CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 78 **Date: JUNE 10, 2004**

CHANGE REQUEST 3111

I. SUMMARY OF CHANGES:

This is a One Time Special Notification (OTSN) for the Medical Review (MR) Progressive Corrective Action (PCA) for Part A

This OTSN replaces CR 2497 and requires that contractors (including Program Safeguard Contractors that have assumed intermediary medical review responsibilities) using the Fiscal Intermediary Shared System (FISS), contractor data centers supporting the FISS standard system, and the FISS standard system maintainer make changes for implementation of the Pub 100-8, §§ 1-4 by the implementation date of this OTSN.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
	NONE

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

One Time Notification

Pub. 100-08	Transmittal: 78	Date: June 10, 2004	Change Request 3111

SUBJECT: Medical Review (MR) Progressive Corrective Action (PCA) for Part A

I. GENERAL INFORMATION

A. Background:

This one time notification (OTN) that replaces CR 2497 and requires that contractors (including Program Safeguard Contractors that have assumed intermediary medical review responsibilities) using the Fiscal Intermediary Shared System (FISS), contractor data centers supporting the FISS shared system, and the FISS shared system maintainer make changes for implementation of the Pub 100-8, §§ 1-4 by the implementation date of this OTN. Systems changes include, but are not limited to developing the following functions and including them in the shared system:

- Select a predetermined "every n^{th} claim" OR number of claims for prepayment medical review,
- Suspend claims in the sample for prepayment review,
- Provide a dataset containing information needed to calculate error rates for providers on PCA review, and
- Track providers and records under PCA.

Contractors shall ensure that all sections of the Pub 100-8, Chapter 3, §§ 1-4, are fully implemented by the implementation date of this OTN. Contractor data centers shall insure that the module that this OTN requires is ready for Medicare contractors to use by the implementation date. The shared system maintainer shall develop and make available the module described below in time for contractors to begin using the system by the implementation date.

B. Policy:

This OTN provides additional detail and requirements to support Pub 100-8 Chapter 3, §§ 1-4 concerning MR PCA. Pub 100-8 instructs all contractors to implement PCA to the extent possible.

II. BUSINESS REQUIREMENTS

In developing these requirements, CMS made the following assumptions:

- The current FISS system suspends claims prepayment The current FISS system can and will suspend a claim before the end of the processing cycle to insure that a claim on which the contractor wishes to do PCA review is not paid before PCA review is initiated. In addition, the existing FISS shared system can and will insure that the contractor does not pay the claim until the contractor completes PCA review, even if the provider resubmits the claim.. The FISS system can and will suspend claims so that, if another item on the claim requires development and the PCA review requires medical records, only one development letter is sent to request records for both purposes.
- The PCA modifications to the system can and will interface with the FISS shared system record request module (i.e., the system module that the

contractor uses to send a letter to request additional documentation before a claim is paid, e.g., the FISS medical policy driver) and identify claim-by-claim, pay/no pay decisions. The FISS system can and will bundle PCA documentation requests with those for other edits that result in suspension for additional documentation.

To restate and clarify this assumption: The SS can and will systematically "bundle" any documentation requests resulting from a PCA review on a claim with any documentation requests resulting from med policy review (claims needing records review via med policy parameter) on the same claim.

- The prepayment module can and will select a claim before it goes to development but after the shared system has initiated automated processing.

- PIMR can produce the outputs required by requirements 3111.8 through 3111.11 and if PIMR is run on its current schedule (i.e., once per month), using PIMR for the OTN will not significantly impact claims processing and will meet the requirements of this OTN.

Requirement #	Requirements	Responsibility
3111.1	Modify the shared system to allow contractors to select a predetermined "every n^{th} claim" OR number of claims for prepayment medical review.	FISS maintainer
3111.2	Modify the shared system to allow contractors to draw a representative sample prepayment utilizing systematic sampling.	FISS maintainer
3111.3	Modify the shared system to allow contractors to extract the sample required in requirement numbers 1 through 2 for (1) all claims or (2) a sample based upon a criteria set containing any of the 16 criteria below: 1. Revenue centers – include the capability for a user to specify a wildcard in any position and individual, ranges, and sets of revenue codes, 2. Revenue centers plus procedure codes, 3. Procedure codes (HCPCS codes) – include the capability for a user to specify a wildcard in any position and up to 50 individual codes or ranges, 4. Procedure codes (ICD-9 codes) – include the capability for a user to specify individual codes or ranges, 5. Combinations of procedure codes (HCPCS codes) and modifiers – include the capability for a user to specify individual combinations 6. ICD-9 diagnosis codes (including admitting diagnosis and "e"codes) – include the capability for a user to specify individual codes or ranges, 7. Billing provider numbers - include the capability for a user to specify individual IDs or ranges of IDs, 8. Dates of service - include the capability for a user to specify individual dates or date ranges of from dates, thru dates, and both from and thru dates, 9. Unique physician identification number (UPIN) for attending and referring physicians - include the capability for a user to specify individual numbers **or**	FISS maintainer

Requirement #	Requirements	Responsibility
	ranges, 10. Type of facility based on last four digits of provider number, 11. Type of bill - include the capability for a user to specify a wildcard in any position and individual types or ranges of types, 12. Beneficiary ID - include the capability for a user to specify individual IDs or ID ranges, 13. Covered amount – where this can be done prepayment, 14. Number of units per service on the claim – where this can be done prepayment, 15. Condition codes and/or 16. Billed amount.	
3111.4	The system shall allow a user to specify any of the different individual values and/or ranges of values for each criterion in requirement 3. It shall allow a user to exclude no pay bills, i.e., bills submitted to demonstrate that Medicare will not cover services included on the bill and claims where Medicare will not make payment. A user shall be able to use "and" as well as "or" in the criteria listed in requirement 3 above.	FISS maintainer
3111.5	The system shall allow users to exclude from the sample specific providers for a service specific review.	FISS maintainer
3111.6	The system shall allow contractors to sample from either a subset (e.g., a specific service for a specific provider) or a universe of claims (e.g., all claims for a specific provider) or both (e.g., all claims for one provider and only a sample for a specific service for a second provider).	FISS maintainer
3111.7	The system shall draw the sample at a user-specified rate (every n^{th} claim) and (1) sample at that rate for a user-specified period (from one week to 6 months) OR (2) for a user specified maximum number of claims.	FISS maintainer
3111.8	The system shall provide the following information needed to calculate PCA error rates and variances (See the attachment for definitions of information): a) Medical Review reason code, b) Control Number, c) Provider ID, d) Sum of the rates for submitted revenue centers (sum of the PIMR allowed amount) for the criteria set (items a-c), e) Sum of the rate for allowed revenue centers or submitted charge for allowed revenue centers (sum of the PIMR eligible amounts) for the criteria set (items a-c), f) Number of lines submitted for the criteria set (items a-c), g) Number of lines denied for the criteria set (items a-c), h) Number of units submitted for the criteria set (items a-c), i) Number of units denied for the criteria set (items a-c), j) Number of claims in the universe, k) Number of claims in the sample, l) Sampling rate, and m) Type of review.	FISS maintainer
3111.9	The system shall provide the following information needed identify claims in the sample (provide a line for each claim in the sample. See the attachment for definitions of information): Medial Review reason code, Control number, ICN/DCN of the claim,	

Requirement #	Requirements	Responsibility
	HIC, From Date, . Through Date, and Provider Number.	
3111.10	The information described in the attachment shall be available to users in electronic form at all times. The information in the attachment shall be updated at least every 31 days.	Contractor Data Centers
3111.11	The system shall track the elements in the attachment for claims sampled up to 36 months (Medicare contractors shall be able to specify how many months (1-36) they will track providers).	Contractor Data Centers
3111.12	The system shall perform all functions for both probe and regular PCA prepayment review.	FISS maintainer
3111.13	Where existing systems duplicate PCA requirements, FISS maintainer shall provide for use of the existing system.	FISS maintainer
3111.14	In developing the module, the FISS maintainer should use existing capabilities where possible. Those capabilities might include suspension procedures used with system edits, manual entry of the results of manual review, and generation of beneficiary and provider notices. Where development would be more efficient, functions may be included in separate modules. For example, the maintainer could develop a service specific and a provider specific module. CMS encourages use of existing modules such as SuperOp.	FISS maintainer
3111.15	Shared system maintainer and contractor staff will identify what existing capabilities could be use to meet requirements 13 and 14 of this OTN.	FISS maintainer, and associated FIs
3111.16	The system will process only information that is on a claim. If a claim does not have sufficient information to identify it for selection, the system will not be able to select it. The impact of that fact on the representativeness of the sample cannot be determined. However, all claims that do not have sufficient information to allow processing, i.e., a missing provider number, are returned to the submitter for resubmission. Once the claim is correctly resubmitted, the module shall include the claims in the universe and select the claim if it meets criteria in the sample criteria set. This assures a representative, unbiased sample.	FISS maintainer
3111.17	Shared system maintainer shall develop the module in time for data centers to install and test the module on or before the implementation date.	FISS maintainer
3111.18	Contractor data centers shall assure that the module is tested and ready for each Medicare contractor they serve by the implementation date.	Contractor data centers
3111.19	Contractors shall begin performing all components of PCA by the implementation date. Contractors may either use the modules required by this OTN or another procedure that meets all requirements of this OTN at the same or higher level of efficiency as the module developed for this OTN	Contractor staff

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

This OTN does not add new pricing files or edits. Coinsurance and deductibles do not need to be considered in complying with this requirement; allowed amount includes coinsurance and deductibles. Linkages or modifications to Pricer, outpatient code editor (OCE), and outpatient prospective payment system (OPPS) are not required. PS&R will not be affected.

No new MSNs must be generated because of this application; the activities required by this OTN do not include claims denials. You will make denials as part of the existing review process and you can use MSNs you use in prepayment review for the reviews done on the samples selected for prepayment PCA. You do not need to include a statement regarding PCA in remittance advice regarding a claim you review for PCA.

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

IV. Attachment(s): Contractor/Shared System Interface and Manual Data Requirements

Effective Date: October 1, 2004 **Implementation Date: October 4, 2004** **Pre-Implementation Contact(s): John Stewart (410) 786-1189 Jstewart@CMS.HHS.GOV** **Post-Implementation Contact(s): John Stewart (410) 786-1189 Jstewart@CMS.HHS.GOV**	**These instructions shall be implemented within your current operating budget**

ATTACHMENT

FORMAT FOR THE PCA TRANSFER FILE

ITEM NO	ITEM NAME	DESCRIPTION	ST	END	LEN-GTH	TYPE
1a	MEDICAL REVIEW REASON CODE	The Medical Review reason code that FISS assigns to the edit.	1	5	5	Alpha-numeric
1b	CONTROL NUMBER	The control number that FISS assigns to the edit.	6	15	10	Alpha-numeric
1c	PROVIDER ID	A provider ID used as a criteria for the study. Enter only if Provider ID is one of the criteria for the study. One record shall be created for each Provider ID in the study. Left justify	16	35	20	Alpha - numeric
1d	SUM OF RATES FOR SUBMITTED REVENUE CENTER (SUM OF THE PIMR ALOWED AMOUNT)	Sum of the Medicare fee schedule, outpatient code editor, pricer, and/or outpatient prospective payment system amounts for submitted revenue center codes for the criteria set and provider ID combination, i.e., each combination of items 1, and 2. Round to the nearest dollar. This is the PIMR allowed amount. This amount includes coinsurance and deductible.	36	48	13	Numeric
1e	SUM OF LOWER OF RATE FOR ALLOWED REVENUE CENTER OR SUBMITTED CHARGE (SUM OF THE PIMR ELIGIBLE AMOUNT)	Sum of the lower of the Medicare fee schedule, outpatient code editor, pricer, and/or outpatient prospective payment system amount or submitted amounts for allowed revenue center for the criteria set and provider ID combination, i.e., each combination of items 1 and 2. Round to the nearest dollar. Do not put in commas or dollar signs. This is the PIMR eligible amount. This amount includes coinsurance and deductible.	49	61	13	Numeric
1f	LINES SUBMITTED	Sum of the number of submitted lines in the sample for each criteria set, i.e., each combination of items 1-3. Do not put in commas.	62	65	4	Numeric
1g	LINES DENIED	Sum of the number of lines in the sample denied after PCA review for each criteria set, i.e., each combination of items 1-3. Do not put in commas.	66	69	4	Numeric
1h	UNITS SUBMITTED	Sum of the number of submitted units in the sample for each criteria set, i.e., each combination of items 1-3. Units may be days, services, or some other measure. Do not put in commas.	70	74	5	Numeric

1i	UNITS DENIED	Sum of the number of units in the sample denied after PCA review for each criteria set, i.e., each combination of items 1-3. Units may be days, services, or some other measure. Do not put in commas.	75	79	5	Numeric
1j	NUMBER OF CLAIMS IN THE UNIVERSE	The number of claims in criteria set (item 1-3). Do not put in commas. This line shall be the same for each line of the study.	80	86	7	Numeric ~~w decimal point~~
1k	NUMBER OF CLAIMS IN THE SAMPLE	The number of claims in the sample for each criterion set (item 1-3). Do not put in commas. This line shall be the same for each line of the study.	87	93	7	Numeric
1l	SAMPLING RATE	The sampling rate for each criteria set (items 1-3), i.e., Number in Universe/Number in sample. Round to one decimal place. Field size includes the decimal. This number shall be the same for each line of the study.	94	97	4	Numeric w decimal point
1m	TYPE OF REVIEW INDICATOR	Whether the ORIGINAL INTENT WAS TO REVIEW CLAIMS THAT MEET THE CRITERIA USING complex or routine review. Complex review requires that a medical record be manually reviewed. Routine review requires that claims and history data be manually reviewed but does not require that a medical record be reviewed. Values 1= complex review and 2 = routine review	98	98	1	Alpha – numeric

FORMAT FOR THE ICN/DCN FILE						
ITEM NO	**ITEM NAME**	**DESCRIPTION**	**ST**	**END**	**LEN-GTH**	**TYPE**
2a	MEDICAL REVIEW REASON CODE	The Medical Review reason code that FISS assigns to the edit.	1	5	5	Alpha-numeric
2b	CONTROL NUMBER	The control number that FISS assigns to the edit.	6	15	10	Alpha-numeric
2c	ICN/DCN SELECTED FOR THE SAMPLE	An ICN/DCN selected for PCA review by the system. Include a record for each ICN/DCN in the sample.	16	32	17	Alpha - numeric
2d	HIC	The Health Insurance Claim Number for the Medicare beneficiary that received the services/supplies billed on the claim.	33	44	12	Alpha - numeric
2e	FROM DATE	The date on which delivery of the services/supplies billed on the claims began. Enter in MM/DD/CCYY format.	45	52	8	Numeric
2f	THROUGH DATE	The date on which the delivery of services/supplies billed on the claims ended. Enter in MM/DD/CCYY format.	53	60	8	Numeric
2g	PROVIDER NUMBER	The identification number the contractor assigned to the provider of the services billed on the claim.	61	73	13	Alpha - numeric