Program Memorandum Carriers

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

Transmittal B-01-47 **Date: AUGUST 24, 2001**

CHANGE REQUEST 1636

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

Purpose

This updates Change Request (CR) 1338. There is new information regarding telephone numbers, field sizes and values, and filler fields. Major changes are listed at the end of this Program Memorandum (PM). This document details how Medicare Part B contractors (i.e., carriers and Durable Medical Equipment Regional Carriers (DMERCs)) will interact with the CERT Operations Center. All information from CR 1338 is included in this CR.

Background

CMS, Office of Financial Management, Program Integrity Group, Division of Methods and Strategy has developed the CERT program to produce national, contractor specific, and benefit category specific paid claim error rates. The project will have independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers 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 independent 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 we anticipate 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 us to quickly identify emerging trends. CERT will enhance our ability to take appropriate corrective actions and can be used to better manage Medicare contractor performance. Another byproduct of the CERT program is a large database of independently reviewed claims that we can use to test new software technologies such as data analysis tools or Commercial Off The Shelf (COTS) claims editing software.

We implemented CERT in August 2000 at all DMERC sites (Phase 1) and in November 2000, at all VIPS Medicare System (VMS) users (Phase 2). We implemented CERT in Electronic Data Systems (EDS) Medicare Carrier System (MCS) contractor sites April 2001, (Phase 3). We will implement CERT in Part A Fiscal Intermediacy Shared System (FISS) and Arkansas Part A Standard System (APASS) contractor sites in January 2002, (Phase 4). The HCFA Part B Standard System (HPBSS) must implement CERT by April 2002.

All Verizon users are expect to have transitioned to the EDS MCS by February 1, 2002.

We 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 need to contact the CERT contractor, please contact the DynCorp management team at (804) 264-1778 or (804) 264-3268 (fax). The team is composed of the following individuals:

Laura Castelli, BSN, M
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
CERT Operations Center
1530 E. Parham Road
Richmond, Virginia 23228

E-mail should be directed to lauracastelli@att.net.

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 to 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 Carriers and DMERCs

As CERT is implemented, we will require Intermediaries, Carriers, DMERCs, and Regional Home Health Intermediaries (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: System 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. (We expect 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 10 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 paid) within 10 working days of a 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 10 working days of a CERT contractor 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.

- 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 Medicare contractor has 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.

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

Impact on Carrier and DMERC Standard System

The carrier and DMERC standard systems will be required to create and transmit four files and receive and process one file. The formats of these files for carrier and DMERC standard systems are described in the Attachment; they are subject to change based on feedback from carriers and DMERCs.

Claims Universe File

The carrier and DMERC 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 the 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, that have entered the carrier and DMERC 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 carrier and DMERC 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 carrier and DMERC 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 inputted 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 (or HIC number) changes within the standard system as a result of adjustments, replicates, splits, or other actions taken by the Medicare contractor or because of errors discovered at a later date, 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.

Provider Address File

The names, addresses, and telephone numbers of the billing 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 and referring provider on the *Sampled Claims Resolution File* for all claims, assigned and non-assigned, which contain the same provider number on all claims lines. Each unique provider name, address, and telephone number should be included only once on the *Provider Address File.* If a provider has more than one address listed in the contractor's files, include one record with each address. If the contractor does not have any information on a provider, no record is required. If the contractor has some information on a provider, e.g., a phone number but no address, the contractor should provide a record with the information they have and leave the information they do not have blank.

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.

The standard system contractor will provide a data dictionary of the *Claims Replica File* to the CERT contractor within ten working days of receiving this PM in preparation for implementation of CERT, and will provide updates within sixty calendar days before each expected implementation of a change in the data dictionary or at the same time that the revised dictionary is supplied to data centers, whichever is later.

Below are details on how those requirements should 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 DMERC's has been completed. Medicare contractors are required to provide responses in electronic format as described in the Attachment. Responses provided in electronic form should be made within five working days of a request.

2. Submit a Claims Universe File daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered into the processing system during the day.

   Use the *file* formats from the Attachment for this transmission. Use CONNECT:Direct to transmit the files. Target filenames for transmission to the CERT test environment in the HDC are listed below:

Claims Universe File	D#CER.#NCHPSC.B*****CERTUNV
Sampled Claims Resolution File	D#CER.#NCHPSC.B*****.CERTRSLN
Provider Address File	D#CER.#NCHPSC.B*****CERTPROV
Claims History Replica File	D#CER.#NCHPSC.B****CERTRPLI
Sampled Claims Transaction File	D#CER.#NCHPSC.B****.CERTTRAN

   Target file names for transmission to the CERT production environment in the HDC are listed below:

Claims Universe File	P#CER.#NCHPSC.B*****.CERTUNV
Sampled Claims Resolution File	P#CER.#NCHPSC.B*****.CERTRSLN
Provider Address File	P#CER.#NCHPSC.B*****.CERTPROV
Claims History Replica File	P#CER.#NCHPSC.B*****.CERTRPLI
Sampled Claims Transaction File	P#CER.#NCHPSC.B*****.CERTTRAN

   Each Medicare contractor in Phases 1 and 2 of CERT has identified a HDC User ID they will use to transmit the files. Please notify the CERT contractor at the address included in the "**How to Contact and Make Submissions to the CERT Operations Center"** section of any user ID changes or additions. Medicare contractors in Phases 3 should 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 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*, *Claims History Replica File*, and *Provider Address File* for every claim 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 Replica File, and Provider Address File within 5 working days of a CERT request.

Within 5 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 Replica Files,* and a single *Provider Address File* in the formats contained in the Attachment. Note that more than one *Sampled Claims Resolution File* and *Claims Replica File* may be provided under circumstances where the Claim Control Number has changed since its original assignment and additional claim activity has occurred. It may also occur when the HIC number submitted on the claim has been corrected. 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 and/or to link corrected HIC numbers with HIC numbers submitted on the claim.

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 10 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 payment 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) within10 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 the Attachment. Responses should be made using NDM in the formats provided for *Sampled Claims Resolution File* and *Claims History Replica File* contained in the Attachment. 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.

8. Provide the CERT contractor with the status of appeals and final decisions on appeals within 10 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 the Attachment. Responses should be made using NDM in the format provided for the *Sampled Claims Resolution File* and the Claims Replica *File* in the Attachment. 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.

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 from the date of the CERT request 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 the claim has been adjudicated.

    Requests for status will be transmitted in the format specified in the *Sampled Claims Transaction File* section of the Attachment. Responses should be made using NDM and the formats provided for the *Sampled Claims Resolution File* in the Attachment.

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 CR. 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.

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 As applicable, the CERT contractor will refer 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 CR. 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 requests for discussion with the CERT contractor.

13. Carrier and DMERC prepayment random review requirements contained in the Budget Performance Requirements will be eliminated as a result of CERT implementation. CMS will notify contractors when their random sampling 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 10 working days before they are required to begin sending processed

records or 10 working days after receipt of this CR, whichever is later. Please send the list to the address listed in the **"How to Contact and Make Submissions to the CERT Operations Center"** section.

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 the 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 transmission names for the current *Sampled Claims Transaction Files* are listed below:

AC Number	**Holding File**
635	P#CER.#NCHPSC.D00635.CERTTRAN
811	P#CER.#NCHPSC.D00811.CERTTRAN
885	P#CER.#NCHPSC.D00885.CERTTRAN
5655	P#CER.#NCHPSC.D05655.CERTTRAN
10555	P#CER.#NCHPSC.D10555.CERTTRAN
510	P#CER.#NCHPSC.B00510.CERTTRAN
520	P#CER.#NCHPSC.B00520.CERTTRAN
528	P#CER.#NCHPSC.B00528.CERTTRAN
570	P#CER.#NCHPSC.B00570.CERTTRAN
580	P#CER.#NCHPSC.B00580.CERTTRAN
621	P#CER.#NCHPSC.B00621.CERTTRAN
623	P#CER.#NCHPSC.B00623.CERTTRAN
630	P#CER.#NCHPSC.B00630.CERTTRAN
640	P#CER.#NCHPSC.B00640.CERTTRAN
650	P#CER.#NCHPSC.B00650.CERTTRAN
655	P#CER.#NCHPSC.B00655.CERTTRAN
660	P#CER.#NCHPSC.B00660.CERTTRAN
700	P#CER.#NCHPSC.B00700.CERTTRAN
740	P#CER.#NCHPSC.B00740.CERTTRAN
780	P#CER.#NCHPSC.B00780.CERTTRAN
781	P#CER.#NCHPSC.B00781.CERTTRAN
801	P#CER.#NCHPSC.B00801.CERTTRAN
803	P#CER.#NCHPSC.B00803.CERTTRAN
805	P#CER.#NCHPSC.B00805.CERTTRAN
820	P#CER.#NCHPSC.B00820.CERTTRAN
824	P#CER.#NCHPSC.B00824.CERTTRAN
825	P#CER.#NCHPSC.B00825.CERTTRAN
865	P#CER.#NCHPSC.B00865.CERTTRAN
880	P#CER.#NCHPSC.B00880.CERTTRAN
889	P#CER.#NCHPSC.B00889.CERTTRAN
900	P#CER.#NCHPSC.B00900.CERTTRAN
901	P#CER.#NCHPSC.B00901.CERTTRAN
973	P#CER.#NCHPSC.B00973.CERTTRAN

974	P#CER.#NCHPSC.B00974.CERTTRAN
2050	P#CER.#NCHPSC.B02050.CERTTRAN
5130	P#CER.#NCHPSC.B05130.CERTTRAN
5440	P#CER.#NCHPSC.B05440.CERTTRAN
5535	P#CER.#NCHPSC.B05535.CERTTRAN
14330	P#CER.#NCHPSC.B14330.CERTTRAN
16360	P#CER.#NCHPSC.B16360.CERTTRAN
16510	P#CER.#NCHPSC.B16510.CERTTRAN
21200	P#CER.#NCHPSC.B21200.CERTTRAN
31140	P#CER.#NCHPSC.B31140.CERTTRAN

Within 5 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.*

The target data set names for the current *Sampled Claim Resolution Files* are listed below:

AC Number	**Target File**
635	P#CER.#NCHPSC.D00635.CERTRSLN
811	P#CER.#NCHPSC.D00811.CERTRSLN
885	P#CER.#NCHPSC.D00885.CERTRSLN
655	P#CER.#NCHPSC.D05655.CERTRSLN
10555	P#CER.#NCHPSC.D10555.CERTRSLN
510	P#CER.#NCHPSC.B00510.CERTRSLN
520	P#CER.#NCHPSC.B00520.CERTRSLN
528	P#CER.#NCHPSC.B00528.CERTRSLN
570	P#CER.#NCHPSC.B00570.CERTRSLN
580	P#CER.#NCHPSC.B00580.CERTRSLN
621	P#CER.#NCHPSC.B00621.CERTRSLN
623	P#CER.#NCHPSC.B00623.CERTRSLN
630	P#CER.#NCHPSC.B00630.CERTRSLN
640	P#CER.#NCHPSC.B00640.CERTRSLN
650	P#CER.#NCHPSC.B00650.CERTRSLN
655	P#CER.#NCHPSC.B00655.CERTRSLN
660	P#CER.#NCHPSC.B00660.CERTRSLN
700	P#CER.#NCHPSC.B00700.CERTRSLN
740	P#CER.#NCHPSC.B00740.CERTRSLN
780	P#CER.#NCHPSC.B00780.CERTRSLN
781	P#CER.#NCHPSC.B00781.CERTRSLN
801	P#CER.#NCHPSC.B00801.CERTRSLN
803	P#CER.#NCHPSC.B00803.CERTRSLN
805	P#CER.#NCHPSC.B00805.CERTRSLN
820	P#CER.#NCHPSC.B00820.CERTRSLN
824	P#CER.#NCHPSC.B00824.CERTRSLN
825	P#CER.#NCHPSC.B00825.CERTRSLN
865	P#CER.#NCHPSC.B00865.CERTRSLN
880	P#CER.#NCHPSC.B00880.CERTRSLN
889	P#CER.#NCHPSC.B00889.CERTRSLN

900	P#CER.#NCHPSC.B00900.CERTRSLN
901	P#CER.#NCHPSC.B00901.CERTRSLN
973	P#CER.#NCHPSC.B00973.CERTRSLN
974	P#CER.#NCHPSC.B00974.CERTRSLN
2050	P#CER.#NCHPSC.B02050.CERTRSLN
5130	P#CER.#NCHPSC.B05130.CERTRSLN
5440	P#CER.#NCHPSC.B05440.CERTRSLN
5535	P#CER.#NCHPSC.B05535.CERTRSLN
14330	P#CER.#NCHPSC.B14330.CERTRSLN
16360	P#CER.#NCHPSC.B16360.CERTRSLN
16510	P#CER.#NCHPSC.B16510.CERTRSLN
21200	P#CER.#NCHPSC.B21200.CERTRSLN
31140	P#CER.#NCHPSC.B31140.CERTRSLN

The target data set names for the current *Provider Address Files* are listed below:

AC Number	**Target File**
635	P#CER.#NCHPSC.D00635.CERTPROV
811	P#CER.#NCHPSC.D00811.CERTPROV
885	P#CER.#NCHPSC.D00885.CERTPROV
5655	P#CER.#NCHPSC.D05655.CERTPROV
10555	P#CER.#NCHPSC.D10555.CERTPROV
510	P#CER.#NCHPSC.B00510.CERTPROV
520	P#CER.#NCHPSC.B00520.CERTPROV
528	P#CER.#NCHPSC.B00528.CERTPROV
570	P#CER.#NCHPSC.B00570.CERTPROV
580	P#CER.#NCHPSC.B00580.CERTPROV
621	P#CER.#NCHPSC.B00621.CERTPROV
623	P#CER.#NCHPSC.B00623.CERTPROV
630	P#CER.#NCHPSC.B00630.CERTPROV
640	P#CER.#NCHPSC.B00640.CERTPROV
650	P#CER.#NCHPSC.B00650.CERTPROV
655	P#CER.#NCHPSC.B00655.CERTPROV
660	P#CER.#NCHPSC.B00660.CERTPROV
700	P#CER.#NCHPSC.B00700.CERTPROV
740	P#CER.#NCHPSC.B00740.CERTPROV
780	P#CER.#NCHPSC.B00780.CERTPROV
781	P#CER.#NCHPSC.B00781.CERTPROV
801	P#CER.#NCHPSC.B00801.CERTPROV
803	P#CER.#NCHPSC.B00803.CERTPROV
805	P#CER.#NCHPSC.B00805.CERTPROV
820	P#CER.#NCHPSC.B00820.CERTPROV
824	P#CER.#NCHPSC.B00824.CERTPROV
825	P#CER.#NCHPSC.B00825.CERTPROV
865	P#CER.#NCHPSC.B00865.CERTPROV
880	P#CER.#NCHPSC.B00880.CERTPROV
889	P#CER.#NCHPSC.B00889.CERTPROV

900	P#CER.#NCHPSC.B00900.CERTPROV
901	P#CER.#NCHPSC.B00901.CERTPROV
973	P#CER.#NCHPSC.B00973.CERTPROV
974	P#CER.#NCHPSC.B00974.CERTPROV
2050	P#CER.#NCHPSC.B02050.CERTPROV
5130	P#CER.#NCHPSC.B05130.CERTPROV
5440	P#CER.#NCHPSC.B05440.CERTPROV
5535	P#CER.#NCHPSC.B05535.CERTPROV
14330	P#CER.#NCHPSC.B14330.CERTPROV
16360	P#CER.#NCHPSC.B16360.CERTPROV
16510	P#CER.#NCHPSC.B16510.CERTPROV
21200	P#CER.#NCHPSC.B21200.CERTPROV
31140	P#CER.#NCHPSC.B31140.CERTPROV

The target data set names for the current *Claims History Replica Files* are listed below:

AC Number	**Target File**
635	P#CER.#NCHPSC.D00635.CERTRPLI
811	P#CER.#NCHPSC.D00811.CERTRPLI
885	P#CER.#NCHPSC.D00885.CERTRPLI
5655	P#CER.#NCHPSC.D05655.CERTRPLI
10555	P#CER.#NCHPSC.D10555.CERTRPLI
510	P#CER.#NCHPSC.B00510.CERTRPLI
520	P#CER.#NCHPSC.B00520.CERTRPLI
528	P#CER.#NCHPSC.B00528.CERTRPLI
570	P#CER.#NCHPSC.B00570.CERTRPLI
580	P#CER.#NCHPSC.B00580.CERTRPLI
621	P#CER.#NCHPSC.B00621.CERTRPLI
623	P#CER.#NCHPSC.B00623.CERTRPLI
630	P#CER.#NCHPSC.B00630.CERTRPLI
640	P#CER.#NCHPSC.B00640.CERTRPLI
650	P#CER.#NCHPSC.B00650.CERTRPLI
655	P#CER.#NCHPSC.B00655.CERTRPLI
660	P#CER.#NCHPSC.B00660.CERTRPLI
700	P#CER.#NCHPSC.B00700.CERTRPLI
740	P#CER.#NCHPSC.B00740.CERTRPLI
780	P#CER.#NCHPSC.B00780.CERTRPLI
781	P#CER.#NCHPSC.B00781.CERTRPLI
801	P#CER.#NCHPSC.B00801.CERTRPLI
803	P#CER.#NCHPSC.B00803.CERTRPLI
805	P#CER.#NCHPSC.B00805.CERTRPLI
820	P#CER.#NCHPSC.B00820.CERTRPLI
824	P#CER.#NCHPSC.B00824.CERTRPLI
825	P#CER.#NCHPSC.B00825.CERTRPLI
865	P#CER.#NCHPSC.B00865.CERTRPLI
880	P#CER.#NCHPSC.B00880.CERTRPLI

889	P#CER.#NCHPSC.B00889.CERTRPLI
900	P#CER.#NCHPSC.B00900.CERTRPLI
901	P#CER.#NCHPSC.B00901.CERTRPLI
973	P#CER.#NCHPSC.B00973.CERTRPLI
974	P#CER.#NCHPSC.B00974.CERTRPLI
2050	P#CER.#NCHPSC.B02050.CERTRPLI
5130	P#CER.#NCHPSC.B05130.CERTRPLI
5440	P#CER.#NCHPSC.B05440.CERTRPLI
5535	P#CER.#NCHPSC.B05535.CERTRPLI
14330	P#CER.#NCHPSC.B14330.CERTRPLI
16360	P#CER.#NCHPSC.B16360.CERTRPLI
16510	P#CER.#NCHPSC.B16510.CERTRPLI
21200	P#CER.#NCHPSC.B21200.CERTRPLI
31140	P#CER.#NCHPSC.B31140.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. Please send the address to the CERT Operations Center at the address listed in **"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 should be made in the following formats included in the Attachment 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. The standard system contractor will provide a data dictionary of the Claims Replica file to the CERT contractor before implementation of CERT, and will provide updates as necessary.

The data dictionary should be provided within 10 working days after receipt of this CR. 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 within 60 calendar days before a change is implemented in the standard system that will affect the data transmitted in files for the CERT or at the same time that the revised dictionary is supplied to data centers, whichever is later.

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 should 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 may 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, etc.) 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. The CERT point of contact will be the individual whom the CERT contractor will notify of any changes in requirements or problems with the CERT data. The point of contact will also initiate all non-routine communications from the Medicare contractor to the CERT contractor.

Summary of Major Changes from Previous CRs

This CR contains all information and corrections to CR 1338 plus the following major changes:

1. We require all contractors to begin complying with CERT requirements by April 1, 2002, regardless of the standard system they are using.

2. Information on overpayments and underpayments must be included for follow-up reports.

3. Contractors have 21 working days to respond to CERT review reports.

4. We require contractors to assist the CERT contractor in disseminating information to the provider community

5. Standard systems must be able to cross match claims numbers and/or HIC numbers that have changed since the claims universe file was submitted.

6. We are requiring that both billing and referring provider information be included on the provider file and that provider telephone number be provided on the file if the contractor has the information available.

7. Information on up to 52 line items must be provided for the claims universe and sample claims resolution file.

8. Paid amount is required for the sample Claims Resolution file.

9. ANSI codes are now eight characters rather than six.

10. ANSI reason codes have been modified to provide more detail on the type of review and the outcome of review.

Per CR 1338 (Transmittal Number B-00-61), the *initial effective date* for CERT was August 14, 2000 for DMERCs, and November 1, 2000 for all Part B contractors that use the VIPS standard system. Per CR 1338 (Transmittal Number B-00-61), the *initial effective date* for Medicare contractors using the Part B EDS MCS System was April 1, 2001.

The *effective date* for HPBSS is April 1, 2002.

Per CR 1338 (Transmittal Number B-00-61), the *initial implementation date* for CERT was August 14, 2000 for DMERCs, and November 1, 2000, for all Part B contractors that use the

VIPS standard system. Per CR 1338 (Transmittal Number B-00-61), the *initial implementation date* for Medicare contractors using the Part B EDS MCS System was April 1, 2001.

The *effective and implementation dates* for the changes identified in the "Summary of Major Changes from Previous CRs" section are January 1, 2002 for the DMERCs and all Part B contractors that use the VIPS standard system and the EDS MCS System.

The *implementation date* for HPBSS is April 1, 2002. We expect that HPBSS will begin working on the CERT module as part of the January 2002 release and complete the CERT module for implementation by April 1, 2002.

Implementation date refers to when the contractor begins submitting claims universe files. CMS may adjust the CERT system after the implementation date to accommodate unexpected problems with standard system modules. That may delay the actual start of sampling two months or more.

These instructions should be implemented within your existing current operating budgets

This PM may be discarded after April 1, 2003.

If you have any questions, contact Wayne Slaughter on (410) 786-0038 or John Stewart on (410) 786-1189.

Attachments

ATTACHMENT 1

CERT Formats for Carrier and DMERC Standard Systems

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{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 HCFA 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{tc \l1 "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{tc \l1 "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 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: 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 claimis 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 numberof 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 {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's claims history file. It should not include header or trailer records.

ATTACHMENT 2

Language for Inclusion in Provider Letter

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 Comprehensive Error Rate Testing (CERT) and is being implemented 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., due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How else are providers and suppliers impacted by CERT?

Providers and suppliers of the sampled claims will be asked during the course of the DynCorp review, to provide additional information (e.g., medical records, certificates of medical necessity, etc.) for DynCorp staff to verify services billed were delivered, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information and the name of a contact person.

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.