| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 1186** | **Date: February 8, 2013** |
| | **Change Request 8175** |

**SUBJECT: FISS Prepayment Review Report**

**I. SUMMARY OF CHANGES:** Medicare Administrative Contractors, Zone Program Integrity Contractors and Recovery Audit Contractors perform Prepayment Review on Medicare Claims. Prepayment review impacts a provider's cash flow and may cause financial issues that are brought forward to CMS. CMS needs to have knowledge of the prepayment reviews occurring to monitor and administer the program. This CR will create a report in FISS that lists all claims chosen for prepayment review by system edits implemented by the contractors and/or CMS.

**EFFECTIVE DATE: July 1, 2013**
**IMPLEMENTATION DATE: July 1, 2013**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| N/A | |

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

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

**IV. ATTACHMENTS:**

**One Time Notification**

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

# Attachment - One-Time Notification

| Pub. 100-20 | Transmittal: 1186 | Date: February 8, 2013 | Change Request: 8175 |
|---|---|---|---|

**SUBJECT: FISS Prepayment Review Report**

**EFFECTIVE DATE: July 1, 2013**

**IMPLEMENTATION DATE: July 1, 2013**

## I. GENERAL INFORMATION

**A. Background:** Medicare contractors conduct prepayment review on Medicare providers through system edits implemented by the contractors and/or CMS. At times, these reviews impact a provider financially and this is brought to the attention of CMS. CMS needs to have awareness of the prepayment reviews being completed. This CR creates a report/flat file that can be uploaded to the CMS RAC Data Warehouse so that this information is readily available to CMS. This report/flat file shall include all prepayment reviews, when chosen using medical review parameters and an additional documentation letter will be issued, for any CMS contractor no matter who will actually complete the review.

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

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement.*

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8175.1 | FISS shall create a report in a flat file listing all claims chosen for prepayment review (medical review parameters) where an additional documentation request will be issued before payment is made. | | | | | | | X | | | | |
| 8175.1.1 | The report/flat file shall include all prepayment review meeting the criteria no matter which contractor will complete the review. | | | | | | | X | | | | |
| 8175.2 | If a claim is chosen by the system for prepayment review based on an edit implemented by the contractor and/or CMS, FISS shall put that claim on a monthly report. | | | | | | | X | | | | |
| 8175.3 | The report/flat file shall include all data elements and fields on the attached file layouts. | | | | | | | X | | | | |
| 8175.4 | The report/flat file shall be available by the 5th of | | | | | | | X | | | | |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | every month for the preceding calendar month. | | | | | | | | | | | |
| 8175.4.1 | The EDC shall send the report/flat file to the applicable MAC for upload to the RAC Data Warehouse. | | | | | | | | | | | EDC |
| 8175.5 | The report/flat file shall be uploaded to the CMS RAC Data Warehouse (all claims not just RAC) by the 10th of every month. | X | | | X | | X | | | | | |
| 8175.6 | FISS shall create four PIMR Activity Codes that shall be used to designate the prepayment review as Recovery Auditor. | | | | | | | X | | | | |
| 8175.7 | When implementing a prepayment edit for the recovery auditor review MACs shall designate a PIMR Activity Code that will designate the prepayment review as a recovery auditor review. | X | | | X | | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other | |
| | | Part A | Part B | | | | | | |
| | None | | | | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Alpheus Parkes, Alpheus.Parkes@cms.hhs.gov (Connie Leonard)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

## VI. FUNDING

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

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

**ATTACHMENT: 1**

# Claims Upload File Format

*Please note that all layouts detailed here pertain to the same claim file. The header is the first record in the file, followed by the claim records.

## Header Layout

| Field Name | Location | Length | Attributes | Sample | Valid Values and Notes |
|---|---|---|---|---|---|
| File Type | 1 | 10 | AN-10 | CLAIM | Value:<br>"Claim"<br>Left justified, space fill |
| Filler | 11 | 1 | AN-1 | | Space fill |
| File Format Version | 12 | 3 | AN-3 | 4 | Value: 004 |
| Filler | 15 | 1 | AN -1 | | Space fill |
| Record Count | 16 | 6 | Num-6 | 102 | Number of records contained in file.<br>Right justified, zero fill |
| Filler | 22 | 1 | AN-1 | | Space fill |
| Record Length | 23 | 3 | Num-3 | 188 | 188 |
| Filler | 26 | 1 | AN -1 | | Space fill |
| Create Date | 27 | 8 | Num-8 | 20090617 | File Creation Date<br>Format = YYYYMMDD |
| Filler | 35 | 7 | AN -7 | | Space fill |
| Source ID | 42 | 5 | AN-5 | | Values = Contractor ID of the user who created the file.<br>Left Justified |
| Filler | 47 | 1 | AN-1 | | Space fill |
| MAC Workload Number | 48 | 5 | Num- 5 | 12345 | Workload Number |

| | | | | | |
|---|---|---|---|---|---|
| Filler | 53 | 75 | AN-1 | R | Space fill |

## Claim Record Layout

| Field Name | Start | End | Length / Attributes | Required / Situational | Description - Valid Values and Notes |
|---|---|---|---|---|---|
| Record Type | 1 | 1 | 1-AN | R | Claim Record-C |
| Claim Type | 2 | 2 | 1-A | R | NCH MQA Record Identification Code<br>1 = Inpatient<br>2 = SNF<br>3 = Hospice<br>4 = Outpatient<br>5 = Home Health Agency |
| Out-of-Jurisdiction Flag | 3 | 3 | 1-A | S | Use a space. |
| State Code for the provider | 4 | 5 | 2-A | R | State Codes: ME, CA |
| Place of Service ZIP Code | 6 | 10 | 5-AN | R | US Postal Code where service rendered. |
| Contractor ID | 11 | 15 | 5-AN | R | Claims processing contractor ID number |
| Original Claim ID | 16 | 38 | 23-AN | R | Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim<br><br>For Claim Type 1 through 5 - length must be equal to or greater than 14.<br>For Claim Type 6 - length must be 15.<br>For Claim Type 7 - length must be 14. |
| Type of Bill | 39 | 42 | 4-AN | R/S | * Required for Claim Type 1 - 5. (left justified) |
| Provider Legacy Number | 43 | 55 | 13-AN | S | Unique Provider Legacy Number of the provider that performed the service and filed the claim. |
| Provider NPI | 56 | 65 | 10-AN | R | Unique Provider NPI of the provider that performed the service and filed the claim |
| DME Ordering Provider NPI | 66 | 75 | 10-AN | S | NPI of Provider that prescribed the supplies. |
| Date of Service Start (statement covers from date) | 93 | 100 | 8-N | R | Date service started/performed<br>YYYYMMDD |

| | | | | | |
|---|---|---|---|---|---|
| Date of Service End (statement covers thru date) | 101 | 108 | 8-N | R | Date service ended<br>YYYYMMDD |
| Provider Type | 109 | 110 | 2-AN | R | Type of Provider or Supplier<br>Valid Values:<br>1 = Lab/Ambulance<br>2 = Outpatient Hospital<br>3 = Home Health (HHA)<br>4 = Hospice<br>5 = Professional Services (physician/non-physician practitioner)<br>6 = DME by Supplier<br>7 = Skilled Nursing (SNF)<br>8 = Inpatient Hospital<br>9 = Inpatient Rehabilitation (IRF)<br>10 = Critical Access Hospital (CAH)<br>11 = Long Term Care Hospital (LTCH)<br>12 = DME by Physician<br>13 = Ambulatory Surgery Center (ASC)<br>14 = Other |
| CMS Provider Specialty Code | 111 | 112 | 2-AN | S | CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files |
| Review Type | 113 | 114 | 2-AN | R | Pre-Payment Review-PR |
| Date Chosen for Prepayment Review | 115 | 122 | 8-N | R | Date format YYYYMMDD (Date it goes to SB6000 or SB6001) |
| PIMR Activity Code | 123 | 124 | 2-AN | R | |

## Claim Line Item Record Layout

| Field Name | Start | End | Length / Attributes | Required / Situational | Description - Valid Values and Notes |
|---|---|---|---|---|---|
| Record Type | 1 | 1 | 1-AN | R | Line-L |
| Line item number | 2 | 4 | 3-AN | R | Claim line item number; 000 for institutional claims.<br>If line number = 000, then no other lines are acceptable for that claim |
| Original Diagnosis Code Version Indicator | 5 | 5 | 1-N | R | 9 for ICD-9 or 0 for ICD-10; |
| Original Principal Diagnosis Code (institutional) | 6 | 12 | 7-AN | R | Original ICD-9 or ICD-10.<br>Decimal point(.) is not allowed. |
| Original DRG | 13 | 15 | 3-AN | S | Original DRG on claim. It must be three digit numbers.<br>Line 000 only |
| Original ICD Primary Procedure Code | 16 | 22 | 7-AN | S | Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed. |
| Original Non-DRG PPS/Hospice LOC Code | 23 | 27 | 5-AN | S | Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs (RUG/AIs), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims. |
| Original HCPCS | 28 | 32 | 5-AN | S | Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist) |
| Original Units of Service | 33 | 35 | 3-N | S | Original units of service on claim |
| Filler | 36 | 124 | 89-AN | R | Spaces |