Program Memorandum Intermediaries

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

Transmittal A-01-87 **Date: JULY 27, 2001**

CHANGE REQUEST 1588

SUBJECT: Comprehensive Error Rate Testing (CERT) Program - Requirements for Medicare Part A Contractor Operations

Purpose

This Program Memorandum (PM) details how Medicare Part A contractors, i.e., Fiscal Intermediaries (FIs) and Regional Home Health Intermediaries (RHHIs) will interact with the CERT operations center.

Background

CMS's Office of Financial Management, Program Integrity Group, Division of Methods and Strategy developed the CERT program to produce national, contractor specific, and benefit category specific paid claim error rates. Independent reviewers will periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system. These reviewers will medically review claims that are paid; claims that are denied will be validated to ensure that the decision was appropriate. The sampled claim data and decisions of the reviewers will be entered into a tracking and reporting database. The sampled claims will be followed through the system to their final disposition. The outcomes CMS anticipates from this project are a national paid claims error rate; a claims processing error rate, and a provider compliance rate. The tracking database will allow CMS to quickly identify emerging trends. CERT will enhance CMS's ability to take appropriate corrective actions and can be used to better manage Medicare contractor performance. A byproduct of the CERT program is a large database of independently reviewed claims that CMS can use to test new software technologies such as data analysis tools or commercial off the shelf (COTS) claims editing software.

CMS implemented CERT in August 2000 at all durable medical equipment carrier (DMERC) sites (Phase 1), in October 2000 at all other Viable Information Processing System (VIPS) Medicare System (VMS - carriers) users (Phase 2), and at Electronic Data Systems (EDS) contractor sites (carriers) in April 2001 (Phase 3). We plan to implement CERT in all MedicareFiscal Intermediary Standard System (FISS) and Arkansas Part A Standard System (APASS) sites in January 2002. All other sites must implement by October 2002; contractors that have not transitioned to EDS, VIPS, or FISS by that date must have CERT implemented for the standard system they are using.

CMS awarded a program safeguard contractor (PSC) task order to DynCorp in May 2000. DynCorp will serve as the CERT contractor and will be responsible for the CERT operations center. DynCorp is also responsible for developing a CERT tracking and reporting database and system. Therefore, DynCorp will be gathering information from Medicare contractors and standard system contractors to ensure that CERT systems accommodate unique features among operations and systems as appropriate.

How to Contact and Make Submissions to the CERT Operations Center

If you have questions regarding this project or otherwise need to contact the CERT contractor, please contact the DynCorp management team at (804) 264-1778 (phone) or (804) 264-3268 (fax). The team is composed of the following individuals:

Laura Castelli, BSN, MPM Project Director,
Ellen Cartwright, BSN, CCS, CCS-P UMBI Manager,
William Johnson, M.D., Medical Director, and
Susan Toker, BSN Lead Review Analyst

The address of the CERT contractor is

DynCorp
1530 E. Parham Road
Richmond, Virginia 23228

Please direct E-mail to lauracastelli@att.net.

Overview of the CERT Process{tc \l1 "Overview of the CERT Process}

The process begins at the Medicare contractor-processing site where claims that have entered the standard claims processing system on a given day are extracted to create a *claims universe file.* This file is transmitted each day to the CERT operations center, where it is processed 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 Medicare contractors. 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 Medicare contractor and matched to the Medicare contractor's claims history and provider files. A *sampled claims resolution file*, a *claims history replica file*, and a *provider address file* are created by the Medicare contractor and transmitted to the CERT operations center. They are used to update the *sampled claims database* with claim resolutions and provider addresses; the *Claims History Replica* records are added to a database for future analysis.

Software applications at the CERT operations center are used to review, track, and report on the sampled claims. Requests are made of Medicare contractors to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. Reports identifying incorrect claim payment are sent to the appropriate contractor for follow-up. Medicare contractors are to report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Impact on FIs and RHHIs

As CERT is implemented, CMS will require FIs and RHHIs to support the CERT project as follows:

Coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format (**Note:** Systems maintainers must make changes to the standard system. The sampling module will reside on a server in the HCFA Data Center (HDC). Use of the sampling module will be under the supervision of the CERT operations center).

Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered during the day.

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. (CMS expects the volume of such materials to be very low. The anticipated CERT sample is not expected to exceed 200 claims per month (or 2,000 per year) from each contractor. Generally, contractors will have to supply additional materials on ten percent or less of those claims).

Receive overpayment (or underpayment) referrals and undertake appropriate collection action on cases in which the CERT contractor has determined an error has occurred.

Provide the CERT contractor with the status and amounts of overpayments that have been collected (or underpayments that have been made) within ten working days of a CERT request.

Provide the CERT contractor with the requested feedback for those claims identified on the monthly CERT review report within 21 calendar days of the date of the CERT request.

Process appeals stemming from the CERT project, e.g., CERT decisions appealed by providers or beneficiaries.

Provide the CERT contractor with the status of appeals and final decisions on appeals within ten working days of a CERT contractor request.

Provide answers to the CERT contractor on the status of claims that were identified in the sample but, for which, there is no indication that that the Medicare contractor adjudicated the claim. Provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.

Assist the CERT contractor by disseminating information concerning CERT to the provider community (See Attachment 2).

The CERT contractor will discuss the results of its review with the Medicare contractor to ensure that all information available for review has been considered. As applicable, the CERT contractor will refer claims they have determined to be potentially fraudulent to the Medicare contractor.

FIs', carriers', DMERCs', and RHHIs' prepayment random review requirements contained in the Budget Performance Requirements will be eliminated when CERT is fully implemented for the contractor. CMS will notify contractors when their random sampling requirements are eliminated.

Impact on FISS and APASS Standard Systems

The FISS and APASS Systems will be required to create and transmit four files and receive and process one file. The formats for these files for FISS and APASS standard systems are described in Attachment 1; they are subject to change based on feedback from Fiscal FIs and RHHIs. Requirements for carrier and DMERC standard systems are described in Change Request (CR) 1338.

Claims Universe File

The FISS and APASS standard system will be required to create a daily *claims universe file*, which will be transmitted daily to the CERT operations center. The file will be processed through a sampling module residing on the server at HDC. Therefore, it is important that the elements contained in the *claims universe file* are sufficient to support all levels of stratification (by bill, benefit, and provider type) that are to be considered when drawing a sample of claims. The *claims universe file* must contain all claims, except adjustments and inpatient hospital PPS claims, that have entered the FI and RHHI standard claims processing system on any given day. Any claim must be included only once and only on the day that it enters the system. It is necessary for each Medicare contractor and standard system contractor to review the elements of this file and provide feedback on whether or not the variable field lengths are sufficient and whether any other variables should be considered for inclusion given the purpose of this file.

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

The FISS and APASS standard system will periodically receive a *sampled claims transaction file* from the CERT operations center. This file will include claims that were sampled from the daily *claims universe files.* The FISS and APASS standard system will be required 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* will be a dump of the standard system claims history file in the standard system format. These files will be transmitted

to the CERT operations center. The *sampled claims resolution file* will be input to the CERT claim resolution process and the *claims history replica file* will be added to the Claims History Replica database. If a claim identified on the *sampled claims transaction file* is not found on the standard system claims history file, no record should be created for that claim. It is important that if the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the Medicare contractor, 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.

The format of the *sampled claims resolution file* provided herein is for FIs, RHHIs, and standard system contractors (FISS and APASS).

Provider Address File

The names, addresses, and telephone numbers of the billing providers and referring providers must also be transmitted in a separate file to the CERT operations center along with the *sampled claims resolution file.* The *provider address file* will contain the mailing and telephone contact information for each billing provider and referring provider on the *sampled claims resolution file* for all claims, which contain the same provider number on all claims lines. Each unique provider name, address, and telephone number must be included only once on the *provider address file.* If a provider has more than one address listed in the contractor files, include one record with each address in the provider address file. It the contractor does has neither an address nor a telephone number for the provider, do 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 system should include on the provider address file the information the contractor has and leave the rest of the fields on the record blank.

Assumptions and Constraints{tc \l1 "Assumptions and Constraints}

- Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.

- Files must be transmitted to the CERT operations center via CONNECT:Direct.

- CMS or the CERT contractor will provide Medicare contractors with dataset names for all files that will be transmitted to the CERT operations center.

- The CERT contractor will provide the Medicare contractors with the dataset names with which the *sampled claims transaction file* will be transmitted.

- Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted.

- Standard system contractor will provide a data dictionary of the *claims history replica file* to the CERT contractor to support CERT implementation and will provide updates within 60 calendar days before each expected implementation of a change in the data dictionary.

Below are details on how those requirements must be implemented.

1. *Coordinate with the CERT contractor to provide the requested information in an electronic format for claims identified in the sample.*

   The CERT contractor will make all requests for information or data through letters, e-mail, or via the Network Data Mover (NDM) to the CERT point of contact of each Medicare contractor. Instructions for responding to requests via the NDM will be provided after a test of the process with the DMERCs has been completed. Medicare contractors are required to provide responses in electronic format as described in Attachment 1. Responses provided in electronic form must be made within five working days of a request.

2. *Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims processed during the day.*

   Use the *file* formats from Attachment 1 for this transmission. Use CONNECT:Direct to transmit the files. The target filename for transmission to the CERT test environment in the HDC is D#CER.#NCHPSC.A*****.CERTUNV. Target file names for transmission to the CERT production environment in the HDC is P#CER.#NCHPSC.A*****.CERTUNV. The Medicare contractor data center must replace the "*****" in each file name with the contractor ID number of the contractor for which the file is being submitted.

   Each Medicare contractor in Phases 1, 2, and 3 of CERT has identified a HDC NDM User ID they will use to transmit the files. Notify the CERT contractor at the address included in the "**How to Contact and Make Submissions to the CERT Operations Center"** section above of any NDM user ID changes or additions. Medicare contractors in Phases after 3 must provide HDC User IDs to the CERT operations center at least 30 calendar days before their first sample is due.

3. *Receive a request from the CERT contractor for sampled claims resolution file, claims history replica file, and provider address file on all claims identified in the CERT sample for the period.*

   On a periodic basis, generally monthly, the CERT contractor will make a request via the NDM for the Medicare contractor to return a *sampled claims resolution file*, c*laims history replica file*, and *provider address file* for every claim in listed in the *sampled claims transaction file* that has completed adjudication by the Medicare contractor. The contents of the *sampled claims transaction file* will consist of all claims that recently were selected in the sample for the first time and any claims remaining from prior requests that had not completed the adjudication process by the Medicare contractor at the time of the previous request.

4. *Provide the CERT contractor with the Sample Claims Resolution file, claims history replica file, and provider address file within five working days of a CERT request.*

   Within five working days of a CERT request, provide for every claim listed in the *sampled claims transaction file* that has undergone payment adjudication (i.e., denial, reduction, return, payment approval, etc) all *sampled claims resolution files, all claims history replica files*, and a single *provider address file* in the formats contained in Attachment 1. Note that more than one *sampled claims resolution file* and c*laims history replica file* may be provided under circumstances where the Claim Control Number has changed since its original assignment and claim activity has occurred. Standard systems are expected to provide a look up list, where necessary, to associate the last Claim Control Number submitted to the CERT contractor from the standard system with new Claim Control Numbers assigned to the claim subsequent to that submission.

5. *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 within ten working days of a CERT request*.

   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 by month. Medicare contractors must return the requested information to the CERT operations center at the address specified in the **"How to Contact and Make Submissions to the CERT Operations Center"** section above.

6. *Receive overpayment referrals (or underpayment referrals) and undertake appropriate collection action on cases in which the CERT contractor has determined an error has occurred.*

   The CERT contractor will make referrals in writing. The referrals will be batched by month.

7. *Provide the CERT contractor with the status and amounts of overpayments that have been collected (or underpayments that have been made on previously denied claims) within ten working days of a CERT request.*

   Follow-up requests will be for claims that either the Medicare contractor has denied or for which the CERT contractor has questioned payment of one or more items on the claim (resulting in denial, reduction, or payment of a claim line item previously denied by the Medicare contractor).

   Requests for updates will be transmitted via the NDM process, generally on a monthly basis in the format specified in the *sampled claims transaction file* section of Attachment 1. Responses must be made using NDM in the formats provided for *sampled claims resolution file* and *claims history replica file* contained in Attachment 1. Requests for overpayment information will be timed to maximize the probability that the overpayment has been collected. Additionally, if all of the information needed for tracking overpayment collections (or underpayment on previous denials) cannot be captured in the *sampled claims resolution file,* the CERT contractor will work with the Medicare contractor to specify the format to be used to provide the additional information. The selected format will need to be standardized across all contractors for the various bill types.

8. *Provide the CERT contractor with the status of appeals and final decisions on appeals within ten working days of a CERT contractor request.*

   Requests for updates will be transmitted via the NDM process in the format specified in the *sampled claims transaction file* section of Attachment 1. Responses must be made using NDM in the format provided for the *sampled claims resolution file* and the *claims history replica file* in Attachment 1. Additionally, if all of the information needed for tracking appeals cannot be captured in the *sampled claims resolution file,* the CERT contractor will work with the Medicare contractor to specify the format to be used to provide the additional information. The selected format will need to be standardized across all contractors for the various bill types.

9. *Provide the CERT contractor with the requested feedback for those claims identified on the monthly CERT review report within 21 calendar days of the date of the CERT request.*

   Each month, the CERT contractor will send a description of errors it has found to each Medicare contractor. The CERT point of contact will have 21 calendar days after the date of the description to contact the CERT contractor to discuss decisions with which the Medicare contractor does not agree.

   A request that each Medicare contractor appoints a CERT point of contact is made at the end of this PM. That person will interact with the CERT contractor to request discussions of results of CERT contractor review. Interactions may be in writing, through e-mail or fax, in person, or over the telephone. The Medicare contractor CERT point of contact will initiate all requests for discussion with the CERT contractor.

10. *Provide answers to the CERT contractor on the status of claims that were identified in the sample but, for which, there is no indication that claim has been adjudicated.*

    Requests for status will be transmitted in the format specified in the s*ampled claims transaction file* section of Attachment 1. Responses must be made using NDM and the formats provided for the *sampled claims resolution file* in Attachment 1.

11. *Provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.*

    A request that each Medicare contractor appoints a CERT point of contact is made at the end of this PM. That person will interact with the CERT contractor on all issues. Interactions may be in writing, through e-mail or fax, in person, or over the telephone. The CERT contractor will initiate all requests for clarifications through the CERT point of contact. The point of contract must have adequate arrangements with the contractor's processing center to insure that all required timelines are met.

12. *The CERT contractor will discuss the results of its review with the Medicare contractor to ensure that all information available for review has been considered. The CERT contractor will refer any claims they have determined to be potentially fraudulent to the Medicare contractor.*

    A request that each Medicare contractor appoints a CERT point of contact is made at the end of this PM. That person will interact with the CERT contractor to request discussions of results of CERT contractor review. Interactions may be in writing, through e-mail or fax, in person, or over the telephone. The Medicare contractor CERT point of contact will initiate all requests for discussion with the CERT contractor.

13. *FIs and RHHIs prepayment random review requirements contained in the Budget Performance Requirements will be eliminated as a result of full CERT implementation. CMS will notify contractors when the requirements are eliminated.*

    CERT implementation begins once contractors start submitting the *claims universe file* to the HDC on a daily basis and CMS begins to draw a sample for review. CMS will notify each contractor when the conditions for the contractor's discontinuing prepayment random review are met.

14. *Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.*

    This requirement applies only when the routine processing cycle does not run. For example, if the Medicare contractor routinely processes claims every other day, zero count records do not have to be submitted for days on which processing is not routinely done. To ensure the CERT contractor knows when to expect records, CMS requests that the Medicare contractor send a copy of their processing schedule, if they do not process claims every day, to the CERT contractor ten working days before they are required to begin sending processed records or ten working days after receipt of this PM, whichever is later. Send the list to the address listed in the " **How to Contact and Make Submissions to the CERT Operations Center"** section above.

15. *Files must be transmitted to the CERT operations center via CONNECT:Direct. Following are the target dataset names for all files that will be transmitted to the CERT operations center.*

A manual monthly process is in place to upload the sampled claims transaction file containing the data for all Medicare contractors to the mainframe. A batch job is executed to separate the sampled claim transaction file into smaller files based on Medicare contractor. The files are placed into the function send mode of the NDM process. The files are then transmitted to each Medicare contractor (schedule to be determined). The format for the transmission name for the sampled claims transaction files is P#CER.#NCHPSC.A*****.CERTTRN. The data center for the transmitting contractor replaces "*****" with the contractor number.

The transmission name for the *Sampled Claims Transaction Files* are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTTRN
A00020	P#CER.#NCHPSC.A00020.CERTTRN
A00030	P#CER.#NCHPSC.A00030.CERTTRN
A00040	P#CER.#NCHPSC.A00040.CERTTRN
A00090	P#CER.#NCHPSC.A00090.CERTTRN
A00101	P#CER.#NCHPSC.A00101.CERTTRN
A00130	P#CER.#NCHPSC.A00130.CERTTRN
A00131	P#CER.#NCHPSC.A00131.CERTTRN
A00140	P#CER.#NCHPSC.A00140.CERTTRN
A00150	P#CER.#NCHPSC.A00150.CERTTRN
A00160	P#CER.#NCHPSC.A00160.CERTTRN
A00180	P#CER.#NCHPSC.A00180.CERTTRN
A00181	P#CER.#NCHPSC.A00181.CERTTRN
A00190	P#CER.#NCHPSC.A00190.CERTTRN
A00230	P#CER.#NCHPSC.A00230.CERTTRN
A00250	P#CER.#NCHPSC.A00250.CERTTRN
A00260	P#CER.#NCHPSC.A00260.CERTTRN
A00270	P#CER.#NCHPSC.A00270.CERTTRN
A00308	P#CER.#NCHPSC.A00308.CERTTRN
A00310	P#CER.#NCHPSC.A00310.CERTTRN
A00320	P#CER.#NCHPSC.A00320.CERTTRN
A00332	P#CER.#NCHPSC.A00332.CERTTRN
A00340	P#CER.#NCHPSC.A00340.CERTTRN
A00350	P#CER.#NCHPSC.A00350.CERTTRN
A00363	P#CER.#NCHPSC.A00363.CERTTRN
A00370	P#CER.#NCHPSC.A00370.CERTTRN
A00380	P#CER.#NCHPSC.A00380.CERTTRN
A00400	P#CER.#NCHPSC.A00400.CERTTRN
A00410	P#CER.#NCHPSC.A00410.CERTTRN
A00430	P#CER.#NCHPSC.A00430.CERTTRN
A00450	P#CER.#NCHPSC.A00450.CERTTRN
A00452	P#CER.#NCHPSC.A00452.CERTTRN
A00453	P#CER.#NCHPSC.A00453.CERTTRN
A00460	P#CER.#NCHPSC.A00460.CERTTRN
A50333	P#CER.#NCHPSC.A50333.CERTTRN
A52280	P#CER.#NCHPSC.A52280.CERTTRN
A57400	P#CER.#NCHPSC.A57400.CERTTRN
A57401	P#CER.#NCHPSC.A57401.CERTTRN

Within five working days of the receipt of the *Sampled Claims Transaction File*, each Medicare contractor will NDM the related claims data to the CERT contractor in the *Sampled Claims Resolution File*, the *Sampled Claims Replica File*, and the *Provider Address File.*

Target data set names for the *sampled claim resolution files* are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRSLN
A00020	P#CER.#NCHPSC.A00020.CERTRSLN
A00030	P#CER.#NCHPSC.A00030.CERTRSLN
A00040	P#CER.#NCHPSC.A00040.CERTRSLN
A00090	P#CER.#NCHPSC.A00090.CERTRSLN
A00101	P#CER.#NCHPSC.A00101.CERTRSLN
A00130	P#CER.#NCHPSC.A00130.CERTRSLN
A00131	P#CER.#NCHPSC.A00131.CERTRSLN
A00140	P#CER.#NCHPSC.A00140.CERTRSLN
A00150	P#CER.#NCHPSC.A00150.CERTRSLN
A00160	P#CER.#NCHPSC.A00160.CERTRSLN
A00180	P#CER.#NCHPSC.A00180.CERTRSLN
A00181	P#CER.#NCHPSC.A00181.CERTRSLN
A00190	P#CER.#NCHPSC.A00190.CERTRSLN
A00230	P#CER.#NCHPSC.A00230.CERTRSLN
A00250	P#CER.#NCHPSC.A00250.CERTRSLN
A00260	P#CER.#NCHPSC.A00260.CERTRSLN
A00270	P#CER.#NCHPSC.A00270.CERTRSLN
A00308	P#CER.#NCHPSC.A00308.CERTRSLN
A00310	P#CER.#NCHPSC.A00310.CERTRSLN
A00320	P#CER.#NCHPSC.A00320.CERTRSLN
A00332	P#CER.#NCHPSC.A00332.CERTRSLN
A00340	P#CER.#NCHPSC.A00340.CERTRSLN
A00350	P#CER.#NCHPSC.A00350.CERTRSLN
A00363	P#CER.#NCHPSC.A00363.CERTRSLN
A00370	P#CER.#NCHPSC.A00370.CERTRSLN
A00380	P#CER.#NCHPSC.A00380.CERTRSLN
A00400	P#CER.#NCHPSC.A00400.CERTRSLN
A00410	P#CER.#NCHPSC.A00410.CERTRSLN
A00430	P#CER.#NCHPSC.A00430.CERTRSLN
A00450	P#CER.#NCHPSC.A00450.CERTRSLN
A00452	P#CER.#NCHPSC.A00452.CERTRSLN
A00453	P#CER.#NCHPSC.A00453.CERTRSLN
A00460	P#CER.#NCHPSC.A00460.CERTRSLN
A50333	P#CER.#NCHPSC.A50333.CERTRSLN
A52280	P#CER.#NCHPSC.A52280.CERTRSLN
A57400	P#CER.#NCHPSC.A57400.CERTRSLN
A57401	P#CER.#NCHPSC.A57401.CERTRSLN

Target data set names for the *provider address files* are in the format: P#CER.#NCHPSC.A*****.CERTPROV. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the *provider address files* are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTPROV
A00020	P#CER.#NCHPSC.A00020.CERTPROV
A00030	P#CER.#NCHPSC.A00030.CERTPROV
A00040	P#CER.#NCHPSC.A00040.CERTPROV
A00090	P#CER.#NCHPSC.A00090.CERTPROV
A00101	P#CER.#NCHPSC.A00101.CERTPROV
A00130	P#CER.#NCHPSC.A00130.CERTPROV
A00131	P#CER.#NCHPSC.A00131.CERTPROV
A00140	P#CER.#NCHPSC.A00140.CERTPROV
A00150	P#CER.#NCHPSC.A00150.CERTPROV
A00160	P#CER.#NCHPSC.A00160.CERTPROV
A00180	P#CER.#NCHPSC.A00180.CERTPROV
A00181	P#CER.#NCHPSC.A00181.CERTPROV
A00190	P#CER.#NCHPSC.A00190.CERTPROV
A00230	P#CER.#NCHPSC.A00230.CERTPROV
A00250	P#CER.#NCHPSC.A00250.CERTPROV
A00260	P#CER.#NCHPSC.A00260.CERTPROV
A00270	P#CER.#NCHPSC.A00270.CERTPROV
A00308	P#CER.#NCHPSC.A00308.CERTPROV
A00310	P#CER.#NCHPSC.A00310.CERTPROV
A00320	P#CER.#NCHPSC.A00320.CERTPROV
A00332	P#CER.#NCHPSC.A00332.CERTPROV
A00340	P#CER.#NCHPSC.A00340.CERTPROV
A00350	P#CER.#NCHPSC.A00350.CERTPROV
A00363	P#CER.#NCHPSC.A00363.CERTPROV
A00370	P#CER.#NCHPSC.A00370.CERTPROV
A00380	P#CER.#NCHPSC.A00380.CERTPROV
A00400	P#CER.#NCHPSC.A00400.CERTPROV
A00410	P#CER.#NCHPSC.A00410.CERTPROV
A00430	P#CER.#NCHPSC.A00430.CERTPROV
A00450	P#CER.#NCHPSC.A00450.CERTPROV
A00452	P#CER.#NCHPSC.A00452.CERTPROV
A00453	P#CER.#NCHPSC.A00453.CERTPROV
A00460	P#CER.#NCHPSC.A00460.CERTPROV
A50333	P#CER.#NCHPSC.A50333.CERTPROV
A52280	P#CER.#NCHPSC.A52280.CERTPROV
A57400	P#CER.#NCHPSC.A57400.CERTPROV
A57401	P#CER.#NCHPSC.A57401.CERTPROV

Target data set names for the c*laims history replica file* is in the format: P#CER.#NCHPSC.A*****.CERTRPLI. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the *claims history replica file* are listed below:

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRPLI
A00020	P#CER.#NCHPSC.A00020.CERTRPLI
A00030	P#CER.#NCHPSC.A00030.CERTRPLI
A00040	P#CER.#NCHPSC.A00040.CERTRPLI
A00090	P#CER.#NCHPSC.A00090.CERTRPLI
A00101	P#CER.#NCHPSC.A00101.CERTRPLI
A00130	P#CER.#NCHPSC.A00130.CERTRPLI
A00131	P#CER.#NCHPSC.A00131.CERTRPLI
A00140	P#CER.#NCHPSC.A00140.CERTRPLI
A00150	P#CER.#NCHPSC.A00150.CERTRPLI
A00160	P#CER.#NCHPSC.A00160.CERTRPLI
A00180	P#CER.#NCHPSC.A00180.CERTRPLI
A00181	P#CER.#NCHPSC.A00181.CERTRPLI
A00190	P#CER.#NCHPSC.A00190.CERTRPLI
A00230	P#CER.#NCHPSC.A00230.CERTRPLI
A00250	P#CER.#NCHPSC.A00250.CERTRPLI
A00260	P#CER.#NCHPSC.A00260.CERTRPLI
A00270	P#CER.#NCHPSC.A00270.CERTRPLI
A00308	P#CER.#NCHPSC.A00308.CERTRPLI
A00310	P#CER.#NCHPSC.A00310.CERTRPLI
A00320	P#CER.#NCHPSC.A00320.CERTRPLI
A00332	P#CER.#NCHPSC.A00332.CERTRPLI
A00340	P#CER.#NCHPSC.A00340.CERTRPLI
A00350	P#CER.#NCHPSC.A00350.CERTRPLI
A00363	P#CER.#NCHPSC.A00363.CERTRPLI
A00370	P#CER.#NCHPSC.A00370.CERTRPLI
A00380	P#CER.#NCHPSC.A00380.CERTRPLI
A00400	P#CER.#NCHPSC.A00400.CERTRPLI
A00410	P#CER.#NCHPSC.A00410.CERTRPLI
A00430	P#CER.#NCHPSC.A00430.CERTRPLI
A00450	P#CER.#NCHPSC.A00450.CERTRPLI
A00452	P#CER.#NCHPSC.A00452.CERTRPLI
A00453	P#CER.#NCHPSC.A00453.CERTRPLI
A00460	P#CER.#NCHPSC.A00460.CERTRPLI
A50333	P#CER.#NCHPSC.A50333.CERTRPLI
A52280	P#CER.#NCHPSC.A52280.CERTRPLI
A57400	P#CER.#NCHPSC.A57400.CERTRPLI
A57401	P#CER.#NCHPSC.A57401.CERTRPLI

The CERT contractor will retrieve the target files on the 6th workday after transmission of the *Sampled Claims Transaction Files*. The files will be processed through a screening module on the mainframe and then transferred to the CERT database. If a file is not received by COB of the 5th day, it will be processed in the following month's sample.

Transmittal of the *Sampled Claims Transactions File* will be handled via the NDM and may include an e-mail notification to the Medicare contractor concerning any deviations from established schedules and other information as appropriate. Medicare contractors must provide the CERT contractor with an e-mail address for requests. At least 30 calendar days before the due date for implementation of CERT, send the address to the CERT operations center at the address listed in the " **How to Contact and Make Submissions to the CERT Operations Center"** section.

16. *Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted within 24 hours of notification.*

    Requests for retransmissions will be made to the CERT point of contact via telephone. Retransmissions must be made in one of the following formats included in Attachment 1 as appropriate:

    Claims universe file
    Sampled claims resolution file,
    Claims history replica file, and/or
    Provider address file

    NDM retransmissions to the data sets described above.

17. *Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor before implementation of CERT or when it becomes available and will provide updates as necessary.*

    The data dictionary must be provided within ten working days after receipt of this PM or within 10 days of the data dictionary becoming available, whichever is later. Send it in Microsoft Word 97 format to the CERT operations center at the address provided in the **"How to Contact and Make Submissions to the CERT Operations Center"** section. Updates must be provided to the CERT contractor at least 60 calendar days before a change is implemented in the standard system that will affect the data transmitted in files for CERT.

18. *Assist the CERT contractor by disseminating information concerning CERT to affected providers.*

    At least 90 calendar days before the implementation of CERT at their site, contractors must inform affected providers of the CERT program. A sample letter that may be included in the provider bulletin is attached as Attachment 2.

CERT Point of Contact at Medicare Contractors

Medicare contractors must provide the CERT contractor with the name, phone number, address, fax number, and e-mail address of a point of contact. Although it is preferable to have a single point of contact, Medicare contractors must provide a separate point of contact for exchange of electronic data versus 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) Send the information to the CERT operations center at the address provided in the **"How to Contact and Make Submissions to the CERT Operations Center"** section above. The CERT point of contact will be the individual that the CERT contractor will notify of any changes in requirements or problems with CERT data. The point of contact will also initiate all non-routine communications from the Medicare contractor to the CERT contractor.

The *effective date* for this PM for Medicare contractors using the Part A FISS and APASS systems is January 1, 2002.

The *implementation date* for this PM for Medicare contractors using the Part A FISS and APASS systems is January 1, 2002.

These instructions should be implemented within existing current operating budgets.

This PM may be discarded after July 31, 2002.

If you have any questions, contact John Stewart on (410) 786-1189.

Attachment

ATTACHMENT 1

CERT FILE DESCRIPTIONS FOR PART A CONTRACTORS AND STANDARD SYSTEMS

Claims Universe File Format

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 'A' or 'R'
Remarks: A = FI
R = RHHI
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

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Internal Control Number	X(23)	7	29	Spaces
Beneficiary HICN	X(12)	30	41	Spaces
Provider Number	X(6)	42	47	Spaces
Type of Bill	X(3)	48	50	Spaces
Claim From Date	X (8)	51	58	Spaces
Claim Through Date	X (8)	59	66	Spaces
Condition Code	X (2)	67	68	Spaces
PPS Indicator Code	X(1)	69	69	Space
Revenue Code Count	S9(3)	70	72	Zeroes
Revenue Code group:				
The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)				
	From and **Thru** values relate to the 1st line item			
Revenue Code	9(4)	73	76	Zeroes
HCPCS/Rate	X(5)	77	81	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: **Internal Control Number**
Definition: Number assigned by the standard system to uniquely identify the claim
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: **Beneficiary HICN**
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: **Provider Number**
Definition: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: **Type of Bill**
Definition: Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code
Validation: Must be a valid bill type

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

<u>For facility type code 1 thru 6, and 9</u>

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only)
or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient
(formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7
1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be between 1 and 9
Remarks: N/A
Requirement: Required

Data Element: **Claim From Date**
Definition: The first day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: N/A
Requirement: Required

Data Element: **Claim Through Date**
Definition: The last day on the billing statement covering services rendered to the beneficiary
Validation: Must be a valid date
Remarks: N/A
Requirement: Required

Data Element: **Condition Code alias Claim Related Condition Code**
Definition: The code that indicates a condition relating to an institutional claim that may effect payer processing
Validation: Must be a valid code
Remarks: N/A
Requirement: Required

Data Element: **PPS Indicator Code alias Claim PPS Indicator Code**
Definition: The code indicating whether (1) the claim is Prospective Payment System (PPS) and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE)
Validation: Effective National Claims History (NCH) weekly process date 10/3/97 - 5/29/98:
0 = not PPS bill (claim contains no PPS indicator)
2 = PPS bill (claim contains PPS indicator) Effective NCH weekly process date 6/5/98:
0 = not applicable (claim contains neither PPS nor deemed insured MQGE status indicators)
1 = Deemed insured MQGE (claim contains deemed insured MQGE indicator but not PPS indicator)
2 = PPS bill (claim contains PPS indicator but no deemed insured MQGE status indicator)
3 = Both PPS and deemed insured MQGE (contains both PPS and deemed insured MQGE indicators)

Remarks: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces
Requirement: Spaces or code

Data Element: **Revenue Code Count**
Definition: Number indicating number of revenue code lines on the claim
Validation: Must be a number 01 – 450
Remarks: N/A
Requirement: Required

Claim Line Item Fields

Data Element: **Revenue Code**
Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid National Uniform Billing Committee (NUBC) approved code
Remarks: Do not include an entry for revenue code '0001'
Requirement: Required

Data Element: **HCPCS Rate alias Revenue Center HCFA Procedure Coding System Code**
Definition: HCFA's common procedure coding system (HCPCS) is a collection of codes that represent procedures, supplies, products, and services that may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels or groups
Validation: Must be a valid code
Remarks: N/A
Requirement: Blank or code

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	‘3’
Number of Claims	S9(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
Validation: Must be equal to the number of claims records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Sampled Claims Transaction File{tc \l1 "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 Claim Record

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
Mode of Entry Indicator	X(1)	8	8	Space
Original Claim Control Number	X(23)	9	31	Spaces
Internal Control Number	X(23)	32	54	Spaces
Beneficiary HICN	X(12)	55	66	Spaces
Beneficiary Name	X(30)	67	96	Spaces
Beneficiary Date of Birth	X(8)	97	104	Spaces
Beneficiary Gender	X(1)	105	105	Spaces
Billing Provider Number	X(6)	106	111	Spaces
Referring Provider Number	X(15)	112	126	Spaces
Claim Paid Amount	9(7)v99	127	133	Zeroes
Claim ANSI Reason Code 1	X(8)	134	141	Spaces
Claim ANSI Reason Code 2	X(8)	142	149	Spaces
Claim ANSI Reason Code 3	X(8)	150	157	Spaces
Claim ANSI Reason Code 4	X(8)	158	165	Spaces
Claim ANSI Reason Code 5	X(8)	166	173	Spaces
Claim ANSI Reason Code 6	X(8)	174	181	Spaces
Claim ANSI Reason Code 7	X(8)	182	189	Spaces
Statement covers From Date	X(8)	190	197	Spaces
Statement covers Thru Date	X(8)	198	205	Spaces
Claim Entry Date	X(8)	206	213	Spaces
Claim Adjudicated Date	X(8)	214	221	Spaces
Condition Codes	9(1)	222	222	Spaces
Type of Bill	X(3)	223	225	Spaces
Line Item Count	9(3)	226	240	Zeroes
Line Item group: The following group of fields occurs from 1 to 450 times (depending on Line Item Count)				

From and **Thru** values relate to the 1st line item**.**

Field Name	Picture	From	Thru	Initialization
Performing Provider Number	X(15)	241	255	Spaces
Performing Provider Specialty	X(2)	256	257	Spaces
Revenue Center Code	X(4)	258	261	Spaces
SNF RUG-III Code	X(3)	262	264	Spaces
APC Adjustment Code	X(4)	265	268	Spaces
MCS Adjustment Code	X(3)	269	271	Spaces
HCPCS Procedure Code	X(5)	272	276	Spaces
HCPCS Modifier 1	X(2)	277	278	Spaces
HCPCS Modifier 2	X(2)	279	280	Spaces
HCPCS Modifier 3	X(2)	281	282	Spaces
HCPCS Modifier 4	X(2)	283	284	Spaces
HCPCS Modifier 5	X(2)	285 x	286	Spaces
Service From Date	X(8)	287	294	Spaces
Service To Date	X(8)	295	302	Spaces
Type of Service	X(1)	303	303	Spaces
Diagnosis Code	X(5)	304	308	Spaces
CMN Control Number	X(15)	309 x	323	Spaces

Field Name	Picture	From	Thru	Initialization
Submitted Charge	X9(7)v99	324	332	Zeroes
ANSI Reason Code 1	X(8)	333	340	Spaces
ANSI Reason Code 2	X(8)	341	348	Spaces
ANSI Reason Code 3	X(8)	349	356	Spaces
ANSI Reason Code 4	X(8)	357	364	Spaces
ANSI Reason Code 5	X(8)	365x	372	Spaces
ANSI Reason Code 6	X(8)	373	380	Spaces
ANSI Reason Code 7	X(8)	381	388	Spaces
ANSI Reason Code 8	X(8)	389	396	Spaces
ANSI Reason Code 9	X(8)	397	404	Spaces
ANSI Reason Code 10	X(8)	405	412	Spaces
ANSI Reason Code 11	X(8)	413	420	Spaces
ANSI Reason Code 12	X(8)	421	428	Spaces
ANSI Reason Code 13	X(8)	429	436	Spaces
ANSI Reason Code 14	X(8)	437 x	444	Spaces
Manual Medical Review Indicator	X(1)	445	445	Space
Resolution Code	X(5)	446	450	Spaces
Final Allowed Charge	X9(7)v99	451	459	Zeroes
Filler	X(25)	460	484	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 'A' or 'R'
Remarks: A = Part A
R = RHHI
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: Required

Data Element: **Internal 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 Name**
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: Birth date of the beneficiary
Validation: N/A
Remarks: N/A
Requirement:

Data Element: **Beneficiary Gender**
Definition: Gender of the beneficiary
Validation: N/A
Remarks: N/A
Requirement:

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 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 or supplier
Validation: N/A
Remarks: N/A
Requirement: Must be present if on bill

Data Element: **Claim Paid Amount**
Definition: Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier and represents what CMS paid to the institutional provider, physician, or supplier, i.e., The net amount paid after co-insurance and deductibles.
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
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6

Claim 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 American National Standards Institute (ANSI) Ambulatory Surgical Center (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 through 7 should be sent if available

Data Element: **Statement Covers From Date**

Definition: The beginning date the statement

Validation: Must be a valid date

Remarks: N/A

Requirement: Required

Data Element: **Statement Covers To Date**

Definition: The ending date the statement

Validation: Must be a valid date

Remarks: N/A

Requirement: Required

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

Remarks: Format must be CCYYMMDD

Requirement: Required

Data Element: **Condition Code alias NCH Claim Type Code**

Definition: Code used to identify the type of record being processed in NCH

Validation:
10 = HHA claim
20 = Non swing bed SNF
30 = Swing bed SNF claim
40 = Outpatient claim
50 = Hospice claim
60 = Inpatient claim
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

Remarks: N/A

Requirement: Required

Data Element: **Type of Bill**

Definition: Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as “frequency” code

Validation: Must be a valid bill type

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

<u>For facility type code 1 thru 6, and 9</u>

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

<u>For facility type code 7</u>

1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)

7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be between 1 and 9

Remarks: N/A
Requirement: Required

Data Element: **Line Item Count**
Definition: Number indicating number of service lines on the claim
Validation: Must be a number 001 - 450
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: Not Required

Data Element: **Revenue Center Code**
Definition: Code assigned to each cost center for which a charge is billed
Validation: Must be a valid NUBC-approved code
Remarks: Do not include an entry for revenue code '0001'
Requirement: Required

Data Element: **SNF RUG-III Code**
Definition: Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.
Validation: N/A
Remarks: N/A

Requirement: Required for SNF inpatient bills

Data Element: **APC Adjustment Code**
Definition: The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code.

The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.

Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: MDS **Code**
Definition: Minimum Data Set Version 2 (MDS)
Validation: N/A
Remarks: N/A
Requirement: Required for SNF bills

Data Element: **HCPCS Procedure Code**
Definition: The HCPCS/CPT-4 code that describes the service
Validation: Must be a valid HCPCS/CPT-4 code
Remarks: N/A
Requirement: Required if present on bill

Data Element: **HCPCS Modifier 1**
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
HCPCS Modifier 5
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: Must be greater than 0. Default to 1 if not present
Remarks: N/A
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: **Type of Service**

Definition: Code that classifies the service
Validation: Must be a type of service
Remarks: N/A
Requirement: Required

Data Element: **Diagnosis Code**
Definition: Code identifying a diagnosed medical condition resulting in the line item service
Validation: Must be a valid ICD-9-CM diagnosis code
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: N/A
Requirement: Required on DMERC claims, for services for which a CMN is required

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: Must be a numeric value if the standard system can calculate the value, blanks if the standard system cannot calculate the value.
Remarks: N/A
Requirement: Required if the standard system can calculate the value. Enter blanks if the standard system cannot calculate the value

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
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 14
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: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC' ,'DEO', 'RTP', 'REDMR', 'REDMC", 'REO', 'APPAM', 'DENAM', 'REDAM.' Report all other ANSI Reason Codes included on the bill.

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 manually routine
APPMC = Approved manually complex
DENMR = Denied manually routine
DENMC = Denied manually complex
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable
REDMR = Reduced manually routine
REDMC = Reduced manually complex
REO = Reduced for non-medical review reasons
APPAM = Approved after automated medical review
DENAM = Denied after automated medical review
DENAM = 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: N/A
Requirement: Required

Data Element: **Filler**
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

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{tc \l1 "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 'A ' or 'R '
Remarks: A= FI
R = RHHI
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 the 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 payee 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: First line of provider's address
Validation: N/A
Remarks: This is the address1of the billing/pricing provider or referring provider
Requirement: Required

Data Element: **Provider Address 2**
Definition: Second 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 state code
Validation: Must be a valid state code
Remarks: This is the state of the billing/pricing provider or the referring provider
Requirement: Required

Data Element: **Provider Zip Code**
Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the payee 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 phone number
Validation: Must be a valid phone number
Remarks: This is the phone number of the billing/pricing or referring provider
Requirement: Required

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: Required

Data Element: **Provider Type**
Definition: 1=Billing 2=Referring
Validation: Must be a 1 or a 2
Remarks: This field indicates whether the provider (whose name, address, and phone number are included in the record) billed the service or referred the beneficiary to the billing provider
Requirement: Required

Data Element: **Filler**
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required

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	S9(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 {tc \l1 "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 claims history file. It should not include header or trailer records

Attachment 2

Language for Inclusion in Provider Letter

In order to improve the processing and medical decision making involved with payment of Medicare claims, CMS began a new program effective August 2000. This program is called CERT and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (DynCorp of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. DynCorp's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. CMS will use the DynCorp findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. On a monthly basis, DynCorp will request a small sample of claims, approximately 200 from each contractor, as the claims are entered into their system. DynCorp will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., questions of medical necessity or inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefit from improved claims accuracy and payment processes.

How are providers and suppliers of sampled claims impacted by CERT?

You may be asked during DynCorp's review to provide more information such as medical records or certificates of medical necessity so that DynCorp can verify that billing was proper and that claims processing procedures were appropriate. You will be advised what documentation is need and the name of your contact.

General questions regarding the CERT initiative may be directed to Laura Castelli, DynCorp Project Director for the CERT Program, at (804) 264-1778. Otherwise, providers and suppliers will be contacted ONLY if their claim(s) is selected and DynCorp requires additional information.