CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 67 **Date: FEBRUARY 27, 2004**

CHANGE REQUEST 2976

I. SUMMARY OF CHANGES: This transmittal communicates the Comprehensive Error Rate Testing (CERT) requirements to Carriers, DMERCs, FIs, and PSCs that have MR tasks.

NEW/REVISED MATERIAL-EFFECTIVE DATE: March 12, 2004
***IMPLEMENTATION DATE: March 12, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/Table of Contents
N	12/3-Comprehensive Error Rate Testing (CERT) Program Safeguard Contractor (PSC)
N	12/3.1-Affiliated Contractor (AC)/full PSC Communication with the CERT Contractor
N	12/3.2-Overview of the CERT Process
N	12/3.3-AC/full PSC Requirements Surrounding CERT Reviews
N	12/3.3.1-Providing Sample Information to the CERT Contractor
N	12/3.3.2-Providing Review Information to the CERT Contractor
N	12/3.3.3-Providing Feedback Information to the CERT Contractor
N	12/3.3.3.1-Disputing/Disagreeing with a CERT Decision
N	12/3.4- Handling Overpayments and Underpayments Resulting from the CERT Findings
N	12/3.5-Handling Appeals Resulting from CERT Initiated Denials
N	12/3.6-Tracking Overpayments and Appeals
	12/3.7-Potential Fraud
N	12/3.8-AC/full PSC Requirements Involving CERT Information Dissemination
N	12/3.9-AC/full PSC CERT Points of Contact
N	12/3.10-AC/full PSC Error Rate Reduction Plan (EERP)
R	Exhibits/Table of Contents
N	Exhibits/34-Overview of the CERT Process

N	Exhibits/34.1-CERT File Descriptions for Part A Contractors and Standard Systems
N	Exhibits/34.2-CERT Formats for Carrier and DMERC Standard Systems
N	Exhibits/34.3-Language for Inclusion in Provider Letter
N	Exhibits/34.4-Monthly CERT Error Review Report
N	Exhibits/34.5-CERT Quarterly Error Reconciliation Report
N	Exhibits/34.6-CERT PSC Contractor Feedback Data Entry Screen Version 1.01
N	Exhibits/34.7-Data Items Included on CERT Reports

III. FUNDING: *Medicare contractors only: Included in the 2003 BPR and CRs 1172, 1588, 1636, 1754, 1891, 1981, 2002, 2226. Contractors should adjust their MR strategies as needed to accomplish these activities.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Attachment - Business Requirements

Pub. 100-08	Transmittal: 67	Date: February 27, 2004	Change Request 2976

I. GENERAL INFORMATION

A. Background: This CR manualizes the requirements of CR 1173, 1588, 1636, 1754, 1891, 1981, 2002, and 2226, which describe the interaction between carriers/DMERCs/FIs/PSCs and the Comprehensive Error Rate Testing (CERT) Contractor.

B. Policy:

C. Provider Education: Carriers/DMERCs/FIs/full PSCs should educate providers in the importance of responding to CERT contractors' requests for medical records and answering/directing provider questions to the proper representative.

Carriers/DMERCs/FIs/full PSCs shall inform affected provider communities by posting either a summary or relevant portions of this instruction on their Web sites within two weeks of the issuance date of this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about "The CERT Process" is available on your Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2976.1 Ch.12, Sec. 3.3	Carriers/DMERCs/FIs/full PSCs shall return certain files to the CERT contractor within 5 working days.	Carriers/DMERCs/ FIs/full PSCs
2976.2 Ch.12, Sec.3.3.1	Carriers/DMERCs/FIs/full PSCs shall use NDM and the formats in Exhibits 34.1 and 34.2 when sending resolution files to CERT contractor.	Carriers/DMERCs/ FIs/full PSCs
2976.3 Ch.12, Sec. 3.3.1	Carriers/DMERCs/FIs/full PSCs shall provide sample information to the CERT contractor.	Carriers/DMERCs/ FIs/full PSCs
2976.4 Ch.12, Sec. 3.3.2	Carriers/DMERCs/FIs/full PSCs shall provide review information to the CERT contractor.	Carriers/DMERCs/ FIs/full PSCs
2976.5 Ch.12, Sec. 3.3.3	Carriers/DMERCs/FIs/full PSCs shall provide feedback information to the CERT contractor.	Carriers/DMERCs/ FIs/full PSCs

Requirement #	Requirements	Responsibility
2976.6 Ch.12, Sec. 3.4	Carriers/DMERCs/FIs/full PSCs shall correct and make underpayments or collect on cases where the CERT contractor has found an error. Carriers/DMERCs/FIs/full PSCs shall use the 'HCFA' indicator in such cases.	Carriers/DMERCs/ FIs/full PSCs
2976.7 Ch.12, Sec. 3.5	Carriers/DMERCs/FIs/full PSCs shall process appeals of the CERT denials via the normal appeals channels.	Carriers/DMERCs/ FIs/full PSCs
2976.8 Ch.12, Sec. 3.6	Carriers/DMERCs/FIs/full PSCs shall provide the CERT contractor with the status of appeals and final decisions on appeals within ten working days of receipt of the CERT contractor request.	Carriers/DMERCs/ FIs/full PSCs
2976.9 Ch.12, Sec. 3.8	Carriers/DMERCs/FIs/full PSCs shall disseminate information concerning CERT to the provider community.	Carriers/DMERCs/ FIs/full PSCs
2976.10 Ch.12, Sec. 3.9	Carriers/DMERCs/FIs/full PSCs shall provide CERT with two Points of Contact (POC): (1) IT POC and (2) a MR POC.	Carriers/DMERCs/ FIs/full PSCs
2976.11 Ch.12, Sec. 3.10	Carriers/DMERCs/FIs/full PSCs shall develop an Error Rate Reduction Plan.	Carriers/DMERCs/ FIs/full PSCs
2976.12 Ch.12, Sec.3.10	Carriers/DMERCs/FIs/full PSCs shall educate providers in the importance of responding to CERT contractors' requests for medical records and answering/directing provider questions to the proper representative.	Carriers/DMERCs/ FIs/full PSCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS: None

IV. OTHER CHANGES

Citation	Change
Ch. 12, Sec. 3	Provides an overview of the CERT program.
Ch. 12, Sec. 3.1	Lists the address ACs should use to contact the CERT contractor.
Ch. 12, Sec. 3.2	Describes the CERT process.
Ch. 12, Sec. 3.3.3.1	Describes the dispute/disagree process.
Ch. 12, Sec. 3.7	States that the CERT contractor will refer case of potential fraud to the appropriate AC.

V. CONTACTS

Effective Date: March 12, 2004 **Implementation Date: March 12, 2004** **Pre-Implementation Contact(s):** Melanie Combs (410) 786-7683 **Post-Implementation Contact(s):** Melanie Combs (410) 786-7683	**These instructions shall be implemented within your current operating budget.**

Medicare Program Integrity Manual
Chapter 12 – Carrier, DMERC, FI and full PSC Interaction with the Comprehensive Error Rate Testing Contractor

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(Rev. 67, 02-27-04)

3 - Comprehensive Error Rate Testing (CERT) Program Safeguard Contractor (PSC)

(Rev. 67, 02-27-04)

CMS has developed the CERT program to produce national, contractor's specific, and service-specific paid claim error rates. The program has independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers medically review claims that are paid and claims that are denied to ensure that the decision was appropriate.

The outcomes are a provider compliance error rate, paid claims error rate, and a claims processing error rate.

The CERT contractor is responsible for operating the CERT Operations Center and for gathering information from Medicare contractors. For the purpose of this section of the manual, the term "affiliated contractor" (or AC) shall be used to refer to carriers, DMERCS, and FIs. The term "full PSC" shall be used to refer to any PSC tasked with prepayment medical review responsibilities.

3.1 - Affiliated Contractor (AC)/ full PSC Communication with the CERT Contractor

(Rev. 67, 02-27-04)

When ACs/full PSCs have questions regarding the CERT program or need to contact the CERT contractor, they should contact the AdvanceMed management team at (804) 264-1778 or (804) 264-3268 (fax).

The address of the CERT contractor is

AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, Virginia 23228

3.2 - Overview of the CERT Process

(Rev. 67, 02-27-04)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all ACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the ACs' claims history

and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the AC or full PSC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate AC or full PSC for follow-up. ACs/full PSCs then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

3.3 – AC/full PSC Requirements Surrounding CERT Reviews

(Rev. 67, 02-27-04)

ACs/full PSCs must supply the CERT contractor with the sample claims resolution file within five working days of receipt of the CERT request. This request is called the sampled claims transaction file. The AC/full PSC must enter the indicator data to allow the shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. If the CERT contractor requests claim information in the sampled claims transaction file, and receives no automated resolution file from the AC/full PSC, the CERT contractor will score the claim as an error and notify the AC/full PSC's CERT POC.

3.3.1 - Providing Sample Information to the CERT Contractor

(Rev. 67, 02-27-04)

Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of Exhibits 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). The AC's response must be made using NDM and the formats provided for the sampled claims resolution file in Exhibit 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). Full PSCs are not responsible for this task.

The ACs/full PSCs must coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format. The sampling module will reside on a server in the CMS Data Center (CMSDC). The ACs/full PSCs will use the sampling module under the supervision of the CERT Operations Center.

ACs/full PSCs must submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered during the day. Estimated claim volume is 2000 claims/cluster/year.

The ACs/full PSCs must respond to the CERT contractor within five working days of receipt of the request from the CERT contractor. If the AC/full PSC receives a request for a claim that is no longer in the system or a claim that needed to be replaced, the AC/full PSC must provide a

legitimate reason and send appropriate documents to the CERT contractor. In the case that a claim is requested for a patient that does not exist, the AC/full PSC should contact the provider. For all other requests, the AC/full PSC will provide the following three files to the CERT contractor:

A. Claims Universe File

The standard systems will create a mechanism for the data centers to be able to create the claims universe file, which will be transmitted daily to the CERT operations center. The file will be processed through a sampling module residing on the server at CMSDC. FIs and RHHIs, must insure that the claims universe file contains all claims, except HHA RAP claims, adjustments, and inpatient hospital PPS claims, that have entered the FI and RHHI standard claims processing system on any given day. Carriers and DMERCs must insure that the claims universe file contains all claims processing system on any given day. Any claim must be included only once and only on the day that it enters the system.

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

The standard systems will create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CERT operations center. This file will include claims that were sampled from the daily claims universe files. The standard systems will 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 are transmitted to the CERT operations center. The sampled claims resolution file is input to the CERT claim resolution process and the claims history replica file is added to the Claims History Replica database. If a claim identified on the sampled claims transaction file is not found on the standard system claims history file, no record should be created for that claim. It is important that if the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the AC, that the sampled claims resolution file(s) and claims history replica file(s) be provided for each iteration of the claim (e.g., that adjustments and other actions be contained in the transmitted files). The sampled claims transaction file will always contain the claim control number of the original claim.

See Exhibit 34.2 for format of the sampled claims resolution file.

C. Provider Address File

The ACs must transmit the names, addresses, and telephone numbers of the billing providers and attending physicians in a separate file to the CERT Operations Center along with the sampled claims resolution file. The provider address file must contain the mailing and telephone contact information for each billing provider and attending physician on the sampled claims resolution file for all claims, which contain the same provider number on all claims' lines. Each unique provider name, address, and telephone number must be included only once on the provider address file. If a provider has more than one address listed in the AC files, the AC shall include one record for each address in the provider address file. If the AC has neither an address nor a telephone number for the provider, then the AC must not include a record for that provider in a

provider address file. If the contractor has only partial information on a provider, e.g., a telephone number but no address, the AC should include on the provider address file the information the AC has and leave the rest of the fields on the record blank.

Exhibit 34.1 lists the assumptions and constraints associated with these three files.

The functional area that is performing these activities should capture costs and workloads associated with providing sample information to the CERT contractors.

3.3.2 - Providing Review Information to the CERT Contractor

(Rev. 67, 02-27-04)

Upon request, the ACs and full PSCs must provide the CERT contractor with all applicable materials (e.g., medical records) used to deny (in-part or total) or approve a sampled claim for medical review reasons or deny a sampled claim due to claims processing procedures. Generally, ACs and full PSCs will have to supply additional materials on ten percent or less of those claims sampled.

The CERT contractor will request the additional information in written form. The CERT contractor will include a checklist of items required for each record in each request. The requests will be batched on a daily basis. ACs/full PSCs must return the requested information to the CERT Operations Center at the address specified in the "Affiliated Contractor (AC)/ full PSC Communication with the CERT contractor" section 3.2 above. ACs/full PSCs must send this material within ten working days of receipt of the CERT request, except for incentive pilot contractors who must send this material within six working days of receipt of the CERT request.

The functional area that is performing these activities should capture costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractors.

3.3.3 - Providing Feedback Information to the CERT Contractor

(Rev. 67, 02-27-04)

Requests for Feedback Information

- *Each month, the CERT contractor will send a description of errors it has found to each AC and full PSC. ACs/full PSCs will use the CERT feedback file to provide feedback to the CERT contractor.*

- *Beginning in January 2004, the CERT contractor will send an electronic copy of every medical record involved in an overpayment or underpayment situation to the AC/full PSC. The AC/full PSC shall store this medical record at least until the provider and beneficiary appeals' timeframes have expired. These records will be provided on cd-rom and will be sent to the AC/full PSC at about the same time the feedback file is sent.*

Sending Feedback Information to the CERT Contractor

- *The ACs/ full PSCs must provide the CERT contractor with the requested feedback in accordance with the following schedules:*

  For Feedback files received in either March or June

  - *The AC must return the feedback file within ten working days.*
  - *If the CERT contractor has not received documentation by the 11th day the CERT contractor will score it as an error.*

  For Feedback files received in every month except March and June

  - *If the AC is providing an estimated contractor recalculated final amount paid, the AC must return the feedback file within ten working days.*
  - *ACs/full PSCs may have portions of the tool blank if CWF fails to produce a new price in a timely manner. Uncompleted claims will be returned to the AC in the following months feedback file.*
  - *If the AC is providing an exact contractor recalculated final amount paid, the AC must return the feedback file within 25 working days.*

- *The ACs/ full PSCs must provide answers to the CERT contractor on the status of claims that the CERT contractor identified in the sample, but for which there is no indication the AC has adjudicated the claim. These claims will not be included on the feedback files because the CERT contractor does not have them to review. The CERT contractor will request the status on these claims by sending the AC/full PSC a letter. It will list both the claims in the sample that the CERT contractor received and a list of claims that are missing. The AC/ full PSC should provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.*

- *The AC/ full PSC may request a meeting with the CERT contractor to discuss the results of the CERT review. During these meetings the AC/ full PSC shall ensure that the CERT contractors considered all information available for review.*

Repricing

In the case of RUGs, HRG, APCs, and other bundled payment groups, the AC/full PSC must determine if the error does not affect the payment amount. In cases where the error does not affect payment, the AC/full PSC shall notify the CERT contractor of such so that the CERT contractor can back out the error.

The first step ACs/full PSCs should follow when reviewing a claim is to calculate the amount in error and then notify CERT via the feedback report (see 3.6.5). If an AC/full PSC knows the amount in error by looking at the face of the claim, (e.g., a full denial) enter the amount in error and return the feedback file to the CERT contractor. If the AC/full PSC cannot tell the amount in error from the face of the claim, (e.g. a partial denial) enter the claim data into the "adjustment" system, which will calculate the amount in error for the AC/full PSC. Then return the feedback file to the CERT contractor.

APASS users input the adjustment into the system. The AC/full PSC might have an overpayment. Once the overpayment amount has been calculated, the AC/full PSC enters this number into the feedback file. If this amount is lower than the threshold required for collecting the overpayment, the AC/full PSC must delete the adjustment from the system. FISS users follow the same procedure except if the amount is lower, then the AC/full PSC must inactivate the adjustment in the system.

The functional area that is performing these activities should capture costs and workloads associated with the CERT feedback process (including but not limited to: CMD discussions about CERT findings, biweekly CERT conference calls, and time spent responding to inquiries from the CERT contractor).

3.3.3.1 - Disputing/ Disagreeing with a CERT Decision

(Rev. 67, 02-27-04)

Disputes

If the AC/ full PSC does not agree with a CERT decision, and the AC/ full PSC subjected the claim to complex prepayment MR, then the AC/ full PSC may file a 'dispute'. For each 'dispute' the CERT contractor will forward the file for the line to the CMS Central Office Clinical Panel ('CO Panel'). The CO Panel will have 20 working days to complete its review and render a determination on the line (exception: the CO Panel will have three working days to render a determination on incentive pilot disputes). Effective beginning with the feedback files received in April 2004, each AC/full PSC will be allowed to file up to one dispute of an O or T line per calendar year quarter in addition to any line subject to complex prepayment medical review. The AC/full PSC must make their dispute decision with each feedback file (i.e., If the AC/full PSC receives the feedback file on April 23, 2004 and they choose to dispute an O or T line with this feedback file, they cannot dispute any O or T lines on the May or June feedback file.). The disputing contractor must provide sufficient written evidence to support their dispute upon submission. If such supporting evidence is lacking, the CO panel will uphold the CERT decision. Should the AC/full PSC elect not to submit a dispute in a given quarter, the unused opportunity does not carry over to the following quarter, rather the opportunity to dispute is lost for the quarter in question.

Disagrees

If the AC/full PSC does not agree with a CERT decision, but the AC/ full PSC does not choose to 'dispute' the claim, then the AC/ full PSC may mark the case as a 'disagree' in the feedback file, and include an explanation of their rationale.

3.4 - Handling Overpayment and Underpayments Resulting from the CERT Findings

(Rev. 67, 02-27-04)

If the feedback file indicates that an overpayment was made when the AC/full PSC made its original decision on the claim, the AC shall undertake appropriate collection (or payment) actions. The AC may list the adjustment indicator as 'HCFA' until such time as a CERT indicator exists. ACs should fill in the bill type ('xxH') such that the first and second positions

describe the bill type and the third position is H, which indicates there were adjustments due to CERT. If the AC/full PSC has the ability to create a denial code, they should create a "CERT initiated denial" denial code.

For inpatient or outpatient services, Part B should follow overpayment collection procedures in Pub 100-4 Claims Processing Chapter 1, 130.4.1. Overpayment collection procedures for inpatient services can be found in Pub 100-4 Claims Processing 3, 50.

The AC should use their own discretion when handling non-assigned claims. Since non-assigned claims generally go to the beneficiaries, some ACs choose to recoup payments while others choose not to recoup.

ACs should allocate costs and workloads associated with issuing CERT initiated over/underpayments as they do all other over/underpayments.

If the AC/full PSC requires more information about the reason for the overpayment/underpayment than is available in the feedback file, the AC/full PSC may contact CERT contractor Ellen Cartwright at (804) 264 – 1778 ext. 106.

3.5 - Handling Appeals Resulting from CERT Initiated Denials

(Rev. 67, 02-27-04)

The ACs shall process appeals stemming from the CERT project (e.g., CERT decisions appealed by providers or beneficiaries). ACs must not automatically uphold the CERT contractor's decision. Instead, the ACs shall insure that the appeal is handled in the normal way (i.e. reviewed by a different reviewer, etc.)

ACs must allocate the costs and workloads associated with handling appeals of CERT initiated denials as they do all other appeals.

3.6 – Tracking Overpayments and Appeals

(Rev. 67, 02-27-04)

The AC must provide the CERT contractor with the status and amounts of overpayments that have been collected (or underpayments that have been paid) within 30 working days of the AC taking action. Beginning in December 2003, the CERT contractor will send each AC a file of claims that are overpayments and subject to appeal. This file will be sent via CMS secure email as an attached file or USPS (mail carrier).

The ACs must provide the CERT contractor with the status of appeals and final decisions on appeals within ten working days of receipt of the CERT contractor request. An appeal's status request on a claim from a CERT contractor does not imply the case was actually sent through the appeals process. For example, the CERT contractor will request the appeal status on claims, where the CERT contractor did not receive any records and deemed the claim an error 16 full denial, and on claims where the AC has requested the medical records. The AC is responsible for responding to the CERT contractor's request with the appeal status of a claim, even if the

response is, "Claim ### is still pending". If the AC receives appeal information on a claim, the AC should inform the CERT contractor of the status of the claim and need not wait for another CERT request.

The functional area that is performing these activities should capture costs and workloads associated with tracking and reporting overpayment/underpayment and appeals information to the CERT contractors.

3.7 - Potential Fraud

(Rev. 67, 02-27-04)

The CERT contractor will refer any claims they have determined to be potentially fraudulent to the appropriate AC or BI PSC.

3.8 – AC/full PSC Requirements Involving CERT Information Dissemination

(Rev. 67, 02-27-04)

ACs/full PSCs must assist the CERT contractor by disseminating information concerning CERT to the provider community. As part of the CERT process, providers are required to send documents supporting claims per the request of CERT contractors. Unfortunately, many providers do not comply. Some providers are uncooperative because they believe it is a HIPAA violation to send patient records to CERT. Others are unaware to the process and fail to see the importance of cooperating in a timely fashion. ACs/full PSCs should educate the provider community about the CERT program, emphasizing the importance of providers responding to the CERT contractor's requests for medical records and explaining the consequences that will incur by not cooperating with these requests, and the significance of these errors. Provider education is at the discretion of the AC/full PSC. Several ways to disseminate CERT information include answering/directing provider questions to the proper representative, posting articles (or this instruction) to your websites, sending a summary of the CERT process to the provider listserv. Each AC/full PSC specified which of these ways or other ways that will be used to educate providers about CERT in their Error Rate Reduction Plans. ACs will be able to contact CERT contractors and obtain a list of providers who are not responding to CERT request attempts. ACs are encouraged to contact these providers, but only after the provider received the initial CERT request and ten days have past. (See exhibit 34.3)

ACs must allocate costs and workloads associated with the dissemination of CERT information to LPET CAFM code 24116.

3.9 – AC/full PSC CERT Points of Contact

(Rev. 67, 02-27-04)

ACs must provide the CERT contractor with the name, phone number, address, fax number, and e-mail address of two points of contact (POC): an IT POC and an MR POC. The CERT contractor will contact the AC's IT POC to handle issues involving the exchange of electronic data. The CERT contractor will contact the AC's MR POC to handle issues involving exchange

of information in written form or through discussion (e.g., error reports on payment determinations, discussions on medical review decisions, status of overpayment collections, status of appeals).

3.10 – AC/full PSC Error Rate Reduction Plan (ERRP)

(Rev. 67, 02-27-04)

Every November, CMS will provide to each AC/full PSC, the Medicare Fee-for-Service Improper Payments Report that includes various types of error rates including contractor-specific error rates. The AC must share error rate data with the PSC responsible for data analysis in their jurisdiction. For DMERCs, and carriers and full PSCs, the release of the report will begin in November 2003. For Fls, this will begin in 2004. Within 30 days of receipt of the long version of the report, the AC/ full PSC, must develop an Error Rate Reduction Plan describing the corrective actions they plan to take in order to lower the paid claims error rate, claims processing error rate, and provider compliance error rate. Beginning in 2004, CMS will develop and implement an automated reporting format (on the CERT confidential web-site) into which contractors will enter their Error Rate Reduction Plans. This plan must describe:

- *New adjustments the AC/full PSC has made or will make to its MR/LPET Strategy.*
- *New coordination activities under taken with other components within AC/full PSC (e.g., developing a system to route certain provider calls from the provider call center to the MR or LPET unit for resolution).*
- *New information being communicated to providers including the message point and the vehicle (e.g. including in post-pay denial letters the LMRP ID# associated with the denial, issuing additional CBRs to every provider who bills the three types of service with the highest error rate, etc.).*

The AC must work closely with their PSCs. The plans must specify both:

1. *Corrective actions they have <u>already put in place</u>*
2. *Which <u>new</u> corrective actions they have planned for the future*

ACs who are affiliated with a "full-model" PSC (where the AC has turned all MR, LPET, and BI responsibility over to a PSC), the PSC is responsible for the creation of the Error Rate Reduction Plan. The PSC will work in cooperation with the AC to obtain language regarding areas where the PSC has no authority such as non-MR/LPET actions.

In the case of an MR PSC (where the AC has only turned post pay MR and BI responsibility over to a PSC) or BI PSC (where the AC has only turned BI responsibility over to a PSC), the AC remains responsible for the development of the Error Rate Reduction Plan. The AC will work in cooperation with the PSC to obtain language regarding post pay MR, LPET, and/or BI actions.

Each Quarter (January 1, April 1, July 1, and October 1), the AC/full PSC must submit an update report informing CMS of their progress on the Error Rate Reduction Actions described in their plan. Beginning in 2004, ACs/full PSCs will submit these updates via the CERT confidential website and a separate email to <u>CERT@cms.hhs.gov</u>, to the appropriate Consortium Contractor Management Officer (CCMO) and to the Consortium Contractor Management Specialist (CCMS). The CCMS will forward the CERRP to those BFEs who have responsibility for monitoring the contractor submitting the CERRP for their comments. The CCMS and BFEs

will determine if the CERRP is reasonable to reduce the contractor's error rate. CCMS will "approve" the entire plan after all appropriate BFEs give their "approval" regarding the portion of the plan that deals with their functional area.

Each DMERC and Carrier cluster must submit an ERRP within 30 calendar days after the end of each quarter during the fiscal year, with the exception of the first quarter's plan which may be submitted no more than 45 days after the end of the first quarter. The deadlines for submitting the ERRPs are as follows:

First quarter – February 15
Second quarter – April 30
Third quarter – July 30
Fourth quarter – October 30

Clusters that have submitted ERRPs in the past may simply update/modify their existing plans for submission to the Web site. However, clusters that have not submitted ERRPs in the past must generate a new plan for submission.

Medicare Program Integrity Manual Exhibits

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34 - Overview of the CERT Process

(Rev. 67,02-27-04)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all ACs. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the ACs' claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the AC or full PSC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate AC or full PSC for follow-up. ACs/full PSCs then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Exhibit 34.1 - CERT File Descriptions For Part A Contractors and Standard Systems

(Rev. 67,02-27-04)

Claims Universe File Format

Claims Universe File				
Claims Universe Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
Universe Date	*X(8)*	*8*	*15*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***

Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill,*** *1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: *Universe Date*
Definition: *Date the universe of claims entered the standard system*
Validation: *Must be a valid date not equal to a universe date sent on any previous claims universe file*
Remarks: *Format is CCYYMMDD. May use standard system batch processing date*
Requirement: *Required*

Claims Universe File				
Claims Universe Claim Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Internal Control Number	X(23)	7	29	Spaces
Beneficiary HICN	X(12)	30	41	Spaces
Provider Number	X(9)	42	50	Spaces
Type of Bill	X(3)	51	53	Spaces
Claim From Date	X (8)	54	61	Spaces
Claim Through Date	X (8)	62	69	Spaces
Condition Code 1	X (2)	70	71	Spaces
Condition Code 2	X (2)	72	73	Spaces
Condition Code 3	X (2)	74	75	Spaces
Condition Code 4	X (2)	76	77	Spaces
Condition Code 5	X (2)	78	79	Spaces
Condition Code 6	X (2)	80	81	Spaces
Condition Code 7	X (2)	82	83	Spaces
Condition Code 8	X (2)	84	85	Spaces
Condition Code 9	X (2)	86	87	Spaces
Condition Code 10	X (2)	88	89	Spaces
Condition Code 11	X (2)	90	91	Spaces
Condition Code 12	X (2)	92	93	Spaces
Condition Code 13	X (2)	94	95	Spaces
Condition Code 14	X (2)	96	97	Spaces
Condition Code 15	X (2)	98	99	Spaces
Condition Code 16	X (2)	100	101	Spaces
Condition Code 17	X (2)	102	103	Spaces
Condition Code 18	X (2)	104	105	Spaces
Condition Code 19	X (2)	106	107	Spaces
Condition Code 20	X (2)	108	109	Spaces
Condition Code 21	X (2)	110	111	Spaces
Condition Code 22	X (2)	112	113	Spaces
Condition Code 23	X (2)	114	115	Spaces
Condition Code 24	X (2)	116	117	Spaces
Condition Code 25	X (2)	118	119	Spaces
Condition Code 26	X (2)	120	121	Spaces
Condition Code 27	X (2)	122	123	Spaces
Condition Code 28	X (2)	124	125	Spaces
Condition Code 29	X (2)	126	127	Spaces
Condition Code 30	X (2)	128	129	Spaces
PPS Indicator Code	X(1)	130	130	Spaces
Revenue Code Count	S9(3)	131	133	Zero
Revenue Code group:				

Claims Universe File				
Claims Universe Claim Record				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
The following group of fields occurs from 1 to 450 times (depending on Revenue Code Count)				
	From *and* ***Thru*** *values relate to the 1st line item*			
Revenue Center Code	*X(4)*	*134*	*137*	*Spaces*
HCPCS	*X(5)*	*138*	*142*	*Spaces*

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = claim record*
Requirement: *Required*

Data Element: ***Internal Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*
Validation: *N/A*
Remarks: *Do not include hyphens or spaces*
Requirement: *Required*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*
Validation: *N/A*
Remarks: *Do not include hyphens or spaces*
Requirement: *Required*

Data Element: ***Provider Number***
Definition: *First nine characters of number assigned by the Standard System to identify the billing/pricing provider or supplier*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Type of Bill***

Definition: *Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code*

Validation: *Must be a valid bill type*

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)

7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be alphanumeric
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim From Date***
Definition: *The first day on the billing statement covering services rendered to the beneficiary*
Validation: *Must be a valid date*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim Through Date***
Definition: *The last day on the billing statement covering services rendered to the beneficiary*
Validation: *Must be a valid date*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Condition Code 1***
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16

Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30

Definition: *The code that indicates a condition relating to an institutional claim that may effect payer processing*
Validation: *Must be a valid code as defined in the Intermediary Manual Part 3, Chapter IX - Processing - Reports - Records, Section 3871: MAGNETIC TAPE PROCESSING OF BILLS -- CODING STRUCTURES*
Remarks: *N/A*
Requirement: *Required if claim has a condition code*

Data Element: ***PPS Indicator Code alias Claim PPS Indicator Code***
Definition: *The code indicating whether (1) the claim is Prospective Payment System (PPS), (2) Unknown or (0) not PPS.*
Validation: *0 = Not PPS*
1 = PPS
2 = Unknown
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Revenue Code Count***
Definition: *Number indicating number of revenue code lines on the claim. Include line 1 in the count*
Validation: *Must be a number 01 – 450*
Remarks: *N/A*
Requirement: *Required*

Claim Line Item Fields

Data Element: ***Revenue Code***
Definition: *Code assigned to each cost center for which a charge is billed*
Validation: *Must be a valid National Uniform Billing Committee (NUBC) approved code*
Remarks: *Include an entry for revenue code '0001'*
Requirement: *Required*

Data Element: ***HCPCS***
Definition: *Healthcare common procedure coding system (HCPCS) is a collection of codes that represent procedures, supplies, products, and services that may be provided*

to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels or groups

Validation: *Must be a valid code*
Remarks: *N/A*
Requirement: *Blank or code*

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3'*
Number of Claims	*S9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Number of Claims***
Definition: *Number of claim records on this file*
Validation: *Must be equal to the number of claims records on the file*
Remarks: *Do not count header or trailer records*
Requirement: *Required*

Sampled Claims Transaction File Format

Sampled Claims Transaction File				
Sampled Claims Transaction File Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: ***N/A***
Requirement: Required

Data Element: ***Record Type***
Definition: ***Code indicating type of record***
Validation: ***N/A***
Remarks: ***1 = Header record***
Requirement: Required

Data Element: ***Contractor Type***
Definition: ***Type of Medicare contractor(s) included in the file***
Validation: ***Must be 'A' or 'R'***
Where the Type of Bill, 1st position = 3, Claim Type should be 'R'.
Where the Type of Bill, 1st/2nd positions = 81 or 82, Claim Type should be 'R'.
All others will be Claim Type 'A'.
Remarks: ***A = FI only***
R = RHHI only or both FI and RHHI
Requirement: Required

Sampled Claims Transaction File
Sampled Claims Transaction File Detailed Record

Field Name	***Picture***	***From***	***Thru***
Contractor ID	*X(5)*	*1*	*5*
Record Type	*X(1)*	*6*	*6*
Claim Control Number	*X(23)*	*7*	*29*
Beneficiary HICN	*X(12)*	*30*	*41*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*

Data Element: ***Claim Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = Detail Record*
Requirement: *Required*

Sampled Claims Transaction File Format

Sampled Claims Transaction File				
Sampled Claims Transaction File Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
Number of records	*S9(9)*	*8*	*16*	*0*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: ***Number of Records Included***
Definition: *Number of records in the transaction file.*
Validation: *Must be greater than 0 and equal to the number of records on the file.*
Remarks: *Header and trailer records are not included in the file*
Requirement: *Required*

Sampled Claims Resolution File Format

Sampled Claims Resolution File				
Sampled Claims Resolution File Header Record (one record per file)				
Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	***X(5)***	***1***	***5***	***Spaces***
Record Type	***X(1)***	***6***	***6***	***'1'***
Contractor Type	***X(1)***	*7*	*7*	***Spaces***

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Sampled Claims Resolution File

Sampled Claims Resolution Claim Detailed Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Number	9(1)	7	7	Zero
Claim Type	X(1)	8	8	Space
Mode of Entry Indicator	X(1)	9	9	Space
Original Claim Control Number	X(23)	10	32	Spaces
Internal Control Number	X(23)	33	55	Spaces
Beneficiary HICN	X(12)	56	67	Spaces
Beneficiary Name	X(30)	68	97	Spaces
Beneficiary Date of Birth	X(8)	98	105	Spaces
Beneficiary Gender	X(1)	106	106	Spaces
Billing Provider Number	X(9)	107	115	Spaces
Attending Physician Number	X(15)	116	130	Spaces
Claim Paid Amount	9(7)v99	131	139	Zeroes
Claim ANSI Reason Code 1	X(8)	140	147	Spaces
Claim ANSI Reason Code 2	X(8)	148	155	Spaces
Claim ANSI Reason Code 3	X(8)	156	163	Spaces
Claim ANSI Reason Code 4	X(8)	164	171	Spaces
Claim ANSI Reason Code 5	X(8)	172	179	Spaces
Claim ANSI Reason Code 6	X(8)	180	187	Spaces
Claim ANSI Reason Code 7	X(8)	188	195	Spaces
Statement covers From Date	X(8)	196	203	Spaces
Statement covers Thru Date	X(8)	204	211	Spaces
Claim Entry Date	X(8)	212	219	Spaces
Claim Adjudicated Date	X(8)	220	227	Spaces
Condition Code 1	X(2)	228	229	Spaces
Condition Code 2	X(2)	230	231	Spaces
Condition Code 3	X(2)	232	233	Spaces
Condition Code 4	X(2)	234	235	Spaces
Condition Code 5	X(2)	236	237	Spaces
Condition Code 6	X(2)	238	239	Spaces
Condition Code 7	X(2)	240	241	Spaces
Condition Code 8	X(2)	242	243	Spaces
Condition Code 9	X(2)	244	245	Spaces
Condition Code 10	X(2)	246	247	Spaces
Condition Code 11	X(2)	248	249	Spaces
Condition Code 12	X(2)	250	251	Spaces
Condition Code 13	X(2)	252	253	Spaces
Condition Code 14	X(2)	254	255	Spaces
Condition Code 15	X(2)	256	257	Spaces
Condition Code 16	X(2)	258	259	Spaces
Condition Code 17	X(2)	260	261	Spaces
Condition Code 18	X(2)	262	263	Spaces
Condition Code 19	X(2)	264	265	Spaces

Sampled Claims Resolution File				
Sampled Claims Resolution Claim Detailed Record				
Field Name	**Picture**	**From**	**Thru**	**Initialization**
Condition Code 20	X(2)	266	267	Spaces
Condition Code 21	X(2)	268	269	Spaces
Condition Code 22	X(2)	270	271	Spaces
Condition Code 23	X(2)	272	273	Spaces
Condition Code 24	X(2)	274	275	Spaces
Condition Code 25	X(2)	276	277	Spaces
Condition Code 26	X(2)	278	279	Spaces
Condition Code 27	X(2)	280	281	Spaces
Condition Code 28	X(2)	282	283	Spaces
Condition Code 29	X(2)	284	285	Spaces
Condition Code 30	X(2)	286	287	Spaces
Type of Bill	X(3)	288	290	Spaces
Diagnosis Code 1	X(5)	291	295	Spaces
Diagnosis Code 2	X(5)	296	300	Spaces
Diagnosis Code 3	X(5)	301	305	Spaces
Diagnosis Code 4	X(5)	306	310	Spaces
Diagnosis Code 5	X(5)	311	315	Spaces
Diagnosis Code 6	X(5)	316	320	Spaces
Diagnosis Code 7	X(5)	321	325	Spaces
Diagnosis Code 8	X(5)	326	330	Spaces
Diagnosis Code 9	X(5)	331	335	Spaces
ICD9-CM Procedure Code 1	X(4)	336	339	Spaces
ICD9-CM Procedure Code 2	X(4)	340	343	Spaces
ICD9-CM Procedure Code 3	X(4)	344	347	Spaces
ICD9-CM Procedure Code 4	X(4)	348	351	Spaces
ICD9-CM Procedure Code 5	X(4)	352	355	Spaces
ICD9-CM Procedure Code 6	X(4)	356	359	Spaces
ICD9-CM Procedure Code 7	X(4)	360	363	Spaces
ICD9-CM Procedure Code 8	X(4)	364	367	Spaces
ICD9-CM Procedure Code 9	X(4)	368	371	Spaces
ICD9-CM Procedure Code 10	X(4)	372	375	Spaces
Claim Demonstration Identification Number	9(2)	376	377	Zeroes
PPS Indicator	X(1)	378	378	Spaces
Total Line Item Count	9(3)	379	381	Zeroes
Record Line Item Count	9(3)	382	384	Zeroes
Line Item group: The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to 150 times for the Record (depending on Record Line Item Count)				

From *and* ***Thru*** *values relate to the 1st line item.*

Field Name	**Picture**	**From**	**Thru**	**Initialization**

Field Name	Picture	From	Thru	Initialization
Revenue center code	X(4)	385	388	Spaces
SNF-RUG-III code	X(3)	389	391	Spaces
APC adjustment code	X(5)	392	396	Spaces
HCPCS Procedure Code	X(5)	397	401	Spaces
HCPCS Modifier 1	X(2)	402	403	Spaces
HCPCS Modifier 2	X(2)	404	405	Spaces
HCPCS Modifier 3	X(2)	406	407	Spaces
HCPCS Modifier 4	X(2)	408	409	Spaces
HCPCS Modifier 5	X(2)	410	411	Spaces
Line Item Date	X(8)	412	419	Spaces
Submitted Charge	9(7)v99	420	428	Zeroes
Medicare Initial Allowed Charge	9(7)v99	429	437	Zeroes
ANSI Reason Code 1	X(8)	438	445	Spaces
ANSI Reason Code 2	X(8)	446	453	Spaces
ANSI Reason Code 3	X(8)	454	461	Spaces
ANSI Reason Code 4	X(8)	462	469	Spaces
ANSI Reason Code 5	X(8)	470	477	Spaces
ANSI Reason Code 6	X(8)	478	485	Spaces
ANSI Reason Code 7	X(8)	486	493	Spaces
ANSI Reason Code 8	X(8)	494	501	Spaces
ANSI Reason Code 9	X(8)	502	509	Spaces
ANSI Reason Code 10	X(8)	510	517	Spaces
ANSI Reason Code 11	X(8)	518	525	Spaces
ANSI Reason Code 12	X(8)	526	533	Spaces
ANSI Reason Code 13	X(8)	534	541	Spaces
ANSI Reason Code 14	X(8)	542	549	Spaces
Manual Medical Review Indicator	X(1)	550	550	Spaces
Resolution Code	X(5)	551	555	Spaces
Final Allowed Charge	9(7)v99	556	564	Zeroes
Filler	X(25)	565	589	Spaces

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: ***Contractor ID***
Definition: *Contractor's CMS CROWD assigned number*
Validation: *Must be a valid CMS CROWD Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = Claim record*
Requirement: *Required*

Data Element: ***Record Number***
Definition: *The sequence number of the record. A claim may have up to three records*
Validation: *Must be between 1 and 3*
Remarks: *None*
Requirement: *Required*

Data Element: ***Claim Type***
Definition: *Type of claim*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = Part A*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: ***Mode of Entry Indicator***
Definition: *Code that indicates if the claim is paper, EMC, or unknown*
Validation: *Must be 'E', 'P', or 'U'*
Remarks *E = EMC*
P = Paper
U= Unknown
Use the same criteria to determine EMC, paper, or unknown as that used for workload reporting
Requirement: *Required*

Data Element: ***Original Claim Control Number***
Definition: *The Claim Control Number assigned to the claim in the universe file. This will be the number assigned by the Standard System to provide a crosswalk to pull all claims associated with the sample claim if a crosswalk is used for the claim.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Internal Control Number***
Definition: *Number currently assigned by the Standard System to uniquely identify the claim*
Validation: *N/A*
Remarks: *This number may be different from the Original Claim Control Number if the standard system has assigned a new Claims Control Number to an adjustment to the claims requested. The number assigned to the adjustment or the original claim control number if no adjustment has been made.*
Requirement: *Required*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary Name***
Definition: *Name of the beneficiary*
Validation: *N/A*
Remarks: *First, middle initial, and last names must be strung together to form a formatted name (e.g. John E Doe). If there are more than 30 characters, truncate the last name*
Requirement: *Required*

Data Element: ***Beneficiary Date of Birth***
Definition: *Birth date of the beneficiary*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary Gender***
Definition: *Gender of the beneficiary*

Validation: *'M' = Male, 'F' = Female, or 'U' = Unknown*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Billing Provider Number***
Definition: *First nine characters of number assigned by the Standard System to identify the billing/pricing provider or supplier*
Validation: *Must be present if claim contains the same billing/pricing provider number on all lines*
Remarks: *N/A*
Requirement: *Required for all claims containing the same billing/pricing provider on all lines*

Data Element: ***Attending Physician Number***
Definition: *The UPIN submitted on the claim used to identify the physician that is responsible for coordinating the care of the patient while in the facility.*
Validation: *N/A*
Remarks: *Left justify*
Requirement: *Required*

Data Element: ***Claim Paid Amount***
Definition: *Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier and represents what CMS paid to the institutional provider, physician, or supplier, i.e., The net amount paid after co-insurance and deductibles.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Claim ANSI Reason Code 1***
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Claim ANSI Reason Code 4
Claim ANSI Reason Code 5
Claim ANSI Reason Code 6
Claim ANSI Reason Code 7
Definition: *Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid American National Standards Institute (ANSI) Ambulatory Surgical Center (ASC) claim adjustment code and applicable group code. See Appendix _.*
Remarks: *Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code*
Requirement: *Report all ANSI reason codes on the bill*

Data Element: ***Statement Covers From Date***
Definition: *The beginning date of the statement*
Validation: *Must be a valid date*
Remarks: ***Format must be CCYYMMDD***
Requirement: ***Required***

Data Element: ***Statement Covers Thru Date***
Definition: *The ending date of the statement*
Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

Data Element: ***Claim Entry Date***
Definition: *Date claim entered the standard claim processing system, the receipt date*
Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

Data Element: ***Claim Adjudicated Date***
Definition: *Date claim completed adjudication, i.e., process date*
Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

Data Element: ***Condition Code 1***
Condition Code 2
Condition Code 3
Condition Code 4
Condition Code 5
Condition Code 6
Condition Code 7
Condition Code 8
Condition Code 9
Condition Code 10
Condition Code 11
Condition Code 12
Condition Code 13
Condition Code 14
Condition Code 15
Condition Code 16
Condition Code 17
Condition Code 18
Condition Code 19
Condition Code 20
Condition Code 21
Condition Code 22
Condition Code 23
Condition Code 24
Condition Code 25
Condition Code 26
Condition Code 27
Condition Code 28
Condition Code 29
Condition Code 30
Definition: *The code that indicates a condition relating to an institutional claim that may effect payer processing*
Validation: *Must be a valid code as defined in the Intermediary Manual Part 3, Chapter IX - Processing - Reports - Records, Section 3871: MAGNETIC TAPE PROCESSING OF BILLS -- CODING STRUCTURES*
Remarks: *N/A*
Requirement: *Required if there is a condition code for the bill.*

Data Element: ***Type of Bill***
Definition: *Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code*
Validation: *Must be a valid bill type*

In the first position, type of facility must be coded as one of the following:

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital) (eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care) (eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

In the second position, facility type must be coded as follows:

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural Health Clinic
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Outpatient Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)

3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

The third position, sequence in episode, must be between 0 and 9

Remarks: *N/A*
Requirement: *Required*

Data Element: ***Diagnosis Code 1***
Diagnosis Code 2
Diagnosis Code 3
Diagnosis Code 4
Diagnosis Code 5
Diagnosis Code 6
Diagnosis Code 7
Diagnosis Code 8
Diagnosis Code 9
Definition: *Code identifying a diagnosed medical condition resulting in one or more items of service*
Validation: *Must be a valid ICD-9-CM diagnosis code*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***ICD9-CM Procedure Code 1***
ICD9-CM Procedure Code 2
ICD9-CM Procedure Code 3
ICD9-CM Procedure Code 4
ICD9-CM Procedure Code 5
ICD9-CM Procedure Code 6
ICD9-CM Procedure Code 7
ICD9-CM Procedure Code 8
ICD9-CM Procedure Code 9
ICD9-CM Procedure Code 10
Definition: *Code identifying a service*
Validation: *Must be a valid ICD-9-CM procedure code*
Remarks: *N/A*
Requirement: *Required if on bill*

Data Element: ***Claim Demonstration Identification Number***
Definition: *The number assigned to identify a demonstration project.*
Validation: *Must be numeric or zeroes*
Remarks: *N/A*
Requirement: *Required only if carried on claim record*

Data Element: ***PPS Indicator***
Definition: *The code indicating whether (1) the claim is Prospective Payment System (PPS) or (0) not PPS.*
Validation: *0 = Not PPS*
1 = PPS
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Total Line Item Count***
Definition: *Number indicating number of service lines on the claim*
Validation: *Must be a number 001 - 450*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Line Item Count***
Definition: *Number indicating number of service lines on this record*
Validation: *Must be a number 001 - 150*
Remarks: *N/A*
Requirement: *Required*

Claim Line Item Fields

Data Element: ***Revenue Center Code***
Definition: *Code assigned to each cost center for which a charge is billed*
Validation: *Must be a valid NUBC-approved code*
Remarks: *Include an entry for revenue code '0001'*
Requirement: *Required*

Data Element: ***SNF RUG-III Code***
Definition: *Skilled Nursing Facility Resource Utilization Group Version III (RUG-III) descriptor. This is the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the Minimum Data Set (MDS) assessment reference date and (2) the type of assessment for payment purposes.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required for SNF inpatient bills*

Data Element: ***APC Adjustment Code***
Definition: *The Ambulatory Payment Classification (APC) Code or Home Health Prospective Payment System (HIPPS) code.*

The APC codes are the basis for the calculation of payment of services made for hospital outpatient services, certain PTB services furnished to inpatients who have no Part A coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness.

The HIPPS code identifies (1) the three case-mix dimensions of the Home Health Resource Group (HHRG) system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, is the basis of payment for each episode.

Validation: *N/A*
Remarks: *Left justify the APC Adjustment Code*
Requirement: *Required*

Data Element: ***HCPCS Procedure Code***
Definition: *The HCPCS/CPT-4 code that describes the service*
Validation: *Must be a valid HCPCS/CPT-4 code*
Remarks: *N/A*
Requirement: *Required if present on bill*

Data Element: ***HCPCS Modifier 1***
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
HCPCS Modifier 5

Definition: *Codes identifying special circumstances related to the service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required if available*

Element: *Line Item Date*
Definition: *The date the service was initiated*
Validation: *Must be a valid date.*
Remarks: *Format is CCYYMMDD*
Requirement: *Required if on bill and included in the standard system*

Data Element: ***Submitted Charge***
Definition: *Actual charge submitted by the provider or supplier for the service or equipment*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Medicare Initial Allowed Charge***
Definition: *Amount Medicare allowed for the service or equipment before any reduction or denial*
Validation: *Must be a numeric value if the standard system can calculate the value, blanks if the standard system cannot calculate the value.*
Remarks: *N/A*
Requirement: *Required if the standard system can calculate the value. Enter blanks if the standard system cannot calculate the value*

Data Element: ***ANSI Reason Code 1***
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
ANSI Reason Code 8
ANSI Reason Code 9
ANSI Reason Code 10
ANSI Reason Code 11
ANSI Reason Code 12
ANSI Reason Code 13
ANSI Reason Code 14
Definition: *Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid ANSI ASC claim adjustment codes and applicable group codes*
Remarks: *Format is GGRRRRRR where:*
GG is the group code and RRRRRR is the adjustment reason code
Requirement: *Report all ANSI Reason Codes included on the bill.*

Data Element: ***Complex Manual Medical Review Indicator***
Definition: *Code indicating whether or not the service received complex manual medical review. 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, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. 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. If sufficient documentation accompanies a claim to*

allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: *Must be 'Y' or 'N'*
Remarks: *Set to 'Y' if service was subjected to complex manual medical review, else 'N'*
Requirement: *Required*

Data Element: ***Resolution Code***
Definition: *Code indicating how the contractor resolved the line.*

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): 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, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. 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. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.

Validation: *Must be 'APP', 'APPMR', 'APPMC', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC' or 'REO', 'DENAM', 'REDAM'*
Remarks:
APP = Approved as a valid submission
APPMR = Approved manually routine
APPMC = Approved manually complex
DENMR = Denied manually routine
DENMC = Denied manually complex
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable
REDMR = Reduced manually routine
REDMC = Reduced manually complex
REO = Reduced for non-medical review reasons
DENAM = Denied after automated medical review
REDAM = Reduced after medical review
Requirement: *Required*

Data Element: ***Final Allowed Charge***
Definition: *Final amount paid to the provider for this service or equipment plus patient responsibility.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Filler***
Definition: *Additional space -- use to be determined*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Sampled Claims Resolution File				
Sampled Claims Resolution Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3'*
Number of Claims	*9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Number of Claims***
Definition: *Number of sampled claim resolution records (not number of claims - there may be one to three records per claim) on this file (do not count header or trailer record)*
Validation: *Must be equal to the number of sampled claims resolution records on the file*
Remarks: *N/A*
Requirement: *Required*

Provider Address File				
Provider Address Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
File Date	*X(8)*	*8*	*15*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare contractor(s) included in the file*
Validation: *Must be 'A' or 'R'*
Where the ***Type of Bill****, 1st position = 3,* ***Claim Type*** *should be 'R'.*
Where the ***Type of Bill****, 1st/2nd positions = 81 or 82,* ***Claim Type*** *should be 'R'.*
All others will be ***Claim Type*** *'A'.*
Remarks: *A = FI only*
R = RHHI only or both FI and RHHI
Requirement: *Required*

Data Element: ***File Date***
Definition: *Date the provider address file was created*
Validation: *Must be a valid date not equal to a file date sent on any previous provider address file*
Remarks: *Format is CCYYMMDD*
Requirement: *Required*

Provider Address File				
Provider Address Detail Record				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'2'*
Sequence Number	*X(1)*	*7*	*7*	*Spaces*
Provider Number	*X(15)*	*8*	*22*	*Spaces*
Provider Name	*X(25)*	*23*	*47*	*Spaces*
Provider Address 1	*X(25)*	*48*	*72*	*Spaces*
Provider Address 2	*X(25)*	*73*	*97*	*Spaces*
Provider City	*X(15)*	*98*	*112*	*Spaces*
Provider State Code	*X(2)*	*113*	*114*	*Spaces*
Provider Zip Code	*X(9)*	*115*	*123*	*Spaces*
Provider Phone Number	*X(10)*	*124*	*133*	*Spaces*
Provider FAX Number	*X(10)*	*134*	*143*	*Spaces*
Provider Type	*X(1)*	*144*	*144*	*Spaces*
Filler	*X(25)*	*145*	*169*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = Detail record*
Requirement: *Required*

Data Element: ***Sequence Number***
Definition: *Number occurrence number of addresses when there are multiple addresses for a provider.*
Validation: *Must be between 1 and 3*
Remarks: *Enter 1 if there is only one address for a provider*
Requirement: *Required*

Data Element: ***Provider Number***
Definition: *Number assigned by the standard system to identify the billing/pricing provider or submitted on the claim to identify the attending physician*
Validation: *N/A*
Remarks: *Left justify*
Requirement: *Required*

Data Element: ***Provider Name***
Definition: *Provider's name*
Validation: *N/A*
Remarks: *This is the payee name of the billing/pricing provider or attending physician Must be formatted into a name for mailing (e. g., Roger A Smith M.D. or Medical Associates, Inc.)*
Requirement: *Required*

Data Element: ***Provider Address 1***
Definition: *First line of provider's address*
Validation: *N/A*
Remarks: *This is the address1of the billing/pricing provider or attending physician*
Requirement: *Required*

Data Element: ***Provider Address 2***
Definition: *Second line of provider's address*
Validation: *N/A*
Remarks: *This is the address2 of the billing/pricing provider or attending physician*
Requirement: *Required if available*

Data Element: ***Provider City***
Definition: *Provider's city name*
Validation: *N/A*
Remarks: *This is the city of the billing/pricing provider or attending physician*
Requirement: *Required if available*

Data Element: ***Provider State Code***
Definition: *Provider's state code*
Validation: *Must be a valid state code*
Remarks: *This is the state of the billing/pricing provider or the attending physician*
Requirement: *Required if available*

Data Element: ***Provider Zip Code***
Definition: *Provider's zip code*
Validation: *Must be a valid postal zip code*
Remarks: *This is the payee zip code of the billing/pricing provider or attending physician Provide 9-digit zip code if available, otherwise provide 5-digit zip code*
Requirement: *Required if available*

Data Element: ***Provider Phone Number***
Definition: *Provider's phone number*
Validation: *Must be a valid phone number*
Remarks: *This is the phone number of the billing/pricing or attending physician. It will not be requested until the Spring of 2002*
Requirement: *Required*

Data Element: ***Provider Fax Number***
Definition: *Provider's fax number*
Validation: *Must be a valid fax number*
Remarks: *This is the fax number of the billing/pricing provider or attending physician*
Requirement: *Provide this information if available*

Data Element: ***Provider Type***
Definition: *1=Billing 2=Attending*
Validation: *Must be a 1 or a 2*
Remarks: *This field indicates whether the provider (whose name, address, and phone number are included in the record) billed the service or referred the beneficiary to the billing provider*
Requirement: *Required*

Data Element: ***Filler***
Definition: *Additional space -- use to be determined*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Provider Address File				
Provider Address Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3 '*
Number of Records	*S9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Number of Records***
Definition: *Number of provider address records on this file (do not count header or trailer record)*
Validation: *Must be equal to the number of provider address records on the file*
Remarks: *N/A*
Requirement: *Required*

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system claims history file. It should not include header or trailer records

Exhibit 34.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 67, 02-27-04)

File Formats *Error! Bookmark not defined.*

Claims Universe File				
Claims Universe Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
Universe Date	*X(8)*	*8*	*15*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare Contractor*
Validation: *Must be 'B' or 'D'*
Remarks: *B = Part B*
D = DMERC
Requirement: *Required*

Data Element: ***Universe Date***
Definition: *Date the universe of claims entered the standard system*
Validation: *Must be a valid date not equal to a Universe Date sent on any previous Claims Universe file*
Remarks: *Format is CCYYMMDD. May use standard system batch processing date*
Requirement: *Required*

Claims Universe File				
Claims Universe Claim Record				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*2"*
Claim Control Number	*X(15)*	*7*	*21*	*Spaces*
Beneficiary HICN	*X(12)*	*22*	*33*	*Spaces*
Billing Provider	*X(15)*	*34*	*48*	*Spaces*
Line Item Count	*S9(2)*	*49*	*50*	*Zeroes*
Line Item group: *The following group of Fields occurs from 1 to* 52 *Times (depending on Line Item Count).*				
		From and Thru values relate to the 1st line item		
Performing Provider Number	*X(15)*	*51*	*65*	*Spaces*
Performing Provider Specialty	*X(2)*	*66*	*67*	*Spaces*
HCPCS Procedure Code	*X(5)*	*68*	*72*	*Spaces*

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = claim record*
Requirement: *Required*

Data Element: ***Claim Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Billing Provider Number***
Definition: *Number assigned by the standard system to identify the billing/pricing provider or supplier*
Validation: *NA*
Remarks: *Must be present if claim contains the same billing/pricing provider number on all lines. Otherwise move all zeroes to this field*
Requirement: *Required*

Data Element: ***Line Item Count***
Definition: *Number indicating number of service lines on the claim*
Validation: *Must be a number 01 – 52*
Remarks: *N/A*
Requirement: *Required*

Claim Line Item Fields

Data Element: ***Performing Provider Number***
Definition: *Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Performing Provider Specialty***
Definition: *Code indicating the primary specialty of the performing provider or supplier*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***HCPCS Procedure Code***
Definition: *The HCPCS/CPT-4 code that describes the service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Claims Universe File				
Claims Universe Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3'*
Number of Claims	*9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: *Number of Claims*
Definition: *Number of claim records on this file (Do not count header or trailer record.)*
Validation: *Must be equal to the number of claims records on the file*
Remarks: *N/A*
Requirement: *Required*

Sampled Claims Transaction File			
Field Name	***Picture***	***From***	***Thru***
Contractor ID	*X(5)*	*1*	*5*
Claim Control Number	*X(15)*	*6*	*20*
Beneficiary HICN	*X(12)*	*21*	*32*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*

Data Element: ***Claim Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*

Sampled Claims Resolution File				
Sampled Claims Resolution Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
File Date	*X(8)*	*8*	*15*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare Contractor*
Validation: *Must be 'B' or 'D'*
Remarks: *B = Part B*
D = DMERC
Requirement: *Required*

Data Element: ***File Date***
Definition: *Date the Sampled Claims Resolution file was created*
Validation: *Must be a valid date not equal to a File Date sent on any previous Sampled Claims Resolution file*
Remarks: *Format is CCYYMMDD*
Requirement: *Required*

Sampled Claims Resolution File
Sampled Claims Resolution Detail Record (one record per claim)

Field Name	*Picture*	*From*	*Thru*	*Initialization*
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'2'*
Claim Type	*X(1)*	*7*	*7*	*Space*
Assignment Indicator	*X(1)*	*8*	*8*	*Space*
Mode of Entry Indicator	*X(1)*	*9*	*9*	*Space*
Original Claim Control Number	*X(15)*	*10*	*24*	*Spaces*
Claim Control Number	*X(15)*	*25*	*39*	*Spaces*
Beneficiary HICN	*X(12)*	*40*	*51*	*Spaces*
Beneficiary Name	*X(30)*	*52*	*81*	*Spaces*
Beneficiary Date Of Birth	*X(8)*	*82*	*89*	*Spaces*
Billing Provider Number	*X(15)*	*90*	*104*	*Spaces*
Referring Provider Number	*X(15)*	*105*	*119*	*Spaces*
Paid Amount	*9(7)v99*	*120*	*128*	*Zeroes*
Claim ANSI Reason Code 1	*X(8)*	*129*	*136*	*Spaces*
Claim ANSI Reason Code 2	*X(8)*	*137*	*144*	*Spaces*
Claim ANSI Reason Code 3	*X(8)*	*145*	*152*	*Spaces*
Claim Entry Date	*X(8)*	*153*	*160*	*Spaces*
Claim Adjudicated Date	*X(8)*	*161*	*168*	*Spaces*
Line Item Count	*9(2)*	*169*	*170*	*Zeroes*
Line Item group:				
The following group of fields occurs from 1 to 52 times (depending on Line Item Count).				
	From and Thru values relate to the 1st line item			
Performing Provider Number	*X(15)*	*171*	*185*	*Spaces*
Performing Provider Specialty	*X(2)*	*186*	*187*	*Spaces*
HCPCS Procedure Code	*X(5)*	*188*	*192*	*Spaces*
HCPCS Modifier 1	*X(2)*	*193*	*194*	*Spaces*
HCPCS Modifier 2	*X(2)*	*195*	*196*	*Spaces*
HCPCS Modifier 3	*X(2)*	*197*	*198*	*Spaces*
HCPCS Modifier 4	*X(2)*	*199*	*200*	*Spaces*
Number of Services	*999v9*	*201*	*204*	*Zeroes*
Service From Date	*X(8)*	*205*	*212*	*Spaces*
Service To Date	*X(8)*	*213*	*220*	*Spaces*
Place of Service	*X(2)*	*221*	*222*	*Spaces*
Type of Service	*X(1)*	*223*	*223*	*Spaces*
Diagnosis Code	*X(5)*	*224*	*228*	*Spaces*
CMN Control Number	*X(15)*	*229*	*243*	*Spaces*
Submitted Charge	*9(7)v99*	*244*	*252*	*Zeroes*
Medicare Initial Allowed Charge	*9(7)v99*	*253*	*261*	*Zeroes*
ANSI Reason Code 1	*X(8)*	*262*	*269*	*Spaces*
ANSI Reason Code 2	*X(8)*	*270*	*277*	*Spaces*
ANSI Reason Code 3	*X(8)*	*278*	*285*	*Spaces*
ANSI Reason Code 4	*X(8)*	*286*	*293*	*Spaces*
ANSI Reason Code 5	*X(8)*	*294*	*301*	*Spaces*

ANSI Reason Code 6	*X(8)*	*302*	*309*	*Spaces*
ANSI Reason Code 7	*X(8)*	*310*	*317*	*Spaces*
Manual Medical Review Indicator	*X(1)*	*318*	*318*	*Space*
Resolution Code	*X(5)*	*319*	*323*	*Spaces*
Final Allowed Charge	*9(7)v99*	*324*	*332*	*Zeroes*
Filler		*X(25)*	*333*	*357*
Spaces				

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = Claim record*
Requirement: *Required*

Data Element: ***Claim Type***
Definition: *Type of claim*
Validation: *Must be 'B' or 'D'*
Remarks: *B = Part B*
D = DMERC
Requirement: *Required*

Data Element: ***Assignment Indicator***
Definition: *Code indicating whether claim is assigned or non-assigned*
Validation: *Must be 'A' or 'N'*
Remarks: *A = Assigned*
N = Non-assigned
Requirement: *Required*

Data Element: ***Mode of Entry Indicator***
Definition: *Code that indicates if the claim is paper or EMC*
Validation: *Must be 'E' or 'P'*
Remarks: *E = EMC*
P = Paper
Use the same criteria to determine EMC or paper as that used for workload reporting
Requirement: *Required*

Data Element: ***Original Claim Control Number***
Definition: *Number assigned by the standard system to provide a crosswalk to pull all claims associated with the sample claim*
Validation: *N/A*
Remarks: *N/A*
Requirement:

Data Element: ***Claim Control Number***
Definition: *Number assigned by the standard system to uniquely identify the claim*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary HICN***
Definition: *Beneficiary's Health Insurance Claim Number*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Beneficiary Name***
Definition: *Name of the beneficiary*
Validation: *N/A*
Remarks: *First, middle and last names must be strung together to form a formatted name (e.g., John E Doe)*
Requirement: *Required*

Data Element: ***Beneficiary Date of Birth***
Definition: *Date on which beneficiary was born.*
Validation: *Must be a valid date*
Remarks: *Month, day and year on which the beneficiary was born*
Requirement: *Required*

Data Element: ***Billing Provider Number***
Definition: *Number assigned by the standard system to identify the billing/pricing provider or supplier.*
Validation: *Must be present if claim contains the same billing/pricing provider number on all lines*
Remarks: *N/A*
Requirement: *Required for all claims, assigned and non-assigned, containing the same billing/pricing provider on all lines*

Data Element: ***Referring Provider Number***
Definition: *Number assigned by the Standard System to identify the referring provider.*
Validation: *N/A*
Remarks: *Enter zeros if there is no referring provider.*
Requirement: *Required.*

Data Element: ***Paid Amount***
Definition: *Net amount paid after co-insurance and deductible. Do not include interest you paid in the amount reported.*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required.*

Data Element: ***Claim ANSI Reason Code 1***
Claim ANSI Reason Code 2
Claim ANSI Reason Code 3
Definition: *Codes showing the reason for any adjustments to this claim, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid ANSI ASC claim adjustment codes and applicable group codes*
Remarks: *Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code*
Requirement: *ANSI Reason Code 1 must be present on all claims. Codes 2 and 3 should be sent, if available.*

Data Element: ***Claim Entry Date***
Definition: *Date claim entered the standard claim processing system*
Validation: *Must be a valid date*
Remarks: *Format must be CCYYMMDD*
Requirement: *Required*

Data Element: ***Claim Adjudicated Date***
Definition: *Date claim completed adjudication*
Validation: *Must be a valid date. Format must be CCYYMMDD*
Remarks: *This must represent the processed date that may be prior to the pay date if the claim is held on the payment floor after a payment decision has been made*
Requirement: *Required*
Data Element: *Line Item Count*
Definition: *Number indicating number of service lines on the claim*
Validation: *Must be a number 01 – 52*
Remarks: *N/A*
Requirement: *Required*

Claim Line Item Fields

Data Element: ***Performing Provider Number***
Definition: *Number assigned by the standard system to identify the provider who performed the service or the supplier who supplied the medical equipment*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Performing Provider Specialty***
Definition: *Code indicating the primary specialty of the performing provider or supplier*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Referring Provider Number***
Definition: *Number assigned by the standard system to identify the referring provider*
Validation: *N/A*
Remarks: *Enter zeros if there is no referring provider*
Requirement: *Required*

Data Element: ***HCPCS Procedure Code***
Definition: *The HCPCS/CPT-4 code that describes the service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***HCPCS Modifier 1***
HCPCS Modifier 2
HCPCS Modifier 3
HCPCS Modifier 4
Definition: *Codes identifying special circumstances related to the service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required if available*

Data Element: ***Number of Services***
Definition: *The number of service rendered in days or units*
Validation: *N/A*
Remarks: *The last position should contain the value to the right of the decimal in the number of services. Put a zero in the last position for whole numbers.*
Requirement: *Required*

Data Element: ***Service From Date***
Definition: *The date the service was initiated*
Validation: *Must be a valid date less than or equal to Service To Date*
Remarks: *Format is CCYYMMDD*
Requirement: *Required*

Data Element: ***Service To Date***
Definition: *The date the service ended*
Validation: *Must be a valid date greater than or equal to Service From Date*
Remarks: *Format is CCYYMMDD*
Requirement: *Required*

Data Element: ***Place of Service***
Definition: *Code that identifies where the service was performed*
Validation: *N/A*
Remarks: *Must be a value in the range of 00 □ 99*
Requirement: *Required*

Data Element: ***Type of Service***
Definition: *Code that classifies the service*
Validation: *The code must match a valid CWF type of service code*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Diagnosis Code***
Definition: *Code identifying a diagnosed medical condition resulting in the line item service*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***CMN Control Number***
Definition: *Number assigned by the standard system to uniquely identify a Certificate of Medical Necessity*
Validation: *N/A*
Remarks: *Enter a zero if no number is assigned*
Requirement: *Required on DMERC claims*

Data Element: ***Submitted Charge***
Definition: *Actual charge submitted by the provider or supplier for the service or equipment*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Medicare Initial Allowed Charge***
Definition: *Amount Medicare allowed for the service or equipment before any reduction or denial*
Validation: *N/A*
Remarks: *This charge is the lower of the fee schedule or billed amount (i.e., Submitted Charge), except for those services (e.g., ASC) that are always paid at the fee schedule amount even if it is higher than the Submitted Charge. If there is no fee schedule amount, then insert the Submitted Charge.*
Requirement: *Required*

Data Element: ***ANSI Reason Code 1***
ANSI Reason Code 2
ANSI Reason Code 3
ANSI Reason Code 4
ANSI Reason Code 5
ANSI Reason Code 6
ANSI Reason Code 7
Definition: *Codes showing the reason for any adjustments to this line, such as denials or reductions of payment from the amount billed*
Validation: *Must be valid ANSI ASC claim adjustment codes and applicable group codes*
Remarks: *Format is GGRRRRRR where: GG is the group code and RRRRRR is the adjustment reason code*

Requirement: *Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of 'DENMR', 'DENMC' ,'DEO', 'RTP', 'REDMR', 'REDMC', or 'REO','APPAM','DENAM','REDAM'.*

Data Element: ***Manual Medical Review Indicator***
Definition: *Code indicating whether or not the service received complex manual medical review. 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, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. 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. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance if all relative pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.*
Validation: *Must be 'Y' or 'N'*
Remarks: *Set to 'Y' if service was subjected to complex manual medical review, else 'N'*
Requirement: *Required*

Data Element: ***Resolution Code***
Definition: *Code indicating how the contractor resolved the line.*

Automated Review (AM): An automated review occurs when a claim/line item passes through the contractor's claims processing system or any adjunct system containing medical review edits.

Routine Manual Review (MR): Routine review uses human intervention, but only to the extent that the claim reviewer reviews a claim or any attachment submitted by the provider. It includes review that involves review of any of the contractor's internal documentation, such as claims history file or policy documentation. It does not include review that involves review of medical records or other documentation requested from a provider. A review is considered routine if a medical record is requested from a provider and not received. Include prior authorization reviews in this category.

Complex Manual Review (MC): 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, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform the review, i.e., at a minimum; a Licensed Practical Nurse must perform the review. 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. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, the review is complex. For instance if all relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.
Validation: *Must be 'APP', 'APPMR', 'APPMC', ', 'DENMR', 'DENMC', 'DEO', 'RTP', 'REDMR', 'REDMC' or 'REO','APPAM','DENAM','REDAM'.*

Remarks:

APP = Approved as a valid submission
APPMR = Approved after manual medical review routine
APPMC = Approved after manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DENMR = Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
DENMR = Denied after manual medical review routine
DENMC = Denied for medical review reasons or for insufficient documentation medical necessity, manual medical review complex. If this codes is selected, set the Manual Medial Review Indicator to 'Y.'
DEO = Denied for non-medical reasons, other than denied as unprocessable.
RTP = Denied as unprocessable (return/reject)
REDMR = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
REDMC = Reduced for medical review reasons or for insufficient documentation of medical necessity, manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.'
REO = Reduced for non-medical review reasons.
APPAM = Approved after automated medical review
DENAM = Denied after automated medical review
REDAM = Reduced after medical review

Requirement: Required.

Data Element: ***Final Allowed Charge***
Definition: Final Amount allowed for this service or equipment after any reduction or denial
Validation: N/A
Remarks: This represents the contractor's value of the claim gross of co-pays and deductibles
Requirement: Required

Data Element: ***Filler***
Definition: Additional space TBD
Validation: N/A
Remarks: N/A
Requirement: None

Sampled Claims Resolution File				
Sampled Claims Resolution Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3'*
Number of Claims	*9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Number of Claims***
Definition: *Number of sampled claim resolution records on this file (Do not count header or trailer record.)*
Validation: *Must be equal to the number of sampled claims resolution records on the file*
Remarks: *N/A*
Requirement: *Required*

Provider Address File				
Provider Address Header Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'1'*
Contractor Type	*X(1)*	*7*	*7*	*Spaces*
File Date	*X(8)*	*8*	*15*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *1 = Header record*
Requirement: *Required*

Data Element: ***Contractor Type***
Definition: *Type of Medicare Contractor*
Validation: *Must be 'B' or 'D'*
Remarks: *B = Part B*
D = DMERC
Requirement: *Required*

Data Element: ***File Date***
Definition: *Date the Provider Address file was created*
Validation: *Must be a valid date not equal to a File Date sent on any previous Provider Address file*
Remarks: *Format is CCYYMMDD*
Requirement: *Required*

Provider Address File
Provider Address Detail Record

Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*"2"*
Provider Number	*X(15)*	*7*	*21*	*Spaces*
Provider Name	*X(25)*	*22*	*46*	*Spaces*
Provider Address 1	*X(25)*	*47*	*71*	*Spaces*
Provider Address 2	*X(25)*	*72*	*96*	*Spaces*
Provider City	*X(15)*	*97*	*111*	*Spaces*
Provider State Code	*X(2)*	*112*	*113*	*Spaces*
Provider Zip Code	*X(9)*	*114*	*122*	*Spaces*
Provider Phone Number	*X(10)*	*123*	*132*	*Spaces*
Provider Fax Number	*X(10)*	*133*	*142*	*Spaces*
Provider Type	*X(1)*	*143*	*143*	*Spaces*
Filler	*X(25)*	*144*	*168*	*Spaces*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *2 = Detail record*
Requirement: *Required*

Data Element: ***Provider Number***
Definition: *Number assigned by the standard system to identify the billing/pricing provider or supplier or referring provider*
Validation: *N/A*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Provider Name***
Definition: *Provider's name*
Validation: *N/A*
Remarks: *This is the name of the billing/pricing provider or referring provider must be formatted into a name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc.).*
Requirement: *Required*

Data Element: ***Provider Address 1***
Definition: *1st line of provider's address*
Validation: *N/A*
Remarks: *This is the payee address1of the billing/pricing provider or referring provider*
Requirement: *Required*

Data Element: ***Provider Address 2***
Definition: *2nd line of provider's address*
Validation: *N/A*
Remarks: *This is the address2 of the billing/pricing provider or referring provider*
Requirement: *Required if available*

Data Element: ***Provider City***
Definition: *Provider's city name*
Validation: *N/A*
Remarks: *This is the city of the billing/pricing provider or referring provider*
Requirement: *Required*

Data Element: ***Provider State Code***
Definition: *Provider's billing state code*
Validation: *Must be a valid state code*
Remarks: *This is the state of the billing/pricing provider or referring provider*
Requirement: *Required*

Data Element: ***Provider Zip Code***
Definition: *Provider's billing zip code*
Validation: *Must be a valid postal zip code*
Remarks: *This is the zip code of the billing/pricing provider or referring provider. Provide 9-digit zip code if available, otherwise provide 5-digit zip code*
Requirement: *Required*

Data Element: ***Provider Phone Number***
Definition: *Provider's telephone number*
Validation: *Must be a valid telephone number*
Remarks: *This is the phone number of the billing/pricing provider or referring provider*
Requirement: *None*

Data Element: ***Provider Fax Number***
Definition: *Provider's fax number*
Validation: *Must be a valid fax number*
Remarks: *This is the fax number of the billing/pricing provider or referring provider*
Requirement: *None*

Data Element: ***Provider Type***
Definition: *1=billing/pricing provider 2= referring provider*
Validation: *Must be a valid provider type*
Remarks: *This field indicates whether the information provided on the record is for the billing/pricing provider or referring provider*
Requirement: *Required*

Data Element: ***Filler***
Definition: *Additional space TBD*
Validation: *N/A*
Remarks: *N/A*
Requirement:

Provider Address File				
Provider Address Trailer Record (one record per file)				
Field Name	***Picture***	***From***	***Thru***	***Initialization***
Contractor ID	*X(5)*	*1*	*5*	*Spaces*
Record Type	*X(1)*	*6*	*6*	*'3'*
Number of Records	*9(9)*	*7*	*15*	*Zeroes*

DATA ELEMENT DETAIL

Data Element: ***Contractor ID***
Definition: *Contractor's CMS assigned number*
Validation: *Must be a valid CMS Contractor ID*
Remarks: *N/A*
Requirement: *Required*

Data Element: ***Record Type***
Definition: *Code indicating type of record*
Validation: *N/A*
Remarks: *3 = Trailer record*
Requirement: *Required*

Data Element: ***Number of Records***
Definition: *Number of provider address records on this file (do not count header or trailer record)*
Validation: *Must be equal to the number of provider address records on the file*
Remarks: *N/A*
Requirement: *Required*

Claims History Replica file
Claims History Record (one record per claim)

DATA ELEMENT DETAIL

This format of this file will be identical to each individual standard system's claims history file. It should not include header or trailer records.

Exhibit 34.3 - Language for Inclusion in Provider Letter

Rev. 67, 02-27-04)

In order to improve the processing and medical decision making involved with payment of Medicare claims, CMS began a new program effective August 2000. This program is called CERT and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (AdvanceMed of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. AdvanceMed's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that the contractor decisions regarding the claims were accurate and based on sound policy. CMS will use the AdvanceMed findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by AdvanceMed. On a monthly basis, AdvanceMed will request a small sample of claims, approximately 200 from each contractor, as the claims are entered into their system. AdvanceMed will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., questions of medical necessity or inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How are providers and suppliers of sampled claims impacted by CERT?

You may be asked during AdvanceMed's review to provide more information such as medical records or certificates of medical necessity so that AdvanceMed can verify that billing was proper and that claims processing procedures were appropriate. You will be advised what documentation is need and the name of your contact.

General questions regarding the CERT initiative may be directed to the CERT Program, at (804) 264-1778. Otherwise, providers and suppliers will be contacted ONLY if their claim(s) is selected and AdvanceMed requires additional information.

Exhibit 34.4 - Monthly CERT Error Review Report (Rev. 67, 02-27-04)

AC FEEDBACK

Contractor Name: *X (79)*
Contractor Number: *99999*
Sample ID: XXXXXXXX

Sample Month: *MM/YYYY*
Report Generated: *MM/DD/YYYY*

HICN: XXXXXXXXXXXX
ICN: XXXXXXXXXXXXXXXXXXXXXXX

Claim Adjustment Date: XX/XX/XXXX
Adjusted ICN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Line Nbr	***Carrier Decision (A/D)***	***Disagreement Code***	***Original HCPCS***	***Adjusted HCPCS***	***Amt of O/P in Question***	***Final Allowed Amount***
999	***X***	***XX***	***XXXXXXXXX***	***XXXXXXXXX***	***9999999.99***	***9999999.99***
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	***X***	***XX***	***XXXXXXXXX***	***XXXXXXXXX***	***9999999.99***	***9999999.99***
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	***X***	***XX***	***XXXXXXXXX***	***XXXXXXXXX***	***9999999.99***	***9999999.99***
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
999	***X***	***XX***	***XXXXXXXXX***	***XXXXXXXXX***	***9999999.99***	***9999999.99***
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						

Exhibit 34.5 - CERT Quarterly Error Reconciliation Report (Rev. 67, 02-27-04)

Contractor Name: ***X (79)***
Contractor Number: ***99999***
Sample ID: XXXXXXXX

Sample Month: ***MM/YYYY***
Report Generated: ***MM/DD/YYYY***

HICN: XXXXXXXXXXXXX
ICN: XXXXXXXXXXXXXXXXXXXXXXXXX

Claim Adjustment Date: XX/XX/XXXX
Adjusted ICN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Line Nbr	Carrier Decision (A/D)	Disagreement Code	Original HCPCS	Adjusted HCPCS	Amt of O/P in Question	Final Allowed Amount	CERT Response to AC Rebuttal (A/D)	CMS Panel Decision (A/D)
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
999	X	XX	XXXXXXXXX	XXXXXXXXX	9999999.99	9999999.99	X	X
Carrier Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CERT Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								
CMS Narrative: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX								

MISCELLANEOUS CHARTS THAT I HAVE REMOVED

The transmission name for the Sampled Claims Transaction Files are listed below:

AC Number	*Holding File*
A00010	*P#CER.#NCHPSC.A00010.CERTTRN*
A00020	*P#CER.#NCHPSC.A00020.CERTTRN*
A00030	*P#CER.#NCHPSC.A00030.CERTTRN*
A00040	*P#CER.#NCHPSC.A00040.CERTTRN*
A00090	*P#CER.#NCHPSC.A00090.CERTTRN*
A00101	*P#CER.#NCHPSC.A00101.CERTTRN*
A00130	*P#CER.#NCHPSC.A00130.CERTTRN*
A00131	*P#CER.#NCHPSC.A00131.CERTTRN*
A00140	*P#CER.#NCHPSC.A00140.CERTTRN*
A00150	*P#CER.#NCHPSC.A00150.CERTTRN*
A00160	*P#CER.#NCHPSC.A00160.CERTTRN*
A00180	*P#CER.#NCHPSC.A00180.CERTTRN*
A00181	*P#CER.#NCHPSC.A00181.CERTTRN*
A00190	*P#CER.#NCHPSC.A00190.CERTTRN*
A00230	*P#CER.#NCHPSC.A00230.CERTTRN*
A00250	*P#CER.#NCHPSC.A00250.CERTTRN*
A00260	*P#CER.#NCHPSC.A00260.CERTTRN*
A00270	*P#CER.#NCHPSC.A00270.CERTTRN*
A00308	*P#CER.#NCHPSC.A00308.CERTTRN*
A00310	*P#CER.#NCHPSC.A00310.CERTTRN*
A00320	*P#CER.#NCHPSC.A00320.CERTTRN*
A00332	*P#CER.#NCHPSC.A00332.CERTTRN*
A00340	*P#CER.#NCHPSC.A00340.CERTTRN*
A00350	*P#CER.#NCHPSC.A00350.CERTTRN*
A00363	*P#CER.#NCHPSC.A00363.CERTTRN*
A00370	*P#CER.#NCHPSC.A00370.CERTTRN*
A00380	*P#CER.#NCHPSC.A00380.CERTTRN*
A00400	*P#CER.#NCHPSC.A00400.CERTTRN*
A00410	*P#CER.#NCHPSC.A00410.CERTTRN*
A00430	*P#CER.#NCHPSC.A00430.CERTTRN*
A00450	*P#CER.#NCHPSC.A00450.CERTTRN*
A00452	*P#CER.#NCHPSC.A00452.CERTTRN*
A00453	*P#CER.#NCHPSC.A00453.CERTTRN*
A00460	*P#CER.#NCHPSC.A00460.CERTTRN*
A50333	*P#CER.#NCHPSC.A50333.CERTTRN*
A52280	*P#CER.#NCHPSC.A52280.CERTTRN*
A57400	*P#CER.#NCHPSC.A57400.CERTTRN*
A57401	*P#CER.#NCHPSC.A57401.CERTTRN*

AC Number	***Holding File***
635	*P#CER.#NCHPSC.D00635.CERTTRAN*
811	*P#CER.#NCHPSC.D00811.CERTTRAN*
885	*P#CER.#NCHPSC.D00885.CERTTRAN*
5655	*P#CER.#NCHPSC.D05655.CERTTRAN*
10555	*P#CER.#NCHPSC.D10555.CERTTRAN*
510	*P#CER.#NCHPSC.B00510.CERTTRAN*
520	*P#CER.#NCHPSC.B00520.CERTTRAN*
528	*P#CER.#NCHPSC.B00528.CERTTRAN*
570	*P#CER.#NCHPSC.B00570.CERTTRAN*
580	*P#CER.#NCHPSC.B00580.CERTTRAN*

AC Number	Holding File
621	P#CER.#NCHPSC.B00621.CERTTRAN
623	P#CER.#NCHPSC.B00623.CERTTRAN
630	P#CER.#NCHPSC.B00630.CERTTRAN
640	P#CER.#NCHPSC.B00640.CERTTRAN
650	P#CER.#NCHPSC.B00650.CERTTRAN
655	P#CER.#NCHPSC.B00655.CERTTRAN
660	P#CER.#NCHPSC.B00660.CERTTRAN
700	P#CER.#NCHPSC.B00700.CERTTRAN
740	P#CER.#NCHPSC.B00740.CERTTRAN
780	P#CER.#NCHPSC.B00780.CERTTRAN
781	P#CER.#NCHPSC.B00781.CERTTRAN
801	P#CER.#NCHPSC.B00801.CERTTRAN
803	P#CER.#NCHPSC.B00803.CERTTRAN
805	P#CER.#NCHPSC.B00805.CERTTRAN
820	P#CER.#NCHPSC.B00820.CERTTRAN
824	P#CER.#NCHPSC.B00824.CERTTRAN
825	P#CER.#NCHPSC.B00825.CERTTRAN
865	P#CER.#NCHPSC.B00865.CERTTRAN
880	P#CER.#NCHPSC.B00880.CERTTRAN
889	P#CER.#NCHPSC.B00889.CERTTRAN
900	P#CER.#NCHPSC.B00900.CERTTRAN
901	P#CER.#NCHPSC.B00901.CERTTRAN
973	P#CER.#NCHPSC.B00973.CERTTRAN
974	P#CER.#NCHPSC.B00974.CERTTRAN
2050	P#CER.#NCHPSC.B02050.CERTTRAN
5130	P#CER.#NCHPSC.B05130.CERTTRAN
5440	P#CER.#NCHPSC.B05440.CERTTRAN
5535	P#CER.#NCHPSC.B05535.CERTTRAN
14330	P#CER.#NCHPSC.B14330.CERTTRAN
16360	P#CER.#NCHPSC.B16360.CERTTRAN
16510	P#CER.#NCHPSC.B16510.CERTTRAN
21200	P#CER.#NCHPSC.B21200.CERTTRAN
31140	P#CER.#NCHPSC.B31140.CERTTRAN

Within 5 working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

The target data set names for the current Sampled Claim Resolution Files are listed below:

AC Number	**Target File**
635	P#CER.#NCHPSC.D00635.CERTRSLN
811	P#CER.#NCHPSC.D00811.CERTRSLN
885	P#CER.#NCHPSC.D00885.CERTRSLN
655	P#CER.#NCHPSC.D05655.CERTRSLN
10555	P#CER.#NCHPSC.D10555.CERTRSLN
510	P#CER.#NCHPSC.B00510.CERTRSLN
520	P#CER.#NCHPSC.B00520.CERTRSLN

528	*P#CER.#NCHPSC.B00528.CERTRSLN*
570	*P#CER.#NCHPSC.B00570.CERTRSLN*
580	*P#CER.#NCHPSC.B00580.CERTRSLN*
621	*P#CER.#NCHPSC.B00621.CERTRSLN*
623	*P#CER.#NCHPSC.B00623.CERTRSLN*
630	*P#CER.#NCHPSC.B00630.CERTRSLN*
640	*P#CER.#NCHPSC.B00640.CERTRSLN*
650	*P#CER.#NCHPSC.B00650.CERTRSLN*
655	*P#CER.#NCHPSC.B00655.CERTRSLN*
660	*P#CER.#NCHPSC.B00660.CERTRSLN*
700	*P#CER.#NCHPSC.B00700.CERTRSLN*
740	*P#CER.#NCHPSC.B00740.CERTRSLN*
780	*P#CER.#NCHPSC.B00780.CERTRSLN*
781	*P#CER.#NCHPSC.B00781.CERTRSLN*
801	*P#CER.#NCHPSC.B00801.CERTRSLN*
803	*P#CER.#NCHPSC.B00803.CERTRSLN*
805	*P#CER.#NCHPSC.B00805.CERTRSLN*
820	*P#CER.#NCHPSC.B00820.CERTRSLN*
824	*P#CER.#NCHPSC.B00824.CERTRSLN*
825	*P#CER.#NCHPSC.B00825.CERTRSLN*
865	*P#CER.#NCHPSC.B00865.CERTRSLN*
880	*P#CER.#NCHPSC.B00880.CERTRSLN*
889	*P#CER.#NCHPSC.B00889.CERTRSLN*
900	*P#CER.#NCHPSC.B00900.CERTRSLN*
901	*P#CER.#NCHPSC.B00901.CERTRSLN*
973	*P#CER.#NCHPSC.B00973.CERTRSLN*
974	*P#CER.#NCHPSC.B00974.CERTRSLN*
2050	*P#CER.#NCHPSC.B02050.CERTRSLN*
5130	*P#CER.#NCHPSC.B05130.CERTRSLN*
5440	*P#CER.#NCHPSC.B05440.CERTRSLN*
5535	*P#CER.#NCHPSC.B05535.CERTRSLN*
14330	*P#CER.#NCHPSC.B14330.CERTRSLN*
16360	*P#CER.#NCHPSC.B16360.CERTRSLN*
16510	*P#CER.#NCHPSC.B16510.CERTRSLN*
21200	*P#CER.#NCHPSC.B21200.CERTRSLN*
31140	*P#CER.#NCHPSC.B31140.CERTRSLN*

The target data set names for the current Provider Address Files are listed below:

AC Number	***Target File***
635	*P#CER.#NCHPSC.D00635.CERTPROV*
811	*P#CER.#NCHPSC.D00811.CERTPROV*
885	*P#CER.#NCHPSC.D00885.CERTPROV*
5655	*P#CER.#NCHPSC.D05655.CERTPROV*
10555	*P#CER.#NCHPSC.D10555.CERTPROV*
510	*P#CER.#NCHPSC.B00510.CERTPROV*
520	*P#CER.#NCHPSC.B00520.CERTPROV*
528	*P#CER.#NCHPSC.B00528.CERTPROV*

570	*P#CER.#NCHPSC.B00570.CERTPROV*
580	*P#CER.#NCHPSC.B00580.CERTPROV*
621	*P#CER.#NCHPSC.B00621.CERTPROV*
623	*P#CER.#NCHPSC.B00623.CERTPROV*
630	*P#CER.#NCHPSC.B00630.CERTPROV*
640	*P#CER.#NCHPSC.B00640.CERTPROV*
650	*P#CER.#NCHPSC.B00650.CERTPROV*
655	*P#CER.#NCHPSC.B00655.CERTPROV*
660	*P#CER.#NCHPSC.B00660.CERTPROV*
700	*P#CER.#NCHPSC.B00700.CERTPROV*
740	*P#CER.#NCHPSC.B00740.CERTPROV*
780	*P#CER.#NCHPSC.B00780.CERTPROV*
781	*P#CER.#NCHPSC.B00781.CERTPROV*
801	*P#CER.#NCHPSC.B00801.CERTPROV*
803	*P#CER.#NCHPSC.B00803.CERTPROV*
805	*P#CER.#NCHPSC.B00805.CERTPROV*
820	*P#CER.#NCHPSC.B00820.CERTPROV*
824	*P#CER.#NCHPSC.B00824.CERTPROV*
825	*P#CER.#NCHPSC.B00825.CERTPROV*
865	*P#CER.#NCHPSC.B00865.CERTPROV*
880	*P#CER.#NCHPSC.B00880.CERTPROV*
889	*P#CER.#NCHPSC.B00889.CERTPROV*
900	*P#CER.#NCHPSC.B00900.CERTPROV*
901	*P#CER.#NCHPSC.B00901.CERTPROV*
973	*P#CER.#NCHPSC.B00973.CERTPROV*
974	*P#CER.#NCHPSC.B00974.CERTPROV*
2050	*P#CER.#NCHPSC.B02050.CERTPROV*
5130	*P#CER.#NCHPSC.B05130.CERTPROV*
5440	*P#CER.#NCHPSC.B05440.CERTPROV*
5535	*P#CER.#NCHPSC.B05535.CERTPROV*
14330	*P#CER.#NCHPSC.B14330.CERTPROV*
16360	*P#CER.#NCHPSC.B16360.CERTPROV*
16510	*P#CER.#NCHPSC.B16510.CERTPROV*
21200	*P#CER.#NCHPSC.B21200.CERTPROV*
31140	*P#CER.#NCHPSC.B31140.CERTPROV*

The target data set names for the current Claims History Replica Files are listed below:

AC Number	***Target File***
635	*P#CER.#NCHPSC.D00635.CERTRPLI*
811	*P#CER.#NCHPSC.D00811.CERTRPLI*
885	*P#CER.#NCHPSC.D00885.CERTRPLI*
5655	*P#CER.#NCHPSC.D05655.CERTRPLI*
10555	*P#CER.#NCHPSC.D10555.CERTRPLI*
510	*P#CER.#NCHPSC.B00510.CERTRPLI*
520	*P#CER.#NCHPSC.B00520.CERTRPLI*
528	*P#CER.#NCHPSC.B00528.CERTRPLI*

570	P#CER.#NCHPSC.B00570.CERTRPLI
580	P#CER.#NCHPSC.B00580.CERTRPLI
621	P#CER.#NCHPSC.B00621.CERTRPLI
623	P#CER.#NCHPSC.B00623.CERTRPLI
630	P#CER.#NCHPSC.B00630.CERTRPLI
640	P#CER.#NCHPSC.B00640.CERTRPLI
650	P#CER.#NCHPSC.B00650.CERTRPLI
655	P#CER.#NCHPSC.B00655.CERTRPLI
660	P#CER.#NCHPSC.B00660.CERTRPLI
700	P#CER.#NCHPSC.B00700.CERTRPLI
740	P#CER.#NCHPSC.B00740.CERTRPLI
780	P#CER.#NCHPSC.B00780.CERTRPLI
781	P#CER.#NCHPSC.B00781.CERTRPLI
801	P#CER.#NCHPSC.B00801.CERTRPLI
803	P#CER.#NCHPSC.B00803.CERTRPLI
805	P#CER.#NCHPSC.B00805.CERTRPLI
820	P#CER.#NCHPSC.B00820.CERTRPLI
824	P#CER.#NCHPSC.B00824.CERTRPLI
825	P#CER.#NCHPSC.B00825.CERTRPLI
865	P#CER.#NCHPSC.B00865.CERTRPLI
880	P#CER.#NCHPSC.B00880.CERTRPLI
889	P#CER.#NCHPSC.B00889.CERTRPLI
900	P#CER.#NCHPSC.B00900.CERTRPLI
901	P#CER.#NCHPSC.B00901.CERTRPLI
973	P#CER.#NCHPSC.B00973.CERTRPLI
974	P#CER.#NCHPSC.B00974.CERTRPLI
2050	P#CER.#NCHPSC.B02050.CERTRPLI
5130	P#CER.#NCHPSC.B05130.CERTRPLI
5440	P#CER.#NCHPSC.B05440.CERTRPLI
5535	P#CER.#NCHPSC.B05535.CERTRPLI
14330	P#CER.#NCHPSC.B14330.CERTRPLI
16360	P#CER.#NCHPSC.B16360.CERTRPLI
16510	P#CER.#NCHPSC.B16510.CERTRPLI
21200	P#CER.#NCHPSC.B21200.CERTRPLI
31140	P#CER.#NCHPSC.B31140.CERTRPLI

Target data set names for the sampled claim resolution files are listed below:

AC Number	*Holding File*
A00010	*P#CER.#NCHPSC.A00010.CERTRSLN*
A00020	*P#CER.#NCHPSC.A00020.CERTRSLN*
A00030	*P#CER.#NCHPSC.A00030.CERTRSLN*
A00040	*P#CER.#NCHPSC.A00040.CERTRSLN*
A00090	*P#CER.#NCHPSC.A00090.CERTRSLN*
A00101	*P#CER.#NCHPSC.A00101.CERTRSLN*
A00130	*P#CER.#NCHPSC.A00130.CERTRSLN*
A00131	*P#CER.#NCHPSC.A00131.CERTRSLN*
A00140	*P#CER.#NCHPSC.A00140.CERTRSLN*
A00150	*P#CER.#NCHPSC.A00150.CERTRSLN*
A00160	*P#CER.#NCHPSC.A00160.CERTRSLN*
A00180	*P#CER.#NCHPSC.A00180.CERTRSLN*
A00181	*P#CER.#NCHPSC.A00181.CERTRSLN*
A00190	*P#CER.#NCHPSC.A00190.CERTRSLN*
A00230	*P#CER.#NCHPSC.A00230.CERTRSLN*
A00250	*P#CER.#NCHPSC.A00250.CERTRSLN*
A00260	*P#CER.#NCHPSC.A00260.CERTRSLN*
A00270	*P#CER.#NCHPSC.A00270.CERTRSLN*
A00308	*P#CER.#NCHPSC.A00308.CERTRSLN*
A00310	*P#CER.#NCHPSC.A00310.CERTRSLN*
A00320	*P#CER.#NCHPSC.A00320.CERTRSLN*
A00332	*P#CER.#NCHPSC.A00332.CERTRSLN*
A00340	*P#CER.#NCHPSC.A00340.CERTRSLN*
A00350	*P#CER.#NCHPSC.A00350.CERTRSLN*
A00363	*P#CER.#NCHPSC.A00363.CERTRSLN*
A00370	*P#CER.#NCHPSC.A00370.CERTRSLN*
A00380	*P#CER.#NCHPSC.A00380.CERTRSLN*
A00400	*P#CER.#NCHPSC.A00400.CERTRSLN*
A00410	*P#CER.#NCHPSC.A00410.CERTRSLN*
A00430	*P#CER.#NCHPSC.A00430.CERTRSLN*
A00450	*P#CER.#NCHPSC.A00450.CERTRSLN*
A00452	*P#CER.#NCHPSC.A00452.CERTRSLN*
A00453	*P#CER.#NCHPSC.A00453.CERTRSLN*
A00460	*P#CER.#NCHPSC.A00460.CERTRSLN*
A50333	*P#CER.#NCHPSC.A50333.CERTRSLN*
A52280	*P#CER.#NCHPSC.A52280.CERTRSLN*
A57400	*P#CER.#NCHPSC.A57400.CERTRSLN*
A57401	*P#CER.#NCHPSC.A57401.CERTRSLN*

*P#CER.#NCHPSC.A*****.CERTPROV. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the provider address files are listed below:*

AC Number	***Holding File***
A00010	*P#CER.#NCHPSC.A00010.CERTPROV*
A00020	*P#CER.#NCHPSC.A00020.CERTPROV*
A00030	*P#CER.#NCHPSC.A00030.CERTPROV*
A00040	*P#CER.#NCHPSC.A00040.CERTPROV*
A00090	*P#CER.#NCHPSC.A00090.CERTPROV*
A00101	*P#CER.#NCHPSC.A00101.CERTPROV*
A00130	*P#CER.#NCHPSC.A00130.CERTPROV*
A00131	*P#CER.#NCHPSC.A00131.CERTPROV*
A00140	*P#CER.#NCHPSC.A00140.CERTPROV*

AC Number	Holding File
A00150	P#CER.#NCHPSC.A00150.CERTPROV
A00160	P#CER.#NCHPSC.A00160.CERTPROV
A00180	P#CER.#NCHPSC.A00180.CERTPROV
A00181	P#CER.#NCHPSC.A00181.CERTPROV
A00190	P#CER.#NCHPSC.A00190.CERTPROV
A00230	P#CER.#NCHPSC.A00230.CERTPROV
A00250	P#CER.#NCHPSC.A00250.CERTPROV
A00260	P#CER.#NCHPSC.A00260.CERTPROV
A00270	P#CER.#NCHPSC.A00270.CERTPROV
A00308	P#CER.#NCHPSC.A00308.CERTPROV
A00310	P#CER.#NCHPSC.A00310.CERTPROV
A00320	P#CER.#NCHPSC.A00320.CERTPROV
A00332	P#CER.#NCHPSC.A00332.CERTPROV
A00340	P#CER.#NCHPSC.A00340.CERTPROV
A00350	P#CER.#NCHPSC.A00350.CERTPROV
A00363	P#CER.#NCHPSC.A00363.CERTPROV
A00370	P#CER.#NCHPSC.A00370.CERTPROV
A00380	P#CER.#NCHPSC.A00380.CERTPROV
A00400	P#CER.#NCHPSC.A00400.CERTPROV
A00410	P#CER.#NCHPSC.A00410.CERTPROV
A00430	P#CER.#NCHPSC.A00430.CERTPROV
A00450	P#CER.#NCHPSC.A00450.CERTPROV
A00452	P#CER.#NCHPSC.A00452.CERTPROV
A00453	P#CER.#NCHPSC.A00453.CERTPROV
A00460	P#CER.#NCHPSC.A00460.CERTPROV
A50333	P#CER.#NCHPSC.A50333.CERTPROV
A52280	P#CER.#NCHPSC.A52280.CERTPROV
A57400	P#CER.#NCHPSC.A57400.CERTPROV
A57401	P#CER.#NCHPSC.A57401.CERTPROV

*P#CER.#NCHPSC.A*****.CERTRPLI. The data center for the transmitting contractor replaces "*****" with the contractor number. Target data set names for the claims history replica file are listed below:*

AC Number	Holding File
A00010	P#CER.#NCHPSC.A00010.CERTRPLI
A00020	P#CER.#NCHPSC.A00020.CERTRPLI
A00030	P#CER.#NCHPSC.A00030.CERTRPLI
A00040	P#CER.#NCHPSC.A00040.CERTRPLI
A00090	P#CER.#NCHPSC.A00090.CERTRPLI
A00101	P#CER.#NCHPSC.A00101.CERTRPLI
A00130	P#CER.#NCHPSC.A00130.CERTRPLI
A00131	P#CER.#NCHPSC.A00131.CERTRPLI
A00140	P#CER.#NCHPSC.A00140.CERTRPLI
A00150	P#CER.#NCHPSC.A00150.CERTRPLI
A00160	P#CER.#NCHPSC.A00160.CERTRPLI
A00180	P#CER.#NCHPSC.A00180.CERTRPLI
A00181	P#CER.#NCHPSC.A00181.CERTRPLI
A00190	P#CER.#NCHPSC.A00190.CERTRPLI
A00230	P#CER.#NCHPSC.A00230.CERTRPLI
A00250	P#CER.#NCHPSC.A00250.CERTRPLI
A00260	P#CER.#NCHPSC.A00260.CERTRPLI
A00270	P#CER.#NCHPSC.A00270.CERTRPLI
A00308	P#CER.#NCHPSC.A00308.CERTRPLI
A00310	P#CER.#NCHPSC.A00310.CERTRPLI
A00320	P#CER.#NCHPSC.A00320.CERTRPLI

AC Number	Holding File
A00332	P#CER.#NCHPSC.A00332.CERTRPLI
A00340	P#CER.#NCHPSC.A00340.CERTRPLI
A00350	P#CER.#NCHPSC.A00350.CERTRPLI
A00363	P#CER.#NCHPSC.A00363.CERTRPLI
A00370	P#CER.#NCHPSC.A00370.CERTRPLI
A00380	P#CER.#NCHPSC.A00380.CERTRPLI
A00400	P#CER.#NCHPSC.A00400.CERTRPLI
A00410	P#CER.#NCHPSC.A00410.CERTRPLI
A00430	P#CER.#NCHPSC.A00430.CERTRPLI
A00450	P#CER.#NCHPSC.A00450.CERTRPLI
A00452	P#CER.#NCHPSC.A00452.CERTRPLI
A00453	P#CER.#NCHPSC.A00453.CERTRPLI
A00460	P#CER.#NCHPSC.A00460.CERTRPLI
A50333	P#CER.#NCHPSC.A50333.CERTRPLI
A52280	P#CER.#NCHPSC.A52280.CERTRPLI
A57400	P#CER.#NCHPSC.A57400.CERTRPLI
A57401	P#CER.#NCHPSC.A57401.CERTRPLI

Assumptions and Constraints

- *Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.*

- *Files must be transmitted to the CERT operations center via CONNECT:Direct.*

- *CMS or the CERT contractor will provide Medicare contractors with dataset names for all files that will be transmitted to the CERT operations center.*

- *The CERT contractor will provide the Medicare contractors with the dataset names with which the sampled claims transaction file will be transmitted.*

- *Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted.*

- *Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor to support CERT implementation and will provide updates within 60 calendar days before each expected implementation of a change in the data dictionary. .*

Below are details on how those requirements must be implemented.

1. *Coordinate with the CERT contractor to provide the requested information in an electronic format for claims identified in the sample.*

   The CERT contractor will make all requests for information or data through letters, e-mail, or via the Network Data Mover (NDM) to the CERT point of contact of each Medicare contractor. Instructions for responding to requests via the NDM will be provided after a test of the process with the DMERCs has been completed. Medicare contractors are required to provide responses in electronic format as described in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Responses provided in electronic form must be made within five working days of a request.

2. *Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims processed during the day.*

   *FI and RHHI data centers and contractors should use the file formats from Attachment 1 for this section. Use CONNECT:Direct to transmit the files. The target filename for transmission to the CERT test environment in the CMSDC is D#CER.#NCHPSC.A*****.CERTUNV. Target file names for transmission to the CERT production environment in the CMSDC is*

*P#CER.#NCHPSC.A*****.CERTUNV. The Medicare contractor data center must replace the "*****" in each file name with the contractor ID number of the contractor for which the file is being submitted.*

Carrier and DMERC data centers and contractors should use the file formats from the Attachment 2 for this transmission. Use CONNECT:Direct to transmit the files. Target filenames for transmission to the CERT test environment in the CMSDC are listed below:

Claims Universe File	*D#CER.#NCHPSC.B*****CERTUNV*
Sampled Claims Resolution File	*D#CER.#NCHPSC.B*****.CERTRSLN*
Provider Address File	*D#CER.#NCHPSC.B*****CERTPROV*
Claims History Replica File	*D#CER.#NCHPSC.B****CERTRPLI*
Sampled Claims Transaction File	*D#CER.#NCHPSC.B****.CERTTRAN*

Target file names for transmission to the CERT production environment in the CMSDC are listed below:

Claims Universe File	*P#CER.#NCHPSC.B*****.CERTUNV*
Sampled Claims Resolution File	*P#CER.#NCHPSC.B*****.CERTRSLN*
Provider Address File	*P#CER.#NCHPSC.B*****.CERTPROV*
Claims History Replica File	*P#CER.#NCHPSC.B*****.CERTRPLI*
Sampled Claims Transaction File	*P#CER.#NCHPSC.B*****.CERTTRAN*

Each Medicare contractor in Phases 1, 2, and 3 of CERT has identified a CMSDC NDM User ID they will use to transmit the files. Notify the CERT contractor at the address included in the ***"How to Contact and Make Submissions to the CERT Operations Center"*** *section above of any NDM user ID changes or additions. Medicare contractors in Phases after 3 must provide CMSDC User IDs to the CERT operations center at least 30 calendar days before their first sample is due.*

3. *On a periodic basis, generally monthly, the CERT contractor will make a request via the NDM for the Medicare contractor to return a sampled claims resolution file, claims history replica file, and provider address file for every claim in listed in the sampled claims transaction file that has completed adjudication by the Medicare contractor. The contents of the sampled claims transaction file will consist of all claims that recently were selected in the sample for the first time and any claims remaining from prior requests that had not completed the adjudication process by the Medicare contractor at the time of the previous request.*

4. *Provide the CERT contractor with the Sample Claims Resolution file, claims history replica file, and provider address file within five working days of a CERT request.*

   Within five working days of a CERT request, provide for every claim listed in the sampled claims transaction file that has undergone payment adjudication (i.e., denial, reduction, return, payment approval, etc) all sampled claims resolution files, all claims history replica files, and a single provider address file in the formats contained in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs). Note that more than one sampled claims resolution file and claims history replica file may be provided under circumstances where the Claim Control Number has changed since its original assignment and claim activity has occurred. Standard systems are expected to provide a look up list, where necessary, to associate the last Claim Control Number submitted to the CERT contractor from the standard system with new Claim Control Numbers assigned to the claim subsequent to that submission. If there are clams adjustments that have not been adjudicated when the sample claims transaction file is receive, those adjustments do not need to be included in a sample claims resolution file.

   Included in the requirements for the sampled claims resolution file is a requirement to report the manual medical review indicator for each line on the sampled claim. We have defined this item as follows:

Data Element: ***Complex Manual Medical Review Indicator***

Definition: *Code indicating whether or not the service received complex manual medical review. 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, attached to the claim, or contained in the contractor's history file. The review must require professional medial expertise and must be for the purpose of preventing payments of non-covered or incorrectly coded services. That includes reviews for the purpose of determining if services were medically necessary. Professionals must perform the review, i.e., at a minimum, a Licensed Practical Nurse must perform the review. 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. If sufficient documentation accompanies a claim to allow complex review to be done without requesting additional documentation, count the review as complex. For instance, if relevant pages from the patient's medical record are submitted with the claim, complex MR could be conducted without requesting additional documentation.*

Validation: *Must be 'Y' or 'N' or blank*
Remarks: *Set to 'Y' if service was subjected to complex manual medical review, 'N' if the service was subjected to routine manual medical review, and leave it blank if the service was subjected to automated review.*
Requirement: Not required

A line level MR indicator field is included on the standard system claim records. Providing a Value for the MR indicator on the standard system claim record will allow CERT to distinguish among automated MR, complex MR, and routine MR. Contractors that ***do not*** *enter MR indicators on the review line in question, will not have the opportunity to dispute that line of service.*

The contractor must enter the necessary data to allow the standard processing intermediary shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. We expect contractors to manually put this indicator on the claim. Contractors must enter the following indicators on the claim to document the type of review that they performed (automated, routine, or complex):

Situation	***Payment Decision Contractor***	***Enters***
Contractor receives documentation and performs complex manual medical review on one or more specific lines of service for that claim.	*-Approved* *-Denied* *-Reduced*	***Y*** *in the detail level (line level) complex manual medical review indicator for each line of complex manual medical review. Leave the claim level manual review indicator blank.*

Contractor performs routine manual medical review on one or more specific lines of service for that claim.	*-Approved* *-Denied* *-Reduced*	*N in the detail level (line level) routine manual medical review indicator for each line of routine manual medical review. Leave the claim level manual review indicator blank.*
Contractor does not perform complex or routine manual medical review. The system performs automated medical review on any line of service.	*-Approved* *-Denied* *-Reduced*	*Leave claim and line level manual medical review indicators blank.*

By July 1, 2003, the manual medical review indicator for FIs and RHHIs was implemented. The following requirements went into effect at that time.

A. Contractors must insure that standard system maintainers correctly implement standard system modifications that automatically place the appropriate manual medical review indicator on each line in the sample claims resolution file.

B. If manual review is not performed on the line the manual medical review indicator must be blank. If manual review is performed on a line, the manual medical review indicator must be either a "Y" or an "N."

C. The manual medical review indicator must be "Y" for all lines for which the Medicare contractor has received medical records. When the contractor asks for medical records but the provider does not send every one of the notes that the contractor requested, put a "Y" for the lines corresponding to missing notes.

D. Contractor staff must manually enter information needed to decide if medical records were obtained for lines where that information cannot be obtained from the system claims processing modules.

The medical review indicator was automated for carriers and DMERCs at the beginning of Phases I-III.

Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.

This requirement applies only when the routine processing cycle does not run. For example, if the Medicare contractor routinely processes claims every other day, zero count records do not have to be submitted for days on which processing is not routinely done. To ensure the CERT contractor knows when to expect records, CMS requests that the Medicare contractor send a copy of their processing schedule, if they do not process claims every day, to the CERT contractor ten working days before they are required to begin sending processed records or ten working days after receipt of this PM, whichever is later. Send the list to the address listed in the " ***How to Contact and Make Submissions to the CERT Operations Center"*** *section above.*

Files must be transmitted to the CERT operations center via CONNECT:Direct. Following are the target dataset names for all files that will be transmitted to the CERT operations center.

A manual monthly process is in place to upload the sampled claims transaction file containing the data for all Medicare contractors to the mainframe. A batch job is executed to separate the sampled claim transaction file into smaller files based on Medicare contractor. The files are placed into the function send mode of the NDM process. The files are then transmitted to each Medicare contractor data center (schedule to be determined).

*The format for the transmission name for the sampled claims transaction files is P#CER.#NCHPSC.A*****.CERTTRN for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTTRN for FIs, and P#CER.#NCHPSC.D*****.CERTTRN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.*

Within five working days of the receipt of the Sampled Claims Transaction File, each Medicare contractor will NDM the related claims data to the CERT contractor in the Sampled Claims Resolution File, the Sampled Claims Replica File, and the Provider Address File.

*The format for the data set name for the sampled claims resolution files is P#CER.#NCHPSC.A*****.CERTRSLN for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTRSLN for FIs, and P#CER.#NCHPSC.D*****.CERTRSLN for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.*

*Target data set names for the provider address files are in the format: P#CER.#NCHPSC. A*****.CERTPROV for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTPROV for FIs, and P#CER.#NCHPSC.D*****.CERTPROV for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.*

*Target data set names for the claims history replica file is in the format: P#CER.#NCHPSC. A*****.CERTRPLI for FIs and RHHIs, P#CER.#NCHPSC.B*****. CERTRPLI for FIs, and P#CER.#NCHPSC.D*****.CERTRPLI for DMERCs . The data center for the transmitting contractor replaces "*****" with the contractor number.*

The CERT contractor will retrieve the target files on the 6th workday after transmission of the Sampled Claims Transaction Files. The files will be processed through a screening module on the mainframe and then transferred to the CERT database. If a file is not received by COB of the 5th day, it will be processed in the following month's sample.

Transmittal of the Sampled Claims Transactions File will be handled via the NDM and may include an e-mail notification to the Medicare contractor concerning any deviations from established schedules and other information as appropriate. Medicare contractors must provide the CERT contractor with an e-mail address for requests. At least 30 calendar days before the due date for implementation of CERT, send the address to the CERT operations center at the address listed in the " ***How to Contact and Make Submissions to the CERT Operations Center"*** *section.*

Medicare contractor files that are rejected will result in a call from the CERT operations center indicating the reason for rejection. Rejected files must be corrected and retransmitted within 24 hours (one business day) of notification.

Requests for retransmissions will be made to the CERT point of contact via telephone. Retransmissions must be made in one of the following formats included in Attachments 1 (FIs and RHHIs) and 2 (carriers and DMERCs) as appropriate:

Claims universe file
Sampled claims resolution file,
Claims history replica file, and/or
Provider address file

NDM retransmissions to the data sets described above. If you transmission fails, please call the CERT operations center for instructions.

Standard system contractor will provide a data dictionary of the claims history replica file to the CERT contractor before implementation of CERT or when it becomes available and will provide updates as necessary.

The data dictionary must be provided within ten working days after receipt of this PM or within 10 days of the data dictionary becoming available, whichever is later. Send it in Microsoft Word 97 format to the CERT operations center at the address provided in the ***"How to Contact and Make Submissions to the CERT Operations Center"*** *section. Updates must be provided to the CERT contractor at least 60 calendar days before a change is implemented in the standard system that will affect the data transmitted in files for CERT.*

Exhibit 34.6 – CERT PSC Contractor Feedback Data Entry Screen Version 1.01 (Rev. 67, 02-27-04)

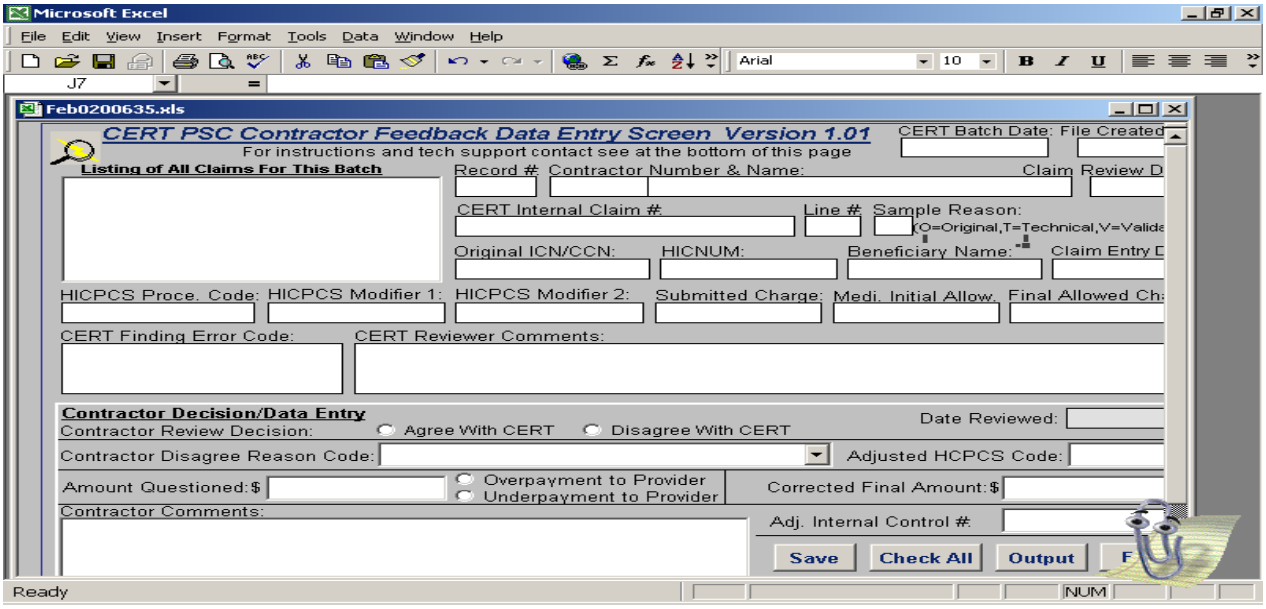

Figure 1: CERT PSC Contractor Feedback Data Entry Screen

Your failure to provide the requested documentation to the CERT PSC will result in a documentation error for that line of service and you may not re-submit the line to the CCRP, even where your staff have previously conducted routine or complex MR.

The CMS will conduct a routine quality assurance review of the CERT program including review of claims with error and non-error findings.

The CERT PSC will provide your CERT PSC Contractor Feedback Data Entry Screen to CMS and will also maintain a tracking database of all such reports you submitted to CMS to include final disposition of error findings submitted to the CCRP. Do not provide that information to other entities; the CMS will handle all requests for copies of those reports.

Exhibit 34.7 - Data Items Included on CERT Reports

(Rev. 67, 02-27-04)

The COCP will receive the following for each line submitted to the CCRP:

Relevant information from the medical record for the disagreed upon line of service,
Explanations from the CERT PSC and the AC of their decisions, and
Specific references to included documentation that the AC or the CERT PSC believes supports their decision.

The COCP will make a decision based upon all information presented to them.

To insure that regional offices (ROs) have an opportunity to be involved in the CCRP, the COCP will invite the participation of RO clinicians in the process.

The COCP at a minimum will consist of four individuals. There will be physician representation from the Center for Medicare Management (CMM), Office of Clinical Standards & Quality (OCSQ), and Program Integrity Group (PIG). There will be at least one registered nurse on this panel. The COCP will request the participation of consortia staff; requests will be made at least one month before participation is expected. The panel may request the assistance of complex medical review experts, coding experts, or clinical specialists. A list of all participants must accompany the final report from the panel.

Members of panels will review the file presented without opportunity for the CERT PSC or you to submit additional material. You may make no further appeal.

The CMS will provide final results from the COCP reviews to you in the CERT Quarterly Error Reconciliation Report (see attachment 5 for the report format); CMS will include in this report only those lines the COCP has confirmed to be in error after the COCP has completed all review of lines you submitted to the CCRP for that quarter.

You will collect overpayments on all lines paid in error included in the Error Report except for errors submitted to the CCRP. You will also collect overpayments on all lines in error included in the CERT Quarterly Error Reconciliation Report. You will pay to the billing providers amounts that you have denied in error and the CERT PSC has identified as such. The CMS does not require collection or payment for errors in coding that do not affect the

amount originally paid, e.g., a line with an incorrect code is paid, but the corrected code (determined after CERT review) is reimbursable at the same amount as the code in error.

You should send all reports to:

AdvanceMed
1530 E. Parham Road
Richmond, Va. 23228.

The CERT PSC will send reports to the CERT point of contact you identified.

On an annual basis, the COCP will conduct random reviews of the decisions on requests submitted to the CCRP. The QA findings shall be sent to the CERT PSC, AC, and applicable parties (i.e., RO or CO).