CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 370	**Date: August 15, 2008**
	Change Request 6141

SUBJECT: Add Provider Measures to the Program Integrity Management Reporting (PIMR) System

I. SUMMARY OF CHANGES: CMS developed the PIMR system for the management of cost, savings, and workload data relative to the medical review (MR) unit and other benefit integrity (BI) functions. Mainly, the PIMR data relates to how contractors resolve billing problems. CMS obtains PIMR information through interfaces with the shared systems. Those interfaces are operated through contractor data centers, i.e., Enterprise Data Center (EDC) or a contractor data center (CDC), transferring data directly from the contractor shared system implementation of PIMR to the central office computer within 15 calendar days following the end of each month.

The PIMR currently measure MR and other BI functions based on frequency of dollars, lines, and services. To obtain a complete picture of MR and BI activities a fourth measure, frequency providers, is needed. This CR adds requirements for reporting on MR and BI activities in terms of that measure.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 370	Date: August 15, 2008	Change Request:

SUBJECT: Add Provider Measures to the Program Integrity Management Reporting (PIMR) System

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: CMS developed the PIMR system for the management of cost, savings, and workload data relative to the medical review (MR) unit and other benefit integrity (BI) functions. Mainly, the PIMR data relates to how contractors resolve billing problems. CMS obtains PIMR information through interfaces with the shared systems. Those interfaces are operated through contractor data centers, i.e., Enterprise Data Center (EDC) or a contractor data center (CDC); transferring data directly from the contractor shared system implementation of PIMR to the central office computer within 15 calendar days following the end of each month.

The PIMR currently measure MR and other BI functions based on frequency of dollars, lines, and services. To obtain a complete picture of MR and BI activities a fourth measure, frequency providers, is needed. This CR adds requirements for reporting on MR and BI activities in terms of that measure.

B. Policy: The PIMR system reporting requirements for medical review (MR) are in Publication 100-08 (Program Integrity Manual), Chapter 7 (MR and BI Reports), Sections 1, 5, and 6-10. They require that Medicare contractors that process Part B Medicare claims report savings and workload through the PIMR system monthly. Section 7.2.8.3 requires reporting of information.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6141.1	The shared systems maintainers shall revise the PIMR module of the shared systems to include the reports defined in Attachment A.						X	X	X		
6141.2	Contractor Data Centers, i.e., EDC or CDC, operating the MCS shared system shall install the revised shared system module developed in requirement 6141.1 so the module begins to operate in time that PIMR reports for claims processed after the implementation date of this CR contain the information requested in Attachment A.								X		CDC and EDCs
6141.3	Contactors shall test the report once delivered to insure that	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	shared system modifications to meet requirement 6141.1 meet the contractor's needs and the requirements of this CR.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Should" denotes 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): John Stewart (410) 786-1189 john.stewart@cms.hhs.gov

Post-Implementation Contact(s): John Stewart (410) 786-1189

VI. FUNDING

A. For Fiscal Intermediaries and Carriers, use the following statement:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC), use the following statement:

The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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: Reporting of Providers Receiving Prepayment Review

ATTACHMENT A

Reporting of Providers Receiving Prepayment Review

The following table provides a definition of the Prepay MR data required by the PIMR system from the contractor shared systems.

NOTE: The ideal interface is a flat file exported from the shared system. The format and order of the file is defined in the table below.

PK = Primary Key

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
P01	**Contractor Number CTRR_NUM**	**A unique number by contract type assigned to each contractor for CROWD reporting.**	**CHAR(5), PK**	**PMR_PPAY_PRVD PMR_EDIT_PRVD**
P02	**Year/Month YR_MO_TXT**	**A code, which specifies the year and month for the data, reported. Format: YYYY/MM (199902)**	**CHAR(6), PK**	**PMR_PPAY_PRVD PMR_EDIT_PRVD**
P03	**Activity Type ACTY_TYPE_CD**	**A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include:** **21001L = Automated Locally Developed Edit,** **21001N = Automated National Edit,** **21001 I = Automated CCI Edit,** **21002 = Manual Routine Review,** **21010 = TPL or Demand Bill Claim Review** **21100 = Payment Safeguard Contractor Support Services that involve use of the shared system** **21210 = Reopenings** **21220 = Prepay Complex Probe Review** **21221 = Prepay Complex Manual Review** **Left justify activity types less than six positions.**	**CHAR(6), PK**	**PMR_PPAY_PRVD PMR_EDIT_PRVD**
P04	**Edit Code EDIT_CD**	**A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of '99999' will be used for those activity types, which do not apply.**	**CHAR(5), PK**	**PMR_EDIT_PRVD**

Item Number	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
P05	**Provider Type PROV_TYPE_CD**	**The first level of indenture for the type of entity providing services or supplies (e.g., physician).**	**CHAR(6), PK**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P06	**Bill/Subtype BILL_TYPE_CD**	**The second level of indenture for the type of entity providing the services or supplies (e.g., surgery).**	**CHAR(6), PK**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P23	**Providers That Billed PRVD_LNS_BILL_ CNT**	**The number of providers who submitted one or more claims during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.**	**NUMERIC(10)**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P24	**Providers Reviewed PRVD_LNS_SUSP_ CNT**	**The number of providers for which a specific activity type reviewed one or more claims during the reporting period. This does not apply to activity types 21001L, 21001N, and 21001I.**	**NUMERIC(10)**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P25	**Denied Providers) PRVD_LNS_CND_ CNT**	**The number of providers for which each activity type denied or** reduced **one of more lines during the reporting period.**	**NUMERIC(10)**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P26	**Allowed Providers PRVD_LNS_BILL_ CNT**	**The number of providers for which each activity type allowed one of more lines during the reporting period.**	**NUMERIC(10)**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**
P27	**Reversed Providers PRVD_LNS_RVRS D_CNT**	**The number of providers that had one or more contractor payment decisions reversed during this period. The decisions may have been for claims that had been denied** or reduced **during the current or prior periods.**	**NUMERIC(10)**	**PMR_PPAY_ PRVD PMR_EDIT_ PRVD**

Level of Detail:
The data shall be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Edit Code (EDIT_CD)

Reporting of Provider Receiving Denials

The following table provides a definition of the data associated with reason for prepayment denial, which is required by the PIMR system from the contractor shared systems.

NOTE: The ideal interface is a flat file exported from the shared system. The format and order of the file is defined in the table below.

PK = Primary Key

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
D1	**Contractor Number CTRR_NUM**	**A unique number by contract type assigned to each contractor for CROWD reporting.**	**CHAR(5), PK**	**PMR_PRVD_DNL**
D2	**Year/Month YR_MO_TXT**	**A code that specifies the year and month for the data reported. Format: YYYY/MM (199902)**	**CHAR(6), PK**	**PMR_PRVD_DNL**
D3	**Activity Type ACTY_TYPE_CD**	**A unique code associated with each prepay MR activity to allow reporting by Activity. Prepay activities include: 21001L = Automated Locally Developed Edit, 21001N = Automated National Edit, 21001 I = Automated CCI Edit, 21002 = Manual Routine Review, 21010 = TPL or Demand Bill Claim Review 21100 = Payment Safeguard Contractor Support Services that involve use of the shared system 21220 = Prepay Complex Probe Review 21221 = Prepay Complex Manual Review** **Left justify activity types less than six positions.**	**CHAR(6), PK**	**PMR_PRVD_DNL**
D4	**Edit Code EDIT_CD**	**A unique code assigned to each locally developed edit. Data at the Edit Code, Provider Type, and Bill/Subtype level only applies to activity types 21001L, 21002, 21220, and 21221.. All other activity types will be summarized by Provider Type and Bill/Subtype. An edit code of "99999' will be**	**CHAR(5), PK**	**PMR_PRVD_DNL**

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
		used for those activity types, which do not apply.		
D5	**Provider Type PROV_TYPE_CD**	**The first level of indenture for the type of entity providing services or supplies (e.g., physician). Provider Type codes are defined in section 2.8.3.**	**CHAR(6), PK**	**PMR_PRVD_DNL**
D6	**Bill/Subtype BILL_TYPE_CD**	**The second level of indenture for the type of entity providing the services or supplies (e.g., surgery). Subtypes and bill types include procedure codes. Bill/subtype codes are defined in section 2.8.3.**	**CHAR(6), PK**	**PMR_PRVD_DNL**
D7	**Reason Code RSN_CD**	**A unique 6 character code that applies to either Reasons for Denials. Reason Codes include** **100001 = Documentation does not . support service, 100002 = Investigation/experimental, 100003 = Items/services excluded, 100004 = Requested information not . received, 100005 = Services not billed under . the appropriate revenue . procedure code, 100006 = Services not documented in . record, 100007 = Services not medically . reasonable and necessary, 100008 = Skilled Nursing Facility . demand bills, 100009 = Daily nursing visits are not . intermittent/part time,**	**CHAR(6), PK**	**PMR_PRVD_DNL**

ITEM NUMBER	PIMR Logical and Physical Name	Definition	Physical Design	Destination Table
		100010 = Specific visits did not include personal care services, 100011 = Home Health demand bills, 100012 = Ability to leave home unrestricted, 100013 = Physicians order not timely, 100014 = Service not ordered/not included in treatment plan, 100015 = Services not included in plan of care, 100016 = No physician certification, 100017 = Incomplete physician order, 100018 = No individual treatment plan 100019 = Other.		
D10	**Denied Providers DNL_PRVD_CNT**	**The number providers that had one or more lines denied or reduced by each activity type and denial reason code during the reporting period.**	**NUMERIC(10)**	**PMR_PRVD_DNL**

Level of Detail:
The data must be broken down by the primary keys identified above the thick solid line in the table.

Contractor Number (CTRR_NUM)
Year/Month (YR_MO_TXT)
Provider Type (PROV_TYPE_CD)
Bill/Subtype (BILL_TYPE_CD
Activity Type (ACTY_TYPE_CD)
Edit Code (EDIT_CD)
Reason Code (RSN_CD