CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 240	Date: FEBRUARY 8, 2008
	Change Request 5915

SUBJECT: Revise the Fiscal Intermediary Shared System (FISS) to Include All 11x Claims in the Nightly Universe Files Generated for the Comprehensive Error Rate Testing (CERT) Program

I. SUMMARY OF CHANGES: Pub. 100-08, Chapter 12, The Comprehensive Error Rate Testing Program, Section 12.3.3.1, requires that an AC/MAC datacenter submit a daily claims universe file containing all claims except HHA RAP claims, adjustments, and inpatient hospital PPS claims that have entered the standard claims processing system. This CR will remove the inpatient hospital PPS claims from the exclusions list.

NEW / REVISED MATERIAL
EFFECTIVE DATE: April 1, 2008
IMPLEMENTATION DATE: April 7, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/12.3.3.1/Providing Sample Information to the CERT Contractor

III. FUNDING:

SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 240	Date: February 8, 2008	Change Request: 5915

SUBJECT: Revise the Fiscal Intermediary Shared System (FISS) to Include All 11x Claims in the Nightly Universe Files Generated for the Comprehensive Error Rate Testing (CERT) Program

Effective Date: April 1, 2008
Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: The CMS has developed Comprehensive Error Rate Testing (CERT) program to produce national, contractor's specific, and service-specific paid claim error rates. In prior years, the CERT program did not review Inpatient PPS claims as part of its sample. Going forward, the CERT program will begin selecting and reviewing Inpatient PPS claims.

Over the course of time, the business needs of CMS FFS processing have changed. Since the QIOs will no longer be responsible for medical review, the CERT must now include inpatient hospital PPS claims in their review. In order to accommodate this need, the FISS module must be updated to include inpatient hospital PPS claims in the daily claims universe file.

Currently, the Fiscal Intermediary Shared System (FISS) does not include Inpatient PPS claims in the nightly universe files generated for the CERT program. The FISS will now be required to include all submitted Inpatient PPS claims in the nightly CERT universe files.

B. Policy: Pub 100-08, Chapter 12, The Comprehensive Error Rate Testing Program, Section 12.3.3.1 requires that an AC/MAC datacenter submit a daily claims universe file containing all claims except HHA RAP claims, adjustments, and inpatient hospital PPS claims that have entered the standard claims processing system. This CR will remove the inpatient hospital PPS claims from the exclusions list.

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	
5915.1	The shared system maintainers shall alter the CERT modules so that all 11x claims are included in the nightly universe files generated for the CERT program.						X				
5915.2	Contractor data centers shall implement, operate, and maintain the shared system changes specified in	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	
	requirement 5915.1 and provided by shared system maintainers.										
5915.3	Contractors shall insure that their data centers have correctly implemented and are operating the changes developed by the shared system to meet requirement 5915.1 of this CR.	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:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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),* use 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.

12.3.3.1 - Providing Sample Information to the CERT Contractor

(Rev. 240; Issued: 02-08-08; Effective: 04-01-08; Implementation: 04-07-08)

The AC/MAC datacenters shall submit a daily file, containing information on claims entered during the day, to the CERT contractor via CONNECT:Direct. The AC/MAC datacenters shall submit the requested information for claims identified in the sample in an electronic format.

Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of exhibits 36.1 and 36.2. The AC/MAC datacenter response shall be made using NDM and the formats provided for the sampled claims resolution file in exhibit 36.1 and 36.2.

All cost and workloads associated with §12.3.3.1 activities shall be allocated to the PM CERT Support code (12901).

A. Claims Universe File

The standard systems will create a mechanism for the datacenters to be able to create the claims universe file, which will be transmitted daily to the CMSDC. The file will be processed through a sampling module residing on the server at CMSDC. Datacenters shall ensure that the claims universe file contains all claims except HHA RAP claims *and* adjustments that have entered the standard claims processing system. The datacenters shall ensure that each claim included in the universe file is unique and may only be selected on the day it enters the system.

B. Sampled Claims Transaction File, Sampled Claims Resolution File and Claims History Replica File

The standard systems shall create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CMSDC. The estimated claim volume is 2000 claims per CERT cluster per year. This file will include claims that were sampled from the daily claims universe files. The standard systems shall create a mechanism for the data centers to be able to match the sampled claims transaction file against the standard system claims history file to create a sampled claims resolution file and a claims history replica file. The claims history replica file is a dump of the standard system claims history file in the standard system format. These files shall be transmitted at the same time to the CMSDC. The resolution file is input to the CERT claim resolution process and the claims history replica file is added to the Claims History Replica database.

The AC/MAC datacenter shall furnish resolution information for all finalized claims included in the transaction file within 5 days of receipt of a request from the CERT contractor. Contractors receiving daily transaction files shall respond with daily resolution files. Resolution information on claims that have not finalized by the initial request shall be included at the first opportunity immediately after the claim has finalized.

The AC/MAC datacenter shall provide the sampled claims resolution file(s) and the claims history replica file(s) for each iteration of the claim when the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the AC/MAC. The sampled claims transaction file will always contain the claim control number of the original claim.

If a claim identified on the transaction file is not found on the standard system claims history file, no record should be created for that claim. These are called no-resolution claims. Each AC/MAC shall take all necessary steps to minimize the number of no-resolution claims it submits to the CERT contractor each year. The AC/MAC may obtain a list of no-resolution claims for a given time period on either the Status Summary of Sample Claims page or the Sample Discards and Errors page of the CERT Claims Status Website.

If the AC/MAC receives a request for a claim for which the shared system is not able to produce a resolution file, the AC/MAC shall research the claim to determine why a resolution record was not produced.

When the AC/MAC identifies a no-resolution claim where the HICN on the finalized claim is different from the HICN on the transaction request, the AC/MAC shall notify the CERT Review Contractor of the correct HICN. The AC/MAC shall not enter an acceptable no-resolution reason code for claims that finalized with a HICN different from the HICN on the transaction request.

No-resolution claims with acceptable no-resolution reasons (see exhibit 36.8) will not be counted as errors. Should the AC/MAC discover that one or more no-resolution claims has an acceptable reason, the AC/MAC shall enter the appropriate acceptable no-resolution reason code on the CERT Claim Status Web site.

The AC/MAC shall keep documentation on file that supports the acceptable no-resolution reason. The AC shall make this documentation available to CMS or OIG upon request.

C. Provider Address File

In addition to the claim resolution file, each AC/MAC data center shall transmit the provider address file containing the names, all known addresses, and telephone numbers of all the billing providers and attending physicians for all the claims on the resolution file. Each unique provider and address combination shall be included only once on each provider address file.

D. Canceling Claims

The chart below describes the circumstances under which a cancelled/voided/deleted claim is considered to be an error.

	ACCEPTABLE Reason for Canceling the Claim	**UNACCEPTABLE Reason for Canceling the Claim**	
		AC paid the claim	**AC denied (full or partial)**
BEFORE the AC receives the Transaction File	These claims will be considered to be "OK": - Not a paid claim error - Not a provider error CERT will score as follows: - Paid: $0/$0 - Provider: $0/$0	These claims will be considered to be all 3 errors: - Is a paid claim error - Is a provider error CERT will score as follows: - Paid: $x/$x - Provider: $x/$x	These claims will be considered to be the following errors: - NOT a paid claim error - Is a provider error CERT will score as follows: - Paid: $0/$0 - Provider: $x/$x
AFTER the AC receives the Transaction File	CERT Contractor will review the SAMPLED version of the claim and score it according to the finding of the review.	Same as above	Same as above