CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1290	**Date: August 27, 2013**
	Change Request 8224

Transmittal 1212, dated May 3, 2013 is being rescinded and replaced by Transmittal 1290 dated August 27, 2013, to include the attachment which was erroneously omitted. All other information remains the same.

SUBJECT: MCS 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 MCS that lists all claims chosen for prepayment review by system edits implemented by the contractors and/or CMS.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 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: 1290	Date: August 27 , 2013	Change Request: 8224

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SUBJECT: MCS Prepayment Review Report

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 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 claims chosen for prepayment review by system edits implemented by the Contractors and/or CMS. The report shall also identify which Contractor performed 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	
8224.1	MCS 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			
8224.1.1	The report/flat file shall include all prepayment review meeting the criteria no matter which contractor will complete the review.								X			
8224.2	If a claim is chosen by the system for prepayment review based on an edit implemented by the contractor and/or CMS, MCS shall put that claim on a monthly report.								X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8224.3	The report/flat file shall include all data elements and fields on the attached file layouts.								X			
8224.4	The report/flat file shall be available by the 5th of every month for the preceding calendar month.								X			
8224.4.1	The EDC shall send the report/flat file to the applicable MAC for upload to the RAC Data Warehouse											EDCs
8224.5	The report/flat file shall be uploaded to the CMS RAC Data Warehouse (all claims, not just Recovery Auditor claims) by the 10th of every month.		X			X						
8224.6	MCS shall create four PIMR Activity Codes that shall be used to designate the prepayment review as Recovery Auditor: 21RACA for the Region A Recovery Auditor 21RACB for the Region B Recovery Auditor 21RACC for the Region C Recovery Auditor 21RACD for the Region D Recovery Auditor								X			
8224.7	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						

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): Amy Cinquegrani, amy.cinquegrani@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; 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	Start	End	Attributes	Sample	Valid Values and Notes	MCS SYSTEM INFORMATION:
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill	
Filler	11	11	AN-1		Space fill	
File Format Version	12	14	AN-3	4	Value: 004	
Filler	15	15	AN -1		Space fill	
Record Count	16	21	Num-6	102	Number of records contained in file. Right justified, zero fill	Valid Value equals the # of file header records + # of Claim 'C' type records + # of Line 'L' type records on the extract file
Filler	22	22	AN-1		Space fill	
Record Length	23	25	Num-3	100	To clarify, the record length is the length of the claim or line that is being reported.	The Header Record Length value will represent the length of all record types on the file. i.e.; All Header, Claim and Line Records will be a fixed length of 100 bytes.
Filler	26	26	AN -1		Space fill	
Create Date	27	34	Num-8	20090617	File Creation Date Format = YYYYMMDD	The MCS cycle date in which in the file was created
Filler	35	41	AN -7		Space fill	
Source ID	42	46	AN-5		Values = Contractor ID of the user who created the file. Left Justified	Valid value is the first contractor ID from the cycles plan code record
Filler	47	47	AN-1		Space fill	
MAC Workload Number	48	52	Num- 5	12345	Workload Number	Valid value is the first contractor ID from the cycles plan code record. i.e., Same value as Source ID.
Filler	53	100	AN-48		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-AN	R	NCH MQA Record Identification Code 6 = Carrier	Always 6 for MCS Professional Claims
Out-of-Jurisdiction Flag	3	3	1-A	S	Use a space.	Not applicable to MCS.
State Code	4	5	2-A	R	State Codes: ME, CA	state code of the Billing Provider's Practice Address
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.	zip code of the Billing Provider's Practice Address
Contractor ID	11	15	5-AN	R	Claims processing contractor ID number	Valid values will be the corresponding contractor ID for the claim
Original Claim ID	16	38	23-AN	R	Unique identifier number assigned by Carrier, A/B MAC or DME MAC to claim **For Claim Type 6 - length must be 15.**	Valid values for MCS will be the 2 digit plan code plus 13 digit ICN for a total of 15.
Provider Legacy Number	39	51	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.	For MCS this will be the Billing Provider PIN #, so for Group claims, the provider that filed that claim, but did not perform the service.
Provider NPI	52	61	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim.	For MCS this will be the Billing Provider NPI #, so for Group claims, the provider that filed that claim, but did not perform the service.
Date of Service Start	62	71	8-N	R	Date service started/performed YYYYMMDD	Valid values for MCS will be the claim level Begin DOS

Date of Service End	72	79	8-N	R	Date service ended YYYYMMDD	Valid values for MCS will be the claim level End DOS
CMS Provider Specialty Code	80	81	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files	For MCS this will be the Billing Provider Specialty, so for Group claims, always specialty 70 for the provider that filed that claim, but did not perform the service.
Review Type	82	83	2-AN	R	Pre-Payment Review-PR	Always PR for Pre-Payment Review
Date Chosen for Prepayment Review	84	91	8-N	R	Date format YYYYMMDD	Valid value for MCS will be the location date the claim went to the initial prepayment review location.
Filler	92	100	9-AN	R	Space fill	

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	
Original Claim ID	2	24	23-AN	R	Unique identifier number assigned by Carrier, A/B MAC or DME MAC to claim For Claim Type 6 - length must be 15.	MCS is always claim type 6. Valid values for MCS will be the 2 digit plan code plus 13 digit ICN for a total of 15.
Line item number	25	27	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim	MCS Line Item number. Since only the service lines that meet the extract criteria will be included, this value for MCS will start with 1 and increment by +1 for each line record for a claim.
MCS Claim Line item number	28	29	2-N	R	This is the corresponding service line number on the claim in MCS. Valid values are 1 - 13.	MCS would like to propose adding this field so there is traceability back to the line number on the claim record within in MCS application.
PIMR Activity Code	30	35	6-AN	R	Identifies which contractor is performing the prepayment review.	Valid values will be any valid MAC, PSC or RAC MCS PIMR Activity code that is assigned to this line/detail service
Original Diagnosis Code Version Indicator	36	36	1-N	R	9 for ICD-9 or 0 for ICD-10;	Valid value is 9 for ICD-9 and 0 for ICD-10
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	37	43	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.	Valid value is the first diagnosis assigned to the detail/service line
Original ICD Procedure Code	44	50	7-AN	S	Original ICD9/ICD10 Procedure Code. Decimal point(.) is not allowed.	Valid values for MCS will always be spaces. Service Line Procedure Code for MCS will always be represented in field titled "Original HCPCS".
Original Non-DRG PPS/Hospice LOC Code	51	55	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.	Part A only; Valid values for MCS will always be spaces
Original HCPCS	56	60	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)	Valid values will be the procedure code from the service line of the claim
Original Units of Service	61	63	3-N	S	Original units of service on claim. Decimal point(.) is not allowed.	Valid value is the unit of service integer value from the service line of the claim
Filler	64	100	37-AN	S	Space fill	