Program Memorandum
Intermediaries Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-34 **Date: MAY 2000**

CHANGE REQUEST 1035

SUBJECT: Program Integrity Management Reporting System

This Program Memorandum (PM) is to advise you of the new Program Integrity Management Reporting (PIMR) System that will change reporting requirements for Medical Review and fraud that are currently found in Medicare Intermediary Manual Part 2, §2301 and Part 3, §3939, and Medicare Carriers Manual Part 3, §§7504.2, 7535-7537.1, and 14021. The effective date for PIMR is October 1, 2000 and the implementation date is October 1, 2000.

The Health Care Financing Administration Program Integrity Group is developing a new system for improving the management of cost, savings, and workload data relative to the medical review unit and fraud unit. The PIMR System will replace: The Report of Benefit Savings (RBS); The Medical Review System 1 (MRS-1); The Focused Medical Review Report (FMR); and The Medicare Focused Medical Review Status Report (MFSR).

The relevant FMR and MFSR data will be collected through PIMR, mainly this data relates to how problems are resolved. Certain aspects of the FMR and MFSR systems will not be continued; we will not obtain data on procedure and diagnostic codes that define aberrancies in the future. However, we will obtain the data (i.e., how aberrancies are resolved) we are currently obtaining on aberrancies on each provider type and provider subtype. That information will be obtained through the interface with the standard system.

PIMR data required for the new system that HCFA cannot extract from existing systems will be collected from contractors monthly. A majority of the data requested will be transferred directly from contractors to the central office computer. Final reporting requirements to be met by standard systems and other sources are provided below. Specific reporting requirements for data that contractors must manually enter are in the first section of this memorandum.

Interface Design
Interface Identification

The PIMR System will require summarized data from other HCFA databases on a monthly basis. The databases include the Contractor Standard Systems, CROWD, CAFM, FID, IRP, and MARS. A Data Transfer Utility will be used for the mapping and transferring of the data.

General Data Definitions

The new system will require data that can be classified under four different categories: effort, workload, denials, and referrals. All definitions including the ones for fully automated edits and CCI apply to all program integrity activities and not just MR. Necessary changes in the MCM, MIM, or the program manual for Program Integrity will be forthcoming. Please note that these instructions are reporting instructions; **they are not instructions for how to perform medical review or benefit integrity activities or requirements for performing those activities.**

For the purposes of PIMR, medical review is defined as review of claims that occurs when review staff:

1) Make a coverage decision (benefit category, statutory exclusion, or reasonable and necessary) and a coding decision to determine the appropriate payment for claims or

2) Investigate complaints, determine whether an educational contact resulted in changed behavior, or identify situations that require prepayment edits and/or the development of a local medical review policy (LMRP).

Medical review can be preformed either before the claim has been paid, i.e., on a prepayment basis, or after the claim has been paid, i.e, on a postpayment basis..

Part B only: When this document refers to "Part B only", it means the requirement applies only to carriers and DMERCs. All other instructions apply to both Part A contractors and Part B contractors.

Units: Reporting units may be reviews, claims, services, referrals, etc. Units are defined for each item. Units are usually reviews. Where they are not, the instructions clearly indicate the units contractors are to report.

Counting Claims, line items, and services: Claims may be counted multiple times if line items on the claims fall into multiple categories. For instance, if a claim contains some line items that are subjected to manual complex review and others that are subjected to manual routine review, the claim would be included in the claim count for both categories. For counts of claims without reference to categories into which different line items on the claim might fall, e.g., claim count by bill type, count each claim only once.

Line items should be counted only once per category, even if there are multiple services for the line item. We wish contractors to report on level of activity, not the number of services provided. Number of services will not be reported in PIMR. That information will be obtained from the National Claims History file, the HCFA repository for claims records, or summary databases such as HCIS or BESS.

Handling claims with multiple reviews: There are two types of multiple reviews: (1) ones due to multiple line items on a claim and (2) ones that result from two different categories of review for the same item or items, e.g., a line item that is subject to prepayment review and postpayment review. For case 1, the line item and claim should be counted once for each line item review. In the second case, you would also count the line item and claim once for each category of review.

We would expect the second situation to occur infrequently. If a line item receives a complex review prepayment, we would not expect it to be subjected to postpayment review except in rare cases in which new information became available on the claim, such as a complaint, an indication of potential fraud resulting from data analysis, etc.

Definition of Coding Decisions: Where used in this memorandum, the term "coding decisions" generally refers to medical review decisions. For example, coding decisions include each of the following:

A contractor reviews product information for a DMEPOS item, finds that the wrong code has been billed, changes the code to the correct code, and completes the claim.

In the situation described above, the contractor denies the claim line with the wrong code and uses the message that the supplier he has incorrectly coded the item.

A local rebundling edit automatically denies a Column II code billed on the same date of service as a Column I code.

Re-review of denials: Once a line item is denied, the provider should appeal the denial if he/she disagrees;

the provider should not resubmit the line item as a new claim. Contractors should not count the re-review of a claim that has been previously fully or partially denied as a review.

The following subsections provides a brief description of the data under those categories.

Effort Data:

Cost - Dollars extracted from CAFM directly associated with each of the activities types described in later sections. Round to the nearest dollar.

FTE - Full-time-equivalent personnel counts extracted from CAFM directly associated with the direct personnel cost of each of the activity types described in later sections.

Workload Data:

Units - The number of workload units vary by activity types. Units may include the counts of edits, medical reviews, special studies, fraud cases, and data analysis. Where a unit is not specified, the unit desired is number of reviews.

Total No. of Claims - Number of claims a specific activity reviews during the reporting period.

No. of Line Items (Part B only) - Number of individual lines a specific activity reviews during the reporting period.

Billed Dollars - The actual charges submitted by providers or suppliers during the reporting period. Round to the nearest dollar.

Allowed Dollars -The amount of the charges which are eligible for payment on claims prior to medical review. Round to the nearest dollar.

Denial Data:

A denial is a claim for which a portion or all of the Medicare approved amount (initial charges allowed) was subsequently denied due to medical review. The amount reported will not be affected by reduction to zero due to offsetting, i.e., if what will be paid after MR is reduced to zero by an offset, the difference between the approved amount and the amount before offset is the savings the contractor should report.

No. Denied Claims - Number claims denied by each activity during the reporting period.

No. Denied Line Items (Part B) - Number line items (Part B only) denied by each activity during the reporting period.

Denied Dollars - The portion of the Medicare approved amount (initial charges allowed) subsequently denied after Medical Review. Round to the nearest dollar.

Eligible Dollars - Amount of charges that were initially billed by the provider or supplier and were eligible for payment on valid claims after Medical Review. This term is also referred to as allowed dollars. Round to the nearest dollar.

Reversed Claims - Number of claims that were reversed during this period from claims that had been denied during this or a prior period. We recognize that reversals always occur postpayment. The contractor will not be required to match a reversal to the period in which the payment denial occurred.

Reversed Line Items - Number of line items (Part B only) that were reversed during this period from line items that had been denied during this or a prior period. We recognize that reversals always occur postpayment. The contractor will not be required to match a reversal to the period

in which the payment denial occurred.

Reversed Dollars - Amount of dollars that were reversed during this period from dollars that had been denied during this or a prior period. Round to the nearest dollar. We recognize that reversals always occur postpayment. The contractor will not be required to match a reversal to the period in which the payment denial occurred.

Denial Reasons - Categories explaining why a claim was denied or why an edit was developed. A listing has been developed. Current reason codes will be used where possible, some existing reason codes may have to be mapped to the new codes for reporting purposes.

We have summarized denial reasons for reporting at a very high level. That level gives us sufficient information to meet our current needs. We also have attempted to stay at a high enough level of summary that contractors can easily comply with our requirements without having to revise their denial reason codes.

Overpayment Assessments Dollars - Amount in dollars from that which were paid in error and should be collected from the provider or supplier. Round to the nearest dollar.

Overpayment Assessments Claims - Number of claims from that which were paid in error and should be collected from the provider or supplier. Round to the nearest dollar.

Overpayment Collected Dollars - Amount in dollars from that which were paid in error and have been collected from the provider or supplier during the reporting period. Round to the nearest dollar.

Overpayment Collected Claims - Number of claims from that which were paid in error and have been collected from the provider or supplier during the reporting period. Round to the nearest dollar. Collected overpayments do not have to be linked to the specific claims from which they resulted.

Referral Data:

$ Referred to Fraud Unit - Dollar amount referred to the Fraud Unit at the contractor. These are referrals within to contractor's organization.

 # Referrals Accepted - Number of referrals accepted by the Fraud Unit. These are referrals within to contractor's organization.

$ Referrals Accepted - Dollar amount of referrals accepted by the Fraud Unit. These are referrals within to contractor's organization.

 # Referred To Law Enforcement (OIG) - Outcome of medical review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Department of Health and Human Services Office of the Inspector General (DHHS OIG).

 # Referrals Accepted by Law Enforcement (OIG) - Number of referrals accepted by the Law Enforcement Authorities other than the DHHS OIG.

Other Referrals - Include actions, such as a referral for provider education based on medical review, where it has been determined that the provider or supplier needs further claim submission education, either individually or in a group setting. The referral may be from either prepayment or postpayment review and occurs internal to the contractor organization. A set of reason codes for other outcomes have been defined in the detailed requirements that follow.

General Reporting Levels

Depending on the situation, the data elements defined above will be reported by several different categories or levels of detail. These levels include: Contractor Number, Year/Month, Activity Type, Provider Type, Bill/Subtype, and Edit. The levels are defined below.

Contractor Number – A unique number by contract type and region assigned to each contractor.

Year/Month – The fiscal year and month in which the data is reported. The format is YYYY/MM. For example the first month (i.e., October of 1998) of fiscal year 1999 is 199901.

Bill/Subtype - Bill Types are for Part A, and Subtypes are for Part B. These are the second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Procedure code modifiers are not used to identify bill type or bill subtype. See Attachments 2-4.

Edit Code – Locally developed automated edits are edits for which the contractor has developed some or all of the logic. These do not include COTS, CCI, or National edits unless the contractor has modified the edit to include other logic; a modified COTS, CCI, or National edit should be reported as a local edit only and not included in the COTS, CCI, or national categories. The data for locally developed edits must be reported for each individual edit by edit code. Data at the automated edit level will only apply to specific prepayment activity types. That decision reflects the current needs of HCFA, i.e., to identify the effectiveness and costs of manual edits. It additional needs arise in the future, we will either revise PIMR (if the requirement is long term) or make an special request (immediate and short term needs).

Each contractor will assigned their own numbers to the edits and describe the edits (i.e., specify procedure, diagnosis, and type of provider) in a registry that is a separate part of the system. Edit numbers will not be standardized across contractors.

An edit code will be described in the manual entry database on the basis of procedure code, diagnosis code, and specialty. A narrative description of each code will also be entered as part of the description. The description will include a description of criteria applied by the edit. The lists of procedure codes and diagnosis codes can be given in the form of ranges of codes. The edit code should correspond to an action code where possible. In the case of procedure code – diagnosis code pair edits, ranges can be used to describe the edits.

One edit may describe both physician and non-physician services. For example, if an edit tests for the number of laboratory tests a provider may perform on a beneficiary, the limit would apply to both physicians and non-physicians.

If a claim suspends for manual review for reasons other than failing a medical review automated edit, it should be reported in the automated edit category.

Classification of edit data into Categories I, II, and III no longer apply in PIMR. We currently do not have a need for that information. The edit description provided for each edit will provide an indication if the edit is provider specific. If the need arises to obtain data by provider specific edits, we will be able to do that on an Ad Hoc basis.

DMERC rebundling edits are defined as locally developed edits for purposes of these requirements.

Activity Type - A set of medical review activities performed by the Medicare contractor. There are essentially four different categories of activities: Prepayment Medical Reviews, Postpayment Medical Reviews, Claims Processing, and Other Activities. They are defined below:

Prepayment Medical Reviews

These reviews occur prior to payment decision. A Manual Prepay Medical Review is a manual review of claim data and/or supporting documentation, when necessary, by health professionals or trained medical review staff. They include manual reviews that result from automated edits (not automated reviews) fully or partially suspending claims for medical review. These are reviews that result in human review whether reviewed initially by automated MR edits or not. If a claim suspends for manual review for reasons other than failing a medical review automated edit, it should be reported in the automated edit category. The above data elements will be transferred for the reporting period for each of the following activities:

Automated Edits: An automated edit is one that never suspends for human intervention. It is an edit that pays or denies claims, i.e., processes the claim to completion, without the claim stopping for resolution. Determine if a claim fall into the automated edit category on a claim by claim basis. Report the number of denials that result from automated edits where this element is required.

Manual Routine Focused Reviews - Routine reviews use human intervention, but only to the extent that the claim reviewer reviews a claim and/or any attachment submitted by the provider. This includes a review of any other of the contractor's internal documentation, such as claims history file or policy documentation. A review is considered routine if a medical record is requested from a provider and not received. Routine Focused refer to routine medical reviews conducted on a continuing basis and targeted at all claims that meet an established or pre-existing set of criteria.

Manual Routine Random Reviews - These are Routine reviews that are done on claims selected using a process of random selection of a representative sample of claims for a given time period. They can be done based on the information contained in the claims records, attached to the claims records, or in the contractor's history files. A review is considered routine if a medical record is requested from a provider and not received. These are reviews that help determine if systematic errors in billing are occurring, and it identifies problem providers that escape detection through focused medical reviews.

Manual Complex Focused Reviews - Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim or contained in the contractor's history file. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. Manual Complex Focused Reviews are complex medical reviews conducted on a continuing basis and targeted at all claims that meet an established or pre-existing set of criteria.

Manual Complex Random Reviews - Complex review goes beyond routine review. It includes the request for, collection of, and evaluation of medical records or any other documentation in addition to the documentation on the claim or contained in the contractor's history file. Review requiring use of the contractor's history file does not make the review a complex review. A review is not considered complex if a medical record is requested from a provider and not received. These are complex reviews that are done on claims selected using a process of random selection of a representative sample of claims for a given time period. These are reviews that help determine if systematic errors in billing are occurring, and it identifies problem providers who escape detection through focused medical reviews.

There are other prepay reviews which are not a result of automated edits kicking out claims for manual review. Those reviews are the result of special requests.

PIMR will not require specific review activities, such as, Directed OIG Reviews or Directed

Law Enforcement Reviews. Review requirement will be set by other Program Instructions or, as in the case with the examples, by requests from agencies outside of HCFA. PIMR instructions only indicate what contractors are required to report.

The following provides a definition of each review:

Directed Fraud Unit Reviews - prepay reviews directed by or directly supporting the Fraud Unit. These are reviews that the MR unit did not start and/or that the fraud unit requested after the MR unit started the review.

Directed OIG Reviews - prepay reviews directed, by or directly supporting, the HHS Office of the Inspector General. These are reviews that the MR unit did not start and/or that the OIG requested after the MR unit started the review.

Directed Law Enforcement Reviews - prepay reviews directed, by or directly supporting, law enforcement. These are reviews that the MR unit did not start and/or that law enforcement requested after the MR unit started the review.

Directed PRO - prepay reviews directed by or directly supporting the Peer Review Organization. These are reviews that the MR unit did not start and/or that the PRO requested after the MR unit started the review.

Fully automated MR edits are another category of prepayment medical reviews. Fully automated MR edits result in a claim or line item being paid or denied without manual review. An automated review occurs when a claim/line item passes through the contractors claims processing system or any adjunct system and is denied in whole or in part because the service(s) is non-covered or not coded correctly. The data referred to here is any resulting data that does not become associated with a manual medical review. Specific data elements will be transferred for the reporting period categorized as one of the following edit types:

Locally Developed - edits that the contractor has developed some or all of the logic. This does not include COTS, CCI, or National edits unless the contractor has modified the edit to include other logic. The data for locally developed edits must be reported for each individual edit by edit code.

National - fully automated MR edits that HCFA creates and the contractors do not modify. The data reported for national edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by national edits will be required for national edits.

COTS - Commercial Off the Shelf (COTS) edits are fully automated MR edits that are purchased or leased from a commercial source and are not modified by the contractor. CCI edits are not included in this category. The data reported for COTS edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by COTS edits will be required for "COTS edits."

CCI - Correct Coding Initiative (CCI) edits are fully automated MR edits that are developed under the Correct Coding Initiative and are provided to the contractor. COTS edits are not included in this category. The data reported for CCI edits will not be reported for each individual edit, but will be reported as a sum. Only data from claims denied by CCI edits will be required for "CCI edits."

Postpayment Medical Reviews

Postpayment reviews occur after a decision to pay has been made. The following Manual Postpay Reviews will require the specific data.

CMR In-house Reviews - Comprehensive Medical Review (CMR) is a process to determine if a provider or group of providers is providing non-covered or medically unnecessary services. CMRs are usually targeted at providers who have demonstrated aberrant billing and/or practice patterns. They also serve as the basis for overpayment assessment and projection. CMR In-house Reviews are performed at the contractor's facility.

CMR On-site Reviews - Comprehensive Medical Review (CMR) is a process to determine if a provider or group of providers is providing non-covered or medically unnecessary services. CMRs are usually targeted at providers who have demonstrated aberrant billing and/or practice patterns. They also serve as the basis for overpayment assessment and projection. CMR reviews performed at the provider's or supplier's facility.

Other Postpay Reviews - a postpayment review that is not part of a CMR. They are:

Review of claims for purposes other than CMR, such as investigating a complaint or follow up to determine if an educational contact resulted in changed behavior;
Decision to initiate suspension of payment for a given provider; Identification of situations that require prepayment edits and/or LMRPs; and/or
Referral to the fraud unit with recommendations for administrative sanctions (including civil and criminal prosecution) for providers who fail to correct their inappropriate practices.

PIMR will not require specific review activities, such as, Directed OIG Reviews or Directed Law Enforcement Reviews. Review requirement will be set by other Program Instructions or, as in the case with the examples, by requests from agencies outside of HCFA. PIMR instructions only indicate what contractors are required to report.

Directed Fraud Unit Reviews - postpay reviews directed by or directly supporting the Fraud Unit. These are reviews that the MR unit did not start and/or that the fraud unit requested after the MR unit started the review.

Directed HCFA CFO Reviews - postpay reviews directed by or directly supporting the CFO Audit. These are reviews that the MR unit did not start and/or that the HCFA or the OIG requested to support the CFO audit after the MR unit started the review.

Directed OIG Reviews - postpay reviews directed by or directly supporting the Department of Health and Human Services Office of the Inspector General (DHHS OIG). These are reviews that the MR unit did not start and/or that the OIG requested after the MR unit started the review.

Directed Law Enforcement Reviews - postpay reviews directed by or directly supporting law enforcement other than the DHHS OIG. These are reviews that the MR unit did not start and/or that law enforcement other than the DHHS OIG requested after the MR unit started the review.

Directed ORT or Wedge Reviews - postpay reviews performed under Operation Restore Trust (ORT) or reviews that support joint agency/state medical review activities. These are reviews that the MR unit did not start and/or that ORT requested after the MR unit started the review.

Directed PRO - postpay reviews directed by or directly supporting the Peer Review Organization (PRO). These are reviews that the MR unit did not start and/or that the PRO requested after the MR unit started the review.

Claims Processing

Claims processing involves information from a contractor's claim processing system. A claim

is an electronic or paper request submitted in the prescribed HCFA format to intermediaries or carriers for payment for Part A or Part B health services rendered by a provider (e.g., hospital, physician, or supplier) to a Medicare beneficiary. Data is required for specific data elements for the following categories:

Claims Received - the number of provider/supplier requests for payment received within a given period that undergo review in accordance with HCFA regulations and manual instructions. The claims are paid, denied, or suspended.

Claims Paid - Claims reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.

Claims Available for MR - claims considered valid by contractor's claims processing function. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data, or claims that are not subject to medical review by the contractor such as hospital outpatient claims paid under a prospective payment system.

Other Activities

Other activities in which the Medicare contractors are performing will required specific data. Those activities are described below:

Data Analysis - Data Analysis is defined as the review of claim information and other related data sources to identify patterns of over utilization or abuse by claim characteristics individually or in the aggregate.

Special Studies - Special Studies are defined as an activity or project with a unique identification designed to develop and demonstrate a new approach to fraud, abuse, or waste protection.

Edit Development - Edit development is the effort necessary to create a computerized logic test developed with the assistance of health professionals that compares the data elements on a Medicare claim for the purposes of (1) making a coverage or local coding determination or (2) suspending a claim so such determinations can be made by health professionals or trained medical review staff prior to payment of the claim. The term edit should be used instead of "screen or audit."

Contractor Policy Development - Contractor Policy Development involves determining that a local medical review policy (LMRP) is needed, using or adapting an existing LMRP or model policy, or developing an LMRP using medical consultants, input from professional organizations, and information from medical literature to address aberrant utilization under benefit category for an item/service.

Court Ordered Medical Reviews - A Court Ordered Medical Review is a review that is required by a judicial order as evidenced by a subpoena or writ and not requested by law enforcement, the OIG, a PRO, or the fraud unit.

Contractor/Standard System Interface-- See Attachments

The *effective date* for this PM is October 1, 2000, for all Part B standard systems. The effective dates Part A standard systems will be set in a separate transmittal. Detailed system requirements will be the same for both Part A and Part B standard systems.

The *implementation date* for this PM is October 1, 2000, for all Part B standard systems. The effective dates Part A standard systems will be set in a separate transmittal. Detailed system requirements will be the same for both Part A and Part B standard systems.

Contractors may implement needed changes any time before the implementation date if they wish.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 27, 2001.

If you have any questions, contact

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ATTACHMENT 1

Contractor/Standard System Interface

The following section identifies the data elements required from the contractor standard systems to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

PostPay Medical Review Data

The following table provides a definition of the PostPay Medical Review data required by the PIMR system from the contractor standard systems. We will provide a module as part of PIMR to allow contractors to enter postpayment data into the system. These specifications are provided for standard systems maintainers that wish to develop modules to transfer post payment data directly to PIMR from the standard system.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Entity Attribute Name	Definition	Physical Design
PMR Postpay Review PMR_PSPY_RVW	Contractor Number CTRR_NUM	A unique identification number assigned to a Medicare contractor for data collection purposes.	CHAR(5), PK
PMR Postpay Review PMR_PSPY_RVW	Year/Month YR_MO_TXT	Defines the year and month in which the data applies.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Provider Type PROV_TYPE_CD	Provides a unique identifier for each provider type. Provider types and codes are currently under review.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Bill/Sub Type BILL_TYPE_CD	Provides a unique identifier for each Bill Type (Part A) and Sub Type (Part B). Specific codes which will be included in the system are currently under review.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Activity Type Code ACTY_TYPE_CD	Defines a unique identification code associated with the Postpay Review activity. This code is used to track workload, denials, and referrals resulting from each activity.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Review Identifier RVW_NUM	Provides a number to differentiate reviews under each Contractor and Postpay activity. The PIMR System will automatically assign a one-up number as Postpay reviews are loaded into the PIMR database. Contractor's should leave this field blank.	CHAR(6), PK
PMR Postpay Review PMR_PSPY_RVW	Claims CLM_CNT	Provides the total number of claims reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Line Items LINE_ITM_CNT	Provides the total number of line items reviewed during each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)

PMR Postpay Review PMR_PSPY_RVW	Billed Dollars BILD_AMT	Provides the dollar amount charged by the provider or supplier which was under review for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Allowed Dollars ALWB_AMT	Provides the amount of the charges which were eligible for payment on claims prior to the Postpay review for each Postpay review by Activity, Provider Type, and Bill/Subtype. Known Problems: None//	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Denied Claims DNL_CLM_CNT	Provides the number of claims that were denied for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Denied Line Items DNL_LINE_ITEM_CNT	Provides the number of line items that were denied for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Denied Dollars DNL_AMT	Provides the dollar amount that was denied for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Eligible Dollars ELGBL_AMT	Provides the amount of the charges which were billed by the provider that are still eligible for payment after the review for each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Reversed Claims RVRS_CLM_CNT	Provides the number of claims which were initially denied but were reversed as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Reversed Line Items RVRS_LINE_ITM_CNT	Provides the number of line items which were initially denied but were reversed as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Reversed Dollars RVRS_AMT	Provides the amount in dollars which were initially denied but were reversed as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Overpayment Assessed Dollars OVPY_ASMT_AMT	Provides the amount in dollars which were originally paid in error but should be collected from the provider or supplier as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Overpayment Collected Dollars OVPY_COL_AMT	Provides the amount in dollars which were originally paid in error but was collected from the provider or supplier as a result of each Postpay review by Activity, Provider Type, and Bill/Subtype.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Review Date RVW_DT	Provides the beginning data of each Postay review as entered into the system	DATE
PMR Postpay Review PMR_PSPY_RVW	Reason Code RSN_CD	Defines a unique identification code by denial reason for each Postpay review that results in a denial.	CHAR(6)
PMR Postpay Review PMR_PSPY_RVW	Other Referral Reason OTH_RFRL_RSN_CD	Defines a unique identification code by "other referrals" from each Postpay review that results in a referral other than fraud referral.	CHAR(6)
PMR Postpay Review PMR_PSPY_RVW	Number Referred to Fraud FRD_RFRL_CNT	Provides the number of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities. Known Problems: None//	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Dollar Referred to Fraud FRD_RFRL_AMT	Provides the dollar amount of referrals as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Number Referred to Other OTH_RFRL_CNT	Provides the number of referrals other than fraud referrals that were referred to another activity as a result of the Postpay Review.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Dollar Referred to Other OTH_RFRL_AMT	Provides the dollar amount of referrals other than fraud referrals that were referred to another activity as a result of the Postpay Review.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Number Accepted ACPT_CNT	Provides the number of referrals accepted by the Fraud Unit or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(10)
PMR Postpay Review PMR_PSPY_RVW	Dollars Accepted ACPT_AMT	Provides the dollar amount of referrals accepted by the Fraud Unit or law enforcement authorities as a result of the Postpay Review where a claim is determined to be the result of fraudulent activities and the claims(s) or provider is referred to the Fraud Unit at the contractor or the law enforcement authorities.	NUMERIC(13)
PMR Postpay Review PMR_PSPY_RVW	Updated By UPDT_BY_TXT	Provides the User Identification of the last person who updated the record.	CHAR(8)

Level of Detail:

The data must be broken down by the primary keys identified above the thick solid line in the

table.

Contractor Number (CTTR_NUM)
Year/Month (YEAR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Review Identifier (RVW_NUM)

1.0 Prepay Medical Review Data

The following table provides a definition of the Prepay Medical Review data required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Year/Month YR_MO_TXT	A code, which specifies the year and month for the data, reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N Automated National Edit, 21001C = Automated COTS Edit, 21001 I = Automated CCI Edit, 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21016 = Directed Fraud Unit Review, 21017 = Directed OIG Review, 21018 = Directed Law Enforcement Review, 21019 = Directed by PRO.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Edit Code EDIT_CD	A unique code assigned to each locally developed automated edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002F, 21002R, 21003F, and 21003R. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_RVW
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_PPAY_RVW PMR_FRD_RFRL
Units UNIT_CNT	The number of units that vary by activity. Activity types 21001L, 21001N, 21001C, and 21001I include number of edits associated with that activity used during the reporting period. All other Activity Types refer to the number of reviews associated with that activity during the reporting period.	NUMERIC(10)	PMR_PPAY_RVW
Claims CLAIM_CNT	The number of claims a specific activity type reviews during the reporting. This does not apply to activity types 21001N, 21001C, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
Line Items (Part B) LINE_ITM_CNT	The number of individual lines a specific activity type reviews during the reporting period. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.	NUMERIC(10)	PMR_PPAY_RVW
Billed Dollars BILD_AMT	The actual charges submitted by providers or suppliers during the reporting period. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.	NUMERIC(13)	PMR_PPAY_RVW

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Allowed Dollars **ALWB_AMT**	**The amount of the charges which are eligible for payment on claims prior to medical. This does not apply to activity types 21001L, 21001N, 21001C, and 21001I.**	**NUMERIC(13)**	**PMR_PPAY_RVW**
Denied Claims **DND_CLM_CNT**	**The number claims denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(10)**	**PMR_PPAY_RVW**
Denied Line Items (Part B) **DND_LINE_ITM_CNT**	**The number of line items denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(10)**	**PMR_PPAY_RVW**
Denied Dollars **DND_AMT**	**The amount of charges which were billed by the provider or supplier and subsequently denied after Medical Review. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(13)**	**PMR_PPAY_RVW**
Eligible Dollars **ELGLL_AMT**	**The amount of charges which were billed by the provider or supplier and are eligible for payment on valid claims after Medical Review broken. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(13)**	**PMR_PPAY_RVW**
Reversed Claims **RVRS_CLM_CNT**	**The number of claims that were reversed during this period from claims that had been denied during this or prior periods. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(10)**	**PMR_PPAY_RVW**
Reversed Line Items **RVRS_LINE_ITM_CNT**	**The number of line items (Part B) that were reversed during this period from line items that had been denied during this or prior periods. This does not apply to activity type codes 21016, 21017, 21018, and 21019.**	**NUMERIC(10)**	**PMR_PPAY_RVW**
Reversed Dollars **RVRS_AMT**	**The amount of dollars that were reversed during this period from dollars that had been denied during this or prior periods. This does not apply to activity type codes 1016, 21017, 21018, and 21019.**	**NUMERIC(13)**	**PMR_PPAY_RVW**
# Referrals **RFRL_CNT**	**The number of claims(s) or providers referred to the Fraud Unit during the reporting period. This does not apply to Activity Types 21001L, 21001N, 21001C, 21001I, 21016, 21017, 21018, and 21019.**	**NUMERIC(10)**	**PMR_FRD_RFRL**
$ Referrals **RFRL_AMT**	**The dollar amount referred to the Fraud Unit at the contractor broken down by Provider Type and Bill/Subtype. This does not apply to Activity Types 21001L, 21001N, 21001C, 21001I, 21016, 21017, 21018, and 21019.**	**NUMERIC(13)**	**PMR_FRD_RFRL**
# Referrals Accepted **ACPT_CNT**	**The number of referrals accepted by the Fraud Unit during the reporting period. This data only applies to Activity Types 21002F, 21002R, 21003F, 21003R, and 21016.**	**NUMERIC(10)**	**PMR_FRD_RFRL**
$ Referrals Accepted **ACPT_AMT**	**The dollar amount of referrals accepted by the Fraud Unit during the reporting period. This data only applies to Activity Types 21002F, 21002R, 21003F, 21003R, and 21016.**	**NUMERIC(13)**	**PMR_FRD_RFRL**

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

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

2.0 Denial Reasons

The following table provides a definition of the data associated with reason for denial, which is required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PPAY_DNL
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PPAY_DNL
Activity Type ACTY_TYPE_CD	A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N Automated National Edit, 21001C = Automated COTS Edit, 21001 I = Automated CCI Edit, 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21016 = Directed Fraud Unit Review, 21017 = Directed OIG Review, 21018 = Directed Law Enforcement Review, 21019 = Directed by PRO.	CHAR(6), PK	PMR_PPAY_DNL
Edit Code EDIT_CD	A unique code assigned to each locally developed automated edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002F, 21002R, 21003F, and 21003R. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply.	CHAR(5), PK	PMR_PPAY_DNL
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_PPAY_DNL
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_PPAY_DNL
Reason Code RSN_CD	A unique 6 character code that applies to either Reasons for Denials. Reason Codes include 100001 = Documentation does not support service, 100002 = Investigation/experimental, 100003 = Items/services excluded, 100004 = Requested information not received, 100005 = Services not billed under the appropriate revenue code, 100006 = Services not documented in record, 100007 = Services no medically reasonable and necessary, 100008 = Skilled Nursing Facility demand bills, 100009 = Daily nursing visits are not intermittent/part time, 100010 = Specific visits did not include personal care services, 100011 = Home Health demand bills, 100012 = Ability to leave home unrestricted, 100013 = Physicians order not timely, 100014 = Service not ordered/not included I treatment plan, 100015 = Services not included in plan of care, 100016 = No physician certification, 100017 = Incomplete physician order, 100018 = No individual treatment plan 100019 = Other.	CHAR(6), PK	PMR_PPAY_DNL
Denied Claims DNL_CLM_CNT	The number claims denied be each activity type during the reporting period. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(10)	PMR_PPAY_DNL
Denied Dollars DNL_AMT	The amount of charges which were billed by the provider or supplier and subsequently denied after Medical Review. This does not apply to activity type codes 21016, 21017, 21018, and 21019.	NUMERIC(13)	PMR_PPAY_DNL

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

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

3.0 Other Referrals

The following table provides a definition of the data associated with other referrals or actions resulting from medical review activities, which is required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	**A unique number by contract type and region assigned to each contractor.**	**CHAR(5), PK**	**PMR_OTH_RFRL**
Year/Month YR_MO_TXT	**A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)**	**CHAR(6), PK**	**PMR_OTH_RFRL**
Activity Type ACTY_TYPE_CD	**A unique 6 character code associated with each of the following activities: 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21007 = Data Analysis, and 28000 = Special Studies.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
Provider Type PROV_TYPE_CD	**The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
Bill/Subtype BILL_TYPE_CD	**The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
Reason Code RSN_CD	**A unique 6 character code that applies to Other Referrals or Actions. Reason Codes include 200001 = Local Medical Review Policy, 200002 = Overpayment recovery, 200003 = Requirement or corrective action plan, 200004 = Suspension of Payment, and 200005 = Education, 200006 = Denial rationales for each claim denied, 200007 = Individual provider training, 200008 = Provider bulletin issued, 200009 = Provider seminar/workshop, 200010 = Medical Review, 200011 = Comprehensive Medical Review, 200012 = Focused Medical Review % increased, 200013 = Prepay medical review, 200014 = Referral to a fraud unit, 200015 = Develop an edit, and 200016 = Other.**	**CHAR(6), PK**	**PMR_OTH_RFRL**
Other Referrals RFRL_CNT	**The number of referrals include, such as a referral for provider education based on medical review, where it has been determined that the provider or supplier needs further claim submission education, either individually or in a group setting. Referrals are categories by the Reason Codes above. The are broken down by Provider Type, Bill/Subtype, and "Other Referral" Reason Code. This only applies to activity types 21002F, 21002R, 21003F, 21003R, 21007, and 28000.**	**NUMERIC(10)**	**PMR_OTH_RFRL**

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

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

4.0 Claims Processing Data

The following table provides a definition of the Claims Processing data required by the PIMR system from the contractor standard systems.

Note: The ideal interface or flat file format exported from the standard systems would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_CLM_PRCS
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_CLM_PRCS
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_CLM_PRCS
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_CLM_PRCS
Claims Received CLM_RCV_CNT	The number of claims received from providers/suppliers for claims processing within the report.	NUMERIC(10)	PMR_CLM_PRCS
Line Items Received LINE_ITM_RCV_CNT	The number of line items (Part B only) received from providers/suppliers for claims processing within the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Billed Dollars Received BILD_RCV_AMT	The amount in dollars of claims received from providers/suppliers for claims processing within the report period.	NUMERIC(13)	PMR_CLM_PRCS
Claims Paid CLM_PD_CNT	The number of claims reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Line Items Paid LINE_ITM_PD_CNT	The number of line items reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(10)	PMR_CLM_PRCS
Dollars Paid PD_AMT	The amount in dollars reviewed and adjudicated that have met the claims payment and MR criteria for payment for the reporting period.	NUMERIC(13)	PMR_CLM_PRCS
Claims Available for MR CLM_AVL_CNT	The number of claims considered valid by contractor's claims processing function. Not included in this total are claims that are technically denied for reasons such as incomplete provider or patient demographic data, or claims that are not subject to medical review by the contractor such as hospital outpatient claims paid under a prospective payment system.	NUMERIC(10)	PMR_CLM_PRCS

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD

(CAFM Interface)

The following section identifies the data elements required from CAFM to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CAFM system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_EFRT PMR_EDIT_DVPT
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_EFFORT PMR_EDIT_DVLPMT
Activity Type ACTY_TYPE_CD	A unique 6 character code associated with each MR activity to allow reporting by Activity. Activities include: 21002F = Manual Routine Focused Review, 21002R = Manual Routine Random Review, 21003F = Manual Complex Focused Review, 21003R = Manual Complex Random Review, 21004 = Postpay Non-CMR, 21005 = Postpay Onsite CMRs, 21006 = In-House CMRs, 21007= Data Analysis, 21008 = Policy Development, 21016 = Prepay Directed Fraud Unit Review, 21017 = Prepay Directed OIG Review, 21018 = Prepay Directed Law Enforcement Review, 21019 = Prepay Directed by PRO, 21020 = Postpay Directed Fraud Unit Review, 21021 = Postpay HCFA CFO Review, 21022 = Postpay Directed OIG Review, 21023 = Postpay Directed Law Enforcement Review, 21024 = Postpay Directed by PRO, 21025 Postpay Directed ORT, 21026 = Edit Development, 21026S = Edit Development Setup, 21026T = Edit Development - Test, 21027 = Court Ordered Medical Review, 21028 = Fraud, 21029 = Fraud Sources, and 28000 = Special Studies.	CHAR(6), PK	PMR_EFRT PMR_EDIT_DVPT (DVPT_STUS_CD for activities 21026S and 21026T only)
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_EFRT
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_EFRT
Cost CST_AMT	The dollars reported as the direct cost from CAFM associated with each Activity Type Code.	NUMERIC(13)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
FTE FTE_CNT	The full-time-equivalent personnel from CAFM associated with the direct personnel cost of each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)
Units UNIT_CNT EDIT_CNT	The number of workload units that vary by each Activity Type Code.	NUMERIC(10)	PMR_EFRT PMR_EDIT_DVPT --(21026S and T only)

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD) **(Except for Edit Development)**
Bill/Subtype (BILL_TYPE_CD) **(Except for Edit Development)**
Activity Type (ACTY_TYPE_CD)

(FID Interface)

The following section identifies the data elements required from FID to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

1.0 Fraud Case Data

The following table provides a definition of the fraud case data required by the PIMR system from the FID system.

Note: The ideal interface or flat file format exported from the FID System would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE	CASE CONTRACTOR	Contractor Identifier CNTRCTR_ID	Use CASE_ID to map case related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, which specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE	ACTION	Action Date ACTN_DT *Note: Action Date and Action Taken should be a key in the FID ACTION table if data is to be captured by each action.*	If ACTN_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE	PRVDR	Provider Type Text PRVDR_TYPE_TXT	Use CASE_ID to map case to Contractor by CNTRCTR_ID and to Provider Type by PRVDR_TYPE_TXT.
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE	BILL_TYPE	Bill Type Identifier BILL_TYPE_ID	Use CASE_ID to map case related data to a Bill Type by BILL_TYPE_ID.
Fraud Source Code FRD_SRC_CD	A unique code that identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal Sources. Beneficiary Integrity - Non IRP and Medical Review Referrals fall under 100004.	CHAR(6), PK	PMR_FRD_CASE	ALGTN_SRC	Allegation Source Text ALGTN_SRC_TXT	Use CASE_ID to map case related data to a fraud source by ALGTN_SRC_TXT.
Fraud Status FRD_STUS_CD	A unique 1 character code which identifies fraud status. Fraud status codes include A = Active, C = Closed, N = Not Applicable. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1) PK	PMR_FRD_CASE	ACTN	Action Text ACTN_TXT	Set FRD_STUS_CD to "A" for all cases the are identified as Opened in ACTN_TXT for all ACTN_DT's within the Year/Month period. Set FRD_STUS_CD to "C" for all cases the are identified as Closed in ACTN_TXT for all ACTN_DT's within the Year/Month period.
Number Cases CASE_CNT	The number of fraud cases broken down by each combination of the keys above for the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID _CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT for ACTN_DT within the YEAR_Month_TXT.
# of Referrals RFRL_CNT	The number of cases referred to the OIG during the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID_CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT where ACTN_TXT denotes OIG Referral in ACTN for ACTN_DT within the within the YEAR_Month_TEXT.

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
# Referrals Accepted ACPT_CNT	The number of cases accepted by OIG during the reporting period.	NUMERIC(10)	PMR_FRD_CASE	FID_CASE	SUM(Case Identifier) SUM(CASE_ID)	SUM(CASE_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_TXT and BILL_TYPE_ID and ALGTN_SRC_TXT and ACTN_TXT where ACTN_TXT denotes OIG Referral in ACTN for ACTN_DT within the within the YEAR_Month_TEXT.

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD

2.0 Payment Suspension Data

The following table provides a definition of the payment suspension data required by the PIMR system from the FID system.

Note: The ideal interface or flat file format exported from the FID System would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical Physical Name	Definition	PIMR Physical Design	PIMR Destination Table	FID Source Table	FID Logical Physical Name	Mapping Logic
Contractor Number CTRR_ NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_SPSN	SUSPNSN_ CNTRCTR	Contractor Identifier CNTRCTR_ID	Use SUSPNSN_ID to map suspension related data to a Contractor by CNTRCTR_ID.
Year/Month YR_MO_TXT	A six-character code, which specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN	SUSPNSN	Effective Date EFCTV_DT	If EFCTV_DT falls within the current Year/Month then move data.
Provider Type PROV_TYPE_ CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_SPSN	SUSPNSN	Provider Type Text PRVDR_TYPE_T XT	Each suspension record includes PRVDR_TYPE_TXT to allow filtering of data.
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Definitions and codes are currently under currently under review.	CHAR(6), PK	PMR_SPSN	SUSPNSN	BILL_TYPE_ID	Each suspension record includes BILL_TYPE_ID to allow filtering of data.
Suspension Type SPSN_TYPE_CD	A unique code, which identifies the type of suspension for the data set. Suspension types include BI = Benefit Integrity and MR = Medical Review.	CHAR(2), PK	PMR_SPSN	SUSPNSN	Suspension Type Text SUSPNSN_TYPE_ CD	Map each FID suspension type to either BI or MR.
Suspended Providers SPSN_PROV_CNT	The number of providers which received Payment Suspensions during the reporting period. Payment Suspensions are defined as the withholding of payment by an intermediary or carrier from a provider or supplier of an approved Medicare Payment amount before a determination of the amount of the overpayment exits.	NUMERIC(10)	PMR_SPSN	SUSPNSN	SUM(Suspension Identifier) SUM(SUSPNSN_I D)	SUM(SUSPNSN_ID) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Claims SPSN_CLAIM_CNT	The number of suspended claims associated with suspended providers for the reporting period.	NUMERIC(10)	PMR_SPSN	SUSPNSN	CLM_SUBMSN_C NT	SUM(CLM_SUBMSN_ CNT) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.
Suspended Dollars SPSN_AMT	The amount in dollars associated with suspended providers for the reporting period.	NUMERIC(13)	PMR_SPSN	SUSPNSN	Suspension Amount SUSPNSN_AMT	SUM(SUSPNSN_AMT) for each combination of CNTRCTR_ID and PROVIDER_TYPE_T XT and BILL_TYPE_ID and SUSPNSN_TYPE_CD for EFCTV_DT within the YEAR_Month_TXT and RMVL_SW set to FALSE.

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

Contractor Number (CTRR_NUM)

Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Suspension Type (SPSN_TYPE_CD)

(MARS Interface)

The following section identifies the data elements required from MARS to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

1.0 Medical Review Overpayment Data

The following table provides a definition of the medical review overpayment data required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_PSPY_RVW
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_PSPY_RVW
Activity Type ACTY_TYPE_CD	A unique code associated with each MR activity to allow reporting by Activity. Activities include: 21004 = Postpay Non-CMR, 21005 = Postpay Onsite CMRs, 21006 = In-House CMRs, 21020 = Postpay Directed Fraud Unit Review, 21021 = Postpay HCFA CFO Review, 21022 = Postpay Directed OIG Review, 21023 = Postpay Directed Law Enforcement Review, 21024 = Postpay Directed by PRO, 21025 Postpay Directed ORT, 21027 = Court Ordered Medical Review.	CHAR(6), PK	PMR_PSPY_RVW
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	VARCHAR(6), PK	PMR_PSPY_RVW
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	VARCHAR(6), PK	PMR_PSPY_RVW
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_PSPY_RVW
Overpayment Collected Claims OVPY_COL_CNT	Number of claims from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_PSPY_RVW
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_PSPY_RVW

Level of Detail:

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

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

2.0 Fraud Case Overpayment Data

The following table provides a definition of the overpayment data associated with fraud cases required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints, 100002 = Incentive Reward Program, 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Fraud Status Code FRD_STUS_CD	A unique code that identifies status of fraud cases. Fraud status codes include A = Active and C = Closed. Active includes all fraud cases pending or opened during the reporting period. Closed fraud cases include cases upon which no further action is expected to be taken.	CHAR(1), PK	PMR_FRD_CASE
Overpayment Assessed Claims OVPY_ASMT_CNT	Number of claims associated with fraud cases from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Assessed Dollars OVPY_ASMT_AMT	Amount in dollars associated with fraud cases from that which were paid in error and should be collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_FRD_CASE
Overpayment Collected Claims OVPY_COL_CNT	Number of claims associated with fraud cases from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(10)	PMR_FRD_CASE
Overpayment Collected Dollars OVPY_COL_AMT	Amount in dollars associated with fraud cases from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_FRD_CASE

Level of Detail:

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Fraud Source (FRD_SRC_CD)
Fraud Status (FRD_STUS_CD)

3.0 Payment Suspension Overpayment Data

The following table provides a definition of the overpayment data associated with payment suspensions required by the PIMR system from the MARS system.

Note: The ideal interface or flat file format exported from the MARS system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_SPSN
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_SPSN
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_SPSN
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	VARCHAR(6), PK	PMR_SPSN
Suspension Type SPSN_TYPE_CD	A unique code that identifies the type of suspensions for the data set. Suspension types include BI = Benefit Integrity and MR = Medical Review.	CHAR(2), PK	PMR_SPSN
Recovered Dollars OVPY_COL_AMT	Amount in dollars associated with suspended providers from that which were paid in error and have been collected from the provider and supplier during the reporting period.	NUMERIC(13)	PMR_SPSN

Level of Detail:

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD)
Suspension Type (SPSN_TYPE_CD)

(CROWD Interface)

The following section identifies the data elements required from CROWD to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CROWD system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes include 100001 = OIG Hotline Complaints and 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	Provides the number of complaints received from Law Enforcement during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD) (Except for Edit Development)
Bill/Subtype (BILL_TYPE_CD) (Except for Edit Development)
Fraud Source Code (FRD_SRC_CD)

(IRP Interface)

The following section identifies the data elements required from IRP to be transferred to the Program Integrity Management Reporting (PIMR) system database on a monthly schedule. The names, definitions, and physical descriptions reflect those currently designed for the PIMR system.

Note: The ideal interface or flat file format exported from the CROWD system would be the format and order as defined in the table.

PK = Primary Key

PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
Contractor Number CTRR_NUM	A unique number by contract type and region assigned to each contractor.	CHAR(5), PK	PMR_FRD_CASE
Year/Month YR_MO_TXT	A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)	CHAR(6), PK	PMR_FRD_CASE
Provider Type PROV_TYPE_CD	The first level of indenture for the type of entity providing services or supplies (e.g., hospital). Provider Type codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Bill/Subtype BILL_TYPE_CD	The second level of indenture for the type of entity providing the services or supplies (e.g., hospital - PPS). Subtypes and Bill types include Procedure codes. Bill/subtype codes are currently under review.	CHAR(6), PK	PMR_FRD_CASE
Fraud Source Code FRD_SRC_CD	A unique code, which identifies the source of fraud cases. Fraud Source Codes from IRP include 100002 = IRP Complaints and 100004 = Other Internal.	CHAR(6), PK	PMR_FRD_CASE
Number Complaints CPNT_CNT	Provides the number of complaints received from Law Enforcement during the reporting period.	NUMERIC(10)	PMR_FRD_CASE

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

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD) (Except for Edit Development)
Bill/Subtype (BILL_TYPE_CD) (Except for Edit Development)
Fraud Source Code (FRD_SRC_CD)

ATTACHMENT 2
FI PROVIDER TYPE

PROVIDER CODE	PROVIDER DESCRIPTION
1	HOSPITAL
2	SKILLED NURSING FACILITY (SNF)
3	HOME HEALTH ASSOCIATION (HHA)
4	CHRISTIAN SCIENCE (CS) HOSPITAL
5	CS EXTENDED CARE
6	INTERMEDIATE CARE
7	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY
8	SPECIAL FACILITY OR ASC SURGERY
9	RESERVED

ATTACHMENT 3
FI PROVIDER SUBTYPE

PROVIDER ID	TYPE	SUB TYPE	PROVIDER TYPE AND SUBTYPE DESCRIPTION
1	1	1	HOSPITAL INPATIENT (INCLUDING PART A)
2	2	1	SKILLED NURSING FACILITY (SNF) INPATIENT (INCLUDING PART A)
3	3	1	HOME HEALTH ASSOCIATION (HHA) INPATIENT (INCLUDING PART A)
4	4	1	CHRISTIAN SCIENCE (CS) HOSPITAL INPATIENT (INCLUDING PART A)
5	5	1	CS EXTENDED CARE INPATIENT (INCLUDING PART A)
6	6	1	INTERMEDIATE CARE INPATIENT (INCLUDING PART A)
9	9	1	RESERVED INPATIENT (INCLUDING PART A)
10	1	2	HOSPITAL INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
11	2	2	SKILLED NURSING FACILITY (SNF) INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
12	3	2	HOME HEALTH ASSOCIATION (HHA) INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
13	4	2	CHRISTIAN SCIENCE (CS) HOSPITAL INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
14	5	2	CS EXTENDED CARE INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
15	6	2	INTERMEDIATE CARE INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
18	9	2	RESERVED INPATIENT (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
19	1	3	HOSPITAL OUTPATIENT (HHA-A ALSO)
20	2	3	SKILLED NURSING FACILITY (SNF) OUTPATIENT (HHA-A ALSO)

ATTACHMENT 3 (CONT)
FI PROVIDER SUBTYPE

PROVIDER ID	TYPE	SUB TYPE	PROVIDER TYPE AND SUBTYPE DESCRIPTION
21	3	3	HOME HEALTH ASSOCIATION (HHA) OUTPATIENT (HHA-A ALSO)
22	4	3	CHRISTIAN SCIENCE (CS) HOSPITAL OUTPATIENT (HHA-A ALSO)
23	5	3	CS EXTENDED CARE OUTPATIENT (HHA-A ALSO)
24	6	3	INTERMEDIATE CARE OUTPATIENT (HHA-A ALSO)
82	7	1	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY RURAL HEALTH
83	7	2	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS FACILITY
84	7	3	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY INDEPENDENT PROVIDER BASED FEDERALLY QUALIFIED HEALTH CENTER (EFF 10/91)
85	7	4	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY OTHER REHABILITATION FACILITY (ORF) ONLY (EFF 4/97; ORF AND COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 10/91)
27	9	3	RESERVED OUTPATIENT (HHA-A ALSO)
28	1	4	HOSPITAL OTHER (PART B)
29	2	4	SKILLED NURSING FACILITY (SNF) OTHER (PART B)
30	3	4	HOME HEALTH ASSOCIATION (HHA) OTHER (PART B)
31	4	4	CHRISTIAN SCIENCE (CS) HOSPITAL OTHER (PART B)
32	5	4	CS EXTENDED CARE OTHER (PART B)
33	6	4	INTERMEDIATE CARE OTHER (PART B)
36	9	4	RESERVED OTHER (PART B)
37	1	5	HOSPITAL INTERMEDIATE CARE - LEVEL I
38	2	5	SKILLED NURSING FACILITY (SNF) INTERMEDIATE CARE - LEVEL I

39	3	5	HOME HEALTH ASSOCIATION (HHA) INTERMEDIATE CARE - LEVEL I

ATTACHMENT 3 (CONT)
FI PROVIDER SUBTYPE

PROVIDER ID	TYPE	SUB TYPE	PROVIDER TYPE AND SUBTYPE DESCRIPTION
40	4	5	CHRISTIAN SCIENCE (CS) HOSPITAL INTERMEDIATE CARE - LEVEL I
41	5	5	CS EXTENDED CARE INTERMEDIATE CARE - LEVEL I
42	6	5	INTERMEDIATE CARE INTERMEDIATE CARE - LEVEL I
45	9	5	RESERVED INTERMEDIATE CARE - LEVEL I
46	1	6	HOSPITAL INTERMEDIATE CARE - LEVEL II
47	2	6	SKILLED NURSING FACILITY (SNF) INTERMEDIATE CARE - LEVEL II
48	3	6	HOME HEALTH ASSOCIATION (HHA) INTERMEDIATE CARE - LEVEL II
49	4	6	CHRISTIAN SCIENCE (CS) HOSPITAL INTERMEDIATE CARE - LEVEL II
50	5	6	CS EXTENDED CARE INTERMEDIATE CARE - LEVEL II
51	6	6	INTERMEDIATE CARE INTERMEDIATE CARE - LEVEL II
54	9	6	RESERVED INTERMEDIATE CARE - LEVEL II
55	1	7	HOSPITAL INTERMEDIATE CARE - LEVEL III
56	2	7	SKILLED NURSING FACILITY (SNF) INTERMEDIATE CARE - LEVEL III
57	3	7	HOME HEALTH ASSOCIATION (HHA) INTERMEDIATE CARE - LEVEL III
58	4	7	CHRISTIAN SCIENCE (CS) HOSPITAL INTERMEDIATE CARE - LEVEL III
86	7	5	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY COMPREHENSIVE REHABILITATION CENTER (CORF)
87	7	6	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 4/97)
88	7	7	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY RESERVED FOR NATIONAL ASSIGNMENT
89	7	8	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY RESERVED FOR NATIONAL ASSIGNMENT

59	5	7	CS EXTENDED CARE INTERMEDIATE CARE - LEVEL III
60	6	7	INTERMEDIATE CARE INTERMEDIATE CARE - LEVEL III
63	9	7	RESERVED INTERMEDIATE CARE - LEVEL III

ATTACHMENT 3 (CONT)
FI PROVIDER SUBTYPE

PROVIDER ID	TYPE	SUB TYPE	PROVIDER TYPE AND SUBTYPE DESCRIPTION
64	1	8	HOSPITAL SWING BEDS
65	2	8	SKILLED NURSING FACILITY (SNF) SWING BEDS
66	3	8	HOME HEALTH ASSOCIATION (HHA) SWING BEDS
67	4	8	CHRISTIAN SCIENCE (CS) HOSPITAL SWING BEDS
68	5	8	CS EXTENDED CARE SWING BEDS
69	6	8	INTERMEDIATE CARE SWING BEDS
72	9	8	RESERVED SWING BEDS
73	1	9	HOSPITAL RESERVED FOR NATIONAL ASSIGNMENT
74	2	9	SKILLED NURSING FACILITY (SNF) RESERVED FOR NATIONAL ASSIGNMENT
75	3	9	HOME HEALTH ASSOCIATION (HHA) RESERVED FOR NATIONAL ASSIGNMENT
76	4	9	CHRISTIAN SCIENCE (CS) HOSPITAL RESERVED FOR NATIONAL ASSIGNMENT
77	5	9	CS EXTENDED CARE RESERVED FOR NATIONAL ASSIGNMENT
78	6	9	INTERMEDIATE CARE RESERVED FOR NATIONAL ASSIGNMENT
81	9	9	RESERVED RESERVED FOR NATIONAL ASSIGNMENT
90	7	9	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY OTHER
91	8	1	SPECIAL FACILITY OR ASC SURGERY HOSPICE (NON-HOSPITAL BASED)
92	8	2	SPECIAL FACILITY OR ASC SURGERY HOSPICE (HOSPITAL BASED)
93	8	3	SPECIAL FACILITY OR ASC SURGERY AMBULATORY SURGICAL CENTER

94	8	4	SPECIAL FACILITY OR ASC SURGERY FREESTANDING BIRTHING CENTER
95	8	5	SPECIAL FACILITY OR ASC SURGERY RURAL PRIMARY CARE HOSPITAL (EFF 10/94)
96	8	6	SPECIAL FACILITY OR ASC SURGERY RESERVED FOR NATIONAL USE
97	8	7	SPECIAL FACILITY OR ASC SURGERY RESERVED FOR NATIONAL USE

ATTACHMENT 3 (CONT)
FI PROVIDER SUBTYPE

PROVIDER ID	TYPE	SUB TYPE	PROVIDER TYPE AND SUBTYPE DESCRIPTION
98	8	9	SPECIAL FACILITY OR ASC SURGERY RESERVED FOR NATIONAL USE
99	8	9	SPECIAL FACILITY OR ASC SURGERY OTHER

ATTACHMENT 3 (CONT)
FI PROVIDER SUBTYPE
FACILITY RANGE CODES USED TO IDENTIFY SUBTYPES

PROVIDER CODE	RANGE CODE	RANGE DESCRIPTION
1	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
2	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
3	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
4	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
5	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
6	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
9	1800-1989	FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)
1	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
2	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
3	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
4	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
5	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
6	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
9	3975-3999	RURAL HEALTH CLINCS (PROVIDER-BASED)
1	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
2	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
3	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
4	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
5	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
6	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
9	3400-3499	RURAL HEALTH CLINCS (PROVIDER-BASED)
1	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
2	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
3	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
4	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
5	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
6	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
9	8500-8899	RURAL HEALTH CLINCS (PROVIDER-BASED)
1	0001-0899	SHORT-TERM (GENERAL AND SPECIALTY) HOSPITALS
1	0900-0999	MULTIPLE HOSPITAL COMPONENT IN A MEDICAL COMPLEX (NUMBERS RETIRED)
1	1300-1399	RURAL PRIMARY CARE HOSPITAL (RPCH)
1	2000-2299	LONG-TERM HOSPITALS (EXCLUDED FROM PPS)
1	3025-3099	REHABILITATION HOSPITALS (EXCLUDED FROM PPS)
1	4000-4499	PSYCHIATRIC HOSPITALS (EXCLUDED FROM PPS)
1		UNKNOWN ACUTE CARE COSTS (RACC) EXPERIMENTS
1	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
2	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
3	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)

4	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
5	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
6	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)

ATTACHMENT 3 (CONT)

FI PROVIDER SUBTYPE

FACILITY RANGE CODES USED TO IDENTIFY SUBTYPES

PROVIDER CODE	RANGE CODE	RANGE DESCRIPTION
9	3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
1	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
2	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
3	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
4	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
5	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
6	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
9	3800-3974	RURAL HEALTH CLINCS (FREE-STANDING)
1	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
2	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
3	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
4	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
5	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
6	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
9	8900-8999	RURAL HEALTH CLINCS (FREE-STANDING)
1	4500-4599	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
2	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
3	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
4	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
5	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
6	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
9	4500-4599	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
1	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
2	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
3	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
4	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
5	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)

6	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
9	4800-4899	COMPHREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
1	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
2	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)

ATTACHMENT 3 (CONT)

FI PROVIDER SUBTYPE

FACILITY RANGE CODES USED TO IDENTIFY SUBTYPES

PROVIDER CODE	RANGE CODE	RANGE DESCRIPTION
3	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
4	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
5	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
6	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
9	4600-4799	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
1	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
2	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
3	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
4	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
5	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
6	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
9	4900-4999	COMMUNITY MENTAL HEALTH CENTERS (CMHC)
1	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
1	000E-999E	NON-FEDERAL EMERGENCY HOSPITAL
3		UNKNOWN STATEWIDE SUBUNIT COMPONENTS OF THE VIRGINIA STATE HHAS
3	7300-7399	SUBUNITS OF 'NONPROFIT' AND 'PROPRIETARY' HOME HEALTH AGENCIES
3	7800-7999	SUBUNITS OF STATE AND LOCAL GOVERNMENTAL HOME HEALTH AGENCIES
7	2300-2299	CHRONIC RENAL DISEASE FACILITIES (HOSPITAL BASED)
7	2500-2899	NON-HOSPITALS RENAL DISEASE TREATMENT CENTERS
7	3500-3699	RENAL DISEASE TREATMENT CENTERS (HOSPITAL SATELLITES)
2	5000-6399	SKILLED NURSING FACILITIES
2	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
3	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
4	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
5	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
6	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
9	6500-6989	OUTPATIENT PHYSICAL THERAPY SERVICES
1	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
2	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)

3	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
4	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
5	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
6	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
9	S001-S999	PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
1	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
2	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
3	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
4	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)

ATTACHMENT 3 (CONT)

FI PROVIDER SUBTYPE

FACILITY RANGE CODES USED TO IDENTIFY SUBTYPES

PROVIDER CODE	RANGE CODE	RANGE DESCRIPTION
5	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
6	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
9	T001-T999	REHABILITATION UNIT (EXCLUDED FROM PPS)
1	U001-U999	SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
2	U001-U999	SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
3	U001-U999	SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
6	U001-U999	SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
9	U001-U999	SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
2	1900-1989	RESERVED FOR FUTURE USE
2	3200-3299	RESERVED FOR FUTURE USE
3	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
3	1000-1199	RESERVED FOR FUTURE USE
3	1400-1499	RESERVED FOR FUTURE USE
3	1900-1989	RESERVED FOR FUTURE USE
3	3200-3299	RESERVED FOR FUTURE USE
4	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
4	1000-1199	RESERVED FOR FUTURE USE
4	1400-1499	RESERVED FOR FUTURE USE
4	1900-1989	RESERVED FOR FUTURE USE
4	3200-3299	RESERVED FOR FUTURE USE
5	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
5	1000-1199	RESERVED FOR FUTURE USE
5	1400-1499	RESERVED FOR FUTURE USE
5	1900-1989	RESERVED FOR FUTURE USE
5	3200-3299	RESERVED FOR FUTURE USE
6	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
6	1000-1199	RESERVED FOR FUTURE USE
6	1400-1499	RESERVED FOR FUTURE USE
6	1900-1989	RESERVED FOR FUTURE USE

6	3200-3299	RESERVED FOR FUTURE USE
7	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
7	1000-1199	RESERVED FOR FUTURE USE
7	1400-1499	RESERVED FOR FUTURE USE
7	1900-1989	RESERVED FOR FUTURE USE
7	3200-3299	RESERVED FOR FUTURE USE
8	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
8	1000-1199	RESERVED FOR FUTURE USE
8	1400-1499	RESERVED FOR FUTURE USE

ATTACHMENT 3 (CONT)

FI PROVIDER SUBTYPE

FACILITY RANGE CODES USED TO IDENTIFY SUBTYPES

PROVIDER CODE	RANGE CODE	RANGE DESCRIPTION
8	1900-1989	RESERVED FOR FUTURE USE
8	3200-3299	RESERVED FOR FUTURE USE
9	1225-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
9	1000-1199	RESERVED FOR FUTURE USE
9	1400-1499	RESERVED FOR FUTURE USE
9	1900-1989	RESERVED FOR FUTURE USE
9	3200-3299	RESERVED FOR FUTURE USE

ATTACHMENT 4
CARRIER PROVIDER TYPE AND SUBTYPE

DESCRIPTION OF CARRIER PROVIDER TYPE

PROVIDER TYPE CODE	SPECIALTY CODE RANGE	RANGE DESCRIPTION
1	01 - 40, 46, 48, 66, 70, 76-79, 81-86, 90-94, and 98-99	PHYSICIAN
2	41-45, 47, 49-65, 67-69,71-75, 80, 87-89, and 95-97	NON-PHYSICIAN

DESCRIPTION OF CARRIER PROVIDER SUBTYPE

PROVIDER TYPE CODE	HCPCS CODE RANGE	PROVIDER SUBTYPE
1	00100 - 01999	ANESTHESIA
2	10040 - 69999	SURGERY
3	70010 - 79999	RADIOLOGY
4	80049 - 89399	PATHOLOGY
5	90281 - 99099	MED EXCEPT ANESTHESIA
6	99141 - 99199	MED EXCEPT ANESTHESIA
7	99201 - 99499	EVALUATION & MANAGE
8	A0000 - A0999	TRANSPORTATION SRVS
9	A2000 - A2999	CHIROPRACTIC
10	A4000 - A8999	DMEPOS
11	B4000 - B9999	DMEPOS
12	E0100 - E1830	DMEPOS
13	G0000 - G9999	MED EXCEPT ANESTHESIA
14	H5000 - H6000	MED EXCEPT ANESTHESIA
15	K0000 - K9999	DMEPOS
16	L0100 - L9999	DMEPOS
17	M0000 - M0799	MED EXCEPT ANESTHESIA
18	M0900 - M0999	ESRD
19	P2000 - P9999	PATHOLOGY
20	V0000 - V5399	MED EXCEPT ANESTHESIA
21	ALL OTHER CODES	OTHER