CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 77 **Date: MAY 28, 2004**

CHANGE REQUEST 3229

I. SUMMARY OF CHANGES: This transmittal communicates the Comprehensive Error Rate Testing (CERT) requirements to Carriers, DMERCs, FIs, and full PSCs.

NEW/REVISED MATERIAL– EFFECTIVE DATE: June 28, 2004
***IMPLEMENTATION DATE: June 28, 2004**

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/Table of Contents
R	12.3.1/Affiliated Contractor (AC)/full PSC Communication with the CERT Contractor
R	12.3.3.1/Providing Sample Information to the CERT Contractor
R	12.3.3.2/Providing Review Information to the CERT Contractor
R	12.3.3.3/Providing Feedback Information to the CERT Contractor
R	12.3.3.3.1/Disputing/Disagreeing with a CERT Decision
R	12.3.4/Handling Overpayments and Underpayments Resulting from the CERTFindings
R	12.3.5/Handling Appeals Resulting from CERT Initiated Denials
R	12.3.6/Tracking Overpayments and Appeals
N	12.3.6.1/Tracking Overpayments
N	12.3.6.2/Tracking Appeals
R	12.3.8/AC/full PSC Requirements Involving CERT Information Dissemination
N	12.3.9/AC/full PSC Error Rate Reduction Plan (ERRP)
N	12.3.10/Contacting Non-Responders
N	12.3.11/Late Documentation
N	12.3.12/Voluntary Refunds
N	12.3.13/LMRP/NCD
R	34/Medicare Program Integrity Manual Exhibits Table of Contents
R	34.2/CERT Formats for Carrier and DMERC Standard Systems
R	34.6/CERT PSC Contractor Feedback Data Entry Screen Version 1.01
R	34.7/Data Items Included on CERT Reports
N	34.8/Acceptable 'No Resolution' Reasons
N	34.9/Types of Replies from Providers in Non-Responder Cases
N	34.10/OIG Referral of Non-Responding Providers
N	34.11/Office Of Audit Services - Regions
N	34.12/Fee-For-Service Appeal Processes

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 77	Date: May 28, 2004	Change Request 3229

SUBJECT: Instructions for Carriers, DMERCs, FIs, and full PSCs when interacting with the Comprehensive Error Rate Testing (CERT) Contractor (i.e., handling appeals of CERT-initiated denials, contacting non-responders, tracking over/underpayments)

I. GENERAL INFORMATION

A. Background: 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. 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.

B. Policy: New and revised requirements for Carriers, DMERCs, FIs, and full PSCs when interacting with providers and the CERT contractor.

C. Provider Education: None. To view the medlearn matters article associated with the previous version of PIM Chapter 12, section 12.3 (CR 2976) go to www.cms.hhs.gov/medlearn/matters.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
Ch.12 Sec. 12.3.3.1 3229.1	Claims identified on the sampled claims transaction file that are not found on the standard system claims history file are called no resolution claims. Since the CERT contractor counts most 'no resolution' claims as errors, the AC shall take all necessary steps to minimize the number of 'no resolution' claims it submits to the CERT contractor each year. Should the AC submit a 'no resolution' claim to the CERT contractor and later locates the needed resolution information; the AC shall provide the late resolution information to the CERT contractor. 'No resolution' claims with acceptable no resolution reasons will not be counted as errors.	Carriers/DMERCs/ FIs/full PSCs

	Exhibit 34.8 lists acceptable 'no resolution' reasons. The AC/full PSC shall keep documentation on file that supports the no resolution acceptable reason. The AC/full PSC shall make this documentation available to CMS or OIG upon request.	
Ch.12 Sec. 12.3.3.1 3229.2	In the case of a full PSC, the claims processing contractor shall provide sample information to the CERT contractor.	Claims Processing Contractor
Ch.12 Sec. 12.3.3.1 3229.3	For work performed in FY 2005, ACs shall allocate all the costs and workloads associated with §12.3.3.1 to the PM CERT Support code (12901). ACs/full PSCs shall use MR staff in concert with staff from other units to supply provider addresses to the CERT contractor. ACs/full PSCs should choose which staff to use in performing all other activities in §12.3.3.1. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.2 3229.4	The full PSC shall provide review information to the CERT contractor.	Full PSC
Ch.12 Sec. 12.3.3.2 3229.5	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractor to the MIP CERT Support code 21901. ACs/full PSCs shall use MR staff in concert with staff from other units to perform the activities listed in §12.3.3.2. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.6	Each month, the CERT contractor shall send a description of errors it has found to each AC/full PSC. ACs/full PSCs shall use the CERT feedback file to provide feedback to the CERT contractor. In the case of the full PSC, the CERT contractor shall send the feedback file to the full PSC, who shall coordinate with its AC to get all fields complete.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.7	In the future, the CERT contractor shall send an electronic copy of every medical record involved in an overpayment or underpayment situation to the AC. In the case of a full PSC, the CERT contractor shall send the electronic copy of the medical records to the full PSC. The full PSC shall forward a copy to its AC. The AC shall store this medical record at least until the provider and beneficiary appeals'	Carriers/DMERCs/ FIs/full PSCs

	timeframes have expired. These records shall be provided on cd-rom and shall be sent to the AC/full PSC at about the same time the feedback file is sent.	
Ch.12 Sec. 12.3.3.3 3229.8	For feedback files received in either March or June the AC shall return the feedback file within ten working days for every 30 lines that are not non-response lines. If the CERT contractor has not received documentation by the day after the AC's response period, the CERT contractor will score it as an error.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.9	For feedback files received in either March or June the AC shall return the feedback file including the non-response lines (error codes 15, 16, and 41) within 30 working days.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.10	If the AC is providing an estimated contractor recalculated final amount paid, the AC shall return the feedback file within ten working days for every 30 lines, for feedback files received in every month except March and June.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.11	The AC/full PSC may leave a feedback line blank. When this occurs, the blank line will be returned in the next feedback file except in the files returned in March and June. Feedback lines left blank in March and June will be scored as errors.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.12	If the CERT contractor sends feedback information to the AC/full PSC, indicating that a claim must be denied due to the provider's failure to submit requested documentation, and the provider later sends in the medical records for that same claim, the CERT contractor shall state on the next feedback file that the claim was denied due to another error type. If after reviewing the medical records, the claim is partially denied due to lack of medical necessity. In these situations the AC/full PSC shall enter the same dollar amounts (i.e., same final calculated amount, etc.). See section 12.3.4-Handling Overpayment and Underpayments Resulting from the CERT Findings, for how to notify the provider about changed denial reasons.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.3.3 3229.13	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.3.3 activities to the MIP CERT Support code (21901). ACs/full PSCs shall use MR	Carriers/DMERCs/ FIs/full PSCs

	staff in concert with staff from other units to provide feedback reports. ACs/full PSCs shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. ACs/full PSCs should use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	
Ch.12, Sec. 12.3.3.3.1 3229.14	The full PSC shall be responsible for disputing and disagreeing with CERT decisions.	Full PSCs
Ch.12, Sec. 12.3.3.3.1 3229.15	For work performed in FY 2005, ACs shall allocate all cost and workloads associated with §3.3.3.1 activities to the MIP CERT Support code (21901). ACs/full PSCs shall use MR staff in concert with staff from other units to provide feedback reports. ACs/full PSCs shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. ACs/full PSCs should use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.4 3229.16	When handling over/underpayments resulting from CERT findings ACs/full PSCs shall not make overpayment/underpayment adjustments on zero dollar errors, unless the AC/full PSC is contacting the provider to notify them of a new denial reason.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.4 3229.17	In situations where the CERT contractor receives medical records for a claim that was previously scored as an error due to non-response, and after reviewing the records the CERT contractor concludes it is a full denial or partially denied due to a different reason, the AC/full PSC shall notify the provider of the changed denial reason.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.4 3229.18	ACs/full PSCs shall not collect overpayments or pay on underpayments on non-assigned claims because beneficiaries are usually liable	Carriers/DMERCs/ FIs/full PSCs

	for these non-assigned claims.	
Ch.12 Sec. 12.3.4 3229.19	In the case of a full PSC, the claims processing contractor shall handle overpayment and underpayment actions.	Claims Processing contractor
Ch.12 Sec. 12.3.4 3229.20	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.4 activities to the PM CERT Support code (12901). ACs/full PSCs shall use claims processing staff to perform these activities. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.5 3229.21	In the case of the full PSC, the claims processing contractor shall process appeals resulting from CERT-initiated denials.	Claims Processing Contractor
Ch.12 Sec. 12.3.5 3229.22	ACs shall send the CERT contractor medical record requests on appeals for all CERT-initiated denials on a flow basis. If the AC believes they have enough documentation to make a determination on the appeal, the AC shall still request the documentation (experience shows that providers sometimes submit different documentation to the CERT contractor than to the AC upon appeal).	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.5 3229.23	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.5 activities to the PM CERT Support code (12901). ACs/full PSCs shall use appeal staff to perform these activities.	Carriers/DMERCs/ FIs
Ch.12 Sec. 12.3.6.1 3229.24	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.6.1 activities to the PM CERT Support code (12901).	Carriers/DMERCs/ FIs
Ch.12 Sec. 12.3.6.2 3229.25	On the first day of every month (beginning March 1), the CERT contractor shall send to every AC an Appeals Request email through normal email. The email will simply ask ACs to provide an update on all CERT-initiated denials that have been appealed. The AC shall respond to this request within 10 working days. In the case of the full PSC, the CERT contractor shall send the request to the full PSC, who shall then forward the list to the claims processing contractor. The claims processing contractor shall provide the CERT contractor with the status of appeals decisions with a cc: to the full PSC.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.6.2	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with	Carriers/DMERCs/ FIs/full PSCs

3229.26	§12.3.6.2 activities to the PM CERT Support code (12901). In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	
Ch.12 Sec. 12.3.8 3229.27	ACs/full PSCs shall share relevant CERT information with Medicare contractors, to whom they have a working relationship with (i.e., ACs and BI PSCs should share information, etc.). Examples of relevant CERT information include Improper Medicare FFS Payments Report, Errors in Medicare FFS Payments Report, and other CERT data.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.8 3229.28	The full PSC shall disseminate CERT information. On occasion, the full PSC should ask the AC to assist them with the dissemination of such information if there is a level of PCOM responsibility. That process would be worked out in the AC/full PSC Joint Operating Agreement.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.8 3229.29	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.8 activities to the MIP CERT Support code (21901). In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.9 3229.30	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.9 activities to the MIP CERT Support code (21901). ACs/full PSCs shall use MR staff in concert with staff from other units to perform these tasks. In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.31	All AC/full PSC claim identification information for providers that have not responded to the CERT contractor's requests shall be posted on the CERT Claims Status Website (www.psccert.org) on a weekly basis. Each week, the website will be updated to indicate whether the requested medical record has been received by the CERT contractor. ACs/full PSCs shall check the CERT Claims Status Website at www.psccert.org at least once a week.	Carriers/DMERCs/ FIs/full PSCs
Ch.12	ACs/full PSCs shall contact all providers who	Carriers/DMERCs/

Sec. 12.3.10 3229.32	have failed to submit medical records within 30 days of a request and encourage them to submit the requested records to the CERT contractor (these providers are known as 'non-responders').	FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.33	ACs/full PSCs shall NOT contact any provider selected for CERT review until 20 days after the CERT contractor's initial request for a medical record.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.34	ACs shall make at least one telephone contact to providers. Contacting providers requires speaking with an individual who has access to medical records for a given provider. CMS does not require that ACs use nurses to make their contacts. ACs should use any level of staff they deem appropriate to make these calls, but generally these contacts should not require the use of a clinician.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.35	ACs/full PSCs shall keep a log of each non-responding provider contact made. The log shall contain at least the date of contact, type of contact, and type of reply they received from the provider. Initially, ACs/full PSCs shall keep track of reply types using any internal system they desire. The excel spreadsheet provided by CMS should be used to track your contacts.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.36	ACs/full PSCs shall refer recalcitrant providers with a claim in question of $40 or more to the OIG. ACs/full PSCs shall aggregate all claims from a provider to determine if the $40 threshold has been met. Recalcitrant means the AC has contacted the provider (at least 20 days after the initial letter was sent) and received one of several replies listed in Exhibit A of CR 3157, and no record has been received by the CERT contractor within ten days of the OIG letter being sent by the CERT contractor or within 10 days of the last AC contact (whichever is later).	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.10 3229.37	For work performed in FY 2004, ACs/full PSCs shall allocate the costs and workloads associated with contacting non-responders to LPET CAFM II Code 24116. ACs/full PSCs shall report in the 'Remarks' field the dollars spent and the number of providers contacted.	Carriers/DMERCs/ FIs/full PSCs

	For work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.10 activities to the MIP CERT Support code (21901). In the case of the full PSC, the full PSC shall report the costs and workloads associated with these tasks into PSC ART.	
Ch.12 Sec. 12.3.11 3229.38	If upon reviewing late documentation, received before the CERT contractor communicates the error to the AC via the feedback process, the CERT contractor finds an error, the AC/full PSC's shall notify the provider of the change in denial reasons. CMS has left the task of notifying the provider of a change in denial reasons at the ACs/full PSCs discretion.	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.11 3229.39	If a provider appeals a CERT-initiated denial, the AC shall communicate the results of its appeal review to the CERT contractor. If a demand letter for overpayment was sent and payment recouped the AC/full PSC shall make the adjustment (i.e., pay the provider the amount he/she was due).	Carriers/DMERCs/ FIs/full PSCs
Ch.12 Sec. 12.3.12 3229.40	If the AC receives a voluntary refund from a provider on a claim in the CERT sample, the AC shall process the refund as they do all other voluntary refunds (i.e., in accordance with PIM Ch. 3, §12.8.4 and §12.8.4.1). • If the AC processes the voluntary refund BEFORE receiving the transaction file containing the claim in question, the AC shall notify the CERT contractor by calling Debbie Blessing at (443) 436 - 6615. • If the AC processes the voluntary refund AFTER receiving the transaction file containing the claim in question, the AC shall not notify the CERT contractor. The AC shall complete the feedback file as though the voluntary refund had not been received.	Carriers/DMERCs/ FIs
Ch.12 Sec. 12.3.13 3229.41	ACs/full PSCs shall ensure that all LMRP/LCDs are made prospectively and not retroactively (unless necessitated by a National Coverage Determinations (NCD) or Coverage	Carriers/DMERCs/ FIs/full PSCs

	Provision Interpretive Manual (CPIM)).	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
Ch.12, Sec. 12.3.9 3229.30	ACs/full PSCs should perform data analysis on high error rate categories identified in the Improper Medicare Fee-for-Service Payments report, and based on the results of their data analysis, plan corrective actions. ACs/full PSCs should not take any corrective action on any individual or group unless data analysis supports that action.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: June 28, 2004 **Implementation Date:** June 28, 2004 **Pre-Implementation Contact(s):** Stacey Stinson, (410) 786 - 9513, sstinson2@cms.hhs.gov **Post-Implementation Contact(s):** Stacey Stinson, (410) 786 - 9513, sstinson2@cms.hhs.gov	**These instructions shall be implemented within your current operating budget.**

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

Table of Contents

(Rev. 77, 05-28-04)

12.3.1 - Communication between the Affiliated Contractor (AC)/ full PSC and the CERT Contractor

(Rev. 77, 05-28-04)

A. CERT Staff

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

B. AC/full PSC CERT Points of Contact (POC)

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).

C. Applications to Assist Communication

A number of applications have been developed to foster the communication and exchange of information between the CERT contractor, ACs, and CMS. Several applications include:

- *CERT Confidential Web site* provides access to:
    - *The CERT Process Resources (i.e., Frequently Asked Questions (FAQs), CERT Review Manual, CERT Review Schedules, Cluster Lists, etc.),*
    - *Reports*
    - *ERRPs, and*
    - *Error Rate Data.*

To apply for access to the CERT Confidential Website, email the Fu contractor at lo@nerdvana.fu.com.

- *Secure Email allows:*

- *ACs/full PSCs to send and receive privacy-protected information (i.e. beneficiary names and HIC numbers) over a secure **email** system.*

- *CERT Points of Contact to receive AC feedback files over secure email rather than receiving them through FedEx via the mailroom. ACs may also return completed AC feedback files to the CERT contractor via secure email rather than sending diskettes via FedEx. Therefore, ACs will no longer have to use diskettes and the postal service to exchange information with the CERT contractor, which will save both time and financial resources.*

To obtain an application for secure email, email the Lauren Block at lblock@cms.hhs.gov.

- *CERT Claims Status Web site displays a:*

  - *Non-Response rate for each contractor/cluster,*
  - *Tardy and missing documentation list about providers (implemented 2/15/04),*
  - *Overpayment and Appeals Tracking System (implemented 4/1/04), and*
  - *Status of all claims in the final sample (beginning Spring/Summer 2004).*

To apply for access to the CERT Claims Status Website, email Michele Brown at brownm@psccert.org.

12.3.2 - Overview of the CERT Process
(Rev. 77, 05-28-04)

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 *CMS Data 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 *CMS Data 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.

12.3.3.1 - Providing Sample Information to the CERT Contractor

(Rev. 77, 05-28-04)

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 at the CMSDC.

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 CMSDC. 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 from their 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

(Rev. 77, 05-28-04)

The standard systems will create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CMSDC. 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 CMSDC. The 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 transaction file is not found on the standard system claims history file, no record should be created for that claim. *These are called 'no resolution' claims. Since the CERT contractor counts most 'no resolution' claims as errors (for the provider compliance error rate and the services processed error rate), the AC shall take all necessary steps to minimize the number of 'no resolution' claims it submits to the CERT contractor each year. Should the AC submit a 'no resolution' claim to the CERT contractor and later locates the needed resolution information; the AC shall provide the late resolution information to the CERT contractor. In the future, ACs can obtain a list of 'no resolution' claims they submitted for a given time period by accessing the Outstanding Documentation Requests report on the Claims Status Website.*

Some 'no resolution' claims will not be counted as errors: those with acceptable no resolution reasons. Exhibit 34.8 contains a list of acceptable no resolution reasons. Should the AC discover that one or more of their 'no resolution' claims has an acceptable reason, the AC shall notify Debby Blessing:

- *At Blessind@dynpsc.org, if the communication does not include a HICN, or*
- *via secure email or fax (443) 436-9413, if a HICN is included and the CERT contractor will send the revised claim record in the next month's transaction file.*

The AC/full PSC must keep documentation on file that supports the 'no resolution' acceptable reason. The AC/full PSC must make this documentation available to CMS or OIG upon request. 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.

Contractors are responsible for correcting and resubmitting these files, if the CERT contractor discovers any mistakes or inaccurate data on previous submissions.

C. Provider Address File

(Rev. 77, 05-28-04)

The ACs must transmit the names, addresses, and telephone numbers of the billing providers and attending physicians in a separate file to the CMSDC along with the sampled claims resolution file. *When submitting the address file to the CERT contractor, ACs should choose to produce a text file of the addresses.* 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. *In the future, if* a *billing* provider*/attending physician* 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 *billing* provider*/attending physician*, 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. *ACs may (but are not required to) compare the addresses they send to the CERT contractor in the Provider Address File with the ACs provider enrollment unit's files that may list "location of medical records". To view the address CERT has for that provider, the AC should go to the Outstanding Documentation Requests report on the CERT Claims Status Website, and click on the CID number associated with that provider. Should the AC want the CERT contractor to send the documentation request letter to a new/updated address, the AC may (1) call a CERT Customer Service Representative at (804) 864-9940, or (2) fax a CERT Customer Service Representative at (804) 864-9980 and specify how the address should be customized. In either case, the AC shall identify the provider by Provider Number and Provider Name.*

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

In the case of a full PSC, it is the claims processing contractor that is responsible for providing sample information to the CERT contractors.

For work performed in Fiscal Year (FY) 2004, the functional area that is performing these activities should capture costs and workloads associated with providing sample information to the CERT contractor. *Beginning with work performed in FY 2005, ACs must allocate all the costs and workloads associated with §12.3.3.1 to the PM CERT Support code (12901). ACs/full PSCs must use MR staff in concert with staff from other units to supply provider addresses to the CERT contractor. ACs/full PSCs may choose which staff to use in performing all other activities in §12.3.3.1. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.3.2 - Providing Review Information to the CERT Contractor *(Rev. 77, 05-28-04)*

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.

In the case of the full PSC, it is the full PSC who is responsible for providing review information to the CERT contractor.

For work performed in FY 2004, 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. *Beginning with work performed in FY 2005, ACs must allocate all costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractor to the MIP CERT Support code 21901. No Supplemental Budget Requests (SBRs) will be considered for this work. ACs/full PSCs shall use MR staff in concert with staff from other units to perform the activities listed in §12.3.3.2. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.3.3 - Providing Feedback Information to the CERT Contractor *(Rev. 77, 05-28-04)*

Requests for Feedback Information

- Each month, the CERT contractor will send a description of errors it has found to each AC/full PSC. ACs/full PSCs will use the CERT feedback file to provide feedback to the CERT contractor. *In the case of the full PSC, the CERT contractor will send the feedback file to the full PSC, who will coordinate with its AC to get all fields complete.*

- *Effective March 1, 2004, the CERT contractor no longer has to communicate non-response errors to the AC/full PSC on a monthly basis. Instead, every July 23rd, the CERT contractor will provide each AC/full PSC with a list of non-response errors that occurred during the current November report period.*

- *In the future*, the CERT contractor will send an electronic copy of every medical record involved in an overpayment or underpayment situation to the AC. *In the case of a full PSC, the CERT contractor will send the electronic copy of the medical records to the full PSC. The full PSC will forward a copy to its AC.* The AC 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 schedule*s*:

  For Feedback files received in either March or June

  - The AC must return the feedback file within ten working days for *every 30 lines that are not non-response lines.*
  - *The AC must return the feedback file including the non-response lines (error codes 15, 16, and 41) within 30 working days. ACs/full PSCs will not have to separate non-response lines from denied lines. The CERT contractor shall send separate feedback files.*
  - If the CERT contractor has not received documentation by the day after the AC's response period, 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 *for every 30 lines*.
- 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 AC/full PSC may leave a feedback line blank. When this occurs the blank line will be returned in the next feedback file except in the files returned in March and June. Feedback lines left blank in March and June will be scored as errors.*

- 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.

- *In situations where the CERT contractor sends feedback information to the AC/full PSC indicating that a claim must be denied due to the providers failure to submit requested documentation, and the provider later sends in the medical records for that same claim, the CERT contractor will state on the next feedback file that the claim was denied due to lack of documentation and after reviewing the medical records, the claim is fully or partially denied due to another reason. In these situations the AC/full PSC shall enter the same dollar amounts (i.e., same final calculated amount, etc.). See section 3.4-Handling Overpayment and Underpayments Resulting from the CERT Findings, for how to notify the provider about changed denial reasons.*

- 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.

In the case of the full PSC, it is the full PSC who is responsible for providing feedback information to the CERT contractor.

For work performed in FY 2004, 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). *Beginning with all work performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.3.3 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. ACs/full PSCs shall use MR staff in concert with staff from other units to provide feedback reports. ACs/full PSCs shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. ACs/full PSCs may use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.3.3.1 - Disputing/ Disagreeing with a CERT Decision
(Rev. 77, 05-28-04)

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). *The CERT contractor will notify the AC of the results a few days after the CO Panel has made their dispute decision.* Effective with the feedback files received in April 2004, each *contractor*/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 *(i.e., a cluster with three contractors may dispute three lines)*. 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. *CMS will review these disagrees on a monthly basis. CMS will notify the CERT contractor who will report CMS finding to the AC/full PSC. CMS will respond only to disagrees that provide an explanation with supporting evidence.*

In the case of the full PSC, it is the full PSC who is responsible for disputing and disagreeing with CERT decisions.

For work performed in FY 2004, 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). *Beginning with all work performed in FY 2005, ACs must allocate all cost and workloads associated with §12.3.3.3.1 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. ACs/full PSCs shall use MR staff in concert with staff from other units to provide feedback reports. ACs/full PSCs shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. ACs/full PSCs may use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.4 - Handling Overpayment and Underpayments Resulting from the CERT Findings

(Rev. 77, 05-28-04)

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 *FI* may list the adjustment indicator as 'HCFA' until such time as a CERT indicator exists. *FIs* 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. *ACs/full PSCs shall not make overpayment/underpayment adjustments on zero dollar errors, unless the AC/full PSC is contacting the provider to notify them of a new denial reason.*

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.

In situations where the CERT contractor receives medical records for a claim that was previously scored as an error due to non-response, and after reviewing the records the

CERT contractor concludes it is a full denial or partially denied due to a different reason, the AC/full PSC must notify the provider of the changed denial reason.

ACs/full PSCs shall not collect overpayments or pay on underpayments on non-assigned claims because beneficiaries are usually liable for these non-assigned claims.

In the case of a full PSC, it is the claims processing contractor that will handle overpayment/underpayment actions.

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 Ellen Cartwright*, the CERT contractor MR manager,* at (804) 264 – 1778 ext. 106.

For work performed in FY 2004, ACs must allocate the costs and workloads associated with handling over/underpayments resulting from CERT findings as they do all other over/underpayments. *Beginning with work performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.4 activities to the PM CERT Support code (12901). ACs/full PSCs shall use claims processing staff to perform these activities. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.5 - Handling Appeals Resulting from CERT Initiated Denials *(Rev. 77, 05-28-04)*

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.). *See Exhibit 34.12 Fee-For-Service Appeal Processes.*

In the case of the full PSC, it is the claims processing contractor that is responsible for processing appeals resulting from CERT-initiated denials.

ACs and claims processing contractors affiliated with a full PSC shall send the CERT contractor medical record requests on appeals for all CERT-initiated denials on a flow basis. Even if the AC believes they have enough documentation to make a determination on the appeal, the AC should still request the documentation (experience shows that providers sometimes submit different documentation to the CERT contractor than to the AC upon appeal). In the future, when the CERT contractor begins sending an electronic copy of every medical record involved in an overpayment or underpayment to the AC, the AC can then cease requesting medical records from the CERT contractor upon provider appeal.

For work performed in FY 2004, ACs must allocate the costs and workloads associated with handling appeals of CERT initiated denials as they do all other appeals. *Beginning with performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.5 activities to the PM CERT Support code (12901). ACs/full PSCs shall use appeal staff to perform these activities. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.6 - Tracking Overpayments and Appeals
(Rev. 77, 05-28-04)

12.3.6.1 - Tracking Overpayments
(Rev. 77, 05-28-04)

Upon request, the AC must provide the CERT contractor with the status and amounts of *completed* overpayment *collections* (or underpayments that have been paid). *'Completed Overpayment Collections' means that the overpayment amount has been fully collected or the AC has given up and referred the debt to Treasury or another entity.*

EXAMPLE: *On day 15, the CERT contractor notifies the AC of an $800 overpayment via the feedback file process for CID # 12345. On day 20, the AC establishes an 'accounts receivable' in its overpayment tracking system. On February 1, the CERT contractor requests an update on all Completed Overpayment Collections. The AC shall not include any information about CID # 12345 in the response since the overpayment collection action has not yet been completed. On February 15, the provider notrifies the AC that they would like to payback the overpayment via $200 offsets per month for the next 4 months. The AC sets the offsets in their system on February 20. On March 1, the CERT contractor requests an update on all completed overpayment collections. The AC shall not include any information about CID # 12345 in its response since overpayment collection action has not yet been completed. On May 20, the AC offsets the final $200 from the provider. On June 1, the CERT contractor requests an update. The AC shall inform the CERT contractor that for CID # 12345, the completed overpayment collection action on May 20.*

In the future, 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).

For FY 2004, the functional area that is performing these activities should capture costs and workloads associated with tracking and reporting overpayment/underpayment information to the CERT contractor. Beginning with work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.6.1 activities to the PM CERT Support code (12901). In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.6.2 - Tracking Appeals
(Rev. 77, 05-28-04)

Appeal Request Email

On the first day of every month (beginning March 1), the CERT contractor shall send to every AC an Appeals Status Request through normal email. The email will simply ask ACs to provide an update on all CERT-initiated denials that have been appealed. The AC shall have 10 working days to respond to this request via normal email. The ACs shall 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.

Which Appeals Affect the Error Rates

If the AC appeal process includes a review of the medical records submitted by the provider with the appeal, the AC must notify the CERT contractor about each appeal of a CERT-initiated denial, including the appeal decision. The CERT contractor will reflect these appeal full and partial reversals in the CERT Claims Database.

In the case of the full PSC, the CERT contractor shall send the request to the full PSC, who shall then forward the list to the claims processing contractor. The claims processing contractor shall provide the CERT contractor with the status of appeals decisions with a cc: to the full PSC.

ACs should reply to the CERT contractor by faxing a reply to Pat Smith at (804) 264-9764, with the including -- for each line of a CERT-initiated denial appealed by the provider -- the following information:

- *CID#*
- *CCN#*
- *Contractor Name*
- *Contractor Number*
- *Contractor staff person's name and phone number*
- *HIC Number*
- *Beneficiary Name*
- *From and To Dates of Service*
- *Medicare Final Allowed Amount (final amount paid to the provider + patient responsibility)*
- *Appeal Decision (overturn the denial, uphold the denial in full, uphold the denial in part)*
- *Date of Appeal Decision*
- *Appeal Level (re-review, hearing officer, ALJ, QIC, DAB, etc.)*
- *Contractor Recalculated Final Allowed Amount as adjusted by the appeal decision*

The future Appeals Tracking System will be a web-based application to collect this data (minus the HIC and beneficiary name).

For FY 2004, the functional area that is performing these activities should capture costs and workloads associated with tracking and reporting appeals information to the CERT contractor. *Beginning with work performed in FY 2005, ACs shall allocate all costs and workloads associated with §12.3.6.2 activities to the PM CERT Support code (12901). In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.8 - AC/full PSC Requirements Involving CERT Information Dissemination

(Rev. 77, 05-28-04)

Sharing CERT Information with Provider Community

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 *20* days have past. (See Exhibit 34.3)

Sharing CERT Information with Medicare Contractors

ACs/full PSCs must share relevant CERT information with Medicare contractors, to whom they have a working relationship with (i.e., ACs and BI PSCs may share information, etc.). Examples of relevant CERT information include Improper Medicare FFS Payments Report, Errors in Medicare FFS Payments Report, and other CERT data.

In the case of the full PSC, the full PSC has the responsibility of disseminating CERT information. On occasion, the full PSC may ask the AC to assist them with the dissemination of such information if there is a level of PCOM responsibility. That process would be worked out in the AC/full PSC Joint Operating Agreement.

For work performed in FY 2004, ACs must allocate costs and workloads associated with the dissemination of CERT information to LPET CAFM code 24116. *Beginning with work performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.8 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.*

12.3.9 - AC/full PSC Error Rate Reduction Plan (ERRP) (Rev. 77, 05-28-04)

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. *Error rate data is available to all PSCs via the CERT confidential website.* 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 <u>already put in place</u>
2. Which <u>new</u> 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 *RO Divisions of Medicare Financial Management*. The *RO Divisions of Medicare Financial Management* will forward the CERRP to those *RO Business Function Experts* (BFEs) who have *the* responsibility *of* monitoring the contractor submitting the CERRP for their comments. The *RO Divisions of Medicare Financial Management* and BFEs will determine if the CERRP is reasonable to reduce the contractor's error rate. *RO Divisions of Medicare Financial Management* 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 website. However, clusters that have not submitted ERRPs in the past must generate a new plan for submission.

When planning corrective actions for high error rate categories identified in the CERT report, the AC/full PSC may not take any punitive action on any individual or group. The AC/full PSC may perform data analysis on these categories, and based on their results, take necessary actions.

For work performed in FY 2004, the functional area that is involved in the preparation of the ERRP should capture the costs and workloads. Beginning with work performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.9 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. ACs/full PSCs shall use MR staff in concert with staff from other units to perform these tasks. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.10 - Contacting Non-Responders
(Rev. 77, 05-28-04)

A. The CERT Claims Status Website

All AC/full PSC claim identification information for providers that have not responded to the CERT contractor's requests will be posted on the CERT Claims Status Website (www.psccert.org) on a weekly basis. Each week, the website will be updated to indicate whether the requested medical record has been received by the CERT contractor.

B. Requirements for Contacting Non-Responders

The documentation cut-off date for the November Report is in May, so in preparation for the report every March each AC/full PSC:

- *Shall check the CERT Claims Status Website at www.psccert.org at least once a week,*
- *Shall contact all providers who have failed to submit medical records within 30 days of the CERT contractor's initial request and encourage them to submit the requested records to the CERT contractor (these providers are known as 'non-responders'),*
- *May contact any provider who has failed to submit medical records within 20 days of the CERT contractor's request and encourage them to submit the requested records to the CERT contractor (these providers are known as 'tardy providers'), and*
- *Shall NOT contact any provider selected for CERT review until 20 days after the CERT contractor's initial request for a medical record.*

Although ACs/full PSCs must contact all non-responders, ACs/full PSCs shall prioritize communications by focusing on contacting first and more frequently, those providers who submitted high dollar claims.

ACs shall make at least one telephone contact to providers. Contacting providers requires speaking with an individual who has access to medical records for a given provider. CMS requires at least one phone contact with each provider because there is no way to ensure that a letter or fax will reach the correct recipient without such a contact. Thus, phone calls and visits to providers are perceived as more effective than sending letters or faxes, while a combination of tactics would be most effective. CMS does not require that ACs use nurses to make their contacts. ACs may use any level of staff they deem appropriate to make these calls, but generally these contacts should not require the use of a clinician. ACs who choose to send letters to encourage providers shall list an AC contact name and phone number in the letter.

When contacting the provider, if they agree to submit the medical records to the CERT contractor, the AC shall ask the provider to include the barcode sheet with the copy. If they no longer have the barcode sheet, the AC shall ask the provider to write the Claim Identification Number (CID) (which the AC shall provide them) on the top of the medical record. ACs shall inform providers that they may fax medical records to 804-864-9980. If providers wish to speak with someone at the CERT contractor, they can call 804-864-9940 to speak with a customer service representative.

ACs/full PSCs may – but are not required – to contact third party providers and encourage them to send the needed records to the CERT contractor. ACs/full PSCs may also pursue other additional educational means to inform providers that they are non-responders and encourage them to respond.

C. Tracking Non-Responder Contacts

ACs/full PSCs shall keep a log of each contact made. The log shall contain at least the date of contact, type of contact, and type of reply they received from the provider. Initially, ACs/full PSCs shall keep track of reply types using any internal system they desire. The excel spreadsheet provided by CMS may be used to track your contacts (see Exhibit 34.10). In the future, the ACs/full PSCs shall enter this data directly into the CERT Claim Status Website. Exhibit 34.9 lists the types of replies into which the ACs/full PSCs should categorize each reply.

D. Requirement to Refer Continued Non-Responders to the OIG

ACs/full PSCs shall refer recalcitrant providers with a claim in question of $40 or more to the regional OIG staff whose email addresses can be found in Exhibit 34.11. ACs/full PSCs shall aggregate all claims from a provider to determine if the $40 threshold has been met. Recalcitrant means that:

1. *By day 30, the AC/full PSC has contacted the provider (anytime after day 20) and got reply A/E1/E2/F/G/I (see Exhibit 34.9), and no record has been received by the CERT contractor within ten days of the OIG letter being sent, or*
2. *The provider refuses to submit the records.*

When referring these providers the AC/full PSC shall include the CID number, the amount in question, the provider's name/phone number/fax number, and the contact history. ACs/full PSCs shall track entry into the spreadsheet by claim (not by line item). Exhibit 34.10 displays the spreadsheet that will be used as the referral to the OIG. In a few months, the ACs will enter this data directly into the CERT Claims Status Website.

ACs/full PSCs shall refer cases to the OIG on a flow basis. For example, if the AC/full PSC contacts Provider 1 on day 25 and the provider indicates they will not submit medical records to the CERT contractor because they do not think it is worth their time, the AC/full PSC shall immediately (within 10 days) refer the provider to the OIG. On the

other hand, if Provider 2 indicates their intention to submit medical records, the AC shall not make the OIG referral until the provider fails to submit records within ten days after the OIG letter is sent by the CERT contractor or within 10 days of the last AC contact (whichever is later). Continuing to contact providers after referring them to the OIG is optional for the AC/full PSC.

E. Customizing Address

During the course of contacting a non-responder, ACs/full PSCs shall verify the address of 'high volume' providers. A 'high volume' provider is one who submitted two or more claims that were selected for CERT review. Should the AC/full PSC determine that the address in the Claim Status Website is wrong or could be improved (e.g. adding: "attn: Compliance Officer", "John Smith", or "Medical Records Unit") the AC shall notify the CERT contractor as follows:

- *Call a CERT Customer Service Representative at (804) 864 – 9940 or (804) 264 – 1778 ext. 164 and specify how the address should be customized, or*
- *Fax a CERT Customer Service Representative at (804) 864 – 9980 or (804) 264 – 3268 and specify how the address should be customized.*

In either case, the AC/full PSC shall identify the provider by Provider Number and Provider Name.

For work performed in FY 2004, ACs/full PSCs must allocate the costs and workloads associated with contacting non-responders to LPET CAFM II Code 24116. ACs/full PSCs must report in the 'Remarks' field the dollars spent and the number of providers contacted. ACs shall not spend more than 10% or $10,000 (choosing the lesser of the two) of LPET budget on workloads associated with §12.3.10 activities. Beginning with work performed in FY 2005, ACs must allocate all costs and workloads associated with §12.3.10 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.11- Late Documentation Received by the CERT Contractor (Rev. 77, 05-28-04)

If documentation is not received by the 55th day, the CERT contractor scores the claim as an error. Any documentation received by the CERT contractor after the 55th day is considered 'late documentation'.

- *If the CERT contractor receives late documentation BEFORE the CERT contractor communicates the error to the AC via the feedback process, the CERT contractor shall review the late documentation and, if justified, revise each rate throughout the November report, May report, or updated data deliverable. If upon reviewing the late documentation the CERT*

contractor finds an error, it is the AC/full PSC's responsibility to notify the provider of the change in denial reasons. CMS has left the task of notifying the provider of a change in denial reasons at the ACs/full PSCs discretion.

- *If the CERT contractor receives late documentation AFTER the CERT contractor communicates the error to the AC via the feedback process, the CERT contractor shall check with the AC to see if the provider has appealed the denial.*

    - *If the provider appeals the CERT-initiated denial, the CERT contractor will not review the late documentation. The AC shall communicate the results of its appeal review to the CERT contractor. If a demand letter for overpayment was sent and payment recouped the AC/full PSC is responsible for making the adjustment (i.e., pay the provider the amount he/she was due).*

    - *If the provider has not submitted an appeal, the CERT contractor shall review the late documentation and if justified, revise the error in each rate throughout the November report, May report, or updated data deliverable. The CERT contractor shall notify the AC of the revised decision.*

12.3.12- Voluntary Refunds
(Rev. 77, 05-28-04)

If the AC receives a voluntary refund from a provider on a claim in the CERT sample, the AC shall process the refund as they do all other voluntary refunds (i.e., in accordance with PIM Ch. 3, §12.8.4 and §12.8.4.1).

- *If the AC processes the voluntary refund BEFORE receiving the transaction file containing the claim in question, the AC shall notify the CERT contractor by calling (443) 436 - 6615.*

- *If the AC processes the voluntary refund AFTER receiving the transaction file containing the claim in question, the AC should not notify the CERT contractor. The AC shall complete the feedback file as though the voluntary refund had not been received.*

12.3.13- Local Medical Review Policy (LMRP)/ National Coverage (NCD)
(Rev. 77, 05-28-04)

ACs/full PSCs shall ensure that all LMRP/LCDs are made prospectively and not retroactively (unless necessitated by a National Coverage Determinations (NCD) or Coverage Provision Interpretive Manual (CPIM)).

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(Rev. 77, 05-28-04)

Exhibit 34.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 77, 05-28-04)

(Rev. 67, 02-27-04)

File Formats Error! Bookmark not defined.

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

DATA ELEMENT DETAIL

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

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

Data Element: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

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

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	2"
Claim Control Number	X(15)	7	21	Spaces
Beneficiary HICN	X(12)	22	33	Spaces
Billing Provider	X(15)	34	48	Spaces
Line Item Count	S9(2)	49	50	Zeroes
Line Item group: The following group of Fields occurs from *1 to 52* Times (depending on Line Item Count).				
	From and Thru values relate to the 1st line item			
Performing Provider Number	X(15)	51	65	Spaces
Performing Provider Specialty	X(2)	66	67	Spaces
HCPCS Procedure Code	X(5)	68	72	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

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

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

Data Element: **Claim Control Number**
Definition: Number assigned by the standard system to uniquely identify the claim
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Beneficiary HICN**
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Billing Provider Number**
Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier
Validation: NA
Remarks: Must be present if claim contains the same billing/pricing provider number on all lines. Otherwise move all zeroes to this field
Requirement: Required

Data Element: **Line Item Count**
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: **Performing Provider Number**
Definition: Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Performing Provider Specialty**
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **HCPCS Procedure Code**
Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

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

DATA ELEMENT DETAIL

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

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

Data Element: Number of Claims
Definition: Number of claim records on this file (Do not count header or trailer record.)
Validation: Must be equal to the number of claims records on the file
Remarks: N/A
Requirement: Required

Sampled Claims Transaction File			
Field Name	**Picture**	**From**	**Thru**
Contractor ID	X(5)	1	5
Claim Control Number	X(15)	6	20
Beneficiary HICN	X(12)	21	32

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's CMS assigned number

Data Element: **Claim Control Number**
Definition: Number assigned by the standard system to uniquely identify the claim

Data Element: **Beneficiary HICN**
Definition: Beneficiary's Health Insurance Claim Number

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

DATA ELEMENT DETAIL

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

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

Data Element: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: **File Date**
Definition: Date the Sampled Claims Resolution file was created
Validation: Must be a valid date not equal to a File Date sent on any previous Sampled Claims Resolution file
Remarks: Format is CCYYMMDD
Requirement: Required

Sampled Claims Resolution File
Sampled Claims Resolution Detail Record (one record per claim)

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Claim Type	X(1)	7	7	Space
Assignment Indicator	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Original Claim Control Number	X(15)	10	24	Spaces
Claim Control Number	X(15)	25	39	Spaces
Beneficiary HICN	X(12)	40	51	Spaces
Beneficiary Name	X(30)	52	81	Spaces
Beneficiary Date Of Birth	X(8)	82	89	Spaces
Billing Provider Number	X(15)	90	104	Spaces
Referring Provider Number	X(15)	105	119	Spaces
Paid Amount	9(7)v99	120	128	Zeroes
Claim ANSI Reason Code 1	X(8)	129	136	Spaces
Claim ANSI Reason Code 2	X(8)	137	144	Spaces
Claim ANSI Reason Code 3	X(8)	145	152	Spaces
Claim Entry Date	X(8)	153	160	Spaces
Claim Adjudicated Date	X(8)	161	168	Spaces
Line Item Count	9(2)	169	170	Zeroes
Line Item group: The following group of fields occurs from *1 to 52* times (depending on Line Item Count).				
	From and Thru values relate to the 1st line item			
Performing Provider Number	X(15)	171	185	Spaces
Performing Provider Specialty	X(2)	186	187	Spaces
HCPCS Procedure Code	X(5)	188	192	Spaces
HCPCS Modifier 1	X(2)	193	194	Spaces
HCPCS Modifier 2	X(2)	195	196	Spaces
HCPCS Modifier 3	X(2)	197	198	Spaces
HCPCS Modifier 4	X(2)	199	200	Spaces
Number of Services	999v9	201	204	Zeroes
Service From Date	X(8)	205	212	Spaces
Service To Date	X(8)	213	220	Spaces
Place of Service	X(2)	221	222	Spaces
Type of Service	X(1)	223	223	Spaces
Diagnosis Code	X(5)	224	228	Spaces
CMN Control Number	X(15)	229	243	Spaces
Submitted Charge	9(7)v99	244	252	Zeroes
Medicare Initial Allowed Charge	9(7)v99	253	261	Zeroes
ANSI Reason Code 1	X(8)	262	269	Spaces
ANSI Reason Code 2	X(8)	270	277	Spaces
ANSI Reason Code 3	X(8)	278	285	Spaces
ANSI Reason Code 4	X(8)	286	293	Spaces
ANSI Reason Code 5	X(8)	294	301	Spaces

ANSI Reason Code 6	X(8)	302	309	Spaces
ANSI Reason Code 7	X(8)	310	317	Spaces
Manual Medical Review Indicator	X(1)	318	318	Space
Resolution Code	X(5)	319	323	Spaces
Final Allowed Charge	9(7)v99	324	332	Zeroes
Filler		X(25)	333	357
Spaces				

DATA ELEMENT DETAIL

Claim Header Fields

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

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

Data Element: **Claim Type**
Definition: Type of claim
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: **Assignment Indicator**
Definition: Code indicating whether claim is assigned or non-assigned
Validation: Must be 'A' or 'N'
Remarks: A = Assigned
N = Non-assigned
Requirement: Required

Data Element: **Mode of Entry Indicator**
Definition: Code that indicates if the claim is paper or EMC
Validation: Must be 'E' or 'P'
Remarks: E = EMC
P = Paper
Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: Required

Data Element: **Original Claim Control Number**
Definition: Number assigned by the standard system to provide a crosswalk to pull all claims associated with the sample claim
Validation: N/A
Remarks: N/A
Requirement:

Data Element: **Claim Control Number**
Definition: Number assigned by the standard system to uniquely identify the claim
Validation: N/A

Remarks: N/A
Requirement: Required
Data Element: **Beneficiary HICN**
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Beneficiary Nam**e
Definition: Name of the beneficiary
Validation: N/A
Remarks: First, middle and last names must be strung together to form a formatted name (e.g., John E Doe)
Requirement: Required

Data Element: **Beneficiary Date of Birth**
Definition: Date on which beneficiary was born.
Validation: Must be a valid date
Remarks: Month, day and year on which the beneficiary was born
Requirement: Required

Data Element: **Billing Provider Number**
Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier.
Validation: Must be present if claim contains the same billing/pricing provider number on all lines
Remarks: N/A
Requirement: Required for all claims, assigned and non-assigned, containing the same billing/pricing provider on all lines

Data Element: **Referring Provider Number**
Definition: Number assigned by the Standard System to identify the referring provider.
Validation: N/A
Remarks: Enter zeros if there is no referring provider.
Requirement: Required.

Data Element: **Paid Amount**
Definition: Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.
Validation: N/A
Remarks: N/A
Requirement: Required.

Data Element: **Claim ANSI Reason Code 1**
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Definition: Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code
Requirement: ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.

Data Element: **Claim Entry Date**
Definition: Date claim entered the standard claim processing system

Validation: Must be a valid date
Remarks: Format must be CCYYMMDD
Requirement: Required

Data Element: **Claim Adjudicated Date**
Definition: Date claim completed adjudication
Validation: Must be a valid date. Format must be CCYYMMDD
Remarks: This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made
Requirement: Required

Data Element: Line Item Count
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 01 – 52
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: **Performing Provider Number**
Definition: Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Performing Provider Specialty**
Definition: Code indicating the primary specialty of the performing provider or supplier
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Referring Provider Number**
Definition: Number assigned by the standard system to identify the referring provider
Validation: N/A
Remarks: Enter zeros if there is no referring provider
Requirement: Required

Data Element: **HCPCS Procedure Code**
Definition: The HCPCS/CPT-4 code that describes the service
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **HCPCS Modifier 1**
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
Definition: Codes identifying special circumstances related to the service
Validation: N/A
Remarks: N/A
Requirement: Required if available

Data Element: **Number of Services**

Definition: The number of service rendered in days or units
Validation: N/A
Remarks: The last position should contain the value to the right of the decimal in the number of services. Put a zero in the last position for whole numbers.
Requirement: Required

Data Element: **Service From Date**
Definition: The date the service was initiated
Validation: Must be a valid date less than or equal to Service To Date
Remarks: Format is CCYYMMDD
Requirement: Required
Data Element: **Service To Date**
Definition: The date the service ended
Validation: Must be a valid date greater than or equal to Service From Date
Remarks: Format is CCYYMMDD
Requirement: Required

Data Element: **Place of Service**
Definition: Code that identifies where the service was performed
Validation: N/A
Remarks: Must be a value in the range of 00 □ 99
Requirement: Required

Data Element: **Type of Service**
Definition: Code that classifies the service
Validation: The code must match a valid CWF type of service code
Remarks: N/A
Requirement: Required

Data Element: **Diagnosis Code**
Definition: Code identifying a diagnosed medical condition resulting in the line item service
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **CMN Control Number**
Definition: Number assigned by the standard system to uniquely identify a Certificate of Medical Necessity
Validation: N/A
Remarks: Enter a zero if no number is assigned
Requirement: Required on DMERC claims

Data Element: **Submitted Charge**
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Medicare Initial Allowed Charge**
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial
Validation: N/A
Remarks: This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted

Charge. If there is no fee schedule amount, then insert the Submitted Charge.
Requirement: Required

Data Element: **ANSI Reason Code 1**
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
Definition: Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed
Validation: Must be valid ANSI ASC claim adjustment codes and applicable group codes
Remarks: Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code

Requirement: Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC' ,'DEO', 'RTP', 'REDMR', 'REDMC',
or 'REO','APPAM','DENAM','REDAM'.

Data Element: **Manual Medical Review Indicator**
Definition: Code indicating whether or not the service received complex manual medical review. Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.
Validation: Must be 'Y' or 'N'
Remarks: Set to 'Y' if service was subjected to complex manual medical review, else 'N'
Requirement: Required

Data Element: **Resolution Code**
Definition: Code indicating how the contractor resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims

history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: Must be 'APP', 'APPMR', 'APPMC', ', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC' or 'REO','APPAM','DENAM','REDAM'.

Remarks:

APP = Approved as a valid submission
APPMR = Approved after manual medical review routine
APPMC = Approved after manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DENMR = Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMR = Denied after manual medical review routine
DENMC = Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO = Denied for non-medical reasons, other than denied as unprocessable.
RTP = Denied as unprocessable (return/reject)
REDMR = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO = Reduced for non-medical review reasons.
APPAM = Approved after automated medical review
DENAM = Denied after automated medical review
REDAM = Reduced after medical review

Requirement: Required.

Data Element: **Final Allowed Charge**

Definition: Final Amount allowed for this service or equipment after any reduction or denial
Validation: N/A
Remarks: This represents the contractor's value of the claim gross of co-pays and deductibles
Requirement: Required

Data Element: **Filler**
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement: None

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

DATA ELEMENT DETAIL

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

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

Data Element: **Number of Claims**
Definition: Number of sampled claim resolution records on this file (Do not count header or trailer record.)
Validation: Must be equal to the number of sampled claims resolution records on the file
Remarks: N/A
Requirement: Required

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

DATA ELEMENT DETAIL

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

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

Data Element: **Contractor Type**
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = Part B
D = DMERC
Requirement: Required

Data Element: **File Date**
Definition: Date the Provider Address file was created
Validation: Must be a valid date not equal to a File Date sent on any previous Provider Address file
Remarks: Format is CCYYMMDD
Requirement: Required

Provider Address File
Provider Address Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Provider Number	X(15)	7	21	Spaces
Provider Name	X(25)	22	46	Spaces
Provider Address 1	X(25)	47	71	Spaces
Provider Address 2	X(25)	72	96	Spaces
Provider City	X(15)	97	111	Spaces
Provider State Code	X(2)	112	113	Spaces
Provider Zip Code	X(9)	114	122	Spaces
Provider Phone Number	X(10)	123	132	Spaces
Provider Fax Number	X(10)	133	142	Spaces
Provider Type	X(1)	143	143	Spaces
Filler	X(25)	144	168	Spaces

DATA ELEMENT DETAIL

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

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

Data Element: **Provider Number**
Definition: Number assigned by the standard system to identify the billing/pricing provider or supplier or referring provider
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Provider Name**
Definition: Provider's name
Validation: N/A
Remarks: This is the name of the billing/pricing provider or referring provider must be formatted into a name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).
Requirement: Required

Data Element: **Provider Address 1**
Definition: 1st line of provider's address
Validation: N/A
Remarks: This is the payee address1of the billing/pricing provider or referring provider
Requirement: Required

Data Element: **Provider Address 2**
Definition: 2nd line of provider's address
Validation: N/A
Remarks: This is the address2 of the billing/pricing provider or referring provider

Requirement: Required if available

Data Element: **Provider City**
Definition: Provider's city name
Validation: N/A
Remarks: This is the city of the billing/pricing provider or referring provider
Requirement: Required

Data Element: **Provider State Code**
Definition: Provider's billing state code
Validation: Must be a valid state code
Remarks: This is the state of the billing/pricing provider or referring provider
Requirement: Required

Data Element: **Provider Zip Code**
Definition: Provider's billing zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code of the billing/pricing provider or referring provider. Provide 9-digit zip code if available, otherwise provide 5-digit zip code
Requirement: Required

Data Element: **Provider Phone Number**
Definition: Provider's telephone number
Validation: Must be a valid telephone number
Remarks: This is the phone number of the billing/pricing provider or referring provider
Requirement: None

Data Element: **Provider Fax Number**
Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: This is the fax number of the billing/pricing provider or referring provider
Requirement: None

Data Element: **Provider Type**
Definition: 1=billing/pricing provider 2= referring provider
Validation: Must be a valid provider type
Remarks: This field indicates whether the information provided on the record is for the billing/pricing provider or referring provider
Requirement: Required

Data Element: **Filler**
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement:

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

DATA ELEMENT DETAIL

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

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

Data Element: **Number of Records**
Definition: Number of provider address records on this file (do not count header or trailer record)
Validation: Must be equal to the number of provider address records on the file
Remarks: N/A
Requirement: Required

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system's claims history file. It should not include header or trailer records.

Exhibit 34.6 – CERT PSC Contractor Feedback Data Entry Screen Version 1.01

(Rev. 77, 05-28-04)

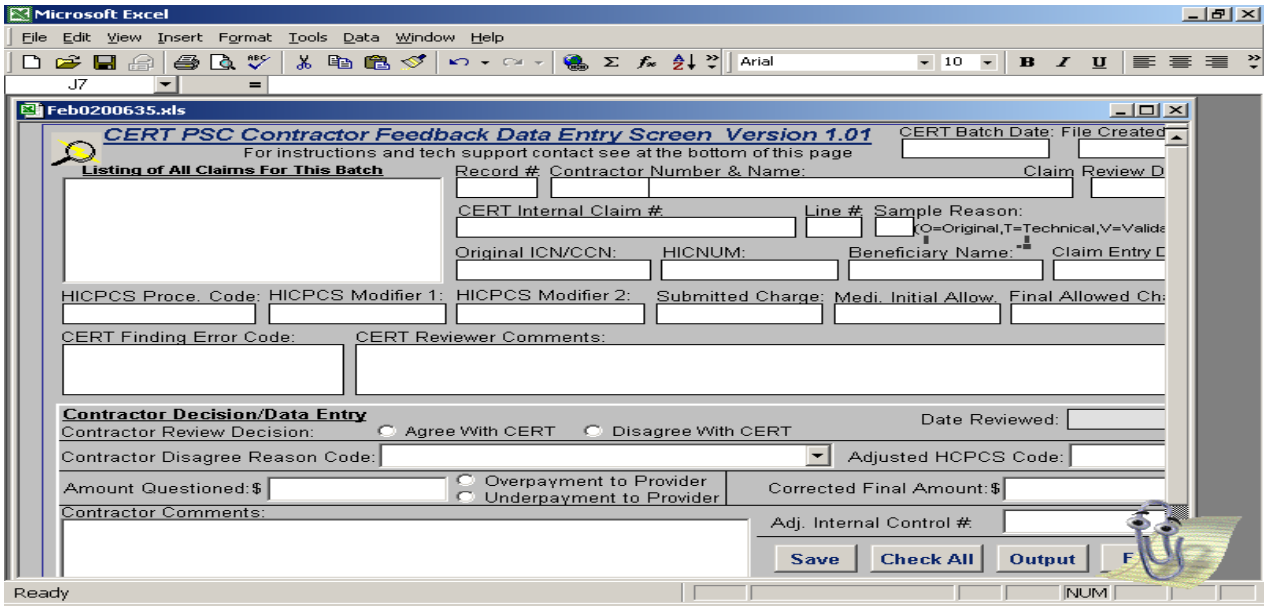

Figure 1: CERT PSC Contractor Feedback Data Entry Screen

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the *CERT Contractor Resolution Process* (CCRP), even where your staff have previously conducted routine or complex MR.

The CMS will conduct a routine quality assurance review of the CERT program including review of claims with error and non-error findings.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

Exhibit 34.7 - Data Items Included on CERT Reports

(Rev. 77, 05-28-04)

The *CMS Central Office Clinical Panel* (COCP) will receive the following for each line submitted to the CCRP:

Relevant information from the medical record for the disagreed upon line of service, Explanations from the CERT PSC and the AC of their decisions, and

Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The COCP will make a decision based upon all information presented to them.

To insure that regional offices (ROs) have an opportunity to be involved in the CCRP, the COCP will invite the participation of RO clinicians in the process.

The COCP at a minimum will consist of four individuals. There will be physician representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PIG). There will be at least one registered nurse on this panel. The COCP will request the participation of consortia staff; requests will be made at least one month before participation is expected. The panel may request the assistance of complex medical review experts, coding experts, or clinical specialists. A list of all participants must accompany the final report from the panel.

Members of panels will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CMS will provide final results from the COCP reviews to you in the CERT Quarterly Error Reconciliation Report (see attachment 5 for the report format); CMS will include in this report only those lines the COCP has confirmed to be in error after the COCP has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. You will pay to the billing providers amounts that you have denied in error and the CERT PSC has identified as such. The CMS does not require collection or payment for errors in coding that do not affect the amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact you identified.

On an annual basis, the COCP will conduct random reviews of the decisions on requests submitted to the CCRP. The QA findings shall be sent to the CERT PSC, AC, and applicable parties (i.e., RO or CO).

Exhibit 34.8 - Acceptable 'No Resolution' Reasons
(Rev. 77, 05-28-04)

The following are valid reasons for a 'no resolution' claim:

1. *Only six line items may be submitted on each HCFA 1500 claim form.*
2. *The patient's Health Insurance Claim Number (HICN) is missing; incomplete or invalid (i.e., not in the proper format) or no valid HICN can be found.*
3. *The provider number is missing or incomplete.*
4. *No services are identified on the bill.*
5. *The current HCFA 1500 form and the current UB-92 form are not used.*
6. *The front and back of the HCFA 1500 (12/90) claim form are required on the same sheet and they are not displayed this way.*
7. *The patient's address is missing.*
8. *Block 11 (insured' policy group or FECA Number) of the HCFA 1500 is not completed.*
9. *The beneficiary's signature information is missing.*
10. *The ordering physician's name and/or UPIN is missing or invalid (block 17,17A of the HCFA 1500).*
11. *The place of service code is missing or invalid (block 24B of the HCFA 1500).*
12. *The submitted charges are missing (block 24F of the HCFA 1500).*
13. *The days or units are missing (block 24G of the HCFA 1500).*
14. *The signature is missing from block 31 of the HCFA 1500.*
15. *An itemized receipt is missing.*
16. *The name of the store is not on the receipt that includes the price of the item.*
17. *A breakdown of charges is not provided.*
18. *The Certificate of Medical Necessity (CMN) was not with the claim.*
19. *The CMN form is incomplete or invalid.*
20. *Dates of service are missing or incomplete (block 24A of the HCFA 1500).*

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21. *A provider notifies the contractor that claim(s) were billed in error and requests the claim be deleted.*
22. *The provider goes into the claims processing system and deletes a claim.*
23. *The patient's name does not match any HICN.*
24. *Valid procedure codes were not used and/or services are not described (block 24D of the HCFA 1500).*
25. *A description for the item is missing.*
26. *The initial date on the CMN is invalid or incomplete.*

Problems 1-20 are valid reasons for a 'no resolution' claim and ACs should RTP, deny, or void/cancel/delete the claims (while maintaining an audit trail). ACs should handle problems 21-26 by denying the claims and recording the decision in the AC's claims processing system. Under no circumstances should denied claims be totally deleted from the claims processing system (i.e., contractors must maintain an audit trail for all deleted claims).

Exhibit 34.9 - Types of Replies from Providers in Non-Responder Cases

(Rev. 77, 05-28-04)

A – *Provider indicates they have or they will submit the requested medical record to the CERT contractor.*

E1 – *Provider indicates that another department within the provider is responsible for fulfilling documentation requests.*

E2 – *Provider indicates that a different provider – a third party – has the relevant medical record.*

F – *Provider indicates they have the medical record but refuse to provide it without payment for copying/mailing charges*

G – *Provider indicates they have the medical record but refuse to provide it for some other reason.*

H – *Extenuating Circumstances (fire, flood, explosion etc.)*

I – *Other*

Exhibit 34.10 – OIG Referral of Non-Responding Providers[1]

Referral #	1	2	3	4	5	6	7	8
Contractor Number								
Billing Provider ID #								
CID #								
Date of referral to OIG								
Dates of service								
HCPCS/ Revenue Code								
Cumulative $ value of claims from this billing provider ID								
# and date of AC phone calls to billing provider where this claim was discussed								
Name of person contacted at the provider								
Phone # of the person contacted								
Type of Reply								
# and date of AC faxes to billing provider where this claim was mentioned								
# and date of AC letters to billing provider sent where this claim was mentioned								
If Type of Reply = "Other," briefly explain								
If Type of Reply = E2, list the contact info for the third party								
# and date of AC phone calls to third party where this claim was discussed								
Type of Reply								
If Type of Reply = "Other," briefly explain								
# and date of AC faxes to third party where this claim was mentioned								
# and date of AC letters sent to third party where this claim was mentioned								

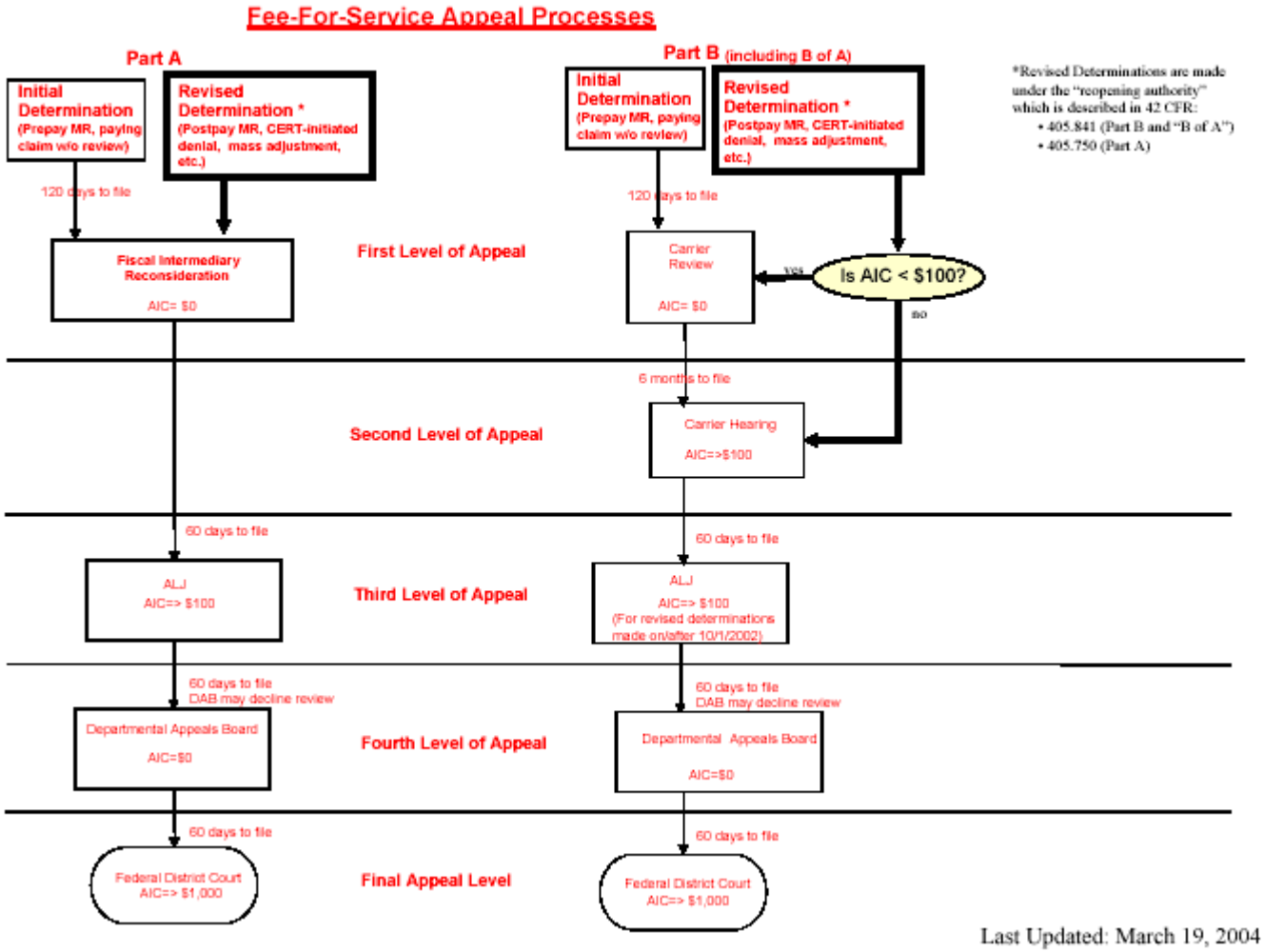
[1] The Revised OIG Referral is an Excel Spreadsheet. This table is being used only as a visual aide and should not be used to refer recalcitrant providers.

Exhibit 34.11 - Office Of Audit Services - Regions

Region	Name	States	E-mail Address
I	Boston		
		Connecticut	PFUR1@oig.hhs.gov
		New Hampshire	
		Maine	
		Rhode Island	
		Massachusetts	
		Vermont	
II	New York		PFUR2@oig.hhs.gov
		New Jersey	
		New York	
		Puerto Rico	
		(Virgin Islands)	
III	Philadelphia		PFUR3@oig.hhs.gov
		District of Columbia	
		Virginia	
		Maryland	
		West Virginia	
		Pennsylvania	
IV	Atlanta		PFUR4@oig.hhs.gov
		Alabama/Cahaba	
		Georgia	
		Mississippi	
		Kentucky	
		South Carolina/Palmetto	
		Florida	
		Tennessee	
		North Carolina	
V	Chicago		PFUR5@oig.hhs.gov
		Minnesota	
		Indiana	
		Illinois	
		Ohio	
		Michigan	
		Wisconsin	
VI	Dallas		PFUR6@oig.hhs.gov
		Arkansas	
		Oklahoma	
		Louisiana	
		Texas (THE)	
		New Mexico	
VII	Kansas City		PFUR7@oig.hhs.gov
		Colorado	
		Missouri	
		North Dakota	
		Wyoming	
		Iowa	
		Montana	
		South Dakota	
		Kansas	
		Nebraska	
		Utah	

Region	Name	States	E-mail Address
IX	San Francisco	Alaska Hawaii Oregon Arizona Idaho Washington California Nevada	PFUR9@oig.hhs.gov

Exhibit 34.12 Fee-For-Service Appeal Processes



Last Updated: March 19, 2004