CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 496	**Date: December 12, 2013**
	Change Request 8362

Transmittal 487, dated September 13, 2013, is being rescinded and replaced by Transmittal 496, dated December 12, 2013, to correctly renumber the section from 3.5.3 to 3.5.4 in both Table of Contents and the Manual Instructions. Also, since all legacy contractors have now transitioned to MACs, FIs and Carriers have been unchecked from the business requirements. All other information remains the same.

SUBJECT: Tracking Medicare Contractors' Postpayment Reviews

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to instruct the Medicare Administrative Contractors (MACs) to enter claim information on complex reviews into the Recovery Audit Contractor Data Warehouse. This includes information on all claims where an additional documentation request was sent, even if the review did not result in an improper payment.

EFFECTIVE DATE: October 3, 2013
IMPLEMENTATION DATE: October 3, 2013
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/3.5.4/Tracking Medicare Contractor’s Postpayment Reviews

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding or implementation activities will be provided to contractors through the regular budget process.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 496	Date: December 12, 2013	Change Request: 8362

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SUBJECT: Tracking Medicare Contractors' Postpayment Reviews

EFFECTIVE DATE: October 3, 2013

IMPLEMENTATION DATE: October 3, 2013

I. GENERAL INFORMATION

A. Background: Given the volume of claims submitted to Medicare on a daily basis, CMS can only perform a limited amount of medical review prior to payment, commonly referred to as pre-payment review. CMS must rely on conducting claim review after payment, commonly referred to as postpayment review, to determine if claims were billed appropriately and in accordance with Medicare payment and coverage criteria. While several Medicare contractors are responsible for auditing Medicare claims, CMS is continuously working to improve the collaboration between auditing contractors to ensure accurate and efficient auditing of Medicare claims while reducing provider burden and ensuring beneficiary access to health services. Certain claims require the provider to submit additional documentation in order to substantiate the services/items that were billed. The CMS needs visibility into all claims that are reviewed on a postpayment basis, even if those reviews do not identify improper payments. This CR requires Contractors to enter all claim information into the Recovery Audit Contractor Data Warehouse for all postpayment complex claim reviews where an additional documentation request was sent.

B. Policy: Medical review authorities can be found in Section 1893 of the Social Security Act.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8362.1	Medicare Administrative Contractors (MACs) shall input into the Recovery Audit Data Warehouse all claims chosen for review by the MAC where an additional documentation request letter was issued to the provider after payment was made.	X	X	X	X								
8362.1.1	MACs shall include all postpayment reviews, even those that did not result in an improper payment.	X	X	X	X								

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8362.2	MACs should submit a flat file to the data warehouse or manually upload the necessary claims.	X	X	X	X								
8362.2.1	The MACs shall use the attached file layout for claims uploaded to the Recovery Audit Data Warehouse.	X	X	X	X								
8362.3	Claims shall be submitted to the Recovery Audit Data Warehouse by the 20th day of every month for the previous month.	X	X	X	X								
8362.4	MAC staff who need access to the Data Warehouse shall contact RAC@cms.hhs.gov.	X	X	X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Amy Cinquegrani, 410-786-8627 or amy.cinquegrani@cms.hhs.gov
Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
Funding or implementation activities will be provided to contractors through the regular budget process.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(Rev. 496, Issued: 12-12-13)

Transmittals for Chapter 3

3.5.4 - Tracking Medicare Contractors' Postpayment Reviews
(Rev.496, Issued:12-12-13, Effective: 10-03-13, Implementation: 10-03-13)

Medicare Administrative Contractors (MACs) shall input all postpayment complex reviews into the Recovery Audit Data Warehouse. All claims chosen for review by the MAC where an additional documentation request letter was issued to the provider after payment was made shall be included. MACs shall include all reviews, even those that did not result in an improper payment.

Claims may be manually uploaded into the data warehouse or submitted by flat file. The MACs shall use the attached file layout for claims uploaded to the Recovery Audit Data Warehouse. Claims shall be submitted to the Recovery Audit Data Warehouse by the 20th day of every month for the previous month.

MAC staff who need access to the Data Warehouse shall contact RAC@cms.hhs.gov.

Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	4	Value: 004
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill
Record Length	23	3	Num-3	188	188
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified
Filler	47	1	AN-1		Space fill
MAC Jurisdiction	48	1	AN-1	F	A-N

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = Carrier 7 = Durable Medical Equipment

Out-of-Jurisdiction Flag	3	3	1-A	S	Use "Z" for claims from out-of-jurisdiction providers. All other cases, use space.
State Code	4	5	2-A	R	State Codes: ME, CA
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.
Workload ID	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim For Claim Type 1 through 5 - length must be equal to or greater than 14. For Claim Type 6 - length must be 15. For Claim Type 7 - length must be 14.
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5.
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.
Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Original Claim Paid Amount	76	84	9.2-N	R	Amount of original payment made from Medicare fund ex: 999999.99
Original Claim Paid Date	85	92	8-N	R	Date claim was paid YYYYMMDD
Date of Service Start	93	100	8-N	R	Date service started/performed YYYYMMDD
Date of Service End	101	108	8-N	R	Date service ended YYYYMMDD
Provider Type	109	110	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice

					5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC) 14 = Other
CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files
Review Type	113	114	2-AN	R	Automated Review-AR Complex Review-CR Semi-Automated Review-SA
Review Status	115	116	2-AN	S	Valid Values: UP = Underpayment Reimbursed in Full; OP = Overpayment Paid in Full; AP = Appealed Claim; RC = Review Concluded without identification of improper payment; CR = Debt Resolved by Contractor. Example: MAC notifies RAC that provider has declared bankruptcy or has disappeared. PR = Debt Resolved by Provider. Example: Provider supplies new evidence in discussion period; RAC agrees and reverses improper payment finding. TR = Terminated by CMS. Example: Claim was excluded while under review. ER = Closed due to error in record (can be reloaded as new corrected record)

					RE = Reopen claim(to activate a closed claim)
Adjustment ID	117	139	23-AN	R*	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim
Date Code A	140	141	2-AN	R*	Type of date: 01-Initial selection of record for audit 02-Request for medical records 03-Received medical records from provider 04-Results letter sent to provider (complex review) 05-Demand letter sent. 06-Claim closed 07-No findings letter sent. * Date Code 01 is always required.
Date A	142	149	8-N	R	Date format YYYYMMDD
Date Code B	150	151	2-AN	S	Type of date:
Date B	152	159	8-N	S	Date format YYYYMMDD
Date Code C	160	161	2-AN	S	Type of date:
Date C	162	169	8-N	S	Date format YYYYMMDD
Date Code D	170	171	2-AN	S	Type of date:
Date D	172	179	8-N	S	Date format

					YYYYMMDD
Demand Letter Amount	180	188	9.2-N	R*	ex: 999999.99 * Submit negative amounts for underpayments

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Line-L
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim
Original Diagnosis Code Version Indicator	5	5	1-N	R	9 for ICD-9 or 0 for ICD-10;
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	6	12	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.
Final Diagnosis Code Version Indicator	13	13	1-N	S	9 for ICD-9 or 0 for ICD-10;
Final Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	14	20	7-AN	S	Final diagnosis code after audit. Decimal point(.) is not allowed.
Original DRG	21	23	3-AN	S	Original DRG on claim. It must be three digit numbers. Line 000 only
Final DRG	24	26	3-AN	S	Final DRG after audit. It must be three digit numbers. Line 000 only
Original ICD Procedure Code	27	33	7-AN	S	Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed.
Final ICD Procedure Code	34	40	7-AN	S	Final ICD9/ICD10 Procedure Code after audit. Decimal point(.) is not allowed.

Original Non-DRG PPS/Hospice LOC Code	41	45	5-AN	S	Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs (RUG/AIs), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims.
Final Non-DRG PPS/Hospice LOC Code	46	50	5-AN	S	Final APC/HIPPS/LOC after audit
Original HCPCS	51	55	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Final HCPCS	56	60	5-AN	S	Final HCPCS after audit. Not generally used for inpatient claims
Original Units of Service	61	63	3-N	S	Original units of service on claim
Final Units of Service	64	66	3-N	S	Final units of service on claims
Original BETOS Code	67	69	3-AN	S	Original Berenson-Eggers type of service (BETOS) code for the given HCPCS
Final BETOS Code	70	72	3-AN	S	Final BETOS code for the given HCPCS
Filler	73	188	116-AN	R	Spaces