CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1091	**Date: May 16, 2012**
	Change Request 7601

Transmittal 977, dated October 27, 2011, is being rescinded and replaced by Transmittal 1091 to amend the header record in the attached file layout. All other information remains the same.

SUBJECT: Enhancements to the Recovery Audit Mass Adjustment/Reporting Process in the Fiscal Intermediary Shared System (FISS)

I. SUMMARY OF CHANGES: The CMS directed enhancement of the existing file-based Recovery Audit mass adjustment/reporting process in the Fiscal Intermediary Shared System (FISS) via Change Requests 6928 (July 2010) and 7272 (July 2011); this CR directs a variety of additional utility and usability enhancements.

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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 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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1091	Date: May 16, 2012	Change Request: 7601

Transmittal 977, dated October 27, 2011, is being rescinded and replaced by Transmittal 1091to amend the header record in the attached file layout. All other information remains the same.

SUBJECT: Enhancements to the Recovery Audit Mass Adjustment/Reporting Process in the Fiscal Intermediary Shared System (FISS)

Effective Date: April 1, 2012

Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: The CMS directed enhancement of the existing file-based Recovery Audit mass adjustment/reporting process in the Fiscal Intermediary Shared System (FISS) via Change Requests 6928 (Transmittal 673 dated April 16, 2010) and 7272 (Transmittal 904 dated June 8, 2011); this CR directs a variety of additional utility and usability enhancements.

B. Policy: The nationwide Recovery Audit program was mandated under Division B, Title III, Section 302 of the Tax Relief and Healthcare Act of 2006. All references to the mass adjustment process in the business requirements table refer to the file-based process, not the co-existing online process.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7601.1	The mass adjustment input layout shall include new fields for admission type, admission source and provider names, as well as the ability to capture fractional units and new claim-/line-level filler space to facilitate future expansion. This information will be provided on the input file by the Recovery Auditor. **NOTE:** The description of the workload ID in the file headers has been clarified to 'Primary workload						X				

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	ID of EDC processing region.'										
7601.2	'Adjusted Principal Diagnosis' is also captured in the adjusted diagnosis section of the input layout and shall be removed as a separate field.						X				
7601.3	FISS shall use the new 'Special Action' flag on the input layout to identify adjustments that shall be handled as exceptions to normal automated processing.						X				
7601.3.1	FISS shall allow Recovery Auditors to use Special Action Code 'S' to create adjustments that shall immediately suspend for further action by the claim processing contractor. **NOTE:** Use of this functionality shall be coordinated with the contractor and shall be limited to adjustments that cannot be completed through the existing automated process (i.e., those where the field being changed is not on the input layout). CMS's intent is to reduce contractor burden by eliminating the need to key information that can be copied from the original claim; Recovery Auditors shall submit all data that would otherwise be required for automated adjustment.						X				
7601.3.1.1	Contractors shall be able to segregate these adjustments for special attention and/or convenient selection via a specific FISS location or similar functionality to allow for easy access by contractors. This can be accomplished by storing these adjustments in a separate location on FISS to allow for ease of finding the adjustments by contractors.						X				
7601.4	The 'Overpayment or Underpayment' field on the mass adjustment outcome layout shall be renamed to 'Adjustment Outcome', with the following valid codes: O = Overpayment U = Underpayment N = No change in payment						X				
7601.5	Mass adjustment outcome files shall include the						X				

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	revised DRG code.										
7601.6	FISS shall begin sending Recovery Auditor-initiated adjustments to Periodic Interim Payment (PIP) provider claims to HIGLAS via the 837 interface.						X				
7601.6.1	HIGLAS shall create appropriate receivables/payables and demand letters for the received adjustments offsetting amounts due against PIP payments as with adjustments to non-PIP providers' claims.										HIGLAS
7601.6.2	The Provider Statistical and Reimbursement (PS&R) System shall recognize Recovery Auditor-initiated adjustments (created under BR 7601.6 and 7601.6.1) and shall segregate those adjustments from the reconciliation process to ensure that overpayments and underpayments are only corrected once.										CMS/ Provider Audit
7601.6.2.1	The FISS maintainers shall make any changes necessary to facilitate BR 7601.6.2						X				
7601.6.2.2	FISS is not required to resume Legacy PS&R data collection for Recovery Auditor-initiated adjustments, per CR 7487 (Transmittal 929 dated August 1, 2011).						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Elmezzi (jennifer.elmezzi@cms.hhs.gov or 410-786-1023)

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:* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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 does 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.

Attachment

Revised FISS input files (header)

Field #	Field Name	Start	End	Length	Values/comments
1	File type	1	10	10	"FISS-INPUT"
2	Filler	11	11	1	
3	File format version	12	14	3	"***003***"
4	Filler	15	15	1	
5	Record count	16	21	6	Number of records in file, not including header; zero fill
6	Filler	22	22	1	
7	Record length	23	28	6	"***024235***"
8	Filler	29	29	1	
9	File creation date	30	37	8	"YYYYMMDD"
10	Filler	38	38	1	
11	Source ID	39	43	5	***Primary workload ID of EDC processing region***
12	Filler	44	44	1	
13	Region	45	45	1	Region associated with originating RAC
14	Filler	46	***24235***	***24190***	

NOTE 1: All fields in all layouts are left justified/space filled unless otherwise indicated.

NOTE 2: Input and outcome files shall be space filled – record lengths will not vary with line counts.

NOTE 3: *Red/bold/italic* represents changes from the existing CR 7272 (Transmittal 904 dated June 8, 2011) layout; field names from original CR 5494 (Transmittal 267 dated March 30, 2007) process have been removed.

Field #	Field Name	Start	End	Length	Comments
1	FI/RHHI/MAC workload number	1	5	5	At time of original processing; may differ from current number (i.e., Title XVIII vs. MAC)
2	HIC number/prefix/suffix	6	17	12	
3	DCN	18	40	23	
4	Provider NPI	41	50	10	
5	Provider OSCAR/CCN	51	63	13	
6	Claim start date	64	71	8	
7	Claim end date	72	79	8	
8	Claim paid date	80	87	8	
9	***Special action code***	***88***	***88***	***1***	***"S" to force suspension;***
10	Adjustment reason code	***89***	***90***	2	"RI" (RAC)
11	Claim denial reason code	***91***	***95***	5	
12	Adjusted admission date	***96***	***103***	8	
13	***Adjusted admission type***	***104***	***104***	***1***	
14	***Adjusted admission source***	***105***	***105***	***1***	
15	Adjusted patient discharge status	***106***	***107***	2	
16	Adjusted discharge date	***108***	***115***	8	
17	Adjusted DRG	***116***	***118***	3	
18	Adjusted admitting diagnosis	***119***	***126***	8	
19-68	Adjusted diagnosis/POA 1-25	***127***	***326***	200	Seven diagnosis bytes (ICD-9 w/filler or ICD-10 eventually) plus a POA indicator in the 8th position
	Adjusted diagnosis			7	
	Adjusted POA indicator			1	
69	Adjusted attending provider NPI	***327***	***336***	10	
70	***Attending provider last name***	***337***	***353***	***17***	
71	***Attending provider first name***	***354***	***361***	***8***	
72	Adjusted operating provider NPI	***362***	***371***	10	
73	***Operating provider last name***	***372***	***388***	***17***	

Field #	Field Name	Start	End	Length	Comments
74	***Operating provider first name***	***389***	***396***	***8***	
75	Adjusted other provider NPI	***397***	***406***	10	
76	***Other provider last name***	***407***	***423***	***17***	
77	***Other provider first name***	***424***	***431***	***8***	
78	Adjusted principal procedure	***432***	***438***	7	
79	Adjusted principal procedure date	***439***	***446***	8	

Revised FISS input files (continued)

Field #	Field Name	Start	End	Length	Comments
80-127	Adjusted additional procedures 1-24	***447***	***806***	360	
	Adjusted procedure			7	
	Adjusted procedure date			8	
128	Filler	***807***	***1056***	250	
129	Count of revenue codes	***1057***	***1060***	4	
130+	Revenue code 1-225	***1061***	***24235***	***23175***	RAC to submit all revenue/ HCPCS/HIPPS codes, whether changed or not, including the 0001 summary line (total charges, covered charges and non-covered charges). Claims with 6+ NCH segments must be adjusted manually.
	Revenue code			4	
	HCPCS/HIPPS			5	
	Modifier 1			2	
	Modifier 2			2	
	Modifier 3			2	
	Modifier 4			2	
	Modifier 5			2	
	Units			10	***NNNNNNNDDD (implicit decimal)***
	Rate			9	NNNNNNDDD (implicit decimal)
	Date of service			8	YYYYMMDD
	Revised charges			9	Nominal charges for revised allowable units (linear projection from original amount) with implicit decimal: NNNNNNNDD. RAC shall submit partial line denials as two separate lines, one with covered charges and one with non-covered charges.
	Revised covered charges			9	Estimate of covered amount based on allowable units; FISS to calculate exact amounts payable.

Revised non-covered charges	9	Corresponding estimate of non-covered amount based on allowable units.
Line denial reason code	5	
Filler	***25***	

Example:

Original

Line Number	Revenue Code	HCPCS	Qty	Charges	Covered	Non-Covered
1	9999	12345	3	300	300	0
2	0001		3	300	300	0

Adjusted

Line Number	Revenue Code	HCPCS	Qty	Charges	Covered	Non-Covered
1	9999	12345	1	100	100	0
2	9999	12345	2	200	0	200
3	0001		3	300	100	200

Revised FISS initial outcome files (header)

Field #	Field Name	Start	End	Length	Values/comments
1	File type	1	10	10	"FISS-OUT"
2	Filler	11	11	1	
3	File format version	12	14	3	"***002***"
4	Filler	15	15	1	
5	Record count	16	21	6	Number of records in file, not including header; zero fill
6	Filler	22	22	1	
7	Record length	23	28	6	"***027139***"
8	Filler	29	29	1	
9	File creation date	30	37	8	"YYYYMMDD"
10	Filler	38	38	1	
11	Source ID	39	43	5	***Primary workload ID of EDC processing region***
12	Filler	44	44	1	
13	Region	45	45	1	RAC region of adjusted claims
14	Filler	46	***27139***	***27094***	

Revised FISS initial outcome files (content)

Field #	Field Name	Start	End	Length	Comments
1	***Adjustment outcome***	1	1	1	"O" to indicate overpayment; "U" for underpayment; "N" for no change (adjustment complete, pricing remains the same);
2	FI/RHHI/MAC workload number	2	6	5	Workload ID number of the contractor processing the adjustment.
3	Original contractor workload number	7	11	5	The workload ID of the contractor that originally processed the claim, which may differ from that of the contractor that is processing the adjustment (i.e., MAC #12345 adjusts a claim originally processed by FI #54321).
4	Business Segment Identifier	12	15	4	
5	Original DCN	16	38	23	
6	Adjustment DCN	39	61	23	
7	Provider NPI	62	71	10	
8	Provider legacy number (OSCAR/CCN)	72	84	13	
9	Original claim paid date	85	92	8	
10	Adjustment finalization date	93	100	8	
11	***Adjusted DRG***	***101***	***103***	***3***	
12	Original claim paid amount	***104***	***115***	12	Unsigned w/explicit decimal: NNNNNNNNN.DD
13	Adjusted claim paid amount	***116***	***127***	12	Unsigned w/explicit decimal
14	Total error	***128***	***139***	12	Unsigned original – adjusted amounts w/decimal
15+	HCPCS/modifiers + amounts	***140***	***27139***	27000	HCPCS/HIPPS code of the specific service adjusted by the RAC, or other codes that changed as a result of the RAC's adjustment; up to 450 codes per record. These fields help CMS determine the amount of RAC recoveries attributable to specific services versus associated findings (i.e., other lines that re-price as a result of the primary adjustment).
	Adjusted revenue code			4	
	Adjusted HCPCS/HIPPS			5	
	Adjusted modifier 1			2	

	Adjusted modifier 2	2	
	Adjusted modifier 3	2	
	Adjusted modifier 4	2	
	Adjusted modifier 5	2	
	Adjusted units	9	
	Adjusted date of service	8	
	Original amount per service	12	Original amount paid for the specific service
	Adjusted amount per service	12	Revised amount paid for the specific service