CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1115	**Date: August 24, 2012**
	Change Request 7861

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits for Shared Systems (xref CR7787)

I. SUMMARY OF CHANGES: The loss of taxpayer dollars through waste, fraud, and abuse drives up health care costs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, rather than simply tracking down fraudulent providers and pursuing fake claims. CMS program integrity mission also encompasses the operations and oversight necessary to ensure that CMS makes accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible Medicare beneficiaries. Reversing the traditional pay-and-chase approach to program integrity is the main goal of the National Fraud Prevention Program (NFPP), a long-term, sustainable approach that incorporates innovative technologies in integrated solutions. The NFPP is being implemented by the Center for Program Integrity (CPI), the CMS component that is accountable for the prevention and detection of fraud, waste, abuse and other improper payments under the Medicare and Medicaid programs.

EFFECTIVE DATE: January 7, 2013
IMPLEMENTATION DATE: January 7, 2013 for FISS and MCS, Analysis and Coding for VMS; April 1, 2013 full implementation for VMS

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; Contractors activities are to be carried out with 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 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:

One-Time Notification

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

Attachment – One Time Notification

Pub. 100-20	Transmittal: 1115	Date: August 24, 2012	Change Request: 7861

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits for Shared Systems (XREF CR7787)

Effective Date: January 7, 2013

Implementation Date: January 7, 2013 for FISS and MCS, Analysis and Coding for VMS; April 1, 2013 full implementation for VMS

I. GENERAL INFORMATION

A. Background: The loss of taxpayer dollars through waste, fraud, and abuse drives up health care costs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, rather than simply tracking down fraudulent providers and pursuing fake claims. CMS' program integrity mission also encompasses the operations and oversight necessary to ensure that CMS makes accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible Medicare beneficiaries. Reversing the traditional pay-and-chase approach to program integrity is the main goal of the National Fraud Prevention Program (NFPP), a long-term, sustainable approach that incorporates innovative technologies in integrated solutions. The NFPP is being implemented by the Center for Program Integrity (CPI), the CMS component that is accountable for the prevention and detection of fraud, waste, abuse and other improper payments under the Medicare and Medicaid programs.

The vision of the NFPP is to implement proven predictive modeling tools via the Fraud Prevention System (FPS) that can stop payment on high risk claims. However, before applying the tools on claims prepayment or taking action on providers, it is essential that the algorithms are rigorously tested to: 1) avoid a high rate of false positives to ensure that claims are paid for legitimate providers without disruption or additional costs to honest providers, 2) in no way degrade access to care for legitimate beneficiaries, and 3) identify the most efficient analytics in order to appropriate target resources to the highest risk claims or providers. As the FPS is implemented, it is also imperative that the models and analytics are "retrained" and "learn" from how the investigations conclude. For example, if the models identified 100 targets, and 20 were investigated and found to be legitimate, the models will be refined to account for the characteristics of the 20 legitimate targets.

The FPS will become mature in June 2012. CPI seeks the ability to use FPS in conjunction with CWF and the shared systems as an additional prepayment check to ensure proper claims payment. CR 7669 requested analysis and design hours requiring the CWF, shared systems maintainers, and MACs to collaborate with CMS and the FPS contractor to develop requirements for implementing the required changes.

The purpose of this CR is to implement the requirements developed under CR 7669 for the claims processing systems (VMS, MCS and FISS). CWF changes shall be implemented under CR 7787. This change will allow the FPS to review claims approved for payment by CWF and make a payment determination that is returned to the shared systems for appropriate action with as minimal impact on the current claims flow as possible.

B. Policy: Section 4241 of the Small Business Jobs Act of 2010 (Public Law 111-240) mandates the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in the

Medicare program. The system implemented through this legislation has significant potential to improve CMS' ability to prevent payment of fraudulent claims. These tools have been used successfully in the financial and telecommunication sectors and have applicability to Medicare. The legislation requires the program to be in place by July 1, 2011.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7861.1	Contractors shall accept the modified CWF Claims transmit formats for Part A and Part B/DME to include the new FPS fields in both the header and detail line item. See Attachment A for the claims records and transmit changes which correspond to Attachment D in CR 7787.	X	X	X	X	X	X	X	X		FPS Contractor PDAC Contractor
7861.2	Contractors shall accept the new trailer to return Part A FPS response data to the MACS. Trailer will be generated for claim header or detail line. See Attachment B1 for the Part A response trailer layout which correspond to Attachment E1 in CR 7787.	X		X		X	X				
7861.3	Contractor shall accept the new trailer to return Part B/DME FPS response data to the MACS. Trailer will be generated for claim header or detail line. See Attachment B2 for the Part B/DME response trailer layout which corresponds to Attachment E2 in CR 7787.	X	X		X			X	X		
7861.4	Contractors shall deny claims or line items with the new UR error code 'FPSH/D' to identify claims and/or line items that were rejected due to FPS denials for both Part A and Part B/DME. New UR 'FPSH/D' will be transmitted via Trailer 08. Note: The appropriate CARC, RARC and MSN Codes will be included in the new B1 and B2 trailer layouts return from CWF.	X	X	X	X	X	X	X	X		
7861.4.1	Contractors shall retransmit FPS denied claims to CWF in order for FPS to validate claim action. Included in	X	X	X	X	X	X	X	X		EDC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the retransmit shall be the model number, CARC, RARC and MSN message number.										
7861.4.2	Contractors shall use the CARC and RARC supplied on the new FPS response trailer to populate the SPR (Standard Paper Remittance) X12 835v5010A1 ERA (Electronic Remittance Advice) transactions and X12 837v5010A1 COB (Coordination of Benefits) transaction to explain a FPS denial. Note: If the CARC and RARC on the FPS response trailer are invalid, existing logic for replacing an invalid CARC and RARC shall be used.	X	X	X	X	X	X	X	X		
7861.4.3	Contractors shall use Group Code CO to the CARC associated with the FPS denial on the SPR (Standard Paper Remittance) X12 835v5010A1 ERA (Electronic Remittance Advice) and 837v5010A1 for COB transactions	X	X	X	X	X	X	X	X		
7861.4.4	Contractors shall use the MSN code supplied on the new trailers to print the associated message on the MSN to explain the FPS denial.	X	X	X	X	X	X	X	X		
7861.4.5	Contractor shall try to match the FPS CARC to an existing NCPDP Reject Code to the NCPDP D.0 COB transaction		X						X		
7861.5	The attached CWF edits shall take precedence over FPS denials. • Consistency edits • Eligibility and Entitlement edits See Attachment C for a list of the CWF edits that precedes FPS which corresponds to Attachment F in CR 7787. Note: Information for all Contractors, CWF completed this requirement in CR 7787.12.	X	X	X	X	X					
7861.5.1	CWF shall incorporate a desk procedure for notification of new edits. Specifically if the edits take precedence over FPS denials or not. This shall be provided in the CWF technical walkthrough documentation.										Desk Procedures
7861.6	For claims that have been appealed, Contractors shall insert the UR error code 'FPSH' to the 'Override Edit	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Field' at the header level and will be excluded from being sent to the FPS. As outlined in CR 7787.1 Attachment A #10. Note: This situation could arise out of provider appeals where the ruling is made in favor of the provider and the contractor resubmits the claim to be processed.										
7861.6.1	For claims that have been appealed, and contains the UR 'FPSD' in the Override Edit field in the detail lines will be sent to FPS and FPS shall ignore the corresponding lines.	X	X	X	X	X	X	X	X		FPS Contractor
7861.7	CWF shall modify the CWF HIMR screens to include the following fields on the header and detail line item level for 'INPH', 'OUTH', 'HHAH', 'HOSH', 'PTBH', and 'DMEH' . – FPS Model – FPS CARC – FPS RARC – FPS MSN Note: CWF completed this requirement in CR 7787.19.	X	X	X	X	X	X	X	X		NGD
7861.8	This new process is effective for claims received on or after January 7, 2013. Note: CWF shall send the entire universe of claims and FPS shall only process claims with date of receipt January 7, 2013 and after.										FPS Contractor
7861.9	Contractors shall modify the claim record to include the FPS model number.						X	X	X		
7861.9.1	Contractors shall report the FPS model number on the IDR Phase 2 and Phase 3 files.						X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		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, use the box below: NA

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

Pre-Implementation Contact(s):
Rose Salloum 410-786-0190 Rose.Salloum-Byram@cms.hhs.gov
Maura McHale Allison 410-786-2093 MauraMcHaleAllison@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*:
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)*, include the following statement:

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 A

CR 7861

Claim Record and Transmit changes:

Note: Corresponds to Attachment D in CR 7787

CABEHUIN / CABEHUON Part A Header Claim

FPS Model	2	X	0 – 9, A - Z
FPS CARC	3	X	See WPI published CARC list
FPS RARC	5	X	See WPI published RARC list
MSN Code 1	5	X	MSN code 1
MSN Code 2	5	X	MSN code 2 (optional)

CABETLIN Part A Detail Line Item

FPS Line Model	2	X	0 – 9, A - Z
FPS Line CARC	3	X	See WPI published CARC list
FPS Line RARC	5	X	See WPI published RARC list
MSN Code 1	5	X	MSN code 1
MSN Code 2	5	X	MSN code 2 (optional)

CABEHUBC/HUDC Part B Header

FPS Model	2	X	0 – 9, A - Z
FPS CARC	3	X	See WPI published CARC list
FPS RARC	5	X	See WPI published RARC list
MSN Code 1	5	X	MSN code 1
MSN Code 2	5	X	MSN code 2 (optional)

CABEHUBC/HUDC Part B Detail Line Item

FPS Line Model	2	X	0 – 9, A - Z
FPS Line CARC	3	X	See WPI published CARC list
FPS Line RARC	5	X	See WPI published RARC list
MSN Code 1	5	X	MSN code 1
MSN Code 2	5	X	MSN code 2 (optional)

ATTACHMENT B1

CR 7861

Part A FPS response trailer layout from CWF to MACs:

Note: Corresponds to Attachment E1 in CR 7787

Record length variable = 47 bytes to 24,795 bytes
Bytes = 1 - 47 for trailer header data +
48 - 24795 for FPS detail line item data (1 – 450 occurrences)

Field	**Size**	**Usage**	**Remarks**
1. FPSA Trailer Code	2	X	Value to be determined
2. FPSA Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
3. FPSA Header Model	2	X	0 – 9, A - Z
4. FPSA Header CARC	3	X	See WPI published CARC list
5. FPSA Header RARC	5	X	See WPI published RARC list
6. FPSA Header MSN Code 1	5	X	MSN code 1
7. FPSA Header MSN Code 2	5	X	MSN code 2 (optional)
8. Header Filler	22	X	TBD – for future fields
9. FPSA Line Item Count	2	Comp	Total number of line items denied by FPS (0 if FPSA Claim Denial Type = 'H') (1–450 if FPSA Claim Denial Type = D)
10. FPSA Line Items	55		Line item count occurs xx times depending on FPSA line item count
a. Line Item No	2	Comp	001 thru 450
b. Revenue Code	4	X	Revenue code
c. HCPCS Code	5	X	HCPCS
d. Financial Date	4	Comp-3	CCYYDDD (packed)
e. FPSA Line Model	2	X	0 – 9, A - Z
f. FPSA Line CARC	3	X	See WPI published CARC list
g. FPSA Line RARC	5	X	See WPI published RARC list
h. FPSA Line MSN Code 1	5	X	MSN code 1
i. FPSA Line MSN Code 2	5	X	MSN code 2 (optional)
j. Filler	20	X	TBD – for future fields

ATTACHMENT B2

CR 7861

Part B/DME FPS response trailer layout from CWF to MACs:

Note: Corresponds to Attachment E2 in CR 7787

Record length variable = 47 bytes to 749 bytes
Bytes = 1 - 47 for trailer header data +
48 - 749 for FPS detail line item data (1 – 13 occurrences)

Field	Size	Usage	Remarks
1. FPSB Trailer Code	2	X	Value to be determined
2. FPSB Claim Denial Type	1	X	'H' Header– full claim denied or 'D' Detail- Line items denied
3. FPSB Header Model	2	X	0 – 9, A - Z
4. FPSB Header CARC	3	X	See WPI published CARC list
5. FPSB Header RARC	5	X	See WPI published RARC list
6. FPSB Header MSN Code 1	5	X	MSN Code 1
7. FPSB Header MSN Code 2	5	X	MSN Code 2 (optional)
8. Header Filler	22	X	TBD – for future fields
9. FPSB Line Item Count	2	Comp	Total number of line items denied by FPS (0 if FPSB Claim Denial Type = 'H') (1–13 if FPSB Claim Denial Type = D)
10. FPSB Line Items data	54		Line item count occurs xx times depending on FPSB line item count
a. Line Item No	2	Comp	1 thru 13
b. HCPCS Code	5	X	HCPCS
c. From Date	4	Comp-3	CCYYDDD (packed)
d. Thru Date	4	Comp-3	CCYYDDD (packed)
e. FPSB Line Model	2	X	0 – 9, A - Z
f. FPSB Line CARC	3	X	See WPI published CARC list
g. FPSB Line RARC	5	X	See WPI published RARC list
h. FPSB Line MSN Codes 1	5	X	MSN Codes 1
i. FPSB Line MSN Codes 2	5	X	MSN Codes 2 (optional)
j. Filler	19	X	TBD – for future fields

Attachment C

CR 7861

CWF Edits that precedes FPS:

Note: Corresponds to Attachment F in CR 7787

CWF EDIT	Disp Code	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	OTHER	EDIT TYPE	Edit Description
5050	50	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Record has been deleted by CMS.
5052	51 55	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Identification Incorrect - The name and/or claim number shown on the Bill is incorrect or claim number is not in file.
5056	50	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Beneficiary Identification - The Beneficiary number requested by this Claim is not available to the HOST.
5200	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	No Entitlement - There is no record of the Beneficiary's Entitlement to the Type of Services shown on the claim.
5210	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Services After Benefits Terminated.
5211	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	The statement From/Thru Date is greater than the Date of Death on Beneficiary Master Record. (This edit is bypassed for Denied Claims Denied Lines.)
5212	UR			HHA	HOSP	INPT	OUTP	SNF		ELIG	The claim has a patient status of Beneficiary deceased with a Thru Date prior to another claim with a patient status of Beneficiary deceased.
5220	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		ELIG	Services Prior to Date of Entitlement.
5231	UR					INPT				UTIL	Services overlap GHO entitlement and no edit is present in the Detail Override Edit Table. OR Services overlap CHOICES/ESRD Managed Care Demonstration entitlement and the CHOICES/ESRD Identification Number is not present.
5232	UR	PARTB	DME							UTIL	Services overlap GHO entitlement and no edit is present in the Detail Override Edit Table. OR Services overlap CHOICES/ESRD Managed Care Demonstration entitlement and the CHOICES/ESRD

											Identification Number is not present.
5233	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	For PPS claims and claims with Provider Numbers beginning with ‘210’ the Admission Date falls within a risk GHO Paid period but no GHO Paid Code or Condition Code ‘69’ is indicated on the claim OR For Non-PPS Inpatient and SNF claims the Statement Dates fall within or overlap a risk GHO period but no GHO Paid Code or Condition Code '69' is indicated on the claim.
5234	UR			HHA		INPT	OUTP	SNF		UTIL	Beneficiary Master Record with GHO data and incoming claim record is missing GHO Identification Number. (Error does not apply to GHO option one.)
5235	UR			HHA		INPT	OUTP	SNF		UTIL	For PPS claims the Admission Date falls within a risk GHO period the Dates of Service fall within a Hospice Election Period; and Condition Code '07' is not present on the claim.
5236	UR			HHA		INPT	OUTP	SNF		UTIL	For PPS claims the Admission Date is not within a Risk GHO period but the GHO Pay Code on the claim is '1' or the Condition Code '69' is present; the Admission Date falls within a risk GHO period but the Statement Dates fall on or after the Hospice Revocation Date but before the month following the Revocation Date the GHO Pay Code indicated on the claim is other than zero or the Condition Code '69' is present however a risk GHO is not liable for claims during the month of Hospice Revocation; or the Statement Dates are within a Hospice period and the claim has a Condition Code '07' indicating treatment of a non-terminal illness. This includes abbreviated

											Encounter (TOB '11z') records.
524Z	UR	PARTB	DME							UTIL	Service Dates fall within Hospice Period. Bypassed for all CHOICES and ENCOUNTER claims.
525Z	UR	PARTB	DME							UTIL	Service Dates fall within a risk GHO and Hospice Election Period. This edit will be bypassed for all CHOICES claims.
538H	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	Services billed while Beneficiary is incarcerated
538K	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	Information from SSA indicates Beneficiary has been Deported.
6801	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP indicated on claim, no Auxiliary record exists. This indicates no record found. This reject edit will return a disposition 'UR' with an '08' Trailer with error code stated.
6802	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP indicated on claim, no direct match on Auxiliary record iteration, or dates match on claim, but no direct match on MSP type.
6803	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP Auxiliary record exits, no MSP is indicated on the claim, but Dates of Service match.
6805	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP conditional payment claim, but no MSP record with a Validity Indicator equal to 'I' or 'Y' is present for these Dates of Service.

6806	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	MSP Override Code is 'M' or 'N', and no MSP record found with overlapping Date of Service. OR MSP cost avoid of 'E', 'F', 'G', 'H', 'J', 'K', 'Q', 'T', 'U', 'V', 'X', 'Y', '00', '12', '13', '14', '25', or '26', with no MSP record with overlapping Dates of Service that was originated by contractor '11100', '11101', '11102', '11103', '11104', '11105', '11106', '11107', '11108', '11109', '11110', '11112', '11113', '11114', '11125', '11126', '33333', '55555', '77777', '88888', or '99999', found.
6810	UR			HHA	HOSP	INPT	OUTP	SNF	MSP	UTIL	Part A claim was processed and only a Part B (Insurer type 'K') matching record was found.
6811	UR	PARTB	DME						MSP	UTIL	DMEPOS claim was processed, and only a Part A (Insurer Type 'J') matching record was found.
6812	UR	PARTB	DME						MSP	UTIL	MCCD Part B (HUBC) record with Demo Number '37' and Medicare is not primary.
6815	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	Beneficiary has an MSP Type record 'W' on the Auxiliary file and the incoming claim contains payment. (full or conditional)
6816	UR			HHA	HOSP	INPT	OUTP	SNF		UTIL	No matching 'D', 'E', 'H' or 'L' occurrence on MSP Auxiliary file, OR matching 'D', 'E', 'H' or 'L' diagnosis is not a one-on-one or 'within the family' match. (Proposed deletion: See CR7605 for the January 2013 release)
6817	UR	PARTB	DME							UTIL	No matching 'D', 'E', 'H' or 'L' occurrence, on MSP Auxiliary file, OR matching 'D', 'E', 'H' or 'L' diagnosis is not a one-on-one or 'within the family' match. (Proposed deletion: See CR7605 for the January 2013 release)
6818	UR	PARTB	DME	HHA	HOSP	INPT	OUTP	SNF		UTIL	The MSP Auxiliary file contains an 'L', but the diagnosis on the claim and on the MSP occurrence are not a one-on-one or 'within the family' match.

											(Proposed deletion: See CR7605 for the January 2013 release)
(6819)											(Proposed addition to CR 7605 for the January 2013 release.)
6820	UR	PARTB	DME							UTIL	Part B claims contain NPI Placeholder Number ‘9999999998’ or HUDC claims contains Demo Number ‘70’ and the Beneficiary has an open MSSP occurrence or the incoming claims contains an MSP Type Code.
7010	CR			HHA	HOSP		OUTP	SNF		UTIL	The edited Inpatient or Outpatient claim has From/Thru Dates that overlaps a Hospice election period, and not indicated as treatment of a non-terminal condition (Condition Code '07').