15 DOLLARS	Enter the number of dollars for which the item/service is allowed to occur the number of times specified in 'PER.' If there are multiple criteria that require "dollars," enter "multiple" in the blank.	CHAR(12)
E21 TYPE OF BILL FROM	For Part A, enter all Type of Bill (TOB) code criteria used by the edit. TOB is a three-digit alphanumeric code that gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code. 'Type of Bill code from' may exist as a single value or the beginning value of a range of Type of Bill codes. If it exists as the beginning range of applicable Type of Bill codes, then a "Type of Bill code to' must be entered. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(3)
E21 TYPE OF BILL TO	'Type of Bill code to' defines the ending value of a range of Type of Bill codes defined by 'Type of Bill code from'. 'Type of Bill code to' exists only when the Type of Bill code specified in 'Condition code from' exists as the beginning of a range of Type of Bill. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(3)

Attribute Name	Definition	Data Type
E22 REVENUE CODE FROM	For Part A, enter all Revenue Code criteria used by the edits. Revenue codes are defined in the description of the CMS 1450 - Medicare Claims Processing Manual – Pub 100-4 – chapter 25 – section 60 - Form Locator 42. 'Revenue code from' may exist as a single value or the beginning value of a range of revenue codes. If it exists as the beginning range of applicable revenue codes, then a "revenue code to' must be entered. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(4)
E22 REVENUE CODE TO	'Revenue code to' defines the ending value of a range of revenue codes defined by 'revenue code from'. 'Revenue code to' exists only when the revenue code specified in 'revenue code from' exists as the beginning of a range of revenue codes.	CHAR(4)
E23 OCCURRENCE CODE FROM	For Part A, enter all occurrence code criteria used by the edit. Occurrence codes are defined in the description of the CMS 1450 - Medicare Claims Processing Manual – Pub 100-4 – chapter 25 – section 60 – Form Locators 32, 33, 34 and 35. 'Occurrence code from' may exist as a single value or the beginning value of a range of occurrence codes. If it exists as the beginning range of applicable occurrence codes, then a "Occurrence code to' must be entered. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(2)
E23 OCCURRENCE CODE TO	'Occurrence code to' defines the ending value of a range of occurrence codes defined by 'Occurrence code from'. 'Occurrence code to' exists only when the occurrence code specified in 'Occurrence code from' exists as the beginning of a range of revenue (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(2)
E24 CONDITION CODE FROM	For Part A, enter all condition code criteria used by the edit. Condition codes are defined in the description of the CMS 1450 - Medicare Claims Processing Manual – Pub 100-4 – chapter 25 – section 60 – Form Locators 24, 25, 26, 27, 28, 29, and 30. 'Condition code from' may exist as a single value or the beginning value of a range of condition codes. If it exists as the beginning range of applicable condition codes, then a "Condition code to' must be entered. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(2)
E24 CONDITION CODE TO	'Condition code to' defines the ending value of a range of condition codes defined by 'Condition code from'. 'Condition code to' exists only when the condition code specified in 'Condition code from' exists as the beginning of a range of conditions. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(2)
E25 VALUE CODE FROM	For Part A, enter all value code criteria used by the edit. Value codes are defined in the description of the CMS 1450 - Medicare Claims Processing Manual – Pub 100-4 – chapter 25 – section 60 – Form Locators 39, 40, and 41. 'Value code from' may exist as a single value or the beginning value of a range of value codes. If it exists as the beginning range of applicable	CHAR(2)

Attribute Name	Definition	Data Type
	value codes, then a "Value code to' must be entered. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	
E25 VALUE CODE TO	'Value code to' defines the ending value of a range of value codes defined by 'Value code from'. 'Condition code to' exists only when the value code specified in 'Value code from' exists as the beginning of a range of value. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(2)
E17 DIAGNOSIS FROM	Enter all ICD9-CM diagnosis codes for which the item/service is allowed to occur. 'Diagnosis code from' may exist as a single value or the beginning value of a range of diagnosis codes. If it exists as the beginning range of applicable diagnosis codes, then a "Diagnosis code to' must be entered.	CHAR(5)
E17 DIAGNOSIS TO	'Diagnosis code to' defines the ending value of a range of diagnosis codes defined by 'Value code from'. 'Diagnosis code to' exists only when the diagnosis code specified in 'Diagnosis code from' exists as the beginning of a range of value.	CHAR(5)
E18 PROCEDURE CODE FROM	Enter all HCPCS codes or ICD9 procedure codes for which the item/service is allowed to occur. 'Procedure code from' may exist as a single value or the beginning value of a range of procedure codes. If it exists as the beginning range of applicable procedure codes, then a "Procedure code to' must be entered..	CHAR(5)
E18 PROCEDURE CODE TO	'Procedure code to' defines the ending value of a range of procedure codes defined by 'Condition code from'. 'Condition code to' exists only when the procedure code specified in 'Procedure code from' exists as the beginning of a range of procedure.	CHAR(5)
E26 PROCEDURE TYPE CODE	Use this field to indicate if the procedure code is to be included or excluded from the edit criteria. (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(1)
E27 PROVIDER SPECIFIC	If the edit applies to a specific provider, enter a '1,' otherwise enter a '0.' (THIS IS THE COMPLETE DEFINITION – NOT DEFINED ELSEWHERE FOR PIMR)	CHAR(1)

7.2.8.3 - Provider Types and Subtypes

(Rev. 71, 04-09-04)

Provider Types for Parts A and B
(Use These Codes for Reporting Provider Type)

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

Provider Type Code	Part Code	Description
000011	A	HOSPITAL, INPATIENT (INCLUDING PART A)
000012	A	HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000013	A	HOSPITAL, OUTPATIENT (HHA-A ALSO)
000014	A	HOSPITAL, OTHER (PART B)
000015	A	HOSPITAL, INTERMEDIATE CARE - LEVEL I
000016	A	HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000017	A	HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000018	A	HOSPITAL, SWING BED
000019	A	HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000021	A	SKILLED NURSING FACILITY (SNF), INPATIENT (INCLUDING PART A)
000022	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000023	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, OUTPATIENT (HHA-A ALSO)
000024	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, OTHER (PART B)
000025	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL I
000026	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000027	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000028	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, SWING BED
000029	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000031	A	HOME HEALTH ASSOCIATION (HHA), INPATIENT (INCLUDING PART A)
000032	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000033	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, OUTPATIENT (HHA-A ALSO)
000034	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, OTHER (PART B)
000035	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL I
000036	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL 2

Provider Type Code	Part Code	Description
000037	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000038	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, SWING BED
000039	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000041	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INPATIENT (INCLUDING PART A)
000042	A	CHRISTIAN SCIENCE (CS) HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000043	A	CHRISTIAN SCIENCE (CS) HOSPITAL, OUTPATIENT (HHA-A ALSO)
000044	A	CHRISTIAN SCIENCE (CS) HOSPITAL, OTHER (PART B)
000045	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL I
000046	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000047	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000048	A	CHRISTIAN SCIENCE (CS) HOSPITAL, SWING BED
000049	A	CHRISTIAN SCIENCE (CS) HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000051	A	CS EXTENDED CARE, INPATIENT (INCLUDING PART A)
000052	A	CS EXTENDED CARE, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000053	A	CS EXTENDED CARE, OUTPATIENT (HHA-A ALSO)
000054	A	CS EXTENDED CARE, OTHER (PART B)
000055	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL I
000056	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL 2
000057	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL 3
000058	A	CS EXTENDED CARE, SWING BED
000059	A	CS EXTENDED CARE, RESERVED FOR NATIONAL ASSIGNMENT
000061	A	INTERMEDIATE CARE, INPATIENT (INCLUDING PART A)
000062	A	INTERMEDIATE CARE, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000063	A	INTERMEDIATE CARE, OUTPATIENT (HHA-A ALSO)
000064	A	INTERMEDIATE CARE, OTHER (PART B)
000065	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL I

Provider Type Code	Part Code	Description
000066	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL 2
000067	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL 3
000068	A	INTERMEDIATE CARE, SWING BED
000069	A	INTERMEDIATE CARE, RESERVED FOR NATIONAL ASSIGNMENT
000071	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RURAL HEALTH
000072	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS FACILITY
000073	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, INDEPENDENT PROVIDER BASED FEDERALLY QUALIFIED HEALTH CENTER (EFF 10/91)
000074	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, OTHER REHABILITATION FACILITY (ORF) ONLY(EFF 4/97)
000075	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, COMPREHENSIVE REHABILITATION CENTER (CORF)
000076	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 4/97)
000077	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RESERVED FOR NATIONAL ASSIGNMENT
000078	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RESERVED FOR NATIONAL ASSIGNMENT
000079	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, OTHER
000081	A	SPECIAL FACILITY OR ASC SURGERY, HOSPICE [1500-1799] (NON-HOSPITAL BASED)
000082	A	SPECIAL FACILITY OR ASC SURGERY, HOSPICE [1500-1799] (HOSPITAL BASED)
000083	A	SPECIAL FACILITY OR ASC SURGERY, AMBULATORY SURGICAL CENTER
000084	A	SPECIAL FACILITY OR ASC SURGERY, FREESTANDING BIRTHING CENTER
000085	A	SPECIAL FACILITY OR ASC SURGERY, RURAL PRIMARY CARE HOSPITAL (EFF 10/94)
000086	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE
000087	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE

Provider Type Code	Part Code	Description
000088	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE
000089	A	SPECIAL FACILITY OR ASC SURGERY, OTHER
000091	A	RESERVED, INPATIENT (INCLUDING PART A)
000092	A	RESERVED, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000093	A	RESERVED, OUTPATIENT (HHA-A ALSO)
000094	A	RESERVED, OTHER (PART B)
000095	A	RESERVED, INTERMEDIATE CARE - LEVEL I
000096	A	RESERVED, INTERMEDIATE CARE - LEVEL 2
000097	A	RESERVED, INTERMEDIATE CARE - LEVEL 3
000098	A	RESERVED, SWING BED
000099	A	RESERVED, RESERVED FOR NATIONAL ASSIGNMENT

Bill Types for Part A and 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, 0027T, 0032T–0039T, 0046T-0057T, 0061T	SURGERY
000001	000003	70010-79999, 0028T, 0042T	RADIOLOGY
000001	000004	80049-89399, 0006F, 0030T, 0031T, 0040T, 0041T 0043T, 0059T	PATHOLOGY
000001	000005	90281-98939, 0001F, 0009F, 0010F	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, 0029T, 0044T, 0060T	MED EXCEPT ANESTHESIA
000001	000014	H5000-H6000	MED EXCEPT ANESTHESIA

Provider Type Code	Bill Type Code	Code Range	Description
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 (INCLUDES 0002F-0005F, 0007F, 0008F, 0011F, 0045T, and 0058T)
000001	999999		FOR PART B POST PAY AND CLAIMS REPORTING
000002	000001	00100-01999	ANESTHESIA
000002	000002	10040-69999, 0027T, 0032T–0039T, 0046T-0057T, 0061T	SURGERY
000002	000003	70010-79999, 0028T, 0042T	RADIOLOGY
000002	000004	80049-89399, 0006F, 0030T, 0031T, 0040T, 0041T 0043T, 0059T	PATHOLOGY
000002	000005	90281-98939, 0001F, 0009F, 0010F	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, 0029T, 0044T, 0060T	MED EXCEPT ANESTHESIA
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 (INCLUDES 0002F-0005F, 0007F, 0008F, 0011F, 0045T, and 0058T)
000002	999999		FOR PART B POST PAY AND CLAIMS REPORTING
000011 – 000099	999999	ALL PART A	FOR ALL PART B RECORDS

f - Crosswalk Between Medicare Summary Notice Messages and PIMR Denial Reason Codes

(Rev. 71, 04-09-04)

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

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
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% 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
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

	the monthly limit has been reached.	
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 no covered 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
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% of the Medicare approved amount. (**NOTE:** Mandated message - This message must appear on all service lines paid at 100% 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
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
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% 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
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
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
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
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
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
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

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
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
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 $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.	NOT PI
31.6	A payment adjustment was made based on a peer review organization request.	100007
31.7	This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.	NOT PI
31.8	This claim was adjusted to reflect the correct provider.	NOT PI
31.9	This claim was adjusted because there was an error in billing.	NOT PI
31.10	This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.	NOT PI
31.11	The previous notice we sent stated that your doctor could not charge more than ($). 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
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
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
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% of the Medicare approved amount. (**NOTE:** Mandated message -This message must appear on all service lines paid at 100% 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% 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
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
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 ($). (**NOTE:** Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)	NOT PI
40 --	31.13	The Medicare paid amount has been reduced by ($) 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	($) of this approved amount has been applied toward your deductible. (**NOTE:** Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)	NOT PI
40 -- 37.3	( ) was applied to your inpatient deductible. (**NOTE:** Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.) Print the following messages in the "Deductible Section of all MSNs.	NOT PI
40 -- 37.9	You have now met ($) 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

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%). 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

7.2.8.4 - Crosswalk Between Medicare Summary Notice Messages and PIMR Denial Reason Codes

(Rev. 71, 04-09-04)

7.2.8.4.1 - Crosswalk Between Data Items and Definitions

(Rev. 71, 04-09-04)

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED 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

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
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
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

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
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
O01	Contractor Number	F09A	P01, D01, C01, S01
O02	Year/Month	F09B	P02, D02, C02, S02
O03	Activity Type	F09F	P03, D03, C03, S05

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
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
C04	Provider Type	F09C	P05, D05, O04, S03
C05	Bill/Subtype	F09D	P06, D06, O05, S04
C06	Claims Received	F06B, F10A	P08

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
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	
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

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
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
E01	Edit code	F09	
E02	Contractor		S32
E03	Description		
E04	Edit Status		
E05	Policy No.		
E06	Level of Automation		
E07	Type of Edit		
E08	Specialty Code		
E09	Reason Code		
E10	CRITERIA: PER		
E11	CRITERIA: DAYS		
E12	CRITERIA: LOCATION		

DATA ITEM ID	DATA ITEM DESCRIPTION	DEFINI-TION ID	RE-LATED DATA ITEM
E13	CRITERIA: ASC		
E14	CRITERIA: MILES		
E15	CRITERIA: DOLLARS		
E16	CRITERIA: PROC, UNLESS __ CODE		
E17	DIAGNOSIS		
E18	HCPCS		

HDR = HEADER

7.2.8.5 - Crosswalk Between Definitions and Data Items

(Rev. 71, 04-09-04)

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

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
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
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	

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
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	
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

DEFINITION ID	DEFINITION DESCRIPTION	RE-LA-TED DEF	DATA ITEM ID
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	

7.2.8.6 - National Edits

(Rev. 71, 04-09-04)

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 (Pub 6) 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

7.2.8.7 - History of Codes

(Rev. 71, 04-09-04)

ACTIVITY TYPE CODES

A unique 6 character code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include:

Prepayment

21001L = Automated Locally Developed Edit (In initial specifications),
21001N = Automated National Edit (In initial specifications),
21001C = Automated COTS Edit (In initial specifications),
21001 I = Automated CCI Edit (In initial specifications),
21002 = Manual Routine Review (added 10/1/02),
21002F = Manual Routine Focused Review (In initial specifications),
21002R = Manual Routine Random Review (In initial specifications),
21002R = Prepay Routine Reconsiderations (This requirement is for VIPS only – added 1/1/04)
21003F = Manual Complex Focused Review (In initial specifications),
21003R = Manual Complex Random Review (In initial specifications),
21016 = Directed Fraud Unit Review (In initial specifications),
21017 = Directed OIG Review (In initial specifications),
21018 = Directed Law Enforcement Review (In initial specifications),
21019 = Directed by PRO. (In initial specifications)
21201R = Prepay Complex Reconsiderations (This requirement is for VMS only). (added 1/1/04)
21201 = Prepay Complex Probe Review (added 10/1/02)
21201R= Reconsideration (added 10/1/02)
21202 = Prepay Complex Provider Specific Review (added 10/1/02)
21203 = Prepay Complex Service Specific Review (added 10/1/02)
21010 = TPL or Demand Bill Claim Review (added 4/1/03)
21221 = Prepay Complex Manual Review (added 1/1/04)

Postpayment Review

21004 = Postpay Non-CMR (In initial specifications),
21005 = Postpay Onsite CMRs (In initial specifications),
21006 = In-house CMRs (In initial specifications),
21020 = Postpay Directed Fraud Unit Review (In initial specifications),

21021 = Postpay CMS CFO Review (In initial specifications),
21022 = Postpay Directed OIG Review (In initial specifications),
21023 = Postpay Directed Law Enforcement Review (In initial
21024 = Postpay Directed by PRO (In initial specifications),
21025 = Postpay Directed ORT (In initial specifications),
21027 = Court Ordered Postpayment MR (In initial specifications),
21028 = Postpayment Fraud review (In initial specifications),
21030 = Routine Manual Postpay (In initial specifications)
21031 = Complex Manual Provider-Specific Postpay Review (In initial specifications)
21032 = Complex Manual Service-Specific Postpay Review (In initial specifications)
21205 = Postpay Complex Probe Review (In initial specifications)
21222 = Postpay Complex Manual Review (added 1/1/04)

Either prepayment or postpayment MR

28000 = Special Studies (effective 1/1/01 – 9/30/02)
210018 = Special Studies (changed 10/1/02)
21220 = Complex Manual Probe Sample Review (added 1/1/04)
21100 = Program Safeguard Contractor Support Services that involve use of the standard system (added 1/1/04)

Indirect MR activities

21007= Data Analysis (In initial specifications),
21008 = Policy Development (In initial specifications),
21026 = Edit Development (In initial specifications),
21026S = Edit Development Setup (In initial specifications),
21026T = Edit Development - Test (In initial specifications),
21029 = Fraud Sources (In initial specifications)

DENIAL REASON CODES

APPLIES TO ALL CONTRACTORS

100001 = Documentation does not support service,
100002 = Service is not otherwise covered clinical trial service,
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,
100016 = No physician certification (e.g., DME or Home Health), and
100019 = Other.

APPLIES MAINLY TO INTERMEDIARIES

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,
100017 = Incomplete physician order, and
100018 = No individual treatment plan

OTHER REFERRAL REASON CODE

200001 = Develop LMRP,
200002 = Overpayment recovery. Clarification as of January 17, 2001: Overpayment recover occurs when a contractor assesses an overpayment and refers an account for overpayment recovery. Over payment 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 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 for each claim denied. Clarification as of January 17, 2001: 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 = Focused MR because of percent increase in a measure of provider activity,
200013 = Continuous prepay MR,
200014 = Referral to a fraud unit,
200015 = Develop an edit,
200016 = Other,
210017 = Data Analysis, and
210018 = Special Studies.

7.2.8.8 PIMR CR History

(Rev. 71, 04-09-04)

CR #	CR TITLE	DATE ISSUED	IMPLEMEN-TATION DATE
1306	B-00-54: Program Integrity Management Reporting (PIMR) System	10/27/2000	1/1/2001
2308	A-02-112: Program Integrity Management Reporting (PIMR) System for Part A -- Phase 1	11/1/2002	4/1/2003

CR #	CR TITLE	DATE ISSUED	IMPLEMEN-TATION DATE
2307	Program Integrity Management Reporting (PIMR) System for Part B	11/1/2002	4/1/2003
2704	AB-03-113: Update of Codes in the Program Integrity Management Reporting System (PIMR) and the Contractor Administrative Cost and Financial Management System (CAFM II)	8/1/2003	1/1/2004
2495	A-03-038: Program Integrity Management Reporting (PIMR) System for Part A -Phase 2	5/2/2003	10/1/2003
2493	B-03-006: Program Integrity Management Reporting (PIMR) System for Part B - Correction of Multiple Reports of Savings By VIPS Standard Systems (i.e., VIPS Medicare System (VMS) and Durable Medical Equipment Regional Contractor (DMERC) System)	1/24/2003	7/1/2003
2646	This is a One Time Notification for Program Integrity Management Reporting (PIMR) System for Part A - Phase 3	10/31/2003	04/05/2004

7.2.8.9 - Responsibilities Of Maintainers, Data Centers, and Contractors

(Rev. 71, 04-09-04)

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 2.8.2.1 through 2.8.2.4 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 2.8.2.1 through 2.8.2.4 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 2.8.2.1 through 2.8.2.4), entering manual data (sections 2.8.2.5.2 and 2.8.2.6), and making certain that data submissions are correct.

7.2.8.10 - PIMR Activity Codes for FY 2004

(Rev. 71, 04-09-04)

7.2.8.10.1 - PIMR Prepayment Activity Codes

(Rev. 71, 04-09-04)

A unique code associated with each prepay MR activity to allow reporting by activity. Standard systems should provide for the collection and reporting of these codes where appropriate.

Prepay activities include:

21001L = Automated Locally Developed Edit
21001N = Automated National Edit
21001I = Automated CCI Edit
21002 = Manual Routine Review (MCS should include prepay routine reconsiderations for this code. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff may need to re-process.).
21002R = Prepay Routine Reconsiderations (This requirement is for VIPS Medicare System (VMS) only. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff may need to re-process. VMS contractors should report prepay routine reconsiderations here rather than und 21002.)
21010 = TPL or Demand Bill Claim Review (Required only for FIs)
21100 = Program Safeguard Contractor Support Services that involve use of the standard system

21201R= Prepay Complex Reconsiderations (This requirement is for the (VMS) only. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff may need to re-process. VMS contractors should report prepay complex reconsiderations here rather than und 21221)
21220 = Complex Manual Probe Sample Review
21221 = Prepay Complex Manual Review
23007 = MR for Benefit Integrity Unit reviews (For VMS only. The code is only for Durable Medical Equipment Regional Carriers (DMERCs) that are not transitioning to PSCs. It is a code that DMERCs requested to facilitate

tracking of reviews required by their benefit integrity units. Contractors are not required to report the code to PIMR.

Left justify activity types less than six positions.

See section 7.2.8.12 for a comparison of old and new PIMR codes.

7.2.8.10.2 - PIMR Postpayment Activity Codes

(Rev. 71, 04-09-04)

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. Contractors will collect and report this information outside of the standard system.

Postpay activities include:

21220 = Complex Manual Probe Sample Review
21222 = Postpay Complex Manual Review
21100 = Program Safeguard Contractor Support Services that do not involve use of the standard system

7.2.8.11 - Suggested Hierarchy of Activity Codes to Used When the Standard System Assigns More than One Activity Code to a Line

(Rev. 71, 04-09-04)

PRIORITY	ACTIVITY TYPE
1	21220 = Prepay Complex Probe Review
2	21221 = Prepay Complex Manual Review
3	21220A= Prepay Complex Reconsiderations (VMS only)
4	21220B= Prepay Routine Reconsiderations (VMS only)
5	21002 = Manual Routine Review,
6	21010 = TPL or Demand Bill Claim Review (Required only for FIs)
7	21001L = Automated Locally Developed Edit,
8	21001N = Automated National Edit
9	21001I = Automated CCI Edit
10	21100 = Payment Safeguard Contractor Support Services

PRIORITY	ACTIVITY TYPE
11	23007 = MR for Benefit Integrity Unit reviews (DMERCs only)

7.2.8.12 - Comparison of Old and New PIMR Codes

(Rev. 71, 04-09-04)

COMPARISON OF OLD AND NEW PIMR PREPAYMENT CODES	
OLD CODE (FY 2003)	**NEW CODE (FY 2004)**
21001L = Automated Locally Developed Edit	21001L = Automated Locally Developed Edit
21001N Automated National Edit,	21001N = Automated National Edit
21001 I = Automated CCI Edit,	21001I = Automated CCI Edit
21002 = Manual Routine Review,	21002 = Manual Routine Review (MCS should include prepay routine reconsiderations for this code. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff may need to re-process.).
21201 = Prepay Complex Probe Review	21220 = Complex Manual Probe Sample Review
21201R=Re-opening	21002R = Prepay Routine Reconsiderations (This requirement is for VIPS Medicare System (VMS) only. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff might need to re-process. VMS contractors should report prepay routine reconsiderations here rather than under 21002.)

COMPARISON OF OLD AND NEW PIMR PREPAYMENT CODES	
OLD CODE (FY 2003)	**NEW CODE (FY 2004)**
21201R=Re-opening	21201R= Prepay Complex Reconsiderations (This requirement is for the (VMS) only. Reconsiderations include both additional documentation requests that contractors decide to process and denials returned from the formal appeals process that contractor MR staff might need to re-process. VMS contractors should report prepay complex reconsiderations here rather than under 21221)
21202 = Prepay Complex Provider Specific Reviews	21221 = Prepay Complex Manual Review
21203 = Prepay Complex Service Specific Review	21221 = Prepay Complex Manual Review
21010 = TPL or Demand Bill Claim Review.	21010 = TPL or Demand Bill Claim Review (Required only for FIs)
No code	21100 = Program Safeguard Contractor Support Services that involve use of the standard system
No code	23007 = MR for Benefit Integrity Unit reviews (For VMS only. The code is only for durable medical equipment regional carriers (DMERCs) that are not transitioning to PSCs. It is a code that DMERCs requested to facilitate tracking of reviews required by their benefit integrity units. Contractors are not required to report the code to PIMR.

7.3 - Quarterly Carrier MR Savings Report

(Rev. 71, 04-09-04)

Carriers must at the end of each quarter, prepare, and submit the carrier MR savings report to *CMS*. A separate report is prepared for each carrier office that receives a separate budget allocation from *CMS* (does not apply to home offices).

7.3.1 - Purpose and Scope

(Rev. 71, 04-09-04)

The quarterly carrier MR savings report is the primary source of current information about the carrier's program savings from MR activities and the cost benefit ratios resulting from review activities.

The data are used by *CMS* for:

- Preparing reports about the costs and savings for Part B MR;
- Serving as a source for contractor evaluations;
- Identifying effective prepayment screens;
- Comparing the performance of individual carriers;
- Identifying problem areas for resolution; and
- Measuring trends in pre-payment and post-payment activities.

7.3.2 - Submission to *CMS*

(Rev. 71, 04-09-04)

The "Carrier MR Savings Report" is completed quarterly. The report must be entered into the *CMS* database within 45 days of the end of the fiscal year quarter. In addition, carriers send a copy directly to the RO *(for PSCs, the GTL, Co-GTL, and SME)* and send the hard-copy original and any attachments to:

Centers for Medicare & Medicaid Services
Program Integrity Group
Mail Stop: C3-02-16
7500 Security Blvd.
Baltimore, MD 21244

7.3.3 - Completing the Carrier MR Savings Report

(Rev. 71, 04-09-04)

A - Page One - Quarterly MR Savings Data

- Contractor Number - The carrier identification number *CMS* has assigned to the locality.
- Contractor Name - Carrier corporate name.

- Fiscal Quarter and Year - Quarter 01, 02, 03, or 04 and the FY.
- Contact Name - The name of an individual who can answer questions concerning the information on the report.
- Contact Phone - The contact's phone number.
- Extension - Contact's phone extension number.
- Prepayment Cost - Total administrative cost of the carrier's prepayment activities funded by line 5 of the budget this quarter.
- Postpayment Cost - Total administrative cost of the carrier's postpayment activities funded by line 5 of the budget this quarter.
- *CMS* 1565A, line A1 - The total of line A1 entries for this quarter.
- *CMS* 1565, line 11 - The total of line 11 entries for this quarter.
- *CMS* 1565A, line A3 - The total of line A3 entries for this quarter.
- I Dollars Den/Red - Net category I savings.
- I Claims Den/Red - The number of claims denied or reduced through category I screens.
- I Services Den/Red - The number of services denied or reduced through category I screens.
- Hardcopy Sent - Whether a copy of the report or supplemental report information have been sent to *CMS*. Enter Y (yes) or N (no).
- Category II Screens - The number of local category II screens in operation.
- Physicians/Suppliers - The number of physicians/suppliers who generated one or more assigned or unassigned claims during the prior year.
- Remarks - Carriers enter any offset claimed. They indicate the reason and explain any abnormalities in the report.

B - Pages Two and Three: Category II Mandated Screen

- SCRN - The identification number of the mandated screen being reported. Ten screens may be entered on each page. (See MCM §7529.1-.20.)
- SUSPENSIONS # Claims - The number of claims edited for review by this screen during the quarter.
- SUSPENSIONS # Services - The number of services medically reviewed on the edited claims.

- SUSPENSIONS Gross $ - The monetary value of the services reviewed. Show whole dollar amounts; round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.
- DENIED/REDUCED # Services - The number of suspended services that were denied or reduced when reviewed.
- DENIED/REDUCED Gross $ - The monetary value of the services denied and the gross value of the reductions. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.
- REVERSALS # Services - The number of services denied or reduced under this screen that were reversed on appeal during the quarter being reported.
- REVERSALS Gross $ - The monetary value of the reversals. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.
- TOTS - The totals will be calculated by the automated system. Carriers do not enter data on this line.

C - Pages Four and Five - Category II Local Screen

Column headings and definitions correspond to those in PIM Chapter 7 §7.3.3 subsection B. Carriers must show the top 20 local screen identification numbers in the "SCRN" column (10 screens on each page). The "top 20" will generally fluctuate between quarters. They round all cents to the nearest dollar for entry and use gross values that have not been adjusted for reasonable charge or coinsurance. The system will calculate those reductions. They enter these screens in descending order with the screen with the highest "Denied/Reduced Gross $" listed first.

AOLS - Carriers enter the column totals of those local screens not included in the top 20.

D - Page Six: Category III and Postpayment

- Overpayments Est in Qtr - The total value of all overpayments identified as a result of activities funded through line 5 of the budget.
- Claims Suspended - Number of claims edited due to category III screens.
- Services Suspended - Number of services suspended as a result of Category III screens.
- Value of Service Sus - The dollar value of all services edited from routine processing for Category III review. Carriers round cents to nearest dollar. They do not adjust for reasonable charge or coinsurance reductions.
- Services Denied/Reduced - Number of services denied or reduced as a result of Category III screens.

- Denied/Reduced Dollars - Gross dollar amount of the Category III services denied or the amount of the reduction. Carriers round cents to nearest dollar. They do not make reasonable charge or coinsurance adjustments.
- # Flagged Phys/Suppliers - The number of physicians and suppliers flagged for Category III review.
- Overpayments Recovered - Overpayments recovered as a result of activities funded through line 5 of the carrier budget.
- Closed Cases - The number of comprehensive reviews completed during the quarter (do not include program integrity reviews).
- Pending Cases - The number of comprehensive reviews pending at the end of the quarter (do not include program integrity reviews).
- Manually Reviewed Claims - The number of claims manually reviewed during comprehensive reviews this quarter.
- Cases Referred to OIG - The number of cases referred to OIG.
- Cases Returned by OIG - The number of cases returned by OIG for final administrative action.
- Sanctions Effectuated - The number of physicians/suppliers sanctioned upon receipt of an OIG sanction notice during the quarter as a result of activities funded through line 5 of the budget.
- CMP Cases Effectuated - The number of CMPs levied upon receipt of an OIG CMP notice during the quarter.
- Sav Cred MR Sanctions - The savings attributed to sanctions during the quarter. Carriers send documentation to *CMS* substantiating the credit claimed.
- Sav Cred CMP Cases - The savings attributed to CMP cases during the quarter. Carriers send documentation to *CMS* substantiating the credit claimed.

7.4 - Quarterly Intermediary MR Savings Report

(Rev. 71, 04-09-04)

These revised reports replace all prior quarterly MR savings reports for hospice, SNF, HHA, OPT/CORF and ESRD facilities.

7.4.1 - Submission

(Rev. 71, 04-09-04)

The intermediary completes the savings report for each calendar quarter and submits electronically through the Part A Medical Review System within 30 days of the end of the reporting quarter along with the RBS to the *CMS* data center. (See Screens 6 and 7.) It does not submit the reports by hard copy. (See §2301.3 of Intermediary Manual, Part 2.) It also submits a copy to the RO *(for PSCs, the GTL, Co-GTL, and SME)*.

7.4.2 - Completing the Quarterly Intermediary MR Activity Report

(Rev. 71, 04-09-04)

The intermediary enters data in columns provided for each category of provider claims. (See Screens 6 and 7.)

7.4.2.1 - Screen 6

(Rev. 71, 04-09-04)

A - Hospice Claims

- Number of hospice bills denied; and
- Number of hospice bills charged to lesser level (e.g., inpatient respite care changed to routine home care rate).

B - ESRD Claims

- Number of ESRD bills denied for medical necessity; and
- Number of ESRD claims denied because the services should have been included in composite rate.

C - SNF Continued Stay Denials

- Number of SNF bills reviewed; and
- Number of SNF bills fully/partially reversed.

D - CORF

- Number of CORF bills denied.

E - Audits Days Visits/Charges

- Number of HHA visits reviewed on MR audit;
- Outpatient hospital charges reviewed on MR audit; and

- Other provider charges reviewed on MR audit.

F - SNF Audits

- Number of SNF days reviewed on MR audit; and
- Number of SNF days denied on MR audit.

G - Demand Bills Reviewed

- Number of demand bills reviewed for SNFs, HHAs, and other; and
- Amount of savings claimed for HHA and other demand bills that the intermediary affirms.

7.4.2.2 - Screen 7
(Rev. 71, 04-09-04)

A - PT

- Number of PT bills reviewed;
- Amount of charges for PT bills reviewed;
- Number of PT bills denied; and
- Amount of charges denied for PT bills reviewed.

B - OT

- Number of OT bills reviewed;
- Amount of charges for OT bills reviewed;
- Number of OT bills denied; and
- Amount of charges denied for OT bills reviewed.

C - Speech Therapy (ST)

- Number of ST bills reviewed;
- Amount of charges for ST bills reviewed;
- Number of ST bills denied; and
- Amount of charges denied for ST bills reviewed denied.

7.4.2.3 - Other Review Data

(Rev. 71, 04-09-04)

A - MR of SNF Bills

- Number of payment claims reviewed
- Number of payment claims denied
- URC/SNF continued stay denials reviewed
- URC/SNF continued stay partially/fully reversed
- Demand bills reviewed

B – MR With Use of Therapy Screens

	PT	OT	ST
Number of Bills Passing Screens			
Number of Bills Suspending Screens			
Charges on Bills Passing Screens			
Charges on Bills Suspended Screens			
Number of Bills Reviewed			
Number of Bills Denied			
Charges Denied			

C - Other Therapy MR

	PT		OT		ST	
	P/P Sample	Other	P/P Sample	Other	P/P Sample	Other
Number of claims reviewed						
Number of claims denied						
Charges reviewed						
Charges denied						

7.5 - Report of Benefit Savings (RBS)

(Rev. 71, 04-09-04)

Contractors transmit the RBS for each calendar quarter within 30 calendar days after the end of the reporting quarter. They may add, browse, update, or delete records at any time, and as many times as needed, until CO invokes the close out function at the end of each quarter. They will be notified by CO in the *CMS* newsletter when this is to take place. Once the record has been closed they may only browse it. If for any reason a modification is needed to a closed record, they submit a facsimile of the transmitted report with the changes highlighted to:

Centers for Medicare & Medicaid Services
Program Integrity Group
Mail Stop: C3-02-16
7500 Security Boulevard
Baltimore, MD 21244

7.5.1 - Types of Savings to Report- Denials

(Rev. 71, 04-09-04)

Intermediaries report all savings attributable to denials if the services were non-covered under §§1862(a)(1), (7), (8), (9), (10), (12) and (13) of the Act, or because they were not documented on the record as:

- Having been ordered by the physician or provided to the patient; or
- Were determined through MR not to meet other documentation or coverage requirements of the law, regulations or coverage policy issuances.

Intermediaries report savings resulting from MR in the following areas:

- Home health visits;
- Inpatient hospital and SNF ancillaries billed to Part B;
- Non-covered services furnished by a RHC, rehabilitation facility and/or CORF;
- Program integrity reviews performed and overpayments recovered;
- HHA compliance and post-payment reviews;
- Hospice services, i.e., charges for denied days/services and/or difference between charges for level of care billed and level of care determined to be reasonable and necessary;

- Inpatient SNF;
- Overpayments and savings from post-payment MR. The amount reported must be the direct result of MR and determined to be an overpayment;
- Outpatient hospital, HHA and SNF services;
- Laboratory, supplies, or drugs which exceed frequencies outside of the ESRD composite rate and are not medically necessary;
- Claims denied because a provider failed to comply with contractor request for documentation within prescribed time frames;
- Charges denied or deleted from the claim as a result of contractor identification of billing errors during the course of MR. For example, the contractor questions the medical necessity of a service and finds the service was billed in error; and
- Difference between charges for services billed and charges for services determined to be medically necessary e.g., reduction of air ambulance service charges to charges for land ambulance.

The services non-covered under §§1862(a)(1), and (7),(8),(9),(l0),(l2) and (l3) of the Act are items and services that are not reasonable and medically necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

When reporting savings, intermediaries apply the following rules:

- Report savings resulting from medical review by:
    - Health professionals;
    - Clerical staff trained in medical and utilization review and using guidelines developed by health professionals; and
    - Electronic edits developed by health professionals and approved by the RO *(for PSCs, the GTL, Co-GTL, and SME)*;
- Take credit for denials paid under waiver;
- Breakdown HHA savings by *60 day episodes*;
- Do not include savings resulting from bilateral joint reviews. It is a claims processing function to assure that bilateral joints are inserted during the stay;
- Do not report as savings electronic or automatic manual denials of excluded or non-covered services which do not require exercise of medical judgment (e.g., excluded ICD-9 codes; V70.0 routine general medical examination);

- Take credit for the actual number of days on a SNF demand bill if the reviewer concurs with a provider's non-covered determination based on review of the bill and medical information. For services prior to 1/1/89 and on and after 1/1/90, report the coinsurance amount beginning with the 21st day of each benefit period. For services 1/1/89-12/31/89 report coinsurance amount for the first 8 days; and

- For all other SNF bills, take credit for the number of days the reviewer determines to be non-covered. Report the actual coinsurance amount.

7.5.2 - Completion of the RBS

(Rev. 71, 04-09-04)

Intermediaries input data for the RBS through the personal computer or terminal via the *CMS* data center. They input only the bold data elements. Computations are performed by the system. Five screens are provided to capture all data from the RBS.

Intermediaries enter the following information at the beginning of screen number 1.

Contact Name Enter the name of the individual responsible for completing the report.

Contact Phone Enter the area code and phone number of the individual responsible for the report.

The savings categories are on the screens in codes numbered 1 thru 32.

CODE	CATEGORY	SAVINGS
1	Hospital PPS	Charges for excluded or noncovered services billed by hospitals detected by *QIO*; services for hospice patients related to terminal illness.
2	Hospital Non-PPS	Same as PPS; Noncovered services in foreign hospitals.
3	Hospital Outpatient (OP)	Non-covered OP services billed by a hospital.
4	Hospital Ancillary-IP	Non-covered ancillary services billed by a hospital; includes Part B billing for an inpatient and ancillary review when a *QIO* denies a stay.
5	SNF Days	Inpatient SNF days determined to be non-covered.
6	SNF OP Charges	Non-covered OP services billed by a SNF.
7	SNF Ancillary Charges	Non-covered ancillary services billed under Part B for a SNF inpatient; Ancillary services denied on a Part A bill for SNF inpatient.
8	ESRD	Non-covered charges; Charges outside of composite rate which are medically unnecessary for hospital based and free standing facilities.

9	OP PT/Rehab	Non-covered services billed by rehab facilities (bill type 74) other than CORFs.
10	CORF	Self explanatory.
11	RHC	Self explanatory.
12	Other Part B	All Part B non-covered services not covered by an existing category.
13	Program Integrity Savings	Recoveries from PI and other audits conducted.
14	Open Biopsy	Number of reviews resulting in both a DRG assignment to closed biopsy and lower weighted DRG.
15	OP Hospital Audits	Recoveries from non-covered services identified on OP hospital audits.
16	Other Audits	Recoveries from non-covered services identified on all other audits.
17	SNF Demand Days	SNF days determined to be non-covered by provider, and the contractor concurs.
18-23	HHA Visits	Visits provided under a home health plan of care (*CMS*-485) determined to be non-covered on prepayment review.
24	HHA DME/Supplies	Non-covered charges for DME/supplies under a home health plan of treatment detected on pre or post-payment review.
25	OP Home Health	Non-covered charges billed by HHAs under Part B, not under *CMS*-485 plan of care.
26	Hospice	Difference in charges when inappropriate hospice level is billed and non-covered services.
27-32	CCR/HHA visits	HHA visits determined to be non-covered under post-payment review (i.e., coverage compliance or audit).

Intermediaries enter data in the four columns provided for each category on Screens 1-3. They round all charges to the nearest whole dollar. The four columns are:

- TOT DEN SER CHG FOR QTR;
- DEN PD UND WAV OF LIAB;
- DEN REP ON RECON H&A; and
- APP-DED CO INSUR AMTS

A	Total Denied Services/Charges for Quarter	Enter the total charges, visits, or days denied under MR in the reporting quarter.
B	Denials Paid Under Waiver of Liability	Enter the charges/days/visits paid under waiver of liability. If you previously

		reported a claim as denied not paid under waiver, and it is subsequently paid under waiver, report the information in this column only. Exclude denials paid under waiver which were overturned in the current quarter (i.e., included in Item D).
C	Charges Net of Waiver	The difference between Items A and B. Computations are performed by the system.
D	Denied and Reported Charges, Days, or Visits Overturned on Informal Re-Review, Reconsideration, Hearing or Appeal	Enter previously denied charges, days or visits for denials which were overturned (i.e., paid as covered services) upon appeals. Enter these charges, days or visits **only** if they: • Were denied (including denied charges, days, visits paid under waiver); • Were reported as savings in a previous report; or • Are reported as savings for the current quarter in Item A
E	Net Denied Charges, Days, or Visits	The *d*ifference between Items C and D. Computations are performed by the system.
F	Conversion Factors	*CMS* converts days, charges, and visits to costs on the RBS. The updated factors apply to the reported savings shown on the RBS effective for the quarter beginning 10/95. The factors are entered by the system.
G	Factored Amount	The product of net denied charges, days or visits times the conversion factor. This is the factored amount from which Item H (the applicable deductible and coinsurance amounts) are deducted. Computations are performed by the system.
H	Applicable Deductible and Coinsurance Amount	Enter the applicable deductible and coinsurance amounts for Part A and Part B. If the contractor adjusts the deductible amounts later (e.g., as a result of an adjustment), do not adjust the previously

		reported savings. Show an amount in this field for all Part B services that are subject to the 20% coinsurance (i.e., categories 3,4,6,7-12, and 25). Show the sum of applicable deductibles and the 20% coinsurance amounts. The deductible and coinsurance amounts are the amounts that would be applicable (i.e., amounts the program would not pay) if the claim were paid in full. It does not matter whether the beneficiary is held liable for payment for the amounts. If the system does not retain actual coinsurance amounts, compute the 20% by subtracting the deductible amounts from net denied charges on line (E) and multiplying the remainder by 20%. Show coinsurance amounts that would have been applicable to SNF days and SNF demand bill days. If the actual coinsurance amount for each SNF bill cannot be determined, estimate it by applying the current year coinsurance rate to half of the SNF days reported. Enter this amount in category H. Coinsurance should be zero if there is a negative amount in column E. EXAMPLE: The denied days reported in column A = 100. The coinsurance rate is $97.00 per day. Multiply 50 (1/2 of denied days) by $97.00 = $4850 estimated coinsurance.
I	Total Saved	This represents the total benefit savings after all computations. Computations are performed by the system.
J	Total Saved Including Waver Denials	This represents the total benefit savings including waiver. Computations are performed by the system.

For MR cost and number of bills reviewed, intermediaries enter data in the two items provided for each category as follows.

A	Number of Bills Reviewed	Enter the total number of bills reviewed by bill type.
B	MR Cost	Enter the MR cost by review type The

		total MR cost should approximate Interim Expenditure Report (IER) costs for the quarter. However, there may be special implementation or other costs that can be excluded. The RO *(for PSCs, the GTL, Co-GTL, and SME)* will advise you of costs to exclude. Do not enter cumulative costs.
C	Totals	Enter total number of bills reviewed and costs in the space provided.

For the number of bills reviewed, audits, and MR cost, intermediaries enter data in the following 4 items provided for each category.

A	Number of Bills Reviewed	Enter the number of bills reviewed.
B	Number of Providers Audited	Enter the number of providers audited on-site and in-house.
C	MR Cost	Enter cost of on-site and in-house audits.
D	Totals	Enter total number of bills reviewed, providers audits, and costs in the space provided.

7.6 - Retain Data to Support Savings Reported on the RBS

(Rev. 71, 04-09-04)

Intermediaries retain documentation to support the savings reported on the RBS for validation.

At a minimum, documentation must include:

- A record, by quarter reported, of each denied claim with the following data:
- Sufficient identification to retrieve the claim and medical documentation (if applicable);
- Amount of denied or deleted charges and/or number of denied days/visits;
- Deductible amount applicable to claim or which would have applied if claim was paid;
- Coinsurance amount applicable to denied days/charges or which would have applied if days/charges were paid (unnecessary if coinsurance is computed as in PIM Chapter 7 §*7.6* above.);
- Charges/days paid under waiver; and

- Reviewer's ID or automatic denial indication.
- A record, by quarter, of reported days/visits and charges reversed on reconsideration/hearings and appeals.

An auditor or reviewer validating reported savings must be able to review contractor documentation and the claim to verify the entries on the report that the denial was made by the level of staff (or system) required for medical review, and that sufficient medical documentation (e.g., on the claim) was available to make the determination.

7.7 – List of MR Codes, Categories, and Conversion Factors for FY 2004

(Rev. 71, 04-09-04)

Report of Benefit Savings

Conversion Factors for FY 2004

Code	Category	Conversion Factor
1	Hospital PPS	100%
2	Hospital Non-PPS	78.63%
3	Hospital Outpatient	78.72%
4	Hospital Ancillary Charge	62.91%
5	SNF Days Non PPS	$266.39
6	SNF Outpatient Charges	72%
7	SNF Ancillary Charges	80%
8	ESRD	80%
9	Outpatient PT/Rehab	80%
10	CORF	80%
11	Rural Health Center	80%
12	Other Part B	80%
13	Program Integrity Savings	100%
14	Open Biopsy	$3,000 per review
15	All Audits	100%
16	SNF PPS & SNF PPS Demand Days	$266.39
17	SNF Non-PPS Demand Days	$266.39
18	HHA Skilled Nursing Visit	$ 97.38
19	HHA Speech Therapy Visit	$115.70
20	HHA Physical Therapy Visit	$106.47
21	HHA Aide Visit	$ 44.09
22	HHA Occupational Therapy	$107.19
23	HHA Medical Social Services Visit	$156.10
24	HHA DME/Supplies	80%
25	Outpatient HHA (Part B)	80%
26	Hospice	80%
27	CCR Skilled Nursing Visit	$ 97.38
28	CCR Speech Therapy Visit	$115.70
29	CCR Physical Therapy Visit	$106.47
30	CCR Aide Visit	$ 44.09
31	CCR Occupational Therapy Visit	$107.19
32	CCR Medical Social Services Visit	$156.10

Use conversion factors to convert charges to costs.

Program Integrity Manual
Chapter 8 – *Reserved For Future Use*

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Chapter 9 – *Reserved for Future Use*

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Chapter 12 – Carrier, DMERC, FI and full PSC Interaction with the Comprehensive Error Rate Testing Contractor

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(Rev. 71, 04-09-04)

*12.*3 - Comprehensive Error Rate Testing (CERT) Program Safeguard Contractor (PSC)

(Rev. 71, 04-09-04)

CMS has developed the CERT program to produce national, contractor's specific, and service-specific paid claim error rates. The program has independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers medically review claims that are paid and claims that are denied to ensure that the decision was appropriate.

The outcomes are a provider compliance error rate, paid claims error rate, and a claims processing error rate.

The CERT contractor is responsible for operating the CERT Operations Center and for gathering information from Medicare contractors. For the purpose of this section of the manual, the term "affiliated contractor" (or AC) shall be used to refer to carriers, DMERCS, and FIs. The term "full PSC" shall be used to refer to any PSC tasked with prepayment medical review responsibilities.

*12.*3.1 - Affiliated Contractor (AC)/ Full PSC Communication with the CERT Contractor

(Rev. 71, 04-09-04)

When ACs/full PSCs have questions regarding the CERT program or need to contact the CERT contractor, they should contact the AdvanceMed management team at (804) 264-1778 or (804) 264-3268 (fax).

The address of the CERT contractor is

AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, Virginia 23228

*12.*3.2 - Overview of the CERT Process

(Rev. 71, 04-09-04)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled

claims from all ACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the ACs' claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

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

*12.*3.3 – AC/Full PSC Requirements Surrounding CERT Reviews (Rev. 71, 04-09-04)

ACs/full PSCs must supply the CERT contractor with the sample claims resolution file within five working days of receipt of the CERT request. This request is called the sampled claims transaction file. The AC/full PSC must enter the indicator data to allow the shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. If the CERT contractor requests claim information in the sampled claims transaction file, and receives no automated resolution file from the AC/full PSC, the CERT contractor will score the claim as an error and notify the AC/full PSC's CERT POC.

*12.*3.3.1 - Providing Sample Information to the CERT Contractor (Rev. 71, 04-09-04)

Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of Exhibits 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). The AC's response must be made using NDM and the formats provided for the sampled claims resolution file in Exhibit 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). Full PSCs are not responsible for this task.

The ACs/full PSCs must coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format. The sampling module will reside on a server in the CMS Data Center (CMSDC). The ACs/full PSCs will use the sampling module under the supervision of the CERT Operations Center.

ACs/full PSCs must submit a file daily to the CERT contractor (via CONNECT:Direct)

containing information on claims entered during the day. Estimated claim volume is 2000 claims/cluster/year.

The ACs/full PSCs must respond to the CERT contractor within five working days of receipt of the request from the CERT contractor. If the AC/full PSC receives a request for a claim that is no longer in the system or a claim that needed to be replaced, the AC/full PSC must provide a legitimate reason and send appropriate documents to the CERT contractor. In the case that a claim is requested for a patient that does not exist, the AC/full PSC should contact the provider. For all other requests, the AC/full PSC will provide the following three files to the CERT contractor:

A. Claims Universe File

The standard systems will create a mechanism for the data centers to be able to create the claims universe file, which will be transmitted daily to the CERT operations center. The file will be processed through a sampling module residing on the server at CMSDC. FIs and RHHIs, must insure that the claims universe file contains all claims, except HHA RAP claims, adjustments, and inpatient hospital PPS claims, that have entered the FI and RHHI standard claims processing system on any given day. Carriers and DMERCs must insure that the claims universe file contains all claims processing system on any given day. Any claim must be included only once and only on the day that it enters the system.

B. Sampled Claims Transaction File, Sampled Claims Resolution File and Claims History Replica File

The standard systems will create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CERT operations center. This file will include claims that were sampled from the daily claims universe files. The standard systems will create a mechanism for the data centers to be able to match the sampled claims transaction file against the standard system claims history file to create a sampled claims resolution file and a claims history replica file. The claims history replica file is a dump of the standard system claims history file in the standard system format. These files are transmitted to the CERT operations center. The sampled claims resolution file is input to the CERT claim resolution process and the claims history replica file is added to the Claims History Replica database. If a claim identified on the sampled claims transaction file is not found on the standard system claims history file, no record should be created for that claim. It is important that if the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the AC, that the sampled claims resolution file(s) and claims history replica file(s) be provided for each iteration of the claim (e.g., that adjustments and other actions be contained in the transmitted files). The sampled claims transaction file will always contain the claim control number of the original claim.

See Exhibit 34.2 for format of the sampled claims resolution file.

C. Provider Address File

The ACs must transmit the names, addresses, and telephone numbers of the billing providers and attending physicians in a separate file to the CERT Operations Center along with the sampled claims resolution file. The provider address file must contain the mailing and telephone contact information for each billing provider and attending physician on the sampled claims resolution file for all claims, which contain the same provider number on all claims' lines. Each unique provider name, address, and telephone number must be included only once on the provider address file. If a provider has more than one address listed in the AC files, the AC shall include one record for each address in the provider address file. If the AC has neither an address nor a telephone number for the provider, then the AC must not include a record for that provider in a provider address file. If the contractor has only partial information on a provider, e.g., a telephone number but no address, the AC should include on the provider address file the information the AC has and leave the rest of the fields on the record blank.

Exhibit 34.1 lists the assumptions and constraints associated with these three files.

The functional area that is performing these activities should capture costs and workloads associated with providing sample information to the CERT contractors.

12.3.3.2 - Providing Review Information to the CERT Contractor (Rev. 71, 04-09-04)

Upon request, the ACs and full PSCs must provide the CERT contractor with all applicable materials (e.g., medical records) used to deny (in-part or total) or approve a sampled claim for medical review reasons or deny a sampled claim due to claims processing procedures. Generally, ACs and full PSCs will have to supply additional materials on ten percent or less of those claims sampled.

The CERT contractor will request the additional information in written form. The CERT contractor will include a checklist of items required for each record in each request. The requests will be batched on a daily basis. ACs/full PSCs must return the requested information to the CERT Operations Center at the address specified in the "Affiliated Contractor (AC)/ full PSC Communication with the CERT contractor" section 3.2 above. ACs/full PSCs must send this material within ten working days of receipt of the CERT request, except for incentive pilot contractors who must send this material within six working days of receipt of the CERT request.

The functional area that is performing these activities should capture costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractors.

12.3.3.3 - Providing Feedback Information to the CERT Contractor (Rev. 71, 04-09-04)

Requests for Feedback Information

- Each month, the CERT contractor will send a description of errors it has found to each AC and full PSC. ACs/full PSCs will use the CERT feedback file to provide feedback to the CERT contractor.

- Beginning in January 2004, the CERT contractor will send an electronic copy of every medical record involved in an overpayment or underpayment situation to the AC/full PSC. The AC/full PSC shall store this medical record at least until the provider and beneficiary appeals' timeframes have expired. These records will be provided on cd-rom and will be sent to the AC/full PSC at about the same time the feedback file is sent.

Sending Feedback Information to the CERT Contractor

- The ACs/ full PSCs must provide the CERT contractor with the requested feedback in accordance with the following schedules:

  For Feedback files received in either March or June

  - The AC must return the feedback file within ten working days.
  - If the CERT contractor has not received documentation by the 11th day the CERT contractor will score it as an error.

  For Feedback files received in every month except March and June

  - If the AC is providing an estimated contractor recalculated final amount paid, the AC must return the feedback file within ten working days.
  - ACs/full PSCs may have portions of the tool blank if CWF fails to produce a new price in a timely manner. Uncompleted claims will be returned to the AC in the following months feedback file.
  - If the AC is providing an exact contractor recalculated final amount paid, the AC must return the feedback file within 25 working days.

- The ACs/ full PSCs must provide answers to the CERT contractor on the status of claims that the CERT contractor identified in the sample, but for which there is no indication the AC has adjudicated the claim. These claims will not be included on the feedback files because the CERT contractor does not have them to review. The CERT contractor will request the status on these claims by sending the AC/full PSC a letter. It will list both the claims in the sample that the CERT contractor received and a list of claims that are missing. The AC/ full PSC should provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.

- The AC/ full PSC may request a meeting with the CERT contractor to discuss the results of the CERT review. During these meetings the AC/ full PSC shall ensure that the CERT contractors considered all information available for review.

Repricing

In the case of RUGs, HRG, APCs, and other bundled payment groups, the AC/full PSC must determine if the error does not affect the payment amount. In cases where the error does not affect payment, the AC/full PSC shall notify the CERT contractor of such so that the CERT contractor can back out the error.

The first step ACs/full PSCs should follow when reviewing a claim is to calculate the amount in error and then notify CERT via the feedback report (see 3.6.5). If an AC/full PSC knows the amount in error by looking at the face of the claim, (e.g., a full denial) enter the amount in error and return the feedback file to the CERT contractor. If the AC/full PSC cannot tell the amount in error from the face of the claim, (e.g. a partial denial) enter the claim data into the "adjustment" system, which will calculate the amount in error for the AC/full PSC. Then return the feedback file to the CERT contractor.

APASS users input the adjustment into the system. The AC/full PSC might have an overpayment. Once the overpayment amount has been calculated, the AC/full PSC enters this number into the feedback file. If this amount is lower than the threshold required for collecting the overpayment, the AC/full PSC must delete the adjustment from the system. FISS users follow the same procedure except if the amount is lower, then the AC/full PSC must inactivate the adjustment in the system.

The functional area that is performing these activities should capture costs and workloads associated with the CERT feedback process (including but not limited to: CMD discussions about CERT findings, biweekly CERT conference calls, and time spent responding to inquiries from the CERT contractor).

*12.*3.3.3.1 - Disputing/ Disagreeing with a CERT Decision (Rev. 71, 04-09-04)

Disputes

If the AC/ full PSC does not agree with a CERT decision, and the AC/ full PSC subjected the claim to complex prepayment MR, then the AC/ full PSC may file a 'dispute'. For each 'dispute' the CERT contractor will forward the file for the line to the CMS Central Office Clinical Panel ('CO Panel'). The CO Panel will have 20 working days to complete its review and render a determination on the line (exception: the CO Panel will have three working days to render a determination on incentive pilot disputes). Effective beginning with the feedback files received in April 2004, each AC/full PSC will be allowed to file up to one dispute of an O or T line per calendar year quarter in addition to any line subject to complex prepayment medical review. The AC/full PSC must make their dispute decision with each feedback file (i.e., If the AC/full PSC receives the feedback

file on April 23, 2004 and they choose to dispute an O or T line with this feedback file, they cannot dispute any O or T lines on the May or June feedback file.). The disputing contractor must provide sufficient written evidence to support their dispute upon submission. If such supporting evidence is lacking, the CO panel will uphold the CERT decision. Should the AC/full PSC elect not to submit a dispute in a given quarter, the unused opportunity does not carry over to the following quarter, rather the opportunity to dispute is lost for the quarter in question.

Disagrees

If the AC/full PSC does not agree with a CERT decision, but the AC/ full PSC does not choose to 'dispute' the claim, then the AC/ full PSC may mark the case as a 'disagree' in the feedback file, and include an explanation of their rationale.

*12.*3.4 - Handling Overpayment and Underpayments Resulting from the CERT Findings
(Rev. 71, 04-09-04)

If the feedback file indicates that an overpayment was made when the AC/full PSC made its original decision on the claim, the AC shall undertake appropriate collection (or payment) actions. The AC may list the adjustment indicator as 'HCFA' until such time as a CERT indicator exists. ACs should fill in the bill type ('xxH') such that the first and second positions describe the bill type and the third position is H, which indicates there were adjustments due to CERT. If the AC/full PSC has the ability to create a denial code, they should create a "CERT initiated denial" denial code.

For inpatient or outpatient services, Part B should follow overpayment collection procedures in Pub 100-4 Claims Processing Chapter 1, 130.4.1. Overpayment collection procedures for inpatient services can be found in Pub 100-4 Claims Processing 3, 50.

The AC should use their own discretion when handling non-assigned claims. Since non-assigned claims generally go to the beneficiaries, some ACs choose to recoup payments while others choose not to recoup.

ACs should allocate costs and workloads associated with issuing CERT initiated over/underpayments as they do all other over/underpayments.

If the AC/full PSC requires more information about the reason for the overpayment/underpayment than is available in the feedback file, the AC/full PSC may contact CERT contractor Ellen Cartwright at (804) 264 – 1778 ext. 106.

*12.*3.5 - Handling Appeals Resulting from CERT Initiated Denials
(Rev. 71, 04-09-04)

The ACs shall process appeals stemming from the CERT project (e.g., CERT decisions appealed by providers or beneficiaries). ACs must not automatically uphold the CERT

contractor's decision. Instead, the ACs shall insure that the appeal is handled in the normal way (i.e. reviewed by a different reviewer, etc.)

ACs must allocate the costs and workloads associated with handling appeals of CERT initiated denials as they do all other appeals.

*12.*3.6 – Tracking Overpayments and Appeals
(Rev. 71, 04-09-04)

The AC must provide the CERT contractor with the status and amounts of overpayments that have been collected (or underpayments that have been paid) within 30 working days of the AC taking action. Beginning in December 2003, the CERT contractor will send each AC a file of claims that are overpayments and subject to appeal. This file will be sent via CMS secure email as an attached file or USPS (mail carrier).

The ACs must provide the CERT contractor with the status of appeals and final decisions on appeals within ten working days of receipt of the CERT contractor request. An appeal's status request on a claim from a CERT contractor does not imply the case was actually sent through the appeals process. For example, the CERT contractor will request the appeal status on claims, where the CERT contractor did not receive any records and deemed the claim an error 16 full denial, and on claims where the AC has requested the medical records. The AC is responsible for responding to the CERT contractor's request with the appeal status of a claim, even if the response is, "Claim ### is still pending". If the AC receives appeal information on a claim, the AC should inform the CERT contractor of the status of the claim and need not wait for another CERT request.

The functional area that is performing these activities should capture costs and workloads associated with tracking and reporting overpayment/underpayment and appeals information to the CERT contractors.

*12.*3.7 - Potential Fraud
(Rev. 71, 04-09-04)

The CERT contractor will refer any claims they have determined to be potentially fraudulent to the appropriate AC or BI PSC.

*12.*3.8 – AC/full PSC Requirements Involving CERT Information Dissemination
(Rev. 71, 04-09-04)

ACs/full PSCs must assist the CERT contractor by disseminating information concerning CERT to the provider community. As part of the CERT process, providers are required to send documents supporting claims per the request of CERT contractors. Unfortunately, many providers do not comply. Some providers are uncooperative because they believe it is a HIPAA violation to send patient records to CERT. Others are

unaware to the process and fail to see the importance of cooperating in a timely fashion. ACs/full PSCs should educate the provider community about the CERT program, emphasizing the importance of providers responding to the CERT contractor's requests for medical records and explaining the consequences that will incur by not cooperating with these requests, and the significance of these errors. Provider education is at the discretion of the AC/full PSC. Several ways to disseminate CERT information include answering/directing provider questions to the proper representative, posting articles (or this instruction) to your websites, sending a summary of the CERT process to the provider listserv. Each AC/full PSC specified which of these ways or other ways that will be used to educate providers about CERT in their Error Rate Reduction Plans. ACs will be able to contact CERT contractors and obtain a list of providers who are not responding to CERT request attempts. ACs are encouraged to contact these providers, but only after the provider received the initial CERT request and ten days have past. (See exhibit 34.3)

ACs must allocate costs and workloads associated with the dissemination of CERT information to LPET CAFM code 24116.

*12.*3.9 – AC/Full PSC CERT Points of Contact
(Rev. 71, 04-09-04)

ACs must provide the CERT contractor with the name, phone number, address, fax number, and e-mail address of two points of contact (POC): an IT POC and an MR POC. The CERT contractor will contact the AC's IT POC to handle issues involving the exchange of electronic data. The CERT contractor will contact the AC's MR POC to handle issues involving exchange of information in written form or through discussion (e.g., error reports on payment determinations, discussions on medical review decisions, status of overpayment collections, status of appeals).

*12.*3.10 – AC/full PSC Error Rate Reduction Plan (ERRP)
(Rev. 71, 04-09-04)

Every November, CMS will provide to each AC/full PSC, the Medicare Fee-for-Service Improper Payments Report that includes various types of error rates including contractor-specific error rates. The AC must share error rate data with the PSC responsible for data analysis in their jurisdiction. For DMERCs, and carriers and full PSCs, the release of the report will begin in November 2003. For Fls, this will begin in 2004. Within 30 days of receipt of the long version of the report, the AC/ full PSC, must develop an Error Rate Reduction Plan describing the corrective actions they plan to take in order to lower the paid claims error rate, claims processing error rate, and provider compliance error rate. Beginning in 2004, CMS will develop and implement an automated reporting format (on the CERT confidential web-site) into which contractors will enter their Error Rate Reduction Plans. This plan must describe:

- New adjustments the AC/full PSC has made or will make to its MR/LPET Strategy.

- New coordination activities under taken with other components within AC/full PSC (e.g., developing a system to route certain provider calls from the provider call center to the MR or LPET unit for resolution).
- New information being communicated to providers including the message point and the vehicle (e.g. including in post-pay denial letters the LMRP ID# associated with the denial, issuing additional CBRs to every provider who bills the three types of service with the highest error rate, etc.).

The AC must work closely with their PSCs. The plans must specify both:

1. Corrective actions they have already put in place
2. Which new corrective actions they have planned for the future

ACs who are affiliated with a "full-model" PSC (where the AC has turned all MR, LPET, and BI responsibility over to a PSC), the PSC is responsible for the creation of the Error Rate Reduction Plan. The PSC will work in cooperation with the AC to obtain language regarding areas where the PSC has no authority such as non-MR/LPET actions.

In the case of an MR PSC (where the AC has only turned post pay MR and BI responsibility over to a PSC) or BI PSC (where the AC has only turned BI responsibility over to a PSC), the AC remains responsible for the development of the Error Rate Reduction Plan. The AC will work in cooperation with the PSC to obtain language regarding post pay MR, LPET, and/or BI actions.

Each Quarter (January 1, April 1, July 1, and October 1), the AC/full PSC must submit an update report informing CMS of their progress on the Error Rate Reduction Actions described in their plan. Beginning in 2004, ACs/full PSCs will submit these updates via the CERT confidential website and a separate email to CERT@cms.hhs.gov, to the appropriate Consortium Contractor Management Officer (CCMO) and to the Consortium Contractor Management Specialist (CCMS). The CCMS will forward the CERRP to those BFEs who have responsibility for monitoring the contractor submitting the CERRP for their comments. The CCMS and BFEs will determine if the CERRP is reasonable to reduce the contractor's error rate. CCMS will "approve" the entire plan after all appropriate BFEs give their "approval" regarding the portion of the plan that deals with their functional area.

Each DMERC and Carrier cluster must submit an ERRP within 30 calendar days after the end of each quarter during the fiscal year, with the exception of the first quarter's plan which may be submitted no more than 45 days after the end of the first quarter. The deadlines for submitting the ERRPs are as follows:

First quarter – February 15
Second quarter – April 30
Third quarter – July 30
Fourth quarter – October 30

Clusters that have submitted ERRPs in the past may simply update/modify their existing plans for submission to the Web site. However, clusters that have not submitted ERRPs in the past must generate a new plan for submission.