Medicare Program Integrity Manual
Exhibits

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(Rev. 10228, 07-27-20)

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Exhibit 1 - Definitions

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A

Abuse

Billing Medicare for services that are not covered or are not correctly coded.

Affiliated Contractor (AC)

A Medicare carrier, Fiscal Intermediary (FI), or other contractor such as a Durable Medical Equipment Medicare Administrative Contractor (DME MAC), which shares some or all of the *Unified Program Integrity Contractor's (UPIC's)* jurisdiction; Affiliated Contractors perform non-*UPIC* Medicare functions such as claims processing.

B-C

Carrier

The Carrier is an entity that has entered into a contract with CMS to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). DME MACs are those carriers that CMS has designated to process DME, prosthetic, orthotic and supply claims.

Case

A case exists when the *UPIC* or Medicare contractor BI unit has referred a fraud allegation to law enforcement, including but not limited to, documented allegations that: a provider, beneficiary, supplier, or other subject has a) engaged in a pattern of improper billing, b) submitted improper claims with actual knowledge of their truth or falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

Contractor

Contractor includes all intermediaries, carriers, DME MAC, RHHIs, MACs, and *UPICs*.

Centers for Medicare & Medicaid Services (CMS)

CMS administers the Medicare program. CMS' responsibilities include management of AC and Medicare contractor claims payment, managing *UPIC*, AC, and Medicare contractor fiscal audit and/or overpayment prevention and recovery, and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. CMS was formerly known as the Health Care Financing Administration (HCFA).

Closed Case

A FID case shall be closed when no further action will be required of the *UPIC*, or Medicare contractor BI unit by the law enforcement agency(ies) working the case and when the law

enforcement agency(ies) has ended all its activity on the case. Note that even after the case is closed, there may still be administrative actions that the *UPIC*, or Medicare contractor BI unit will take.

D-E

Department of Justice (DOJ)

Attorneys from DOJ and United States Attorney's Offices have criminal and civil authority to prosecute those providers who de-fraud the Medicare program.

Demand Bill or Demand Claim

A demand bill or demand claim is a complete, processable claim that must be submitted promptly to Medicare by the physician, supplier or provider at the timely request of the beneficiary, the beneficiary's representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary's subrogee. A demand bill or demand claim is requested usually, but not necessarily, pursuant to notification of the beneficiary (or representative or subrogee) of the fact that the physician, supplier or provider expects Medicare to deny payment of the claim. When the beneficiary (or representative or subrogee) selects an option on an advance beneficiary notice that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill or claim must be submitted.

F

Federal Bureau of Investigation (FBI)

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding, the FBI has direct access to contractor data and other records to the same extent as OIG.

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

G-H

I

Intermediary

The intermediary is a public or private agency or organization that has entered into an agreement with CMS to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional home health intermediaries (RHHIs) are those FIs that CMS has designated to process Medicare claims received from home health and hospice providers.

J-K-L

Local Coverage Determinations (LCDs)

The LCDs are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

M

Medicare Contractor (Benefit Integrity)

Medicare contractors include all intermediaries and carriers that have not transitioned their benefit integrity work to a *UPIC*.

Medicare Contractor (Medical Review)

Medicare contractors include intermediaries, carriers and MACs.

Misrepresented

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

N

Noncovered (Not Covered)

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

O

Office of Audit Services (OAS)

The OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

Office of Counsel to the Inspector General (OCIG)

The OCIG is responsible for coordinating activities that result in the negotiation and imposition of Civil Monetary Penalties (CMPs), assessments, and other program exclusions. It works with the Office of Investigations (OIG), Office of Audit Services (OAS), CMS, and other organizations in the development of health care fraud and exclusions cases.

Office of Inspector General (OIG)

The OIG investigates suspected fraud or abuse and performs audits and inspections of CMS programs. In carrying out its responsibilities, OIG may request information or assistance from CMS, its *Unified Program Integrity Contractor (UPIC)*, Medicare contractors, and QIOs. OIG has access to CMS's files, records, and data as well as those of CMS'scontractors. OIG investigates fraud, develops cases, and has the authority to take action against individual health

care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor, AC, Medicare contractor, and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. OIG/OI investigates allegations of fraud or abuse whether committed by *UPICs*, ACs, Medicare contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

The OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCIG for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any State health care programs as defined under §1128(h) of the Social Security Act (the Act); or
- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

Offset

The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

P

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DME MACs, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization (QIO)

The Peer Review Improvement Act of 1982 established the utilization and quality control peer review organization (PRO) program. The PRO name has changed to quality improvement organization. CMS contracts with independent physician organizations in each state to administer the QIO program. Their purpose is to ensure that the provisions of the Peer Review Improvement Act of 1982 are met. Under their contracts with CMS, QIOs are required to perform quality of care reviews of the medical services provided to Medicare beneficiaries in settings including, but not limited to: physician offices, acute care hospitals, specialty hospitals (for example psychiatric and rehabilitation hospitals), and ambulatory surgical centers. In the inpatient setting, QIOs also perform provider-requested higher-weighted DRG reviews for acute inpatient prospective payment system (IPPS) hospitals and long-term care hospital (LTCH) claims.

Recoupment

The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Reliable Information

Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists, for example, that claims are or were false or were submitted for non-covered or miscoded services. Reliable information of fraud exists if the following elements are found:

- The allegation is made by a credible person or source. The source is knowledgeable and in a position to know. The source experienced or learned of the alleged act first hand, i.e., saw it, heard it, read it. The source is more credible if the source has nothing to gain by not being truthful. The source is competent; e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source;
- The information is material. The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable (e.g., instructions handwritten by the provider delineating how to falsify claim forms).

- The act alleged is not likely the result of an accident or honest mistake. For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

S

Services

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

Suspension of Payment

Suspension of payment is defined in the regulation 42CFR 405.370 as "the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists." In other words, ACs or Medicare contractors have received processed and approved claims for a provider's items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

T-U-V-W-X

Unified Program Integrity Contractor (UPIC)

The UPIC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract.

Exhibit 2 – Reserved for Future Use

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Exhibit 4 - Reliable Information - (Rev. 3, 11-22-00)

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;
- Corroboration from provider employees (official and unofficial whistle blowers);
- Other sources, such as prepayment and postpayment review of medical records; or
- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

Exhibit 5 - Background Information When IRP is Questioned - (Rev. 3, 11-22-00)

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 allows the federal government to pay a reward to individuals who report evidence of suspected fraud and abuse against the Medicare program. Implementing regulations, issued on June 8, 1998, were effective on July 8, 1998 and provide that a complainant may be rewarded up to 10 percent of the amount recovered, but not more than $1,000. Not everyone is eligible for the reward, though. To be eligible for a reward:

- The information you give has to lead to a recovery of at least $100;
- The suspected fraud must be acts or omissions that are grounds for the government to impose sanctions provided under certain provisions of the law;
- There isn't another reward that you qualify for under another government program;
- You must not have participated in the sanctionable offense with respect to which payment is being made;
- If the person or organization is already under investigation; and

- You are not an immediate family member or an employee of the Department of Health and Human Services, its contractors or subcontractors, the Social Security Administration, the Office of the Inspector General, a State Medicaid agency, the Department of Justice, the FBI, or any other federal, State, or local law enforcement agency at the time he or she came into possession, or divulged information leading to a recovery of Medicare funds.

You'll receive a letter from us acknowledging that we have received your complaint. Some investigations take a long time to complete, and may take several months or years to resolve. You'll be notified by letter of your eligibility to receive a reward after the Medicare funds have been recovered. If you do receive a reward for this information you may be expected to pay any applicable state and federal taxes.

5.1 - Reward Eligibility Notification Letter - (Rev. 3, 11-22-00)

Dear_____:

You are eligible for a reward as part of the Medicare Incentive Reward Program for telling us about Medicare fraud and abuse.

To claim your reward, please fill out the enclosed form and return it to [contractor information] in the enclosed envelope. You have one year from the date of this letter to claim your reward.

In the case of death or incapacitation of the person reporting the potential fraud, a legal representative of that person may claim the reward on his or her behalf when evidence is submitted to justify the claim.

If it is later found that you received the reward caused by your misrepresentation of the facts, all monies paid to you must be returned to Medicare. If you have questions, please contact [contractor information].

Sincerely,

[Contractor Information]

Enclosures

5.2 - Reward Claim Form - (Rev. 3, 11-22-00)

[To be completed by contractor.]

Provider/Supplier Name

Case Number

REWARD CLAIM FORM

Date

Dear [Contractor Information]:

I am claiming the reward for providing information about Medicare fraud by filling out this form as it applies to me. My signature verifies that I am a proper recipient of the incentive reward or that I am the legal representative of the proper recipient of the reward. I also understand that the reward must be repaid by the recipient if it is later determined that the reward should not have been received.

CLAIMANT INFORMATION

Name_____

Street Address_____

City, State, Zip code_____

Telephone Number_____

Claimant (or Representative) Signature_____

REPRESENTATIVE INFORMATION

If the intended recipient of the reward has become incapacitated or has died, his or her executor, administrator, or other legal representative may collect the reward on the individual's behalf or for the individual's estate. In addition to submitting this letter, please also submit certified copies of letters testamentary, letters of administration, or other similar evidence to show your authority to claim the reward. In the space provided below, please submit your name and the mailing address where the check should be sent if that address differs from the information stated above.

Name_____

Street Address_____

City, State, Zip code_____

Telephone Number_____

5.3 - How to Use the IRP Tracking System - (Rev. 3, 11-22-00)

Selected IRP screen exhibits may be viewed from the PIM whenever "Click here to view the selected screen" is indicated in bold.

After you log on to the Winframe, you will see the IRP Tracking group icon. Double click on that icon, then double click on the IRP Tracking to run the application. The first screen IRP Menu will appear.

Click here to view an exhibit of the IRP Menu screen.

A. Screen Use

From the IRP menu screen, click on the item you would like to select. Reference §§5.4 through 5.9 below for explicit instructions on how to use every menu option of the IRP system.

B. Options

1. Pending Case List - This function allows you to view all of the pending cases in the system. See §5.4 below for details on this option.

2. Pending List By Contractor - This function allows you to view all of the pending cases that are listed by each contractor ID number. See §5.5 below for details on this option.

3. New Case - This function allows you to enter a new case into the system. See §5.6 below for details on this option.

4. Closed Case List - This function allows you to view all of the closed cases in the system. See §5.7 below for details on this option.

5. Closed Case List By Contractor - This function allows you to view all of the closed cases that are listed by each contractor's ID number. See §5.8 below for details on this option.

6. Report Menu - This function allows you to open the report menu that contains all available predefined reports.

5.4 - Section I: Pending Case List Screen - (Rev. 3, 11-22-00)

Click here to view an exhibit of the Pending Case List Screen.

View Case- After you select a case number, you can double click on the view case button on the bottom of the screen to view the case detail screen of the case selected. From the case detail screen you may:

1. View Comments

You may enter/edit contractor comments or view CMS comments. DO NOT EDIT CMS COMMENTS. You may save comments or save/close form.

2. Edit Case

You may select view/edit comments and enter/edit contractor comments or view CMS comments. DO NOT EDIT CMS COMMENTS. You may save comments or save/close form. You may also select enter/edit provider to access the provider detail screen. From the provider detail screen you may click on 1) add new provider; 2) delete provider; 3) edit provider; or 4) enter/edit an allegation against a provider. To edit the provider appearing on the screen, click on the edit provider button. You may click on next provider or previous provider to find the one that you want to edit. To enter/edit an allegation, click on the allegation button to get to the view allegations screen. Select the case desired and you may add or delete an allegation or cancel this function.

3. View Report

Click on the view report to get to the case report menu. You may now view the details of the selected case.

5.5 - Section II: Pending Case List by Contractor Screen - (Rev. 3, 11-22-00)

You may perform the same functions as in §5.4 (§I) above: Pending Case List. However, information will be provided specific to the contractor ID number entered.

5.6 - Section III: New Case - (Rev. 3, 11-22-00)

Click here to view an exhibit of the New Case Screen.

Click on the new case button to get the new case screen. You must enter a FID number at this time to enter new case information. You can move from one data field to another by either using the Tab key or the mouse to move the cursor to that data field. After entering all available information, you must remember to click on the enter provider information to access the provider detail screen and click on the enter complainant information to access the complainant detail screen. You may also edit the provider information or complainant information using this same approach. If the provider number is not entered at this time, the system will not allow you to save this provider information. The case number and complainant's first, middle initial and last name must be entered to allow you to save the complainants information.

1. Provider Detail - Enter provider information. Click the “enter allegation” button to get to the “view allegations” screen. At this point, you may add an allegation, delete an allegation, or cancel the screen. An allegation is added by typing in an allegation code next to the provider number and then clicking on "OK". You may exit the screen by clicking on the ok-save edits button.

2. Complainant Detail - Enter complainant information, and then close screen.

5.7 - Section IV: Closed Case List - Rev.)

Click here to view an exhibit of the Closed Case List Screen.

You may perform the same functions as in §5.4 (I) above, however, pending case list information will be provided only for closed cases.

5.8 - Section V: Closed Case List by Contractor - (Rev. 3, 11-22-00)

You may perform the same functions as in §5.5 (§II) above: Pending case list by contractor however, information will be provided for closed cases specific to the contractor ID number entered.

5.9 - Section VI: Report Menu - (Rev. 3, 11-22-00)

Click here to view an exhibit of the Report Menu Screen.

Click here to view an exhibit of the IRP Cases List Screen.

Click here to view an exhibit of the View Case Detail Screen.

Click here to view an exhibit of the Edit Case Detail Screen.

Click here to view an exhibit of the Comments Screen.

Click here to view an exhibit of the Provider Detail Screen.

Click here to view an exhibit of the Provider Edit Detail Screen.

Click here to view an exhibit of the View Allegations Screen.

Click here to view an exhibit of the View Edit Allegations Screen.

Click here to view an exhibit of the View Complainant Detail Screen.

Click here to view an exhibit of the Case Report Screen.

The report menu provides a variety of management reports in brief format and detailed format. Click on the report menu from the main IRP menu. Select the type of report desired from the following list:

A. Brief List

- All Cases;
- Pending Cases;
- Closed Cases;
- Rewarded Cases;
- Recovery From Ten Thousand Up; and
- Notified But Not Rewarded

B. Detail List

- All Cases

C. List By Contractor

- All Cases- Brief; and
- All Cases- Detailed

EXHIBITS

Exhibit 7 - Sample Letter for On-Site Reviews

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME:	CONTRACTOR NAME:
PROVIDER ADDRESS:	CONTRACTOR ADDRESS:

OPENING

Dear _____:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review we have determined that you have been overpaid. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that your facility utilized _____ services at a rate of 50 percent more than that of your peer group.

HOW THE OVERPAYMENT WAS DETERMINED

A random sample of _____ claims processed from 01/01/98 to 06/30/98 was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Our review found that some services you submitted were not reasonable and necessary as required by the Medicare statute or did not meet other Medicare coverage requirements.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable or necessary, and/or you did not follow correct procedures or use care in billing or receiving payment.

The attachment identifies the specific claims that have been determined to be fully or partially non-covered, the specific reasons for denial, an explanation of why you are responsible for the incorrect payment and the amount of the overpayment.

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by _____ and no interest charge will be assessed. Make the check payable to Medicare Part A and send it with a copy of this letter to:

Intermediary's Address

IF YOU DO NOT REFUND WITHIN 30 DAYS:

If you repay the overpayment within 30 days, you will not have to pay any interest charge.

However, if you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time.

On _____ we will automatically begin to recoup the overpayment amount against your pending claims. Recouped payments will be applied to the accrued interest first and then to the principal. If you believe that recoupment should not be put into effect, submit a Statement within 15 days of the date of this letter to the above address, giving the reason(s) why you feel this action should not be taken. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

For copies of the applicable laws and regulations, please contact us at the address shown in our letterhead, to the attention of the _____ Department.

APPEAL RIGHTS:

If you disagree with the overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for a redetermination to:

Address to which redetermination request should be sent

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following national Medicare guidelines in submitting claims for necessary and reasonable _____ services. In addition, you have not followed the Provider Bulletins and letters sent to you regarding local medical review policies and specific problems that we have identified with your billing practices. Your future claims for _____ will be suspended for prepayment review until you correct your billing.

If you have any questions regarding this matter, please contact _____ at _____.

Thank you in advance for your prompt attention to this matter.

Sincerely,

7.1 - Attachment to Letter for Provider Site Reviews - (Rev. 3, 11-22-00)

Following is a list of the claims denied as a result of the review:

- Beneficiary Name: John Smith
- HI Claim Number: 000-00-0000 A
- Service Dates: 12/08/97 - 12/08/97
- Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/97
- Reason for Denial: MRI's are not considered reasonable and medically necessary for the diagnosis of xxxx.
- Why the Provider is Responsible: We believe you knew or should have known that the services were not reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1997, outlined Local Medical Review Policy which indicated that MRI's were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.
- Overpayment: $900.00
- Beneficiary Name: Mary Smith
- HI Claim Number: 000-00-0000B
- Service Dates: 10/01/97 - 10/31/97
- Services Denied and Dates: Physical therapy evaluation and re-evaluation on 10/03/97 and 10/26/97.
- Reason for Denial: The two physical therapy visits are not reasonable and medically necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation.
- Why you are Responsible: In a letter dated 07/30/97 you were notified that such therapy evaluation and re-evaluation were not considered reasonable and necessary. Therefore, you are responsible for the overpayment.
- Overpayment: $ 200.00
- Beneficiary Name: Tom Jones
- HI Claim Number: 000-00-0000A
- Service Dates: 12/10/97 - 12/31/97
- Services Denied and Dates: 10 physical therapy visits from 12/10/97 - 12/31/97
- Reason for Denial: No plan of care signed by a physician.

- Why you are responsible: We find you responsible for the overpayment because regulations at 42 CFR, and manual instructions at §xxxx, clearly require a plan of care signed by a physician for therapy visits.
- Overpayment: $1,200.00

7.2 - Exhibit-Sample Letter--Request For Medical Records - (Rev.)

The intermediary uses the following letter to request necessary medical records from the provider.

DATE:

PROVIDER NAME: INTERMEDIARY NAME:
PROVIDER ADDRESS: INTERMEDIARY ADDRESS:
PROVIDER NUMBER:
OPENING:

Dear XXXXX:

You have been selected for a comprehensive medical review (CMR) of your billing for Medicare services pursuant to CMS's statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that you may be billing inappropriately for services.

We have selected a random sample of ___ claims for services provided during the period _____ through _____. (See attached listing.) For each of these claims, we are requesting the following information:

[The following list is for illustrative purposes. MR should request any documentation that will permit them to conduct a thorough review of the claims submitted with regard to coverage, eligibility, medical reasonableness and necessity, limitation on liability determinations (§1879), without fault determinations (§1870), etc.]

- Form HCFA-485;
- Form HCFA-486, or equivalent information, if applicable;
- Form HCFA-487, or equivalent information, if applicable;
- Flow sheets or treatment sheets, if used;
- Narrative or progress notes, if used;
- Supplemental order, if applicable;
- Itemized breakdown of supplies, if supplies are billed;
- Lab values, if applicable;
- Copy of the UB-92 for each bill;

- Lab reports for any B12 injections;
- Lab or x-ray reports for any calcimar injection;
- Other _____

The above information should be mailed to the following address within 30 days from the date of this letter:

Intermediary Name, Address, and Contact Person

Our medical review staff will review the documentation you submit for each of the claims to determine if the services billed are reasonable and necessary and meet all other requirements for Medicare coverage. Along with our claims payment determination, we will make a limitation on liability decision for services that are subject to the provisions of §1879 of the Social Security Act (the Act), and a determination in accordance with §1870 of the Act (whether you are without fault for any overpayments).

We will project the overpayments identified in the sample to the universe of claims processed during the time frame described above. We will adjust the projected overpayment to reflect any previously denied claims which are payable, denied claims for which you were found not liable under §1879 of the Act, and denied claims for which you were found to be without fault under §1870 of the Act.

Following our review, we will inform you in writing of our findings. We will provide you with a listing of the claims that were reviewed and our determinations with regard to those claims (i.e., full or partial denials and payable claims), the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, the amount of the overpayment or underpayment, and interest accrual on unpaid balances. We will provide you with an explanation of your right to submit a rebuttal statement under 42 CFR 405.370-375 if we determine that you have been overpaid, and your options for repaying any overpayments, or our refund of any underpayments. We will provide you with an explanation of how any overpayment was determined, including the sampling methodology used to project the amount of the overpayment. We will also provide you with a full explanation of your appeal rights, including appeal of the sampling methodology used to determine the overpayment, estimation of the overpayment, coverage decisions, limitation on liability decisions under §1879 of the Act, and our determination as to whether you are without fault under §1870 of the Act.

If you have any questions concerning this request, you may contact me at (telephone number). Your cooperation is appreciated.

Sincerely,

Enclosure: Listing of Sample Claims Requiring Medical Documentation

7.3 - Exhibit: Part A Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

DATE:

PROVIDER NAME: INTERMEDIARY NAME:
PROVIDER ADDRESS: INTERMEDIARY ADDRESS:
PROVIDER NUMBER:

OPENING:
Dear XXXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.750 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

TOTAL OVERPAYMENTS

(List the aggregate overpayments)

Be advised that this overpayment amount is based on your interim payment rate in effect at the time the review was done. Further adjustments may be made when your cost report is settled.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider

specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of the specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclose a list of the specific claims from the sample that have been found not to be covered. See the example within this exhibit.)

The sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclosed an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the amount of the overpayment to us by (insert date, 15 days from date of letter). However, you may request an extended repayment schedule in accordance with 42 CFR 401.607(c). Please contact (name of contact person at the FI/RHHI) on (phone number of contact person) to discuss repayment options for the full amount of the overpayment determined by the projection of errors found on the ___claim sample.

INTEREST

If you refund the overpayment within 30 days, you will not have to pay any interest charge. If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of _____ percent for each full 30-day period that payment is not made on time. Medicare charges interest on its outstanding Part A debts in accordance with §1815(d) of the Act and 42 CFR 405.378.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

As provided in regulations at 42 CFR 401.607(a) and 405.370-375, on (insert date provided in above paragraph captioned, "What You Should Do"), we will automatically begin to recoup the overpayment amount against your pending and future claims. If you do not repay the debt within 30 days, we will apply your payments, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act, we may refer your debt to the Department of Treasury for offset against any monies payable to you by the Federal Government.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

FI Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within fifteen days whether the facts justify continuation, modification, or termination of the overpayment recoupment. We will send you a separate written notice of our determination that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2) of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

If you choose not to submit a rebuttal Statement, the recoupment will automatically go into effect on (insert same date as provided in paragraph captioned, "What You Should Do "). Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.704, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date you receive this letter (unless you can show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations under Part A and overpayment recovery. (See 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual § _____ for further details.)

If you have any questions regarding this matter, please contact _____ at _____. (Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.3.1 - Exhibit: Attachment to the Part A Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev.)

The following is a list of claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A

2. Service Dates: 12/01/96 - 01/15/97

3. Services Denied and Dates: 45 Inpatient SNF Days, 12/1/96 - 1/15/97

4. Reason for Denial: The therapy services rendered were not medically reasonable and necessary because they were for overall fitness and general well being and did not require the skills of a qualified physical therapist (§1879 denial). (Provide details that led you to the conclusion that the services were non-skilled.)

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. We believe you knew or should have known that the services were not medically reasonable and necessary because of the educational contacts made in July 1996 and October 1996 regarding Medicare coverage of therapy services. In these contacts numerous similar examples were cited as noncovered. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: $2,000.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number:000-00-0000 B

2. Service Dates: 01/01/97 - 01/31/97

3. Services Denied and Dates: 31 Inpatient SNF Days, 01/01/97 - 01/31/97

4. Reason for Denial: There was no skilled care furnished on a daily basis. Skilled therapy services were furnished 2-3 times a week, although therapy is available in your facility on a daily basis.

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. The Medicare coverage guidelines in the SNF manual clearly state the requirement for daily skilled services. You were also notified in educational contacts in July 1997 and October 1997 of similar cases. Therefore, you are responsible for the overpayment.

6. Overpayment: $200.00

7.4 - Exhibit: Part B Sample Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev. 213, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

SAMPLE LETTER--MEDICARE PART B

DATE:

PROVIDER NAME: INTERMEDIARY NAME:
PROVIDER ADDRESS: INTERMEDIARY ADDRESS:
PROVIDER NUMBER:

OPENING:
Dear XXXXX:

Thank you for your cooperation during the comprehensive medical review conducted at your facility on _____. Based on this review, we have reopened claims in accordance with the reopening procedures at 42 CFR 405.841 and have determined that you have been overpaid in the amount of _____. We hope the following information answers any questions you may have.

REASON FOR REVIEW

This review was conducted because our analysis of your billing data showed that you may be billing inappropriately for services. (Include in this paragraph any additional details on why the provider was selected for the review.)

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of _____ claims processed from _____ to _____ was selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met. Medical documentation for the selected claims was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that some services you submitted were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we have made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. We projected our findings from the claims that we reviewed to the universe of claims processed during the time frame mentioned above.

GENERAL PROBLEMS IDENTIFIED IN THE REVIEW AND/OR CORRECTIVE ACTIONS TO BE TAKEN

This review has shown that you are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable _____ services. (Reference any provider specific education that occurred regarding these services.) Because of these identified problems, your future claims for _____ may be subject to prepayment review until you correct your billing.

WHY YOU ARE RESPONSIBLE

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act.

A list of specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment is attached. (Enclosed a list of the specific claims and an explanation of fault for each. See the example within this exhibit.)

An explanation of the sampling methodology used in selecting claims for review and the method of overpayment estimation is attached. (Enclose an explanation of the sampling methodology.)

WHAT YOU SHOULD DO

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

_____Address

IF YOU DO NOT REFUND IN 30 DAYS

In accordance with 42 CFR 405.378, simple interest at the rate of _____ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the rate of _____.

We must request that you refund this amount in full. If you are unable to make refund of the amount at this time, advise this office immediately so that we may determine if you are eligible for an extended repayment schedule. (See enclosure for details.) Any extended repayment schedule (where one is approved) would run from the date of this letter.

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT
If payment in full is not received by (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is received.

You have the right to submit a rebuttal Statement in writing within fifteen days from the date of this letter. Your rebuttal Statement should address why the recoupment should not be put into effect on the date specified above. You may include with this Statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. Your rebuttal Statement and evidence should be sent to:

Carrier Name, Address, Telephone #, and Fax #

Upon receipt of your rebuttal Statement and any supporting evidence, we will consider and determine within 15 days whether the facts justify continuation, modification or termination of the overpayment recoupment. We will send you a separate written notice of our determination

that will contain the rationale for our determination. However, recoupment will not be delayed beyond the date Stated in this notice while we review your rebuttal Statement. This is not an appeal of the overpayment determination, and it will not delay recoupment based on §1893(f)(2) of the Act. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; (3) a valid and timely appeal is received; or (4) on the basis of subsequently acquired evidence, we determine that there is no overpayment.

Whether or not you submit a rebuttal Statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extended repayment schedule, and our response to any rebuttal Statement are not initial determinations as defined in 42 CFR 405.803, and thus, are not appealable determinations. (See also, 42 CFR 401.625 and 405.375(c).)

YOUR RIGHT TO CHALLENGE OUR DECISIONS

This letter serves as our revised determination of the claims listed in the attachment. If you disagree with this determination, you may request a redetermination within 120 days of the date of this letter (unless you show us otherwise, receipt is presumed to be five (5) days from the date of this letter). You have the right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and overpayment recovery. (See 42 CFR 405.801, et seq. and 42 CFR 405.701, et seq.) You may ask for a redetermination of the denials for which you are determined to be liable under §1879 of the Act or for which the beneficiary is determined to be liable under §1879 of the Act, but declined, in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under §1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe. (Refer to the appeals procedure in your Provider Manual Section _____ for further details.)

IF YOU HAVE FILED A BANKRUPTCY PETITION

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

If you have any questions regarding this matter, please contact _____ at _____. (Provide correspondence address.)

Thank you in advance for your prompt attention to this matter.

Sincerely,

Enclosures

7.4.1 - Exhibit: Attachment to the Part B Letter Notifying the Provider of the Results, and Request Repayment of Overpayments

(Rev.)

The following is a list of the claims denied as a result of the review:

A. Beneficiary Name: John Smith

1. HI Claim Number: 000-00-0000 A

2. Service Dates: 12/08/96 - 12/08/96

3. Services Denied and Dates: Magnetic Resonance Imaging (MRI) 12/08/96

4. Reason for Denial: MRIs are not considered medically reasonable and necessary for the diagnosis of xxxx (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. You knew or should have known that the services were not medically reasonable and necessary because you were notified in a Provider Bulletin. The Bulletin dated April 1, 1996, outlined Local Medical Review Policy which indicated that MRIs were not covered for the diagnosis of xxxx. Therefore, you are responsible for paying the overpayment amount.

6. Overpayment: $900.00

B. Beneficiary Name: Mary Smith

1. HI Claim Number: 000-00-0000 B

2. Service Dates: 01/01/97 - 01/31/97

3. Services Denied and Dates: Physical Therapy evaluation and re-evaluation on 01/03/97 and 01/26/97

4. Reason for Denial: The two Physical Therapy visits are not medically reasonable and necessary because the medical documentation shows that the patient was ambulatory and had no functional problems which would have required a physical therapy evaluation or re-evaluation (§1879 denial).

5. Why You Are Responsible: We find that you knew or should have known that payment would not be made for such items or services under Part A, and you are not without fault in accordance with §1870 of the Social Security Act. In a letter dated 10/30/96, you were notified that such therapy evaluation and re-evaluation were not considered medically reasonable and necessary. Therefore, you are responsible for the overpayment.

6. Overpayment: $200.00

Exhibit 8 – **Victimized Provider Process Letter Templates**

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

Letter 1: Send to the Medicare Provider/Supplier when you begin your evaluation of the potential identity theft.

[Date]

Dear [Name of Medicare Provider/Supplier]:

VPP Case #

This letter serves notice that CMS has received your complaint alleging that your identity has been stolen or compromised and that you have suffered unwarranted Medicare related financial liabilities as a result.

The Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). CMS, in coordination with its Program Integrity Contractors, conducts an extensive investigation of the allegation; reviews any documentation submitted by the provider regarding the theft (including actions taken to report the theft and to prevent additional loss); evaluates any associated financial liabilities or overpayments; and then makes a final decision regarding the case.

Where evidence compellingly demonstrates that the Medicare provider/supplier is a victim of identity theft, the Medicare provider/supplier shall be released from financial liability specifically associated with specific overpayment(s) associated with the fraudulent claims at issue. Where insufficient evidence exists to release a Medicare provider/supplier from financial liability, the Medicare provider/supplier shall still have the right to appeal any overpayments and any related claim determinations through Medicare's established appeals process, and/or to provide any additional evidence, as appropriate, to seek a new VPP decision.

CMS is in the process of investigating your complaint and reviewing the materials you have submitted. CMS or its Program Integrity Contractors may be contacting you for further information, and you may be asked to sign an attestation, under penalty of perjury, regarding the circumstances of the identity theft. CMS will strive to make a decision no later than 60 days from the date of receipt of your complete attestation and documentation package.

[Name of UPIC] is the Program Integrity Contractor that will be gathering evidence related to your case. Your Point of Contact (POC) is:

[Name and Contact Information]

If you have any additional information that you believe will be helpful to your case, please provide it to the POC. Please note that CMS and the Program Integrity Contractors are assisted best in these investigations and decisions if Medicare providers/suppliers supply the most comprehensive evidence up-front in order to make the investigative and review process as efficient, effective, and informed as possible. The Program Integrity Contractor will conduct an investigation based on evidence received, as well as through other evidence known to it or otherwise obtained, and will present its findings to CMS for a final decision. The Program Integrity Contractor will notify you of CMS's decision in writing.

Please note that the potential release from financial liability for fraudulent claims submitted in your name is restricted solely to those claims, and that the release from financial liability shall not attach to claims that are not the subject of this investigation. Further, the VPP is only for providers who have suffered actual financial harm as a result of identity theft; it is not for Medicare providers/suppliers whose identities may have been stolen, but who have incurred no Medicare financial liability. If you believe that you have been a victim of identity theft, but you have not suffered consequent financial liability, please contact [Name of Contractor] to report the theft and provide as much information as possible to assist CMS to prevent further misuse.

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]

Letter 2: Send to the Medicare Provider/Supplier if CMS decided that identity theft has likely occurred and overpayment collection should stop.

[Insert Date]

[Insert identifying information regarding specific overpayment(s) and affected claims]

Dear [Name of Medicare Provider/Supplier]:

VPP Case #

As we previously informed you, the Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). This letter serves notice that CMS has completed its VPP investigation of your identity theft complaint and has decided that sufficient information exists to confirm identity theft and to relieve you of certain debt(s). CMS has made a decision that you should not be held liable for the following overpayment(s) (describe dollar amount(s) and timeframe(s) of claims at issue). Therefore, pursuant to Chapter 4 of the Medicare Financial Management Manual (IOM Publication 100-06), the Medicare Administrative Contractor (MAC) shall stop its collection efforts upon receipt of CMS' notification. Specifically, the MAC shall:

1. Update its systems, as appropriate, to reflect rescission of the overpayment;
2. Refund any recoupment made against you on the specified overpayment(s) and/or affected claims;
3. Stop the recoupment against you on the specified overpayment(s) and/or affected claims;
4. Discontinue sending demand letters to you on the specified overpayment(s) and/or affected claims;
5. Not refer any specified overpayment(s) and/or affected claims to the Department of Treasury for collection;
6. Recall all specified overpayment(s) and/or affected claims on the debt/s referred to the Department of Treasury.

Please note that the foregoing is solely limited to the specified overpayment(s) and/or affected claims, and shall not apply to claims or overpayments that were not the subject of this case. If you have any questions, please contact:

[Point of Contact at UPIC and Contact Information]

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]

Letter 3: Send to the Medicare Provider/Supplier if CMS informs you that it is unable to determine that identity theft has occurred and overpayment notice with appeal rights has already been issued.

[Insert Date]

[Identifying Information Regarding Overpayment(s) and Affected Claims]

Dear [Name of Medicare Provider/Suppliers]:

VPP Case # _____

As we previously informed you, the Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). This letter serves notice that CMS has completed its VPP investigation of your identity theft allegation with regard to the identified overpayment(s) and/or affected claims, and has decided that insufficient information exists at this time to support a finding of identity theft.

Please be advised that this decision does not affect your appeal rights. You were previously afforded appeal rights in your notice of overpayment, and we refer you to your previously issued overpayment determination notice for guidance on such appeal rights.

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]

Exhibit 9 - Projection Methodologies and Instructions for Reviews of Home Health Agencies for Claims Not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Reimbursement Methods for Home Health Agencies (HHAs)

Based on the findings from the statistical sampling for overpayment estimation, the Fiscal Intermediary (FI)/Regional Home Health Intermediary (RHHI) will project by discipline to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by discipline (e.g., skilled nursing, physical therapy) for a specified time frame within a single cost reporting period. They determine the reimbursement method for the service(s) reviewed as shown below to ascertain the appropriate projection methodology to be used.

The HHAs are reimbursed as follows:

- Discipline: Patient Services--Reimbursed By Cost Per Visit
- Skilled Nursing;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;
- Medical Social Services; and
- Home Health Aide Service
- Other Patient Services - Reimbursed By Lower of Costs or Charges
- Cost of Medical Supplies;
- Cost of Drugs

Note that the reimbursement methodology for HHA's was changed by the BBA for cost report periods beginning on or after October 1, 1997.

B. Procedures for Disciplines 1 through 6, which are reimbursed by cost per visit:

The following procedures apply to disciplines 1 through 6, which are reimbursed by cost per visit:

- The sample may be chosen from a frame including claims with a particular or many disciplines;
- For each discipline, MR determines the total number of visits and number of visits denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, § 3.10.1.5 – Consultation with a Statistical Expert; Chapter 3, §3.10.1.6 – Use of Other Sampling Methodologies; and Chapter 3, §3.10.5.1 – The Point Estimate on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert.

- Multiply the proportion obtained above by the total number of Medicare visits in the frame. This will determine the projected total number of visits to be denied for the period and the adjusted Medicare visits;
- If the adjustment occurs prior to the submission of the cost report, the projected denied visits will be multiplied by the provider's interim payment rate per visit to determine the overpayment amount by discipline subject to collection. The FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options;
- Upon submission of the cost report, total visits on the cost report will not change. The cost per visit computation will remain the same. Only the Medicare visits and the total cost of Medicare services will be reduced. The charges that are applicable to these adjusted costs must also be determined. Both of these adjusted totals are needed to settle the cost report. For cost report periods beginning prior to 10/1/97, HHA cost reports are settled on the lesser of reasonable cost or customary charges. Under the BBA, for cost report periods beginning on or after 10/1/97, the methodology for settling HHA cost reports has changed. Medical Review staff must complete worksheets 1-7 and notify Audit and Reimbursement staff of all necessary adjustments so that the amount can properly be reflected in the cost report.

Worksheets 1 through 7 may be accessed by clicking on the links below:

Worksheet 1: Home Health Agency (HHA) Calculation of Medical Review Audit Adjustment, Form HHA/Audit-1

Worksheet 2: Home Health Agency (HHA) Calculation of Charges Applicable to Adjusted/Denied Visits, Form HHA/Audit-2

Worksheet 3: Home Health Agency (HHA) Medical Review Sampling Results, Form HHA/MR-1, page 1

Worksheet 4: Home Health Agency (HHA)Medical Review Sampling Results, Form HHA/MR-1, page 2

Worksheet 5: Home Health Agency (HHA)Medical Review Sampling Results, Form HHA/MR-1, page 3

Worksheet 6: Home Health Agency (HHA) Summary of Results Medical Review Sampling - Form HHA/MR-2

Worksheet 7: Home Health Agency (HHA) Summary of Results of Medical Review - Form HHA/MR-3

C. Procedures for Other Patient Services

The following procedures apply to other patient services:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;

- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- Determine the ratio of denied Medicare charges to the total Medicare charges in the sample and the 90 percent confidence interval for the ratio. The estimated proportion is a ratio estimate and therefore requires a formula for the standard error appropriate to ratio estimation;
- The lower bound of the confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If the lower bound is zero or negative, there is no overpayment;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If the adjustment occurs prior to the submission of the cost report, the FI/RHHI will proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, as in the case for disciplines 1 through 6, medical review staff must complete worksheets 1 - 7 identified in §5.3.7B above, and provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

D. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with HHAs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections on denied HHA services must be made for each discipline and revenue center, as instructed above;
- When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs;
- Information from the completed Worksheets 1 - 7 identified in §5.3.7B above, must be routed to the FI/RHHI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs; and

- Upon completion of the review, furnish the audit and reimbursement staff with the information listed in PIM Chapter 3 §5.3.1.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered for cost based services based on the denied services, units and charges, and the provider's allowed costs;
- Use the information on denied services to ensure accurate settlement of the cost report and/or any adjustments to interim rates that may be necessary as a result of MR findings. Audit adjustments will be made to PS&R statistics on the cost report to decrease Medicare visits, increase other visits (total visits remain unchanged) and to adjust Medicare charges, as necessary; and
- In the event that a cost report has been settled, determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 10 - Projection Methodologies and Instructions for Reviews of Skilled Nursing Facilities (SNFs) for Claims not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on SNF Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center, to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

Ancillary Service Cost Centers reimbursed by Lower of Costs or Charges are:

- Radiology;
- Laboratory;
- IV Therapy;
- Oxygen Therapy;
- Physical Therapy;
- Occupational Therapy;
- Speech Pathology;
- Electrocardiology;
- Medical Supplies;
- Drugs Charged; and

- Other

NOTE: Effective July 1, 1998, SNF services will be reimbursed in accordance with the provisions in the BBA.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, Sections 3.10.1.5, 3.10.1.6, and 3.10.5.1 on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, Medical Review staff will complete Worksheets 8 - 17, and provide the Audit and Reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 8 through 17 may be viewed by double clicking on the name (link) below:

Worksheet 8: Skilled Nursing Facility (SNF) Calculation of Medical Review Audit Adjustment - Form SNF/MR-1, page 1

Worksheet 9: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 1

Worksheet 10: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 2

Worksheet 11: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 3

Worksheet 12: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 4

Worksheet 13: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 5

Worksheet 14: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 6

Worksheet 15: Skilled Nursing Facility (SNF) Medical Review Sampling Results - Form SNF/MR-1, page 7

Worksheet 16: Skilled Nursing Facility (SNF) Summary of Results of Medical Review Sampling - Form SNF/MR-2

Worksheet 17: Skilled Nursing Facility (SNF) Summary of Results of Medical Review - Form SNF/MR-3

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with SNFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied SNF services must be made by each individual ancillary cost center, as instructed above;
- Denied charges must be segregated between Part A and Part B as the SNF Medicare cost report is set up to apportion costs and make separate settlements for Part A and Part B;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 8 - 17 (PIM chapter 3, §5.3.8 above), must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, MR furnishes the audit and reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. It is expected that, in most cases, cost reports will not have been settled or even filed.

Exhibit 11 - Projection Methodologies and Instructions for Reviews of Comprehensive Outpatient Rehabilitation Facilities (CORFS) for Claims Not Paid Under PPS

(Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on CORF Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount. They determine the sample universe by ancillary service for a specified time frame within a single cost reporting period. When making this determination, the following should be used:

- Ancillary Service Cost Centers that are reimbursed by reasonable costs are:
- Skilled Nursing Care;
- Physical Therapy;
- Speech Pathology;
- Occupational Therapy;
- Respiratory Therapy;
- Medical Social Services;
- Psychological Services;
- Prosthetic and Orthotic Devices;
- Drugs and Biologicals;
- Supplies Charged to Patients;
- DME - Sold; and
- DME - Rented.

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period:

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, MR determines the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of charges to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in Chapter 3, Sections 3.10.1.5, 3.10.1.6, and 3.10.5.1 on alternative scientific

methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;

- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the costs report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete Worksheets 24 - 30, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 24 through 30 may be viewed by double clicking on the name (link) below:

Worksheet 24: Comprehensive Outpatient Rehabilitation Facility (CORF) Calculation of Medical Review Audit Adjustment - Form CORF/Audit-1

Worksheet 25: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 1

Worksheet 26: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 2

Worksheet 27: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 3

Worksheet 28: Comprehensive Outpatient Rehabilitation Facility (CORF) Medical Review Sampling Results - Form CORF/MR-1, page 4

Worksheet 29: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review Sampling - Form CORF/MR-2

Worksheet 30: Comprehensive Outpatient Rehabilitation Facility (CORF) Summary of Results of Medical Review - Form CORF/MR-3

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CORFs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;

- Projections for denied CORF services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- Information from the completed worksheets 24 - 30 in PIM chapter 3, §5.3.9A, must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts); and
- Upon completion of the review, furnish the Audit and Reimbursement staff with the information listed in PIM chapter 3 §5.3D.

The audit and reimbursement staff will:

- Determine the actual cost report overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 12 - Projection Methodologies and Instructions for Reviews of Community Mental Health Centers (CMHCs) for Claims not Paid Under PPS - (Rev.)

Preamble – These methodologies shall be used in conjunction with the instructions found in Chapter 3, §3.10 – Use of Statistical Sampling for Overpayment Estimation.

A. Projecting From a Sample to a Universe on CMHC Claims

Based on the findings from the statistical sampling for overpayment estimation, the FI will project by ancillary cost center to the universe from which the sample was drawn to derive an overpayment amount. Determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

When making this determination, the following should be used:

Ancillary service cost centers that are reimbursed by lower of costs or charges are:

- Drugs and Biologicals
- Occupational Therapy
- Individualized Activity Therapy
- Psychiatric/Psychological Services
- Individual Therapy
- Group Therapy
- Family Counseling

- Diagnostic Services
- Patient Training and Education

The following procedures should be used to determine the sample universe by ancillary service for a specified time frame within a single cost reporting period.

- The sample may be chosen from a frame including claims with a particular or many revenue centers;
- For each revenue center, determine the total charges and the charges in the sample denied by re-adjudication;
- The lower limit of a one-sided 90% confidence interval for the proportion of services to be denied is to be used in computing overpayments. If use of the one-side 90% confidence interval results in a zero or negative, or presents other problems, see the guidance in [Chapter 3, Sections 14.1.5, 14.1.6, and 14.5.1] on alternative scientific methodologies that may be employed for estimating the overpayment and consultation with a statistical expert;
- Multiply the proportion obtained above by the total Medicare charges in the period under review and compute the projected total denied charges;
- Apply the ratio of cost to charges to the revised charges to determine approved costs;
- This results in the amount of denied dollars and constitutes the amount subject to adjustment;
- If adjustment occurs prior to the submission of the cost report, the FI shall proceed to collect the overpayment amount based on discussion with the provider regarding repayment options; and
- Upon submission of the cost report, medical review staff will complete worksheets 18 - 23, then provide audit and reimbursement staff with the information necessary to adjust the cost report and to initiate overpayment collection procedures.

Worksheets 18 through 23 may be viewed by double clicking on the name (link) below:

Worksheet 18: Community Mental Health Clinic (CMHC) Calculation of Medical Review Audit Adjustment - Form CMHC/Audit-1

Worksheet 19: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 1

Worksheet 20: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 2

Worksheet 21: Community Mental Health Clinic (CMHC) Medical Review Sampling Results - Form CMHC/Audit-1, page 3

Worksheet 22: Community Mental Health Clinic (CMHC) Summary of Results of Medical Review Sampling - Form CMHC/MR-2

Worksheet 23: Community Mental Health Clinic (CMHC) Summary of Results of Medical Review - Form CMHC/MR-3

B. Coordination Between Medical Review and Audit and Reimbursement Staff

To preserve the integrity of the PS&R data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, certain principles must be used when projecting overpayments to a universe with CMHCs. Communication between the FI/RHHI's medical review and audit and reimbursement units is essential. These two units must be careful to follow the procedures listed below:

- The same data must be used when the projection is made as was used when the sample was selected;
- Projections for denied CMHC services must be made by each individual ancillary cost center, as instructed above;
- When notifying the provider of the review results, MR must explain that the stated overpayment amount represents an interim payment adjustment. They indicate that subsequent adjustments may be made at cost settlement to reflect final settled costs; and
- Information from the completed worksheets 18 - 23 in PIM chapter 3, §5.3.10A must be routed to the FI's audit and reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the amount of denied charges (actual denied plus projected denied amounts).

The audit and reimbursement staff will:

- Determine the actual overpayment to be recovered based on the denied charges; and
- In the event that a cost report has been settled, they determine the impact and the actions to be taken. In most cases, it is expected that cost reports will not have been settled or even filed.

Exhibit 13 - Postpayment CMR Summary Report Format Example

(Rev. 3, 11-22-00)

Identification Section

Provider	Provider Number
Address	ID No. (SSN or EIN)
If Group, Number of Providers Involved	
See attached for names and individual earnings	
Specialty	Sub-specialty
Repeat providers (years)	

Payment and Utilization Section

Payments: Year	Assigned $	Unassigned $
Total Number of Beneficiaries:		
Average Number of Services Per Beneficiary:		
Average Payment Per Beneficiary		

Provider on Prepayment Review:
For Which Services/procedures:
For What Period:

Carrier Review Conducted Section

Reason Provider Selected for Comprehensive Medical Review:		
Areas on which Comprehensive Medical Review efforts were concentrated:		
See attached for all procedures for which provider exceeded established norms.		
Material Reviewed		
Claims Sampling Method:		
Number of Beneficiaries:	Number of Months per Beneficiary:	
Computer Printouts (Specify):		
Medical Records (Specify):		
Other Records (Specify):		
Did Medical Staff Review Cases?		If so, what percent?
Contacts Made	Number of Cases Reviewed	Reason
Provider		
SNF		
Hospital		
Beneficiary		

Documentation of §1879 of the Act Determinations Section

List the evidence and rationale indicating that the provider knew or should have known that the services were not medically reasonable and necessary.

Documentation of §1870 of the Act Determinations Section

List the evidence and rationale indicating that the provider was "at fault" in causing the overpayment and that the provider is liable for the overpayment (i.e., recovery of overpayment will not be waived).

Exhibit 13.1 - Excluded Providers - (Rev. 3, 11-22-00)

A. Notice to Beneficiaries

To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services furnished by _____ on _____. Effective _____, _____was excluded from receiving payment for items and services furnished to Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services furnished by _____ if rendered more than 20 days from the date of this notice."

B. Notice to Others

The Medicare Patient and Program Protection Act of 1987 provides that payment is denied for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act. It also provides that payment cannot be denied until the supplier of the items and services has been notified of the exclusion.

If claims are submitted by a laboratory or a DME company for any items or services ordered or prescribed by a provider excluded under §§1128 or 1156 of the Act, contractors:

- Pay the first claim submitted by the supplier and immediately give notice of the exclusion; and
- Do not pay the supplier for items or services ordered or prescribed by an excluded provider if such items or services were ordered or prescribed more than 20 days after the date of notice to the supplier, or after the effective date of the exclusion, whichever is later.

To ensure that the notice to the supplier indicates the proper reason for denial of payment, contractors include the following language in the notice:

"We have received a claim for services ordered or prescribed by _____ on _____. Effective _____, _____was excluded from receiving payment for items or services ordered or prescribed for Medicare beneficiaries. This notice is to advise that no payment will be made for any items or services ordered or prescribed by _____ if ordered or prescribed more than 20 days from the date of this notice."

Exhibit 14 - Contractor Denials 1862(a)(1) of the Act - (Rev. 3, 11-22-00)

The determinations which follow a §1862(a)(1) denial may require a decision if the beneficiary or provider knew or could have known that a service would not be covered by Medicare because it would be considered medically unnecessary. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. The beneficiary is liable if it is determined the beneficiary knew, or could reasonably have been expected to know (e.g. utilization review notice from a SNF) that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability (i.e., makes payment to a provider even though a non-covered service is involved) if neither the beneficiary nor the provider knew, or could reasonably be expected to have known, that the services were not covered. Waiver of liability exists when both the beneficiary and the provider did not and could not reasonably have been expected to know that payment would not be made for services.

To find that a beneficiary knew or should have known that a service would not be covered, written notice from the provider is required or evidence that the beneficiary had received a prior denial for the same or similar services. To find that a provider had knowledge that a service

would not be covered, actual or constructive notice is acceptable (e.g., carrier bulletin with final LMRP and effective date). Sufficient notice includes:

- Previous denials for the same service;
- Publication by the contractor in a newsletter or other communication to the provider community that a service is considered not reasonable and necessary or constitutes custodial care;
- Knowledge based on experience; and
- Local standards of practice.

14.1 - Section 1879 of the Act Determination- Limitation of Liability - (Rev. 3, 11-22-00)

Section 1879 provides relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision also applies to denials of home health services beginning July 1, 1987 and ending September 30, 1989, where the beneficiary is not homebound or does not or did not need skilled nursing care on an intermittent basis. The provision applies to all carrier determinations on all assigned claims when claims are denied (prepay or postpay) under §1862(a)(1) of the Act. Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary.

A §1879 determination regarding knowledge is part of the framework for determining whether an actual or potential overpayment exists. If a contractor determines that program payment was proper because neither the beneficiary nor the provider knew or should have known that the service was not reasonable and necessary, no overpayment exists. However, if the contractor determines that either the beneficiary or the provider knew or should have known that a service was not medically reasonable and necessary, an overpayment exists. Contractors must consider waiver of recovery of the overpayment under §1870 of the Act.

A. Documentation of §1879 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary/provider (i.e., demand letters) should include all §1879 determinations as to knowledge of noncoverage, both favorable and unfavorable. Document the §1879 determination in the CMR summary report.

B. Section 1879 of the Act Determinations and Overpayments

An overpayment would be $0 (zero) for postpayment denials for assigned claims and claims submitted to an intermediary from a participating provider because a determination was made that neither the beneficiary nor the provider knew or should have known the services were not covered. Program payment was appropriate. However, if the beneficiary is found to be liable under §1879 of the Act, an overpayment to the beneficiary exists and the contractor must make an §1870 determination.

14.2 - Section 1870 of the Act Determination - Waiver of Recovery of an Overpayment

(Rev. 3, 11-22-00)

Once the contractor has concluded that an overpayment exists (i.e., postpayment review, including §1879 of the Act waiver determinations is complete), it makes a §1870 determination regarding waiver of recovery of the overpayment from the provider. Carriers make this determination for all claims where the provider took assignment. Section 1870, waiver of recovery, is not applicable for the provider on non-assigned postpayment §1862(a)(1) of the Act denied claims because the overpayment is a beneficiary overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims under §1862(a)(1) (A) of the Act denied for not being reasonable and necessary. Section 1870 is the framework for determining whether overpayment recovery is waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived, the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. Section 1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim and this is the basis for the overpayment.

If §1879 of the Act is applicable, the §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was a lack of knowledge by both the beneficiary and the provider.

A. Documentation of §1870 of the Act Determination

The contractor must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or provider (i.e., demand letters) should include all §1870 refund determinations. Also, document the §1870 determination in the CMR summary report.

B. Section 1870 of the Act Determinations and Overpayments

Where waiver of recovery from the provider is appropriate under §1870, the contractor must show an overpayment amount, but also indicate that recovery is being waived.

C. Section 1870 of the Act Determinations and Extrapolations

If recovery of an overpayment from the provider for one or more claims is waived under §1870 (i.e., the provider was without fault), the amount waived must be included when extrapolating in order to get a true projected overpayment as to exactly how much recovery is being waived. Contractors should subtract the projected waived amount from the projected overpayment amount to get the amount the provider must repay.

14.3 - Section 1842(l) of the Act Determination - Refunds to Beneficiary

(Rev. 3, 11-22-00)

For §1862(a)(1) of the Act denials on non-assigned claims involving physician or supplier services, carriers must make a determination under §1842(l) regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for postpayment denials.

Carriers make a §1842(l) physician or supplier refund determination if the reviewer concludes that the services were not reasonable and necessary. For physician or supplier claims where assignment was not taken, a §1842(l) refund determination must be made. Carriers must make a determination for each claim that is denied as not reasonable and necessary.

A physician or supplier cannot be considered overpaid if payment was not made to the physician for the claim. A physician or supplier who takes assignment on a claim-by-claim basis may be audited and the sample may include some non-assigned claims. Consideration of a refund on the non-assigned claims denied based on §1862(a)(1)(A) of the Act is appropriate, but a finding that a refund is appropriate does not create a Medicare overpayment.

A. Documentation of §1842(l) of the Act Determination

The carrier must document the basis for the determination (i.e., rationale), including appropriate references to contractor newsletters, prior denials, sponsored meetings attended by the provider, etc., where applicable. Any correspondence going to the beneficiary or physician, or supplier (i.e., demand letters) should include all §1842(l) refund determinations. Document §1842(l) determinations in the CMR summary report.

B. Section 1842(l) of the Act Determination With Respect to Overpayments

A physician refund obligation under §1842(l) is not a determination of a program overpayment. If the refund obligation arises in connection with a postpayment denial, any overpayment would be a beneficiary overpayment.

Exhibit 14.4 - Effect of Sections 1879 and 1870 of the Social Security Act During Postpayment Reviews

(Rev. 17, 12-12-01)

The Medicare law contains two provisions that affect the determination and the recovery of overpayments. One is §1879 of the Act, which deals with limitation on liability for services determined to be noncovered because they are, for example, custodial or are not reasonable and necessary under Medicare law, or, for home health services, the patient is not confined to home or the skilled nursing services are not intermittent. If the denial involves items or services to which the provisions of §1879 (limitation on liability) apply, MR makes a determination in accordance with instructions in MIM §3431, MCM §7300and CMS Ruling 95-1.

The other law affecting the determination and the recovery of overpayments is §1870 of the Act, which provides a framework within which liability for overpayments is determined and recovery of overpayments is pursued. If the denial of a claim involves items or services to which the provisions of §1879 (limitation on liability) do not apply, or if an overpayment results from a §1879 determination that either the beneficiary or the provider is liable, contractors make a determination as to whether the provider was without fault for the overpayment under the provisions of §1870 in accordance with MIM §3431and MCM §7300.

Exhibit 15 - Consent Settlement Documents - (Rev. 3, 11-22-00)

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires several letters to be sent to providers or suppliers regarding consent settlement. Contractors shall send to the provider or supplier a request for additional information letter, a consent settlement offer letter, and a no action letter if an overpayment was not found or if an overpayment was found, a letter requesting the moneys owed.

A. First Letter in the Consent Settlement Process: Opportunity to Submit Additional Information Before Consent Settlement Offer Notification

Before a consent settlement is offered, contractors must communicate in writing to the provider or supplier that they have the opportunity to submit additional information. This document shall:

- Explain there may be an overpayment due to an initial evaluation of the records;
- Highlight the nature of the problems in the provider's or supplier's billing and practice patterns identified as a result of the preliminary audit;
- Give steps the provider or supplier can take to address the problems; and
- Identify the forty-five (45) day time frame to furnish this additional information.

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842 of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

Based on our preliminary evaluation of your medical records on_____,_ (Fill in date) we have found an indication of a potential overpayment. The purpose of this letter is to describe the nature of the problems identified in our evaluation, the steps that you should take to address these problems, and give you the time frame to furnish additional information concerning the medical records for the claims being reviewed.

During our initial evaluation, we have ascertained the following issues,
(List the problems found.)

To resolve these issues and to determine that there is an overpayment, the following are the steps you may take:
(List action that can be taken to resolve the problems.)

You have forty-five (45) days from the receipt of this letter, ____to submit any additional information concerning the medical records for the claims being reviewed in this evaluation. Send this information to _____. If you have any questions, please contact me at_____.

B. Second Letter in the Consent Settlement Process: Consent Settlement Offer

Consent settlement documents must closely conform to the content of the model language provided below. The consent settlement documents shall explain:

- The responsibility of CMS in conducting audits of providers or suppliers to ensure that Medicare Part B claims have been billed and paid appropriately;
- The date of the initial request for records prior to conducting the audit;
- The steps involved in the audit process;
- The problems in the provider's or supplier's billing and practice patterns identified as a result of the audit;
- To notify the provider or supplier of the potential overpayment calculated as a result of the audit; and
- Two options available to the provider or supplier.

NOTE: The Consent Settlement Documents shall include information regarding statistical sampling for overpayment estimation. Refer to §3.10 of the Program Integrity Manual (PIM) for instructions for the use of statistical sampling for overpayment estimation.

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842(a)(1)(C) of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

On _____, [Fill-in date of initial request for records prior to conducting audit.] you received a notification letter stating that you had the opportunity to submit additional information to us after our preliminary evaluation of your records indicated a potential

overpayment. On _____, [Fill-in date of initial request for records prior to conducting audit.] you also received our request for records to conduct an audit of your practice. The purpose of this letter and attachments is to describe the steps involved in the audit process, to highlight problems in your billing and practice patterns identified as a result of our audit, to notify you of the potential overpayment calculated as a result of our audit, and to outline two options available to you.

Our normal full-scale audit process entails the review of records using statistical sampling for overpayment estimation. However, in the interest of economy and expediency for both you and the Medicare program, as a first step, we elected to perform a limited audit. We reviewed claims and medical records for services rendered to beneficiaries over a period of time, from_____to_____. While_____beneficiaries were randomly selected for our sample from a larger universe of beneficiaries for whom you provided services, it is not done based on our instructions for conducting statistical sampling for overpayment estimation.

You were chosen for an audit because_____ [Fill-in the reason for the audit. The reason may be exceeding peer norms or a call from a beneficiary. For example, if the provider exceeded peer norms the contractor might want to use the following language: "You were chosen for an audit because our records indicate you exceeded the average utilization rates of your peers by_____% for the same time period. Your specialty is listed as_____. The peer group consisted of_____ who billed for the same procedure(s)."] We selected the _____ beneficiaries by identifying the procedure codes where your billing exceeded the norm for your peers. Included in the universe are only those beneficiaries for whom you rendered and billed at least one of these procedure codes that was paid by Medicare during the review period. From this universe of beneficiaries, a computer is used to randomly select the beneficiaries to be included in the sample. All claims for the procedure codes at issue that were rendered to the sampled beneficiaries and paid within the _____ time period were audited. [This sentence may be modified depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is stated, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.] The list of sampled beneficiaries, dates of service, and procedure codes is contained in the attachment to this letter.

The beneficiaries included in our audit resulted in claims being paid by Medicare between_____. [See note in preceding paragraph. Similar rewording may be required here.] These claims and their corresponding medical records were audited, resulting in a potential overpayment of $_____including an actual overpayment of $_____for the_____ beneficiaries. Item 3 under "Audit Results" explains how we calculated the potential overpayment. Please review the attached documents containing the audit results and options along with an explanation of the Extended Repayment Plan.

We must have your response to this letter within sixty (60) days from the date of this letter,_____ If we do not receive a response from you by_____ , statistical sampling for overpayment estimation will be chosen for you by default (see attached discussion of audit results). Be advised that by signing this letter your legal options may be affected. Please also be advised that repayment of the overpayment specified herein in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. You may wish to have legal counsel review this letter before signing it. If you have any questions, please contact me –

at_____.

Sincerely,

Attachments

C. Consent Settlement Attachment 1 Audit Results

IDENTIFYING INFORMATION

List the following information in the heading of the attachment:

- Date;
- Provider Name;
- Provider Address; and
- Provider Number.

SCOPE OF AUDIT

This audit covers services that were paid by Medicare from_____to_____. [Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is currently stated, all claims would have to have been acutally paid within the time period. Whichever method is used, you must be consistent.]

The audit revealed the following problems in your billing and practice patterns:

ISSUES/DETERMINATIONS

A physician reviewer, specializing in _____ [You are required to have a medical specialist involved in the review of the sample claims that are not based on application of clearly articulated existing MR policy. Fill-in the specialty here.] was consulted during the audit process. The following claims and submitted records of determinations were used in the review.

[This area lists the problem areas noted above, such as exceeding peer norms and medical necessity/documentation concerns. Additionally, each of the sampled beneficiaries, dates of services, procedure codes, and the Medical Director's determination on each denied service is noted here. Attach newsletters discussing medical policy and documentation requirements for the problem areas found during the audit.]

[This is also the area where you explain the §1879 and §1870 determinations, perhaps using, in part, the following language:

For §1879: "Based on available information, we believe you knew or should have known that..."

For§1870: "We have made the determination that you were not "without fault" in causing the overpayment. Therefore, we are not waiving your obligation to repay. We cannot find you without fault because..."

Rationale for the §1879 and/or §1870 findings might include all or part of the following language:]

"The management of a medical or supplier practice that includes a large number of Medicare beneficiaries must understand the conditions governing which services will be covered and payable under Part B of the Medicare Program. Pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of carrier newsletter], from a meeting you attended on date, and from your peers in the medical community ."

Carriers need to make specific findings for §1879 and §1870. The rationale for finding provider knowledge or fault with regard to a particular claim may not be the same as for another claim. This may be so even for multiple denials for a particular code since MN is a unique and individualized determination. These individual findings are especially important if #167;1879 and/or §1870 determinations are partially favorable. In such cases, specify which of the sample claims are affected, why, and how much this reduces the actual and total potential overpayment amounts (see §1879) or reduces the amount of the actual and total potential overpayments which must be refunded (see §1870).

Because §1879 and 1870 determinations are difficult concepts, it is important to explain to physicians exactly why they are being held responsible under these provisions. Your explanation must go beyond conclusory statements and/or findings.]

CALCULATIONS

A copy of our calculation worksheet is enclosed for your information. To calculate the potential projected overpayment amount for each denied procedure code, the following formula was used:

[In this section, insert a complete explanation of the methodology used to calculate the overpayment and the projected overpayment for each denied procedure code. The explanation must include the formula used when the audited services were down coded rather than denied and when only one example of a procedure code was audited.]

Procedure Code	Denied Services #Sample	Denied Services #Universe	Down-coded Services #Sample	Down-coded Services #Universe	Potential Overpayment

[This table lists procedure codes, the number of services in the sample and in the universe that were denied or down-coded, and the resulting potential overpayment amount.]

The actual overpayment amount is $_____. The sum of all potential projected procedure code overpayments, including the actual overpayment amount, is $_____.

OPTIONS

You must now select one of the two options explained below. Our normal audit process entails the routine use of Option One. However, we are now making another option available to you as a consent settlement.

If you fail to notify us of your selected option, Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation) will automatically be selected for you by default. Be aware that when statistical sampling for overpayment estimation is selected for audit, records for all of the services at issue must be available for review.

Please send in your response to the options listed below within sixty (60) days from the date of this letter,_____ .

Regardless of the option selected, beneficiaries may not be billed for any of the overpayment amount.

Option One Election to Proceed to Statistical Sampling for Overpayment Estimation

If we do not hear from you within sixty (60) days from the date of this letter, _____, we will proceed with Option One by default. [This is the second step in the audit process if you have been offered a consent settlement on a potential overpayment but do not accept the offer.] This step utilizes statistical sampling for overpayment estimation for the same universe or time period. Your right to appeal to a Hearing Officer, an administrative law judge or to the court remains if you should choose this option. Also, any rights available to you under §1870 and/or 1879 of the Social Security Act remain.

Be aware that this option, either by your selection or by default, means that you are required to submit medical documentation for all of the services at issue in the statistical sampling for overpayment estimation [(just as you would have had to do if we had not first offered you the opportunity for a consent settlement on a potential overpayment).] You should also be aware that this option, whether selected by you or by default, withdraws the option of a consent settlement, as described in Option Two.

If you elect (or accept by default) Option One, it is important that you understand the following information concerning our actions and your responsibilities with regard to the actual overpayments found for the claims involved in the limited audit:

The potential projected overpayment referred to in this correspondence is based on a sample of _____ beneficiaries. We audited claims and medical documentation for the_____ beneficiaries in the sample to arrive at an actual overpayment for these claims. The actual overpayment amount was then projected to the universe of procedure codes to develop the potential projected overpayment. (See above for the actual overpayment amount and the potential projected overpayment amount.)

Option Two involves repayment of the potential projected overpayment, which includes the actual overpayment amount. Choosing Option One does not eliminate your obligation to repay the actual overpayment. Recoupment of the actual overpayment identified for the claims in the limited audit will be pursued individually, but their recovery will be credited against any projected overpayment for the universe to which the claims belong. Your obligation to repay the overpayment for these claims will begin on the date of the official notification of overpayment. You will be notified of your appeal rights on these claims at this same time.

Option Two Acceptance of Consent Settlement Offer

You agree to repay the potential projected overpayment, after providing additional medical documentation relevant to the____ beneficiaries involved in our sample which was in existence at the time the services were rendered.

Review of this information will result in one of three decisions:

- All services in contention could be determined to be appropriate and allowed as originally processed, and the question of any potential overpayment would be eliminated; or
- A portion of the services in question could be determined to be appropriate and allowed as originally processed, and the amount of the potential overpayment would decrease accordingly; or
- The audit results could remain the same and the potential projected overpayment would remain at $_____.

You may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination.

If you select Option Two, you agree to refund the revised potential overpayment amount, if any, which will not exceed the dollar amount calculated in Item 3 of this attachment and printed above.

The revised potential overpayment amount will not exceed the capped amount.

By selecting this option, regarding repayment, you agree that there was a problem in your billing as identified by the carrier, you intend to correct this problem in future billings, and you understand how we reached the potential overpayment, i.e., you understand the sampling methodology used and the methodology to project the potential overpayment. Because you agree that there was a problem and agree to make changes in your practice to resolve this problem, you waive your right to appeal the sampled individual overpayments, the potential overpayment resulting from the projection and the sampling procedures. The appeal rights you are waiving include a hearing before a Hearing Officer, Administrative Law Judge, or in the Courts. You also waive any rights you have under §1870 and/or 1879 of the Social Security Act. (Please see Items 6 and 7 in this attachment for a discussion of these rights.)

Election of Option Two means that, in the absence of potential fraud, we will not audit your claims for any procedure codes projected in our audit during the audit time frame again. In the event of fraud and/or if you fail to correct the identified problems, we reserve the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

ASSESSMENT OF INTEREST

We wish to make you aware, should you elect Option Two, that interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final potential overpayment, if any. Should you choose Option One, interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final overpayment determination. We must assess interest as provided in 42 CFR §405.376. Interest will accrue on the unpaid balance for each thirty (30) day period (or portion thereof) that repayment is delayed. The current interest rate is _____ %.

LIMITATION OF LIABILITY

Section 1879 of the Social Security Act (42 USC §1395pp, 42 CFR §411.406) permits Medicare payment to be made to providers on assigned claims for certain services otherwise not covered because they were not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or were custodial services if neither the beneficiary nor the provider knew, or could reasonably be expected to know, that the services were not medically necessary or were for custodial care. Services affected are those disallowed as not reasonable or necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member and those disallowed as custodial services.

WAIVER OF OBLIGATION TO REPAY UNDER §1870 OF THE SOCIAL SECURITY ACT

Section 1870 of the Social Security Act (42 USC §1395gg, 42 CFR §405.704(b)(14)) permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. This determination is made after §1879 is considered. If it is determined that you or the beneficiary knew or should have known that the service was not medically necessary and reasonable or constituted custodial care as described under the provisions of §1879, we address §1870 and determine whether you were "without fault" with respect to causing the overpayment.

GENERAL

We wish to ensure that you are aware of regulations and provisions of the law relating to continuation of the problems discussed herein. They include exclusion from the Medicare Program in accordance with §1128(b) of the Social Security Act (42 USC §1320a-7), civil monetary penalties or other actions in accordance with §1128A of the Social Security Act (42 USC 1320a-7a), and/or, if appropriate, withholding payment under 42 CFR 405.370.

Your decision regarding this matter must be in writing and received by this office within sixty (60) days from the date of this letter. If your decision is not received by the above-mentioned date, Option One, Election to Proceed to statistical sampling for overpayment estimation, will be selected for you by default.

We have enclosed two copies each of the two option forms for your convenience. Select one of the options, complete and sign both forms corresponding to that option, and send them to my personal attention at the address shown below.

The provider must personally sign the forms. A signature stamp, or the signature of a staff member or attorney is not acceptable. After receipt of the two identical option forms with authorized signatures, we will sign both forms and return one to you.

Name:

Title:

Address:

Telephone number:

D. Consent Settlement Attachment 2: Option One - Election To Proceed To Statistical Sampling For Overpament Estimation

Option One - Election to Proceed to Statistical Sampling for Overpayment Estimation

I,_____:

- have read the results of the audit findings in the letter dated _____.
- elect to proceed to your full-scale audit process, involving use of statistical sampling for overpayment estimation for the same universe of procedure codes and time period as the limited audit, as explained in the letter. I understand the full-scale audit process is the normal audit process, and that the limited audit was offered to me only in the interest of economy and expediency. Upon selection of Option One, I understand that the offer of a consent settlement as stated in Option Two is withdrawn.
- understand that I and/or my office staff will be required to submit medical documentation for all services at issue in the statistical sampling for overpayment estimation, upon request by the carrier.
- understand that all applicable appeals rights, including any right to a hearing officer hearing, an administrative law judge hearing, or court review are available to me. I also retain any rights available under §1879 and/or 1870 of the Social Security Act, as appropriate.
- understand that the claims from the above-referenced limited audit will not be selected for inclusion in the statistical sampling for overpayment estimation; the statistical sampling for overpayment estimation will be a new and independent audit.
- understand that the overpayment identified for claims in the limited audit will be pursued on an individual basis, and that this overpayment will be subtracted from any overpayment resulting from the statistical sampling for overpayment estimation; that I will be provided with appeal rights regarding the overpayment amount on the claims in the limited audit at a later date; and that any interest on the overpayment amount on the claims in the limited audit will be calculated from the date of this later notice with appeal rights.
- understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.

Provider signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Carrier Representative Signature: _____

Date signed: _____

Printed or typed name: _____

Title of signatory: _____

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

E. Consent Settlement Attachment 3 Option Two - Acceptance of Consent Settlement Offer

I,_____:

- have read the results of the audit findings in the letter dated_____.
- understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding a redetermined amount of up to $_____to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.
- have enclosed additional documentation for you to review for the purpose of redetermining the potential overpayment. I understand that I may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination. I understand the redetermined potential overpayment, if any, will not exceed the amount shown above.
- understand that if the redetermined settlement amount is not refunded to Medicare within thirty (30) days from the date of the redetermined potential overpayment notice, the unpaid balance is subject to offset. I may apply for an extended repayment plan and, if approved, may make payments over an approved period of time.
- understand that interest on the amount accrues from the date of the final potential overpayment determination, but that this interest will be waived if repayment is made within thirty (30) days from the date of the final potential overpayment determination.
- understand that claims paid to me from _____ to_____will not be audited in the future. [Reword this statement to reflect services dates if service dates were used in the audit to select claims instead of dates of payment.] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.
- understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.

I,_____, agree by settling this:

- that my right to appeal, which includes a Medicare Part B hearing officer hearing, administrative law judge hearing, or any court appeals regarding this matter, is waived. I also understand any rights available to me under §1879 and/or 1870 of the Social Security Act are waived.

I,_____, do/do not (circle one) wish to request a meeting at this time to discuss the additional documentation I have submitted.

Provider signature:_____

Date signed:_____

Printed or typed name:_____

Title of signatory:_____

Carrier Representative Signature:_____

Date signed:_____

Printed or typed name:_____

Title of signatory:_____

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

F. Consent Settlement Attachment 4: Extended Repayment Plan (ERP)

It has been determined by an audit that there is a potential overpayment amount due to Medicare. It is expected that you will remit the entire amount in one payment within thirty (30) days of the date of the final potential overpayment determination if you select Consent Agreement Option Two (Acceptance of Consent Settlement Offer), or, if you select Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation), the date of the final overpayment determination. However, if you are unable to repay the amount within that time, we are authorized to consider repayment in installments based on validated financial hardship. [Installments are based on the amount of the overpayment as stated in Financial Management, Chapter 4, §§20, 30.] Installments can range from 2-6 months based on the amount of overpayment. Be aware that if repayment is not made within thirty (30) days, interest will be due. If you select Consent Agreement Option Two, interest accrues from the date of the final potential overpayment determination, or if you elect Option One, interest accrues from the date of the final overpayment determination (See 42 CFR 405.378.). Interest will be waived if repayment is made within thirty (30) days of the applicable date cited above for the option chosen. The current rate of interest is _____ percent. If you wish to claim financial hardship, contact _____ to obtain the financial statement of debtor form (CMS-379). This form must be completed and returned with your request for approval of an installment schedule. If compliance with the above is not acceptable to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.

If repayment of the amount due, in a lump sum or on an approved installment plan, is not forthcoming, the Centers for Medicare & Medicaid Services may, at its option; forward the case to the Department of Justice or the Internal Revenue Service (IRS) for enforced collection.

G (1). Third Letter in the Consent Settlement Process: No Action if an Overpayment Was Not Established

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on_____,_ (Fill in date) we have not found an indication of an overpayment. No additional action on your part, is deemed necessary.

If you have any questions, please contact me at_____.

Sincerely,

G (2). Third Letter in the Consent Settlement Process: Request for Money Owed if Overpayment was Established

List the following information in the heading of the letter:

- Date of notice;
- Name of provider;
- Address; and
- City, state, and zip code.

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on_____,_ (Fill in date) we have found an indication of an overpayment and the option of a (state if provider elected the statistical sampling for overpayment estimation or accepted the consent settlement offer) was selected. You owe ___(state the amount of money owed).

If you have any questions, please contact me at_____.

Sincerely,

Exhibit 16 - Model Payment Suspension Letters

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Payment Suspension Initial Notice Based on Fraud (No Prior Notice Given)

Date
Name of Addressee (if known) Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments took effect on {ENTER DATE}. Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. § 405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. We request that you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.}. When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are “reasonable and necessary” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writingor via telephone at {phone number}.
Sincerely,

Name

B. Payment Suspension Initial Notice Based on Fraud (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments will take effect on {ENTER DATE}.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. § 405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the

suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act § 1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

C. Payment Suspension Initial Notice Based on Reliable Information (No Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments took effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days. Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF *UPIC* or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. We request that you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.}. When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are “reasonable and necessary” for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

D. Payment Suspension Initial Notice Based on Reliable Information (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments will take effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF *UPIC* or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not administratively appealable. See 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. See 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of *UPIC* or MAC}, a CMS {*Unified Program Integrity Contractor (UPIC)* or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Social Security Act § 1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

E. Reliable Information that an Overpayment Exists (RIO) Payment Suspension Extension Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of
Medicare Payments Provider/Supplier
Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.372(d), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER UPIC NAME} to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The extension of your payment suspension applies to both claims in process and future claims. We will continue to withhold your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(d). When the payment suspension is terminated, any money withheld as a result of this action shall be applied first to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. See 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the remainder will be released to you.

Should you have any questions, please contact me in writing or by telephone at {phone number}.

Sincerely,

Name

F. Credible Allegation of Fraud (CAF) Payment Suspension Extension Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.371(b), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER *UPIC* NAME} to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The continuation of your payment suspension applies to both claims in process and future claims. We will continue to suspend your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(c)(2). When the payment suspension is terminated, any money withheld as a result of this action shall be applied first to reduce or eliminate any determined overpayments, including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. See 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the remainder will be released to you.

Should you have any questions, please contact me in writing or by telephone at {phone number}.

Sincerely,

Name

G. Payment Suspension Termination Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Termination of Suspension of
Medicare Payments Provider/Supplier
Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Pursuant to 42 C.F.R. §405.372(c), this is to notify you that the Centers for Medicare & Medicaid Services (CMS) has directed us to terminate the payment suspension in effect for your Medicare payments. You were notified of the results of our review and the overpayment(s) we determined on {Enter Date of letter}. This information has been forwarded to {MAC Name} for final action. In the near future, they will issue the overpayment demand letter, along with information regarding your appeal rights and process. When the payment suspension has been removed, any money withheld as a result of this action shall first be applied to reduce or eliminate any overpayment and then to reduce any obligation to CMS or U.S. Department of Health and Human Services per 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Please be advised that this action to terminate your payment suspension should not be construed as any positive determination regarding your Medicare billing, nor is it an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve you of any civil or criminal liability, nor does it offer a defense to any further administrative, civil or criminal actions against you.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

16.1 - Referral Fact Sheet Template

(Rev. 826, Issued: 09-21-18, Effective: 10-22-18, Implementation: 10-22-18)

Confidentiality Notice: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original message.

To:
OIG/DOJ Contact Information

From:
UPIC Contract Information

REFERRAL FACT SHEET

Table 1: Case Fact Sheet

Subject(s) of Investigation (list additional subjects below primary subject)	Name: Address: Phone: NPI: PTAN: Tax ID Number: Effective Date: Specialty:
Allegation Summary	This section shall describe the allegations the UPIC has learned during the course of the Lead/Investigation.
Source of Allegation	
Date Complaint Received (if applicable)	
Dollar Paid for Previous 36 Months	Total dollars paid to the provider for previous 3 years, and timeframe for the calculation

Identified Medicare Program Loss	Dollars at Risk, and timeframe for the calculation
Identified Overpayment(s), if applicable	UPIC to update this section if they've identified an actual and/or extrapolated overpayment through medical review
UPIC Contact Information	
UPIC Case Number	UCM Number(s)

Narrative

- Predication
- History of Non-compliance
  - Previous complaints
  - Prior Investigations, Medical Reviews, and/or Administrative Actions
  - Previous Law Enforcement Referrals and/or Immediate Advisements
  - Previous State Medicaid Investigations and/or Audits
  - Previous MAC or UPIC Provider Education
- Investigative Steps
  - Beneficiary Interviews
  - Provider Interviews

Medical Review

Table 2: Current/Previous Medical Reviews

Postpayment Medical Review				
Timeframe of Postpayment Review	Probe or SVRS Review	Number of Claims Included in Review	Claim Denial Percentage	Identified Overpayment Amount
Denial Reasons and Applicable Policy References per Review: Additional Detail Regarding Postpayment Medical Reviews:				

Prepayment Medical Review					
Prepayment Review Start Date	Prepayment Review End Date	Targeted or 100% Review	If targeted review, provide CPT codes	Number of Claims Reviewed To-Date	Claim Denial Percentage

			selected for review		

Denial Reasons and Applicable Policy References per Review:

Additional Detail Regarding Postpayment Medical Reviews:

Billing Information

Table 3: Provider Billing Summary

Year	HICN Count	Claims	Billed Amount	Paid Amount
Totals:				

Additional Information

Table 4: Additional Relevant Information

Current/Former Employees with Ownership Interest	
PECOS Information	
Provider's Legal Counsel	
Banking Information	
List any other relevant information	

Recommendations

Distribution

- Listing of all individuals that referral will be sent to (including those that are CC'd)

Exhibits

- Provider Enrollment Application(s)
- Provider Electronic Funds Transfer Agreements
- Previous complaints related to the subject provider
- Applicable attestations
- Provider/staff interview summary report(s)
- Beneficiary interview summary report(s)

- Medical Review Findings
- Provider Overpayment Notices
- Provider Prepayment Review Notices
- Provider Payment Suspension Notices
- Any other applicable exhibits/attachments

Exhibit 17 – Signature Attestation Form (for missing or illegible signatures)

(Rev.)

Exhibit 18 - Corrective Action Reporting Formats

(Rev. 617, Issued: 10-09-15, Effective: 11-10-15, Implementation: 11-10-15)

A. Corrective Actions Taken on CMS Identified Vulnerabilities: (A/B)/(DME) MACs

Contractor Name and Jurisdiction: (To be completed by MAC)

Date Report Submitted to CMS: (To be completed by MAC)

New Issue Number	Issue Description	Interim Response	Final Response	Additional Comments		Updated Responses

B. Overpayment Recovery on OIG Claims Format

Contractor Name and Jurisdiction: (To be completed by MAC)

Date Report Submitted to CMS: (To be completed by MAC)

OIG Report Number (e.g. A-01-09-00050) (completed by MAC)	Overpayment Recovery (in dollars) (completed by MAC)	OPTIONAL Overpayments referred or uncollectable (in dollars) (completed by MAC)	Reason for no review of claims and no recovery (if applicable) (completed by MAC)	Final Reporting Date for this audit (completed by CMS)	Other Additional Comments or Actions Taken (if applicable)

Exhibit 19 – Reserved for Future Use –
(Rev.)

Exhibit 20 – Reserved for Future Use - (Rev.)

Exhibit 21 – Regional Home Health Intermediaries/Jurisdictions - (Rev. 3, 11-22-00)

Associated Hospital Services of Maine

Connecticut	Maine	Massachusetts
New Hampshire	Rhode Island	Vermont

Palmetto Government Benefits Administration

Alabama	Arkansas	Florida
Georgia	Illinois	Indiana
Kentucky	Louisiana	Mississippi
New Mexico	North Carolina	Ohio
Oklahoma	South Carolina	Tennessee
Texas		

Blue Cross of California

Alaska	American Samoa	Arizona
California	Guan	Hawaii
Idaho	Nevada	Northern Mariana Islands
Oregon	Washington	

United Government Services

Michigan	Minnesota	New Jersey	New York
Puerto Rico	Virgin Islands	Wisconsin	

Wellmark, Inc

Colorado	Delaware	District of Columbia	Iowa
Kansas	Maryland	Missouri	Montana
Nebraska	North Dakota	Pennsylvania	South Dakota

Utah Virginia West Virginia Wyoming

Exhibit 22 - Office of Inspector General, Office of Investigations Field Offices
(Rev. 3, 11-22-00)

Street Address	Mailing Address	States
BOSTON: Room 1405 JFK Federal Bldg. Boston, MA 02203 (617) 565-2660	HHS, OS, OIG, OI P.O. Box 8767 Boston, MA 02114	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
NEW YORK Room 3900 B Federal Building New York, NY 10278 (212) 264-1691	HHS, OS, OIG, OI P.O. Box 3209 Church St. Station New York, NY 10008	New Jersey New York Puerto Rico Virgin Islands
PHILADELPHIA Room 4430 3535 Market Street Philadelphia, PA 19104 (215) 596-6796	HHS, OS, OIG, OI P.O. Box 8049 Philadelphia, PA 19101	Delaware Pennsylvania West Virginia Maryland Except: - Prince Georges County - Montgomery County Virginia Except: - Fairfax County - Arlington County - City of Alexandria - City of Falls Church
ATLANTA Room 1404 101 Marietta Tower Atlanta, GA 30323 (404) 331-2131/2556	HHS, OS, OIG, OI P.O. Box 2288 Atlanta, GA 30301	Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
CHICAGO 23rd Floor 105 West Adams St. Chicago, IL 60603 (312) 353- 2740	HHS, OS, OIG, OI 23rd Floor 105 West Adams Street Chicago, IL 60603	Illinois Indiana Michigan Minnesota Ohio Wisconsin Missouri Iowa
DALLAS Room 4E1B 1100 commerce St. Dallas, TX 75242	HHS, OS, OIG, OI Room 4E1B 1100 Commerce St. Dallas, TX 75242	Arkansas Louisiana New Mexico Oklahoma

(214) 767-8406		Texas
DENVER Room 327 1961 Stout Street Federal Office Bldg. Denver, CO 80294-3546 (303) 844-5621	HHS, OS, OIG, OI 1961 Stout Street Denver, CO 80294-3546	Colorado Kansas Montana Nebraska North Dakota South Dakota Wyoming</> Utah
SAN FRANCISCO Room 174 50 U.N. Plaza San Francisco, CA 94102 (415) 556-8880	HHS, OS, OIG, OI P.O. Box 42516 San Francisco, CA 94142-2516	Arizona California Guam Hawaii Nevada Samoa
SEATTLE SUB OFFICE Room 209, RX-81 2201 Sixth Avenue Seattle, WA 98121 (206) 442-0547	HHS, OS, OIG, OI P.O. Box 61220 Seattle, WA 98121	Alaska Idaho Oregon Washington
WASHINGTON, D.C. Field Office Room 5193 Cohen Bldg. 330 Independence Av. SW Washington, DC 20201 (202) 619-1900	HHS, OS, OIG, OI Room 5193 Cohen Bldg. 330 Independence Av SW Washington, DC 20201	District of Columbia Maryland Counties: - Prince Georges - Montgomery Counties - Virginia Counties Virginia Cities - Alexandria - Falls Church

Exhibit 23 - PIM Acronyms - (Rev. 3, 11-22-00)

Acronym	Meaning
ABG	Arterial Blood Gas
ABN	Advanced Beneficiary Notice
AC	Affiliated Contractor
ADL	Activities of Daily Living
ADMC	Advance Determination of Medicare Coverage
AIDE	Home Health Aide
AKA	Also Known As
ALJ	Administrative Law Judge
AMA	American Medical Association
AoA	Administration on Aging
ASC	Ambulatory Surgical Center

AUSA	Assistant United States Attorney
BESS	Part B Extract Summary System
BI	Benefit Integrity
CAC	Carrier Advisory Committee
CBR	Cost Benefit Ratio
CFO	Chief Financial Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMD	Contractor Medical Director
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalties Law
CMR	Comprehensive Medical Review
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPE	Contractor Performance Evaluation
CPT	Current Procedural Terminology
CWF	Common working File
DAP	DMERC Advisory Panel
DBA	Doing Business As
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, and Orthotic Supplier
DMERC	Durable Medical Equipment Regional Carrier
DOJ	Department of Justice
DRG	Diagnosis Related Groups
DX	Diagnosis
EMC	Electronic Media Claims
EOMB	Explanation of Medicare Benefits
EPO	Epoetin
ESRD	End Stage Renal Dialysis
FBI	Federal Bureau of Investigation
FHIBA	Federal Health Insurance Benefits Accounts
FI	Fiscal Intermediary
FID	Fraud Investigation Database
FMR	Focused Medical Review

FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GPRA	Government Performance Results Act
GTL	Government Task Leader
HCFA	Health Care Financing Administration
HCIS	Healthcare Customer Information System
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
HI	Health Insurance
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HO	Hearings Officer
ICN/DCN	Internal Control Number/Document Control Number
IER	Interim Expenditure Report
IRP	Incentive Reward Program
IRS	Internal Revenue Service
LMRP	Local Medical Review Policy
MCM	Medicare Carrier Manual
MFCU	Medicaid Fraud Control Unit
MFIS	Medicare Fraud Information Specialist
MFSR	Medicare Focused Medical Review Status
MIM	Medicare Intermediary Manual
MIP	Medicare Integrity Program
MIP-PET	Medicare Integrity Program-Provider Education and Training
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSS	Medical social Services
N/A	Not Applicable
NCP	National Coverage Policy
NMFA	National Medicare Fraud Alert
NOU	Notice of Utilization
NPR	National Performance Review
NSC	National Supplier Clearinghouse

OCIG	Office of Counsel to the Inspector General
OCSQ	Office of Clinical Standards and Quality
OIFO	Office of Investigations Field Office
OIG	Office of Inspector General
OIGOAS	Office of Inspector General Office of Audit Services
OIG/OI	Office of Inspector General Office of Investigations
OP	Outpatient
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
PAL	Provider Audit List
PI	Program Integrity
PIM	Program Integrity Manual
PIN	Provider Identification Number
PIP	Periodic Interim Payments
PM	Program Memorandum
PM-PET	Program Management-Provider Education and Training
POC	Plan of Care
PPAC	Practicing Physicians Advisory Council
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PSC	Program Safeguard Contractor
PS&R	Provider Statistical and Reimbursement
PT	Physical Therapy
PTS	Provider Tracking system
QA	Quality Assurance
QIO	Quality Improvement Organization
RBS	Report of Benefit Savings
RCCO	Regional Chief Counsel's Office
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RMFA	Restricted Medicare Fraud alert
RMRP	Regional Medical Review Policy
RO	Regional Office
ROM	Range of Motion
RRB	Railroad Retirement Board
RT	Record Type
RVU	Relative Value Unit

SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SLP	Speech-Language Pathology
SMI	Supplementary Medical Insurance
SME	Subject Matter Expert
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SOC	Start of Care
SSA	Social Security Administration
SSAFO	Social Security Administration Field Office
ST	Speech Therapy
SUR	State Utilization Review Units
the Act	the Social Security Act
TOB	Type of Bill
TPN	Total Parenteral Nutrition
UPIN	Unique Physician Identification Number

Exhibit 25 – Procedures and Forms for Obtaining Protected Health Information

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Office of the Director

U.S. Department of Justice
Executive Office for United States Attorneys
Room 2616, RFK Main Justice Building
950 Pennsylvania Avenue, NW
Washington, DC 20530
(202) 514-2121

MEMORANDUM -Sent via Electronic Mail

DATE: April 11, 2003

TO: ALL UNITED STATES A TTORNEYS
ALL FIRST ASSISTANT UNITED STATES ATTORNEYS
ALL CRIMINAL CHIEFS
ALL CIVIL CHIEFS

FROM: Guy A. Lewis
Director

SUBJECT: Procedures and Forms for Obtaining Protected Health Information in Law Enforcement and Health Oversight Investigations; Guidance Materials Concerning New HIPAA Privacy Regulations.

ACTION REQUIRED: Please distribute to all Assistant United States Attorneys.

CONTACT PERSONS: Cam Towers Jones
Health Care Fraud Coordinator
Legal Programs
Telephone: (202) 353-8507

Andrea Gross
Affirmative Civil Enforcement Coordinator
Legal Programs
Telephone: (202) 305-3346

New medical privacy rules (located at 45 C.F .R., Parts 160 and 164) take effect on Monday, Apri114, 2003. These rules will affect all Assistant United States Attorneys (AUSAs) who obtain medical information in the course of their work.

In order to assist AUSAs, the Executive Office for United States Attorneys (EOUSA) and the Civil and Criminal Divisions of the Department of Justice have prepared form materials which can be used to obtain medical records in law enforcement and health oversight investigations. Attached is a WordPerfect document titled "Updated Process, Model Letters, and Forms to Request Protected Health Information Pursuant to the HIPAA Privacy Regulation." This document includes (1) a description of the process for obtaining Centers for Medicare and Medicaid Services (CMS) data after Apri114, 2003; (2) a form letter to be used in requesting information from CMS contractors; (3) a form letter to be used in requesting protected health information from entities other than CMS contractors (including federal agencies in affirmative civil and criminal health care fraud cases; and (4) potential paragraphs to be inserted in letters, subpoenas, or other forms of legal process requesting production of protected health information.

EOUSA and the Civil and Criminal Divisions of the Department of Justice have also prepared guidance about the regulation in a "question and answer" format. These guidance materials were distributed at the recent Health Care Fraud Coordinators Conference at the National Advocacy Center. An additional copy is also attached to this memorandum, for your information.

Copies of the documents attached to this memorandum will also be posted on the EOUSA ACEO and Health Care Fraud Web Page at: http://www.usa.doj.gov/staffs/lp/ace/.

If you have any questions regarding implementation of the privacy regulations, you may contact one of the people listed below:

Dan Anderson (Affirmative Civil)
Civil Division
(202) 616-2451

Ian DeWaal (Criminal)
Criminal Division
(202) 514-0669

Jim Gilligan (Civil Defensive/Federal Programs)
Civil Division
(202) 514-3358

Andrea Gross (Affirmative Civil)

Executive Office for United States Attorneys
(202) 305-3346

Cam Towers Jones (Criminal)
Executive Office for United States Attorneys
(202) 353-8507

Sherri Keene (Civil DefensiveIFTCA)
Civil Division
(202) 616-4272

Karen Morrissette (Criminal)
Criminal Division
(202) 514-0640

Attachments

cc: All United States Attorneys' Secretaries

UPDATED PROCESS, MODEL LETTERS AND FORMS TO REQUEST PROTECTED HEALTH INFORMATION PURSUANT TO THE PRIVACY ACT AND HIPAA PRIVACY RULE

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Page 2: Updated Process for Law Enforcement Agency Requests to Obtain CMS/Medicare data.

Page 4: Letter to request protected health information from the Centers for Medicare & Medicaid Services or from CMS's contractors (disclosure of data in CMS Systems of Records).

Page 6: Letter to request protected health information from other covered entities (including other federal agencies in affirmative civil and criminal health care fraud cases).

Page 7: Potential paragraphs to be inserted in letters (or subpoenas, etc) requesting production of protected health information.

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Page 10: Whistleblowers/victims of workplace crime

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Page 20: Patient Authorizations

Page 21: Patient Authorization to Release Medical Information

Page 23: Patient Authorization to Release Psychotherapy Information

Updated Process for Law Enforcement Agency Requests to Obtain CMS/Medicare Data

1. The law enforcement agency should begin by consulting with the appropriate Medicare contractor (usually the *Unified Program Integrity Contractor*, but possibly also the Carrier, Fiscal Intermediary, Quality Improvement Organization, or CMS) to discuss the purpose or goal of the data request. To illustrate, are data being sought to assess allegations of fraud; examine billing patterns; ascertain dollar losses to the Medicare program for a procedure, service or time period; conduct a random sample of claims for medical review, etc? Upon receiving a data request from a law enforcement agency, the Medicare contractor (e.g., *UPIC*) will examine its sources of data for most recent 36-month period for the substantive matter/s in question or for the specific period requested by the law enforcement agency, if necessary. In consultation with the Medicare contractor, the law enforcement agency also should make known the following:

- type of data and "fields of information" needed
- name and/or other identifying information for provider/s (e.g., Tax Identification Number, Unique Physican Identification Number, etc.)
- time period necessary for the inquiry (approximate begin and end dates if the conduct is not ongoing currently), and
- format or medium for data to be provided (i.e., tape, CD-ROM, paper, etc.).

2. As part of the initial consultation process, the Medicare contractor and law enforcement agency should develop appropriate language to insert in the data request "standard form letter." (A copy of an updated "standard form letter" from the law enforcement agency to Medicare contractor, along with various template paragraphs for insertion in the letter to ensure Privacy Act and HIPAA Privacy Rule compliance, are provided as attachments.) After consulting with the appropriate Medicare contractor, the law enforcement agency should send the signed standard form letter, identifying the appropriate authority under which the information is being sought and specifying the details of the request described above, to the Medicare contractor. The Medicare contractor will provide the relevant data, reports and findings to the requesting agency in the format/s requested within 30 days when data for the most recent 36-month period is being sought directly from the Medicare contractor. If it is necessary for the Medicare contractor to seek and acquire other data from CMS or another affiliated Medicare contractor, the time period required to provide the data to the requesting agency will extend beyond 30 days. (Currently, the average response period for data requests made to CMS is 14 weeks.) [1]

3. If appropriate, the Medicare contractor will also use analytic tools to look for other possible indicia of fraud in addition to the specific alleged conduct that was the cause of the law enforcement agency's data request.

4. If, in the view of the requesting law enforcement agency, the Medicare contractor, or CMS, the Medicare contractor's "initial 36-month review" generally verifies the fraud allegations, or if

potential fraud is uncovered through the use of analytic tools, and upon a subsequent request, the Medicare contractor will conduct a supplemental review of Medicare data. The supplemental review will meet the specific needs of the law enforcement agency based on the allegations under investigation and/or findings of the initial 36-month review. Such supplemental reviews may involve retrieving information from original Carrier and/or Fiscal Intermediary data files, as well as the National Claims History (NCH), Common Working File (CWF), or other Medicare data files that may be archived in order to cover the complete time frame involved in the allegations and/or allowed by the statute of limitations. The time period for fulfilling supplemental data requests will be negotiated on a case-by-case basis between CMS and the law enforcement agency making the data request.

5. While steps 1-4 describe the usual process to be followed for handling law enforcement agency requests for CMS/Medicare data, exceptions to this process will be necessary on a case-by-case basis when the law enforcement agency determines that conducting an initial review of the most recent 36-months of data would not be sufficient. For example, exceptions will be necessary if:

a. The most recent 36 months of data would not be helpful to the investigation because the fraud being investigated is alleged to have occurred prior, or in large part prior to, that period.

b. Changes in the payment system used for the type/s of claims in question cause the most current data to be inappropriate for attempting to verify allegations of possible fraud that occurred under a previous payment system.

c. The purpose of the data request cannot be met using only the most recent 36 months of data (e.g., a statistical sampling plan that requires more than 36 months of data to implement the plan correctly and accurately).

d. Litigation deadlines preclude conducting an initial review followed by a more comprehensive supplemental review.

e. Items 5 a-d are illustrative not exhaustive.

6. Each agency (DOJ, FBI, CMS, etc.) will designate a “contact person” for advising their internal agency components and field offices about this updated process for making data requests to CMS/Medicare contractors, and for resolving any conflicts or disagreements that may occur involving specific requests for information.

USE DEPARTMENT OF JUSTICE LETTERHEAD

[DATE]

If this request for data is made to a *Unified Program Integrity Contractor*, Quality Improvement Organization (QIO), Fiscal Intermediary (FI), or Carrier, address to:

Name of contact person
Name of the *UPIC*, QIO, FI, or Carrier
Address

and send a "cc:" to: Regional Office of the Inspector General
Director, Benefit Integrity and Law Enforcement Liaison, CMS

If this request for data is made to CMS, address to:

Centers for Medicare & Medicaid Services
Office of Financial Management
Program Integrity Group
Director, Benefit Integrity and Law Enforcement Liaison
C3-02-16
7500 Security Blvd
Baltimore, MD 21244

and send a "cc:" to: Regional Office of the Inspector General

Re: Request for disclosure of data in CMS Systems of Records

Dear [insert name]:

This letter is to request your assistance in obtaining CMS data from the [insert file name] on [insert type of data needed and providers for which data is needed] for claims during the following time period: [insert time period]. Please provide this data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case].

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Additionally, to ensure Privacy Act compliance, CMS has issued and published routine uses authorizing disclosure of data in CMS systems of records for such purposes. See 63 Federal

Register 38414, July 16, 1998. The focus of our examination is the following: [insert general description of the nature of the law enforcement or health oversight activity being pursued].

You can be assured that the DOJ will take all appropriate measures to ensure that this data will be maintained and used in compliance with Section VI (Confidentiality Procedures) of the Health Care Fraud and Abuse Control Program Guidelines agreed to by the Attorney General and the Secretary of the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996.

I understand that CMS does not commit to processing my request if the estimated cost of doing so exceeds $200,000, and that a CMS representative will contact me if the estimated cost exceeds that amount. Additionally, I understand that CMS officials may intercede should a DOJ request for CMS data create a substantial resource impact on the data processing capabilities of the CMS Data Center, a Medicare Fiscal Intermediary, Carrier, *Unified Program Integrity Contractor*, QIO, or other contractor. For requests initiated by the FBI or United States Attorney's offices, discussions to resolve such resource issues will be conducted between the appropriate CMS official and the appropriate FBI agent or Assistant United States Attorney (AUSA), or if necessary, the appropriate FBI or AUSA supervisor. For requests initiated by DOJ headquarters, or where regional resolution has been unsuccessful, CMS officials may refer such resource issues to the appropriate DOJ headquarters official.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, and office of DOJ official]

USE DEPARTMENT OF JUSTICE LETTERHEAD
MODIFY AS APPROPRIATE FOR YOUR INVESTIGATION AND FOR THE PARTICULAR RECIPIENT OF THE REQUEST (E.G., SUBPOENAED PERSON)

[DATE]

Re: Request for production of protected health information

Dear [insert name]:

This letter is to request that you produce information/data from [source of records] on [insert type of data/information needed and providers for which information is needed] for claims during the following time period: [insert time period]. Please provide this information/data in [specify format, i.e., CD, tape, disk, paper, etc.] directly to [insert name, address, telephone number, and role of the person in connection with the case.]

Instructions to DOJ attorney or investigator filling out letter: INSERT APPROPRIATE PARAGRAPHS FROM THE ALTERNATIVES, ATTACHED, Beginning at page 7.

Thank you for your assistance with this matter. Please call me at [insert phone #] if you have any questions about this request.

Sincerely,

[name, title, office of DOJ official]

POTENTIAL PARAGRAPHS TO BE INSERTED IN LETTERS (OR SUBPOENAS, ETC) REQUESTING PRODUCTION OF PROTECTED HEALTH INFORMATION. PLEASE READ ALL PARAGRAPHS AND ENSURE THAT YOU HAVE INCLUDED ALL NECESSARY PROVISIONS.

HEALTH OVERSIGHT

You are requested to produce this information to the Department of Justice in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. 45 C.F.R. 164.512(d); 45 C.F.R. 164.501.

REQUIRED BY LAW

The information sought in this request is required by law to be produced to the Department of Justice, pursuant to_____, (cite the applicable law or reference the legal process that is attached to this document.) Disclosure is therefore permitted under 45 C.F.R. 164.512(a).

(NOTE TO DRAFTER: IF THIS REQUEST ALSO FALLS WITHIN THE PROVISIONS OF 45 C.F.R. 164.512 (c), (e), OR (f). THEN YOU MUST ALSO MEET THE REQUIREMENT OF THAT SUBSECTION AND YOU MUST ALSO ASSERT THAT YOU HAVE MET THAT REQUIREMENT.

IF YOUR "REQUIRED BY LAW" REQUEST IS MADE IN A HEALTH OVERSIGHT CAPACITY, YOU SHOULD ASSERT THIS FACT SO THAT THE RECIPIENT OF THE REQUEST UNDERSTANDS THAT NO ADDITIONAL REQUIREMENTS NEED BE MET. 45 C.F.R. Section 164.512(d)(1))

WHISTLEBLOWERS/VICTIMS OF WORKPLACE CRIME
(See 65 Fed. Reg. 250, page 82492)

This request for information is made to you in your capacity as a whistleblower, described at 45 C.F.R. 164.502(j)(l)(i) as "[an individual who] believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public. . ." You are requested to produce the information described in Attachment A, hereto, to the Department of Justice in its capacity as a health oversight agency, as permitted by 45 C.F.R. 164.502(j)(l)(ii).

OR

This request for information is made to you in your capacity as a victim of a criminal act and a member of the workforce of a covered entity. You are providing information about the suspected perpetrator of the criminal act, and should limit your disclosure to the following information: a) name and address; b) date and place of birth; c) social security number; d) ABO blood type and Rh factor; e) type of injury; f) date and time of treatment; g) date and time of death; h) distinguishing physical characteristics. This request is made pursuant to 45 C.F.R. 164.502(j)(2).

Disclosures for law enforcement purposes pursuant to
process and as otherwise required by law (45 CFR 164.512(f)(1))

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(1) in that:

[INSERT PARAGRAPH (i), (iiA), (iiB), OR (iiC) BELOW]

(i) the disclosure is required by law [specify the law];

OR

(iiA) the disclosure is in compliance with and limited by the relevant requirements of a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer [attach relevant copies];

OR

(iiB) the disclosure is in compliance with and limited by the relevant requirements of a grand jury subpoena [attach copy];

OR

(iiC) the disclosure is in compliance with and limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or similar process authorized by law [attach copy]. The undersigned further represents that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and de-identified information could not reasonably be used.

Disclosures of information about victims of crimes for law enforcement purposes in response to a law enforcement request (45 CFR 164.512(f)(3))

The undersigned hereby represents that this request for protected health information is made by a law enforcement agency [specify agency] for law enforcement purposes and is permitted by 45 CFR 164.512(f)(3) in that the requested information is about an individual who is or is suspected to be a victim of a crime and that:

[INSERT PARAGRAPH (i) OR (ii) BELOW]

(i) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement]; (examples at page 23)

OR

(ii) the covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance [specify nature of incapacity or emergency circumstance]. The undersigned law enforcement official represents that: the requested information is needed to determine whether a violation of law by a person other than the victim has occurred, and that such information is not intended to be used against the victim; immediate law enforcement activity which depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure. The undersigned further asserts that the circumstances are such that the covered entity, in the exercise of its professional judgment, should determine that the disclosure is in the best interests of the individual.

Disclosures about victims of abuse, neglect or domestic violence (45 C.F.R. 164.512(c))

If the covered entity reasonably believes that the individual (whose personally identifiable health information is requested) is a victim of abuse, neglect or domestic violence, this request for information is permitted by 45 C.F.R. 164.512(c)(1) because the disclosure is to _____, which is a government agency authorized by law to receive reports of such abuse, neglect, or domestic violence, and:

[INSERT PARAGRAPH (i) or (ii) or either (iiiA) or (iiiB) below]

i) the disclosure is required by law [specify the law] and complies with and is limited to the relevant requirements of such law;

OR

ii) the individual has agreed to the disclosure [specify manner of agreement and/or attach written evidence of agreement];

OR, EITHER

iiiA) the disclosure is expressly authorized by statute or regulation, namely, [specify the law] and the covered entity believes the disclosure is necessary to prevent serious harm to the individual or other potential victims;

OR

iiiB) the disclosure is expressly authorized by statute or regulation [specify the law] and the individual is unable to agree because of incapacity [specify nature of incapacity], and the recipient law enforcement or public official authorized to receive the report [specify the agency] hereby represents that the protected health information which is sought is not intended to be used against the individual. The_____[specify agency] further represents that an immediate enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

Locate and Identify

This request for protected health information is made by a law enforcement agency pursuant to the provisions of 45 C.F.R. 164.512(f)(2) which permit the disclosure of the enumerated limited information for identification and location purposes.

A covered entity is permitted to make a disclosure to a law enforcement officer under this paragraph for the purpose of identifying or locating a suspect, fugitive, material witness or a missing person. The following information may be disclosed: (A) name and address; (B) date and place of birth; (C) social security number; (D) ABO blood type and rh factor; (E) type of injury; (F) date and time of treatment; (G) date and time of death (if applicable); (H) a description of distinguishing physical characteristics, including, height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.

Decedents

(NOTE: This section of the regulation can only be used to permit a disclosure to a coroner, pursuant to a request by a coroner. Therefore, it will seldom be used in connection with requests in federal investigations, and even in those cases, the request must originate from a coroner.)

This request for protected health information is made by a [coroner] [medical examiner] pursuant to the provisions of 45 C.F.R. 164.512(g) which permit a covered entity to disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

Correctional institutions and other law enforcement custodial situations

This request for protected health information is made by a [correctional institution][law enforcement agency] with lawful custody of [fill in name of prisoner/detainee]. The undersigned represents that the protected health information is necessary for (check all that apply): ( ) the provision of health care to this individual; ( ) the health and safety of this individual or other inmates; ( ) the health and safety of the custodial officers or employees of, or others at, the correctional institution; ( ) the health and safety of this individual and custodial officers, or other persons responsible for transporting this inmate, or this individual's transfer from one institution, facility or setting to another; ( ) law enforcement on the premises of the correctional institution; or ( ) the administration and maintenance of the safety, security, and good order of the correctional institution. The requested disclosure of protected health information is permitted by the provisions of 45 C.F.R. 164.512(k)(5).

Judicial/Administrative

The Department of Justice, through its undersigned representative, requests this information for judicial and administrative proceedings. Consistent with 45 C.F.R. 164.512(e), this request is [Insert one of the following alternatives]:

A. Pursuant to the order of [a court] [an administrative tribunal], and the only information disclosed is the protected health information expressly authorized by the order [attach copy of order where appropriate]; OR

Pursuant to a subpoena, discovery request, or other lawful process, that is not accompanied by a court-order or order of an administrative tribunal, and

Reasonable efforts have been made to ensure that the individual whose information is sought has been given notice of the request by way of a good faith attempt to provide written notice to the individual, as shown by the accompanying documentation [attach copy of notice to individual and affidavit of service]; and

The notice to the individual included sufficient information about the underlying litigation or proceeding to permit the individual to raise an objection to the [court] [administrative tribunal]; and

The time for the individual to raise objections to the [court] [administrative tribunal] has expired, and

No objections were filed, or

All objections filed by the individual have been resolved by the [court] [administrative tribunal] and the disclosures sought are consistent with such resolution.

OR [alternate, if patient has not been given notice]:

Reasonable efforts have been made to secure a qualified protective order that meets the requirements set forth in 45 C.F.R.. 164.512(e)(1)(v), and:

The parties to the underlying dispute which precipitated this request for protected health information have agreed to a qualified protective order and have presented it to the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate], OR

We have requested a qualified protective order from the [court] [administrative tribunal] with jurisdiction over the dispute [attach copy of proposed protective order, if appropriate].

Minimum Necessary

(NOTE: Do not use this language when the request is authorized by the patient or "required by law", because the "minimum necessary" standard does not apply to disclosures which are required by law." 65 Fed. Reg. 250, 82530, 82600, 82715);
45 C.F.R. 164.502(b)(2)(v)

The information sought in this request is the "minimum necessary to accomplish the intended purpose of the . . . request." 45 C.F.R. 164.502(b)(2)(v). (See 65 Fed. Reg. 82530 "A covered entity is not required to second guess the scope or purpose of the request...")

Insert Only When Suspension of Notification to Individual is Desired

The protected health information concerning the patients

[INSERT EITHER PARAGRAPH (i) OR (ii) BELOW]

(i) listed on Attachment A, hereto, which your organization disclosed to the Department of Justice on_____(specify date) in response to a

OR

(ii) which is disclosed in response to the accompanying

_____ (insert type of request, e.g. grand jury subpoena, other subpoena, oral request, other) was requested in furtherance of a federal_____law enforcement/health oversight (choose one) investigation. An accounting of this disclosure to the individuals concerned would, in this instance, be "reasonably likely to impede the [Department of Justice's] activities " 45 C.F.R. Section 164.528(a)(2)(i). Therefore, pursuant to this request and as required by the provisions of 45 C.F.R. Sec. 164.528(a)(2), you must suspend the individual(s)' right to receive an accounting of this disclosure of protected health information for (months/years).

PATIENT AUTHORIZATIONS

You are requested to release records pertaining to the individual(s) indicated on the enclosed form(s) titled "Authorization to Release Medical Information."

NOTE:

(1) Your state laws may contain medical record release requirements other than those set out on this form.

(2) If psychotherapy notes are requested, please use the separate authorization for this specific purpose. The regulations provide that an authorization for disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes. 45 CFR 164.508(b)(3)(ii).

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:	PATIENT:	RELEASE TO:
[Name of person or class of persons authorized to make disclosure]	NAME: BIRTH DATE:	Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ including but not limited to:

(1) Copy of complete chart, progress notes & interview notes, discharge summaries, operative reports, x-ray & all imagery, laboratory tests, pathology tissue, and all diagnostic studies whether in electronic data or other format.

(2) Billing records

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

__This Authorization will automatically expire upon completion of the litigation [provide case name and number]_____now pending in U.S. District Court for the_____District of_____.

__ This Authorization will automatically expire upon completion of the administrative claim of

_____filed on_____.

__ This Authorization shall be effective until_____.

OTHER CONDITIONS:

__x A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

OR PERSON AUTHORIZED TO SIGN FOR
PATIENT:*_____

_____ _____

MONTH/DAY/YEAR PRINT OR TYPE NAME

*Provide basis of Authorization:____
.

PATIENT AUTHORIZATION TO RELEASE PSYCHOTHERAPY INFORMATION

TO:	PATIENT:	RELEASE TO:
[Name of person or class of persons authorized to make disclosure]	NAME: BIRTH DATE:	Representatives of the United States Attorney's Office or Department of Justice

INFORMATION REQUESTED: I request and authorize the above-named person or class of persons to release the information specified below to representatives of the United States Attorney's Office or the Department of Justice. Any and all records regarding treatment of _____ _____ including but not limited to:

1. All records of psychological or psychiatric testing or treatment, including complete chart, audio and visual recordings, and psychotherapy notes, and

2. Billing records.

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

[Include case name or identify administrative claim]

CERTIFICATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, provided that revocation is in writing, except to the extent that action has already been taken in reliance this Authorization. I understand that the doctor, health care provider, or health plan from whom my medical information is requested in this Authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand the potential for the information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

EXPIRATION:

Check one:

__This Authorization will automatically expire upon completion of the litigation [provide case name and number]_____now pending in U.S. District Court for the_____District of_____.

This Authorization will automatically expire upon completion of the administrative claim of _____ filed on____.

__ This Authorization shall be effective until_____.

OTHER CONDITIONS:

__x A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:

OR PERSON AUTHORIZED TO SIGN FOR PATIENT:*_____

_____ _____

MONTH/DAY/YEAR PRINT OR TYPE NAME

*Provide basis of Authorization:_____.

__ This Authorization shall be effective until _____.

OTHER CONDITIONS:

__x__ A copy of this Authorization or my signature thereon shall be used with the same effectiveness as an original.
__x__ Communications between provider and any representative of the U.S. Attorney's Office/Department of Justice are authorized.

SIGNATURE OF PATIENT:
_____

OR PERSON AUTHORIZED TO SIGN FOR
PATIENT:*_____

_____

_____
_____

MONTH/DAY/YEAR PRINT OR TYPE NAME

*Provide basis of
Authorization:_____.

EXHIBIT 26 - DOJ Report (Excel Spreadsheet)

(Rev. 16, 11-28-01)

Contractor Name	Identification Number	Date of DOJ Request	Nature of Request	DOJ Tracking # (if provided)	Cost to Fill	SBR Y or N	Date of SBR Submission

Exhibit 27 - National Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

NATIONAL MEDICARE FRAUD ALERT TEMPLATE

Distribution of this Fraud Alert is Limited to the Following Audience: CMS regional offices, Medicare Contractor Benefit Integrity units, program safeguard contractors, Medicare Integrity Program (MIP) units, quality improvement organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Medicaid Program Directors

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION METHODOLOGY:

FID CASE (S):

STATUS:

CONTACT:

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS NMFA DATE

Exhibit 28 - Restricted Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

RESTRICTED MEDICARE FRAUD ALERT TEMPLATE

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this alert. Distribution is Limited to the Following Audience: CMS regional offices, Medicare contractor Benefit Integrity units, program safeguard contractors, quality improvement organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspector offices, and the Internal Revenue Service, and the State Medicaid Program Integrity Directors

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION METHODOLOGY:

FID CASE (S):

STATUS:

CONTACT:

NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT PURSUANT TO EXEMPTION (b) (2), (b)(5) AND (b)(7)(E) OF THE FOIA. ITS CONTENTS SHOULD NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN APPROVAL OF THE BENEFITS INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.
THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS RMFA DATE

Exhibit 29 – Reserve for Future Use

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Exhibit 30 - Treatment Codes

(Rev. 23, 03-18-02)

A. Skilled Nursing

These represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

A1 *	Skilled Observation and Assessment	Includes all skilled observation and assessment of the patient where the

	(Inc. V.S., Response to Med., etc)	physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)
A2	Foley Insertion	Insertion and/or removal of the Foley catheter by nurse.
A3	Bladder Instillation	Instilling medications into the bladder.
A4*	Open Wound Care/Dressing	Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) on an addendum, when necessary. See A28 for observation uncomplicated surgical incision.
A5*	Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss, etc.)	Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance on an addendum when necessary. Use this code only if the decubitus being treated presents the following characteristics: 1 -- Partial tissue loss with signs of infection such as foul odor or purulent drainage; 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone. For care of decubitus not meeting this definition, see A29.
A6*	Venipuncture	The HHA specifies the test and frequency to be performed under physician's orders.
A7*	Restorative Nursing	Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g., routine range of motion exercises).
A8	Post Cataract Care	Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.4.A.)

A9	Bowel/Bladder Training	Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified. (See MIM §3114.4.E.1.)
A10	Chest Physio (Including postural drainage)	Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.
A11	Adm. of Vitamin B-12	Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines. (See MIM §3117.4.)
A12	Adm. Insulin	Preparation of insulin syringes for administration by the patient or other person, or the administration by the nurse.
A13	Adm. Other IM/Subq	Administration of any injection other than vitamin B-12 or insulin ordered by the physician.
A14	Adm. IVs/ Clysis	Administration of intravenous fluids or clysis or intravenous medications.
A15	Teach Ostomy or Ileo conduit care	Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.
A16	Teach Nasogastric Feeding	Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.
A17	Reinsertion Nasogastric	Includes changing the tube by the nurse.
A18	Teach Gastrostomy Feeding	Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.
A19	Teach Parenteral Nutrition	Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.
A20	Teach Care of Trach	Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.

A21	Adm. Care of Trach	Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.
A22	Teach Inhalation Rx.	Teaching patient or other person to administer therapy and care for equipment.
A23*	Adm. Inhalation Rx	Administration of inhalation treatment and care of equipment by the nurse.
A24	Teach Adm. of Injection	Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)
A25	Teach Diabetic Care	Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).
A26	Disimpaction/F.U. Enema	Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.
A27*	Other (Spec. Under Orders)	Includes any skilled nursing or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (Form CMS-485).
A28*	Wound Care/Dressing – Closed Incision/Suture Line	Skilled observation and care of surgical incision/suture line including application of dry sterile dressing. (See A4.)
A29*	Decubitus Care	Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, other than that described in A5. The HHA describes size (depth and width) and appearance on the addendum.
A30	Teach Care of Any Indwelling Catheter	Teaching patient or other person to care for indwelling catheter.
A31	Management and Evaluation of Patient Care Plan	The complexity of necessary unskilled services require skilled management of a registered nurse to ensure that these services achieve their purpose, and to

		promote the beneficiary's recovery and medical safety.
A32*	Teaching and Training (other) (spec. under Orders)	Specify under physician orders.

* Code which requires a more extensive descriptive narrative for physician’s orders.

B. Physical Therapy (PT)

These codes represent all services to be performed by the physical therapist. If services are provided by a nurse, they are included under A7. The following is a further explanation of each service:

B1	Evaluation	Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).
B2	Therapeutic Exercise	Exercises designed to restore function. Specific exercise techniques (e.g., Proprioceptive Neuromuscular Facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques, which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion.
B3	Transfer Training	To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques.
B4	Establish or Upgrade Home Program	To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as an adjunct to PT programs.
B5	Gait Training	Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.).

B6	Pulmonary Physical Therapy	Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction.
B7	Ultra Sound	Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.
B8	Electro Therapy	Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, Transcutaneous Electrical Nerve Stimulation (TENS), Functional Electrical Stimulation (FES), biofeedback, High Voltage Galvanic Stimulation (HVGS), etc.).
B9	Prosthetic Training	Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.
B10	Fabrication Temporary Devices	Includes fabrication of temporary prostheses, braces, splints, and slings.
B11	Muscle Re-education	Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.
B12	Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
B13	Reserved	
B14	Reserved	
B15	Other (Spec. Under Orders)	Includes all PT services not identified above. Specific therapy services are identified under physician's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician’s orders.

C. Speech Therapy (ST)

These codes represent the services to be performed by the speech therapist. The following is a further explanation of each service.

C1	Evaluation	Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
C2	Voice Disorders Treatments	Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.
C3	Speech Articulation Disorders Treatments	Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements – usually referred to as apraxia/dyspraxia.
C4	Dysphagia Treatments	Includes procedures designed to facilitate and restore a functional swallow.
C5	Language Disorders Treatments	Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.
C6	Aural Rehabilitation	Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.
C7	Reserved	
C8	Non-oral Communications	Includes any procedures designed to establish a non-oral or augmentive communication system.
C9*	Other (Spec. Under Orders)	Speech therapy services not included above. Specify service to be rendered under physician's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician’s orders.

D Occupational Therapy

These codes represent the services to be rendered by the occupational therapist. The following is a further explanation of each service:

D1	Evaluation	Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.
D2	Independent Living/Daily Living Skills (ADL Training)	Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.
D3	Muscle Re-education	Includes therapy designed to restore function lost due to disease or surgical intervention.
D4	Reserved	
D5	Perceptual Motor Training	Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities, which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.
D6	Fine Motor Coordination	Refers to the skills and the performance in fine motor and dexterity activities.
D7	Neurodevelop-mental Treatment	Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses, which are coordinated at subcortical and cortical levels.
D8	Sensory Treatment	Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.

D9	Orthotics Splinting	Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.
D10	Adaptive Equipment (Fabrication and Training)	Refers to the provision of special devices that increase independent functions.
D11*	Other	Occupational therapy services not quantified above.

* Code which requires a more extensive descriptive narrative for physician's orders.

E. Medical Social Services (MSS)

These codes represent the services to be rendered by the medical social service worker. The following is a further explanation of each service:

E1	Assessment of Social and Emotional Factors	Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.
E2	Counseling for Long-Range Planning and Decision making	Assessment of patient's needs for long term care including: Evaluation of home and family situation; enabling patient/family to develop an in-home care system; exploring alternatives to in-home care; or arrangement for placement.
E3	Community Resource Planning	The promotion of community centered services(s) including education, advocacy, referral and linkage.
E4*	Short Term Therapy	Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.
E5	Reserved	
E6*	Other (Specify Under Orders)	Includes other medical social services related to the patient's illness and need for care. Problem resolution associated with

		high risk indicators endangering patient's mental and physical health including: Abuse/neglect, inadequate food/medical supplies; and high suicide potential. The service to be performed must be written under doctor's orders (Form CMS-485, Item 21).

* Code which requires a more extensive descriptive narrative for physician’s orders.

F. Home Health Aide

These codes represent the services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. The following is a further explanation of each service:

F1	Tub/Shower Bath	Assistance with tub or shower bathing.
F2	Partial/Complete Bed Bath	Bathing or assisting the patient with bed bath.
F3	Reserved	
F4	Personal Care	Includes shaving of patient or shampooing the hair.
F5	Reserved	
F6	Catheter Care	Care of catheter site and/or irrigations under nursing supervision.
F7	Reserved	
F8	Assist with Ambulation	Assisting the patient with ambulation as determined necessary by the nurse care plan.
F9	Reserved	
F10	Exercises	Assisting the patient with exercises in accordance with the plan of care.
F11	Prepare Meal	May be furnished by the aide during a visit for personal care.
F12	Grocery Shop	May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.

F13	Wash Clothes	This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.
F14	Housekeeping	Household services incidental to care and which do not substantially increase the time spent by the home health aide.
F15*	Other (Specify Under Orders)	Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Form CMS-485, Item 21.

- Code which requires a more extensive descriptive narrative for physician's orders.
-

Exhibit 31 - Form CMS-485, Home Health Certification and Plan of Care (Rev. 23, 03-18-02)

View Form CMS-485 (PDF, 10 KB)

Exhibit 32 - Harkin Grantee Winframe Database Access and Operation Instructions - (Rev. 32, 10-25-02)

View the Harkin Grantee Winframe Database Access and Operation Instructions (PDF, 298 KB)

Exhibit 33 - Harkin Grantee Model Form -- (Rev. 32, 10-25-02)

View the Harkin Grantee Model Form (PDF, 74.6 KB)

HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM

DATE:
□□□□□□□
From: (Your Name)_____ Organization: _____

Address:_____ City:_____ State:_____

Zip:_____

Phone: (With Area Code) Fax # E-Mail (If Applicable)

Beneficiary Name: Medicare #: Medicaid #:

Date of Birth:

Address: Phone #: (With Area Code)

City: State: Zip:

Name of Complainant (If Different From Beneficiary):

Address: Phone #: (With Area Code)

City: State: Zip:

Complaint Against: (Name of facility, provider, physician, lab, supplier, etc.)
Claim # (If appropriate)

Date(s) of Service:

Business Address: Phone: (With Area Code)

Provider Number:

City: State: Zip:

Description of Complaint:
Please describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page if you need more room. If you feel you were billed for services or supplies that were not provided, continue on with the non-rendered service section below.

Non-rendered Services Section:

Did you see any provider that day? _____ If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)

Was the service(s) provided on another day? _____ If yes, when? _____

Have you ever seen the provider listed? _____ If yes, when? _____

Have you contacted the provider/supplier regarding this billing? _____ Yes _____ No

If yes, to whom did you speak and what was the result of the conversation?

I authorize _____ and (insert name of project) to discuss my complaint for the purpose of investigating possible fraud or abuse.

I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.

_____ _____

Signature Date

If receiving a telephone complaint write "telephone complaint" on the signature line

Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: (insert name of project)

Exhibit 34 – Reserved for Future Use

(Rev. 548, Issued: 10-17-14; Effective Date: 11-18-14, Implementation Date: 11-18-14)

Exhibit 34.2 - CERT Formats for Carrier and DMERC Standard Systems

(Rev. 77, 05-28-04)

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

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

Field Name	Picture	From	Thru	Initialization
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 34.6 – CERT PSC Contractor Feedback Data Entry Screen Version 1.01

(Rev. 77, 05-28-04)

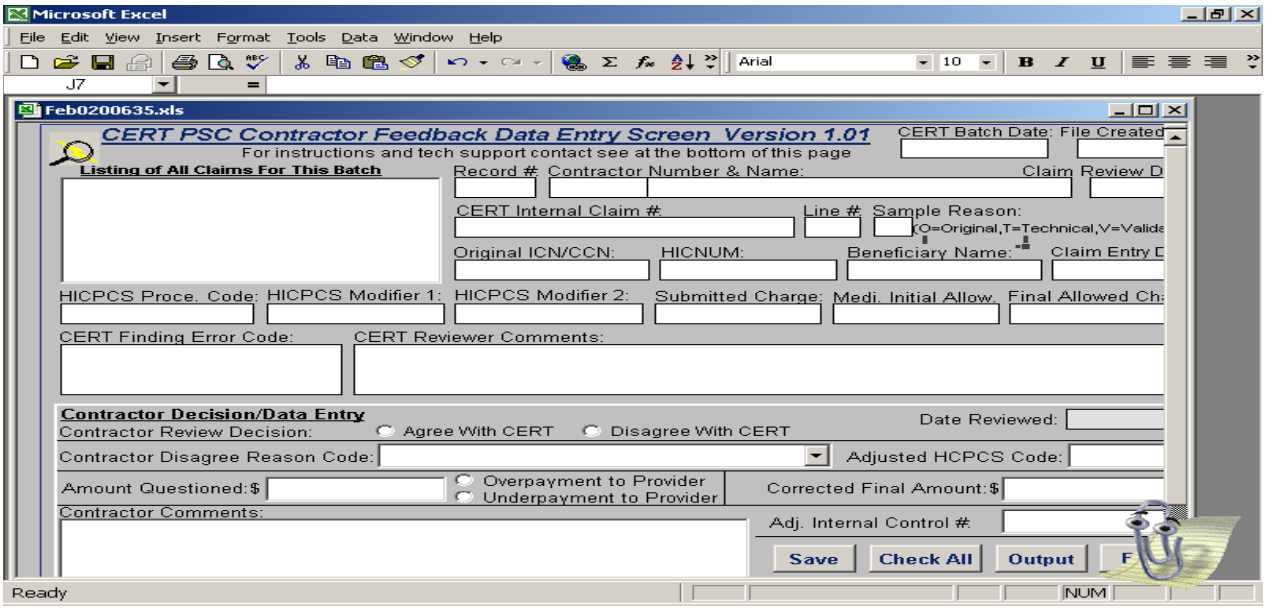

Figure 1: CERT PSC Contractor Feedback Data Entry Screen

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 CERT Contractor Resolution Process (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. 77, 05-28-04)

The CMS Central Office Clinical Panel (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).

Exhibit 35 – Memorandum of Understanding (MOU) with Law Enforcement

DEPARTMENT OF JUSTICE ACCESS TO
MEDICARE CONTRACTOR INFORMATION

Combating Medicare fraud is a goal shared by the Department of Justice (DOJ), Department of Health and Human Services Office of the Inspector General (OIG), and the Health Care Financing (HCFA). Investigating and prosecuting such cases typically requires access to information and documents from Medicare contractors. To ensure that law enforcement's need for this information is met consistent with Medicare contractors' other responsibilities, DOJ, OIG, and HCFA agree to the following procedures:

1. DOJ can request in writing information and documents related to an ongoing civil or criminal health care fraud investigation or prosecution directly from a Medicare contractor. DOJ includes personnel at the Federal Bureau of Investigation (FBI), United States Attorneys Offices, and the Department of Justice in Washington, D.C., including but not limited to the Criminal Division and Civil Division.

2. When DOJ requests information from a Medicare contractor, it must notify the Regional OIG in writing.

   OIG approval is not necessary for DOJ requests for information from a Medicare contractor. OIG notification is intended to prevent duplication in investigative efforts.

3. HCFA approval is not necessary before a Medicare contractor can provide information requested to DOJ.

4. It is presumed that a Medicare contractor will furnish DOJ officials with information and documents related to a civil or criminal health care fraud investigation or prosecution in a timely fashion. However, if a Medicare contractor objects to the request on the basis that it is unduly burdensome in terms of the volume of information requested, the timing of the request, or the format in which DOJ seeks the information, the Medicare contractor may take the following steps:

   a. Contact the requesting DOJ official to explain the basis of the objection. All parties agree to make good faith efforts to reach a resolution that accommodates DOJ's legitimate law enforcement needs and the Medicare contractor's budgetary constraints or other needs.

      Legitimate requests include but are not limited to requests for the following documents:

(1) information contained on claim forms and other records maintained on individual providers or suppliers;

(2) billing procedure updates and other Medicare publications furnished to providers or suppliers;

(3) contractor correspondence to and from providers/suppliers;

(4) billing history of beneficiaries;

(5) analysis performed by Fraud and Abuse Units;

(6) data analysis routinely done by Medicare contractors such as utilization reviews.

DOJ recognizes that general data analysis is typically the prerogative of the Medicare contractor and HCFA and, therefore, agrees to limit requests for data analysis not otherwise performed by the Medicare contractor. HCFA recognizes that OIG and DOJ may have legitimate law enforcement needs for data analysis in ongoing investigations and proceedings. Where DOJ requests data analysis not otherwise performed by the contractor, DOJ should discuss the request with the Medicare contractor to explain the need for such analysis and to determine whether there is an alternative format for a contractor to provide the information.

b. Where the FBI has sought the information, the FBI may involve in the resolution a representative of the United States Attorney's Office, DOJ's Criminal Division or Civil Division.

c. If the Medicare contractor and the requesting DOJ official cannot reach an accommodation, then they may seek the intervention of HCFA's Associate Regional Administrator. It is anticipated that such an appeal will be a rare occurrence prevented by reasonable requests and timely and comprehensive responses.

5. Periodic meetings between DOJ, OIG, HCFA regional officials, and the Medicare contractors should be held at the local levels. Similar meetings between DOJ, OIG, and HCFA should be held at the national levels. Such meetings offer an opportunity to discuss trends in fraudulent practices; to devise possible solutions to stopping ongoing fraud; to report the status of DOJ health care fraud cases—consistent with DOJ's enforcement needs and limitations on permissible disclosure of such information; to resolve problems, if any, concerning requests for information; and generally, to foster cooperation among law enforcement, HCFA, and Medicare contractors.

6. DOJ, OIG, and HCFA agree to conduct training to familiarize their respective personnel on the activities and needs of the others.

7. DOJ will handle the information and documents obtained from Medicare contractors consistent with existing statutory and regulatory provisions protecting confidentiality of patient records including, but not limited to, the Privacy Act of 1974.

8. Contractors requiring further instructions or clarification regarding any aspect of this policy, including the application of any statute or regulation, may contact the appropriate Associate Regional Administrator.

This policy will be revisited six months from the date of its adoption.

_____/s/_____
GERALD M. STERN
Special Counsel for Health Care Fraud
Department of Justice

_____/s/____
JUNE GIBBS BROWN
Inspector General
Department of Health and Human Services

_____/s/_____
BRUCE VLADECK
Administrator
Health Care Financing Administration

_____4/29/94_____
DATE

36 - Overview of the CERT Process

(Rev. 726, Issued: 06-16-17, Effective: 10-01-17, Implementation: 01-02-18 - For VMS and MCS for Business Requirements 11 through 22 and 22.1; 10-02-17 - For FISS)

The CERT process begins at the MAC 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 MACs. 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 MAC and matched to the MAC's 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 MAC 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 MAC 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 MAC for follow-up. MACs 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 36.1 - CERT Formats for A/B MAC (A) MACS and Shared Systems

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Universe Date	X(8)	9	16	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Universe Date

Definition: Date the universe of claims entered the shared 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 shared system batch processing date; however, the Universe Date must not equal the universe date on any previous claims universe file.
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”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Internal Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	Spaces
Billing Provider Number	X(9)	44	52	Spaces
Billing Provider NPI	X(10)	53	62	Spaces
Type of Bill	X(3)	63	65	Spaces
Claim From Date	X (8)	66	73	Spaces
Claim Through Date	X (8)	74	81	Spaces
Condition Code 1	X (2)	82	83	Spaces
Condition Code 2	X (2)	84	85	Spaces
Condition Code 3	X (2)	86	87	Spaces
Condition Code 4	X (2)	88	89	Spaces
Condition Code 5	X (2)	90	91	Spaces
Condition Code 6	X (2)	92	93	Spaces
Condition Code 7	X (2)	94	95	Spaces
Condition Code 8	X (2)	96	97	Spaces
Condition Code 9	X (2)	98	99	Spaces
Condition Code 10	X (2)	100	101	Spaces
Condition Code 11	X (2)	102	103	Spaces
Condition Code 12	X (2)	104	105	Spaces
Condition Code 13	X (2)	106	107	Spaces
Condition Code 14	X (2)	108	109	Spaces
Condition Code 15	X (2)	110	111	Spaces
Condition Code 16	X (2)	112	113	Spaces
Condition Code 17	X (2)	114	115	Spaces
Condition Code 18	X (2)	116	117	Spaces
Condition Code 19	X (2)	118	119	Spaces
Condition Code 20	X (2)	120	121	Spaces
Condition Code 21	X (2)	122	123	Spaces
Condition Code 22	X (2)	124	125	Spaces
Condition Code 23	X (2)	126	127	Spaces
Claim Demonstration Number	X(2)	128	129	Spaces
PPS Indicator Code	X(1)	130	130	Spaces
Claim State	X(2)	131	132	Spaces
Beneficiary State	X(2)	133	134	Spaces
Claim Total Charge Amount	9(8)V99	135	144	Zeroes
Beneficiary MBI	X(11)	145	155	Spaces
Hicn/MBI indicator	X(1)	156	156	Spaces

Field Name	Picture	From	Thru	Initialization
Filler	X(2)	157	158	Spaces
Revenue Code Count	9(3)	159	161	Zero

Claims Universe File
Claims Universe Revenue Code Group (Claim Line Items)
*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

Field Name	Picture	From	Thru	Initialization
Revenue Center Code	X(4)	162	165	Spaces
HCPCS	X(5)	166	170	Spaces
Revenue Center Total Charge	9(8)V99	171	180	Zeroes

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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of
10/1/2007 C = Record Format as
of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Internal Control Number

Definition: Number assigned by the shared 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: Billing Provider Number
Definition: First nine characters of number assigned by Medicare to identify the billing/pricing provider or supplier.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required by May 23, 2007 for claims using HIPAA standard Transactions

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 code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
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: Format is CCYYMMDD
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: Format is 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

Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing.
Validation: Must be a valid code as defined in the Claims Processing Manual (Pub. 100-4) chapter 25 (Completing and Processing CMS-1450 Data Set).
Remarks: N/A
Requirement: Required if claim has a condition code

Data Element: Claim Demonstration Identification Number
Definition: The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: N/A
Requirement: Required when available on claim

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: Claim State
Definition: 2 character abbreviation identifying the state in which the service is furnished
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank.
Remarks: N/A
Requirement: Required if on claim record

Data Element: Beneficiary State
Definition: 2 character abbreviation designating the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS) or blank.
Remarks: N/A
Requirement: Required if on claim record

Data Element: Claim Total Charge Amount

Definition: The total charges for all services included on the institutional claim.
Validation: N/A
Remarks: This field should contain the same amount as revenue center code 0001/total charges.
Requirement: Required

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string
- Different, visibly distinguishable from HICN/RRB numbers
- Contain no more than 2 consecutive numbers
- Contain no more than 2 consecutive alphabetic characters
- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z)
- Must not contain lowercase letters
- Must not contain any special characters

Remarks: Do not include hyphens or spaces
Requirement: Required, when available

Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI
Validation: M = MBI submitted on the claim
H = HICN submitted on the claim
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

<u>Claim Line Item Fields</u>

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 Procedure Code or HIPPS Code
Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code.
Validation: Must be a valid HCPCS/CPT-4 code.
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the 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, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXYY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on bill

Data Element: Revenue Center Total Charge

Definition: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided

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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	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

NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes: B = Record Format as of 10/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement:
Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file.
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only.
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH).
Requirement: Required

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

Claims Transaction File
Claims Transaction 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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Transaction Date	X(8)	9	16	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

NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Transaction file.
Validation: Claim Transaction files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement:
Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Transaction Date
Definition: Date the Transaction file was created
Validation: Must be a valid date not equal to a Transaction date sent on any previous claims Transaction file.
Remarks: Format is CCYYMMDD. May use shared system batch processing date.
Requirement: Required

Sampled Claims Transaction File
Sampled Claims Transaction File Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(23)	9	31	Spaces
Beneficiary HICN	X(12)	32	43	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary's Health Insurance Claim Number
Validation: N/A
Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process.
Requirement: Required

Claims Transaction File
Claims Transaction 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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
Remarks: N/A
Requirement:
Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

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

Claims Resolution File
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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Resolution Date
Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
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 Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Record Number	9(1)	9	9	Zero

Field Name	Picture	From	Thru	Initialization
Mode of Entry Indicator	X(1)	10	10	Space
Original Claim Control Number	X(23)	11	33	Spaces
Internal Control Number	X(23)	34	56	Spaces
Beneficiary HICN	X(12)	57	68	Spaces
Beneficiary Last Name	X(60)	69	128	Spaces
Beneficiary First Name	X(35)	129	163	Spaces
Beneficiary Middle Initial	X(1)	164	164	Spaces
Beneficiary Date of Birth	X(8)	165	172	Spaces
Beneficiary Gender	X(1)	173	173	Spaces
Billing Provider Number	X(9)	174	182	Spaces
Attending Physician UPIN	X(6)	183	188	Spaces
Claim Paid Amount	S9(8)V99	189	198	Zeroes
Claim ANSI Reason Code 1	X(8)	199	206	Spaces
Claim ANSI Reason Code 2	X(8)	207	214	Spaces
Claim ANSI Reason Code 3	X(8)	215	222	Spaces
Claim ANSI Reason Code 4	X(8)	223	230	Spaces
Claim ANSI Reason Code 5	X(8)	231	238	Spaces
Claim ANSI Reason Code 6	X(8)	239	246	Spaces
Claim ANSI Reason Code 7	X(8)	247	254	Spaces
Statement covers From Date	X(8)	255	262	Spaces
Statement covers Thru Date	X(8)	263	270	Spaces
Claim Entry Date	X(8)	271	278	Spaces
Claim Adjudicated Date	X(8)	279	286	Spaces
Condition Code 1	X(3)	287	289	Spaces
Condition Code 2	X(3)	290	292	Spaces
Condition Code 3	X(3)	293	295	Spaces
Condition Code 4	X(3)	296	298	Spaces
Condition Code 5	X(3)	299	301	Spaces
Condition Code 6	X(3)	302	304	Spaces
Condition Code 7	X(3)	305	307	Spaces
Condition Code 8	X(3)	308	310	Spaces
Condition Code 9	X(3)	311	313	Spaces
Condition Code 10	X(3)	314	316	Spaces
Condition Code 11	X(3)	317	319	Spaces
Condition Code 12	X(3)	320	322	Spaces
Condition Code 13	X(3)	323	325	Spaces
Condition Code 14	X(3)	326	328	Spaces
Condition Code 15	X(3)	329	331	Spaces
Condition Code 16	X(3)	332	334	Spaces
Condition Code 17	X(3)	335	337	Spaces
Condition Code 18	X(3)	338	340	Spaces
Condition Code 19	X(3)	341	343	Spaces
Condition Code 20	X(3)	344	346	Spaces
Condition Code 21	X(3)	347	349	Spaces
Condition Code 22	X(3)	350	352	Spaces
Condition Code 23	X(3)	353	355	Spaces
Condition Code 24	X(3)	356	358	Spaces
Condition Code 25	X(3)	359	361	Spaces
Condition Code 26	X(3)	362	364	Spaces
Condition Code 27	X(3)	365	367	Spaces

Field Name	Picture	From	Thru	Initialization
Condition Code 28	X(3)	368	370	Spaces
Condition Code 29	X(3)	371	373	Spaces
Condition Code 30	X(3)	374	376	Spaces
Type of Bill	X(3)	377	379	Spaces
Principal Diagnosis Code	X(7)	380	386	Spaces
Other Diagnosis Code 1	X(7)	387	393	Spaces
Other Diagnosis Code 2	X(7)	394	400	Spaces
Other Diagnosis Code 3	X(7)	401	407	Spaces
Other Diagnosis Code 4	X(7)	408	414	Spaces
Other Diagnosis Code 5	X(7)	415	421	Spaces
Other Diagnosis Code 6	X(7)	422	428	Spaces
Other Diagnosis Code 7	X(7)	429	435	Spaces
Other Diagnosis Code 8	X(7)	436	442	Spaces
Other Diagnosis Code 9	X(7)	443	449	Spaces
Other Diagnosis Code 10	X(7)	450	456	Spaces
Other Diagnosis Code 11	X(7)	457	463	Spaces
Other Diagnosis Code 12	X(7)	464	470	Spaces
Other Diagnosis Code 13	X(7)	471	477	Spaces
Other Diagnosis Code 14	X(7)	478	484	Spaces
Other Diagnosis Code 15	X(7)	485	491	Spaces
Other Diagnosis Code 16	X(7)	492	498	Spaces
Other Diagnosis Code 17	X(7)	499	505	Spaces
Other Diagnosis Code 18	X(7)	506	512	Spaces
Other Diagnosis Code 19	X(7)	513	519	Spaces
Other Diagnosis Code 20	X(7)	520	526	Spaces
Other Diagnosis Code 21	X(7)	527	533	Spaces
Other Diagnosis Code 22	X(7)	534	540	Spaces
Other Diagnosis Code 23	X(7)	541	547	Spaces
Other Diagnosis Code 24	X(7)	548	554	Spaces
Principal Diagnosis Code Version Indicator Code	X(1)	555	555	Spaces
Other Diagnosis Code 1 Version Indicator Code	X(1)	556	556	Spaces
Other Diagnosis Code 2 Version Indicator Code	X(1)	557	557	Spaces
Other Diagnosis Code 3 Version Indicator Code	X(1)	558	558	Spaces
Other Diagnosis Code 4 Version Indicator Code	X(1)	559	559	Spaces
Other Diagnosis Code 5 Version Indicator Code	X(1)	560	560	Spaces
Other Diagnosis Code 6 Version Indicator Code	X(1)	561	561	Spaces
Other Diagnosis Code 7 Version Indicator Code	X(1)	562	562	Spaces
Other Diagnosis Code 8 Version Indicator Code	X(1)	563	563	Spaces
Other Diagnosis Code 9 Version Indicator Code	X(1)	564	564	Spaces

Field Name	Picture	From	Thru	Initialization
Other Diagnosis Code 10 Version Indicator Code	X(1)	565	565	Spaces
Other Diagnosis Code 11 Version Indicator Code	X(1)	566	566	Spaces
Other Diagnosis Code 12 Version Indicator Code	X(1)	567	567	Spaces
Other Diagnosis Code 13 Version Indicator Code	X(1)	568	568	Spaces
Other Diagnosis Code 14 Version Indicator Code	X(1)	569	569	Spaces
Other Diagnosis Code 15 Version Indicator Code	X(1)	570	570	Spaces
Other Diagnosis Code 16 Version Indicator Code	X(1)	571	571	Spaces
Other Diagnosis Code 17 Version Indicator Code	X(1)	572	572	Spaces
Other Diagnosis Code 18 Version Indicator Code	X(1)	573	573	Spaces
Other Diagnosis Code 19 Version Indicator Code	X(1)	574	574	Spaces
Other Diagnosis Code 20 Version Indicator Code	X(1)	575	575	Spaces
Other Diagnosis Code 21 Version Indicator Code	X(1)	576	576	Spaces
Other Diagnosis Code 22 Version Indicator Code	X(1)	577	577	Spaces
Other Diagnosis Code 23 Version Indicator Code	X(1)	578	578	Spaces
Other Diagnosis Code 24 Version Indicator Code	X(1)	579	579	Spaces
Principal Procedure	X(7)	580	586	Spaces
Principal Procedure Date	X(8)	587	594	Spaces
Other Procedure 1	X(7)	595	601	Spaces
Other Procedure 1 Date	X(8)	602	609	Spaces
Other Procedure 2	X(7)	610	616	Spaces
Other Procedure 2 Date	X(8)	617	624	Spaces
Other Procedure 3	X(7)	625	631	Spaces
Other Procedure 3 Date	X(8)	632	639	Spaces
Other Procedure 4	X(7)	640	646	Spaces
Other Procedure 4 Date	X(8)	647	654	Spaces
Other Procedure 5	X(7)	655	661	Spaces
Other Procedure 5 Date	X(8)	662	669	Spaces
Other Procedure 6	X(7)	670	676	Spaces
Other Procedure 6 Date	X(8)	677	684	Spaces
Other Procedure 7	X(7)	685	691	Spaces
Other Procedure 7 Date	X(8)	692	699	Spaces
Other Procedure 8	X(7)	700	706	Spaces
Other Procedure 8 Date	X(8)	707	714	Spaces
Other Procedure 9	X(7)	715	721	Spaces
Other Procedure 9 Date	X(8)	722	729	Spaces
Other Procedure 10	X(7)	730	736	Spaces

Field Name	Picture	From	Thru	Initialization
Other Procedure 10 Date	X(8)	737	744	Spaces
Other Procedure 11	X(7)	745	751	Spaces
Other Procedure 11 Date	X(8)	752	759	Spaces
Other Procedure 12	X(7)	760	766	Spaces
Other Procedure 12 Date	X(8)	767	774	Spaces
Other Procedure 13	X(7)	775	781	Spaces
Other Procedure 13 Date	X(8)	782	789	Spaces
Other Procedure 14	X(7)	790	796	Spaces
Other Procedure 14 Date	X(8)	797	804	Spaces
Other Procedure 15	X(7)	805	811	Spaces
Other Procedure 15 Date	X(8)	812	819	Spaces
Other Procedure 16	X(7)	820	826	Spaces
Other Procedure 16 Date	X(8)	827	834	Spaces
Other Procedure 17	X(7)	835	841	Spaces
Other Procedure 17 Date	X(8)	842	849	Spaces
Other Procedure 18	X(7)	850	856	Spaces
Other Procedure 18 Date	X(8)	857	864	Spaces
Other Procedure 19	X(7)	865	871	Spaces
Other Procedure 19 Date	X(8)	872	879	Spaces
Other Procedure 20	X(7)	880	886	Spaces
Other Procedure 20 Date	X(8)	887	894	Spaces
Other Procedure 21	X(7)	895	901	Spaces
Other Procedure 21 Date	X(8)	902	909	Spaces
Other Procedure 22	X(7)	910	916	Spaces
Other Procedure 22 Date	X(8)	917	924	Spaces
Other Procedure 23	X(7)	925	931	Spaces
Other Procedure 23 Date	X(8)	932	939	Spaces
Other Procedure 24	X(7)	940	946	Spaces
Other Procedure 24 Date	X(8)	947	954	Spaces
Principal Procedure Version Indicator Code	X(1)	955	955	Spaces
Other Procedure 1 Version Indicator Code	X(1)	956	956	Spaces
Other Procedure 2 Version Indicator Code	X(1)	957	957	Spaces
Other Procedure 3 Version Indicator Code	X(1)	958	958	Spaces
Other Procedure 4 Version Indicator Code	X(1)	959	959	Spaces
Other Procedure 5 Version Indicator Code	X(1)	960	960	Spaces
Other Procedure 6 Version Indicator Code	X(1)	961	961	Spaces
Other Procedure 7 Version Indicator Code	X(1)	962	962	Spaces
Other Procedure 8 Version Indicator Code	X(1)	963	963	Spaces
Other Procedure 9 Version Indicator Code	X(1)	964	964	Spaces

Field Name	Picture	From	Thru	Initialization
Other Procedure 10 Version Indicator Code	X(1)	965	965	Spaces
Other Procedure 11 Version Indicator Code	X(1)	966	966	Spaces
Other Procedure 12 Version Indicator Code	X(1)	967	967	Spaces
Other Procedure 13 Version Indicator Code	X(1)	968	968	Spaces
Other Procedure 14 Version Indicator Code	X(1)	969	969	Spaces
Other Procedure 15 Version Indicator Code	X(1)	970	970	Spaces
Other Procedure 16 Version Indicator Code	X(1)	971	971	Spaces
Other Procedure 17 Version Indicator Code	X(1)	972	972	Spaces
Other Procedure 18 Version Indicator Code	X(1)	973	973	Spaces
Other Procedure 19 Version Indicator Code	X(1)	974	974	Spaces
Other Procedure 20 Version Indicator Code	X(1)	975	975	Spaces
Other Procedure 21 Version Indicator Code	X(1)	976	976	Spaces
Other Procedure 22 Version Indicator Code	X(1)	977	977	Spaces
Other Procedure 23 Version Indicator Code	X(1)	978	978	Spaces
Other Procedure 24 Version Indicator Code	X(1)	979	979	Spaces
Claim Demonstration Identification Number	9(2)	980	981	Zeroes
PPS Indicator	X(1)	982	982	Spaces
Action Code	X(1)	983	983	Spaces
Patient Status	X(2)	984	985	Spaces
Billing Provider NPI	X(10)	986	995	Spaces
Claim Provider Taxonomy Code	X(25)	996	1020	Spaces
Medical Record Number	X(17)	1021	1037	Spaces
Patient Control Number	X(20)	1038	1057	Spaces
Attending Physician NPI	X(10)	1058	1067	Spaces
Attending Physician Last Name	X(16)	1068	1083	Spaces
Operating Physician NPI	X(10)	1084	1093	Spaces
Operating Physician Last Name	X(16)	1094	1109	Spaces
Claim Rendering Physician NPI	X(10)	1110	1119	Spaces
Claim Rendering Physician Last Name	X(16)	1120	1135	Spaces
Date of Admission	X(8)	1136	1143	Spaces
Type of Admission	X(1)	1144	1144	Spaces
Source of Admission	X(1)	1145	1145	Spaces
DRG	X(3)	1146	1148	Spaces

Field Name	Picture	From	Thru	Initialization
Occurrence Code 1	X(2)	1149	1150	Spaces
Occurrence Code 1 Date	X(8)	1151	1158	Spaces
Occurrence Code 2	X(2)	1159	1160	Spaces
Occurrence Code 2 Date	X(8)	1161	1168	Spaces
Occurrence Code 3	X(2)	1169	1170	Spaces
Occurrence Code 3 Date	X(8)	1171	1178	Spaces
Occurrence Code 4	X(2)	1179	1180	Spaces
Occurrence Code 4 Date	X(8)	1181	1188	Spaces
Occurrence Code 5	X(2)	1189	1190	Spaces
Occurrence Code 5 Date	X(8)	1191	1198	Spaces
Occurrence Code 6	X(2)	1199	1200	Spaces
Occurrence Code 6 Date	X(8)	1201	1208	Spaces
Occurrence Code 7	X(2)	1209	1210	Spaces
Occurrence Code 7 Date	X(8)	1211	1218	Spaces
Occurrence Code 8	X(2)	1219	1220	Spaces
Occurrence Code 8 Date	X(8)	1221	1228	Spaces
Occurrence Code 9	X(2)	1231	1230	Spaces
Occurrence Code 9 Date	X(8)	1231	1238	Spaces
Occurrence Code 10	X(2)	1239	1240	Spaces
Occurrence Code 10 Date	X(8)	1241	1248	Spaces
Occurrence Code 11	X(2)	1249	1250	Spaces
Occurrence Code 11 Date	X(8)	1251	1258	Spaces
Occurrence Code 12	X(2)	1259	1260	Spaces
Occurrence Code 12 Date	X(8)	1261	1268	Spaces
Occurrence Code 13	X(2)	1269	1270	Spaces
Occurrence Code 13 Date	X(8)	1271	1278	Spaces
Occurrence Code 14	X(2)	1279	1280	Spaces
Occurrence Code 14 Date	X(8)	1281	1288	Spaces
Occurrence Code 15	X(2)	1289	1290	Spaces
Occurrence Code 15 Date	X(8)	1291	1298	Spaces
Occurrence Code 16	X(2)	1299	1300	Spaces
Occurrence Code 16 Date	X(8)	1301	1308	Spaces
Occurrence Code 17	X(2)	1309	1310	Spaces
Occurrence Code 17 Date	X(8)	1311	1318	Spaces
Occurrence Code 18	X(2)	1319	1320	Spaces
Occurrence Code 18 Date	X(8)	1321	1328	Spaces
Occurrence Code 19	X(2)	1329	1330	Spaces
Occurrence Code 19 Date	X(8)	1331	1338	Spaces
Occurrence Code 20	X(2)	1339	1340	Spaces
Occurrence Code 20 Date	X(8)	1341	1348	Spaces
Occurrence Code 21	X(2)	1349	1350	Spaces
Occurrence Code 21 Date	X(8)	1351	1358	Spaces
Occurrence Code 22	X(2)	1359	1360	Spaces
Occurrence Code 22 Date	X(8)	1361	1368	Spaces
Occurrence Code 23	X(2)	1369	1370	Spaces
Occurrence Code 23 Date	X(8)	1371	1378	Spaces
Occurrence Code 24	X(2)	1379	1380	Spaces
Occurrence Code 24 Date	X(8)	1381	1388	Spaces
Occurrence Code 25	X(2)	1389	1390	Spaces

Field Name	Picture	From	Thru	Initialization
Occurrence Code 25 Date	X(8)	1391	1398	Spaces
Occurrence Code 26	X(2)	1399	1400	Spaces
Occurrence Code 26 Date	X(8)	1401	1408	Spaces
Occurrence Code 27	X(2)	1409	1410	Spaces
Occurrence Code 27 Date	X(8)	1411	1418	Spaces
Occurrence Code 28	X(2)	1419	1420	Spaces
Occurrence Code 28 Date	X(8)	1421	1428	Spaces
Occurrence Code 29	X(2)	1429	1430	Spaces
Occurrence Code 29 Date	X(8)	1431	1438	Spaces
Occurrence Code 30	X(2)	1439	1440	Spaces
Occurrence Code 30 Date	X(8)	1441	1448	Spaces
Value Code 1	X(2)	1449	1450	Spaces
Value Amount 1	S9(8)V99	1451	1460	Zeroes
Value Code 2	X(2)	1461	1462	Spaces
Value Amount 2	S9(8)V99	1463	1472	Zeroes
Value Code 3	X(2)	1473	1474	Spaces
Value Amount 3	S9(8)V99	1475	1484	Zeroes
Value Code 4	X(2)	1485	1486	Spaces
Value Amount 4	S9(8)V99	1487	1496	Zeroes
Value Code 5	X(2)	1497	1498	Spaces
Value Amount 5	S9(8)V99	1499	1508	Zeroes
Value Code 6	X(2)	1509	1510	Spaces
Value Amount 6	S9(8)V99	1511	1520	Zeroes
Value Code 7	X(2)	1521	1522	Spaces
Value Amount 7	S9(8)V99	1523	1532	Zeroes
Value Code 8	X(2)	1533	1534	Spaces
Value Amount 8	S9(8)V99	1535	1544	Zeroes
Value Code 9	X(2)	1545	1546	Spaces
Value Amount 9	S9(8)V99	1547	1556	Zeroes
Value Code 10	X(2)	1557	1558	Spaces
Value Amount 10	S9(8)V99	1559	1568	Zeroes
Value Code 11	X(2)	1569	1570	Spaces
Value Amount 11	S9(8)V99	1571	1580	Zeroes
Value Code 12	X(2)	1581	1582	Spaces
Value Amount 12	S9(8)V99	1583	1592	Zeroes
Value Code 13	X(2)	1593	1594	Spaces
Value Amount 13	S9(8)V99	1595	1604	Zeroes
Value Code 14	X(2)	1605	1606	Spaces
Value Amount 14	S9(8)V99	1607	1616	Zeroes
Value Code 15	X(2)	1617	1618	Spaces
Value Amount 15	S9(8)V99	1619	1628	Zeroes
Value Code 16	X(2)	1629	1630	Spaces
Value Amount 16	S9(8)V99	1631	1640	Zeroes
Value Code 17	X(2)	1641	1642	Spaces
Value Amount 17	S9(8)V99	1643	1652	Zeroes
Value Code 18	X(2)	1653	1654	Spaces
Value Amount 18	S9(8)V99	1655	1664	Zeroes
Value Code 19	X(2)	1665	1666	Spaces
Value Amount 19	S9(8)V99	1667	1676	Zeroes
Value Code 20	X(2)	1677	1678	Spaces

Field Name	Picture	From	Thru	Initialization
Value Amount 20	S9(8)V99	1679	1688	Zeroes
Value Code 21	X(2)	1689	1690	Spaces
Value Amount 21	S9(8)V99	1691	1700	Zeroes
Value Code 22	X(2)	1701	1702	Spaces
Value Amount 22	S9(8)V99	1703	1712	Zeroes
Value Code 23	X(2)	1713	1714	Spaces
Value Amount 23	S9(8)V99	1715	1724	Zeroes
Value Code 24	X(2)	1725	1726	Spaces
Value Amount 24	S9(8)V99	1727	1736	Zeroes
Value Code 25	X(2)	1737	1738	Spaces
Value Amount 25	S9(8)V99	1739	1748	Zeroes
Value Code 26	X(2)	1749	1750	Spaces
Value Amount 26	S9(8)V99	1751	1760	Zeroes
Value Code 27	X(2)	1761	1762	Spaces
Value Amount 27	S9(8)V99	1763	1772	Zeroes
Value Code 28	X(2)	1773	1774	Spaces
Value Amount 28	S9(8)V99	1775	1784	Zeroes
Value Code 29	X(2)	1785	1786	Spaces
Value Amount 29	S9(8)V99	1787	1796	Zeroes
Value Code 30	X(2)	1797	1798	Spaces
Value Amount 30	S9(8)V99	1799	1808	Zeroes
Value Code 31	X(2)	1809	1810	Spaces
Value Amount 31	S9(8)V99	1811	1820	Zeroes
Value Code 32	X(2)	1821	1822	Spaces
Value Amount 32	S9(8)V99	1823	1832	Zeroes
Value Code 33	X(2)	1833	1834	Spaces
Value Amount 33	S9(8)V99	1835	1844	Zeroes
Value Code 34	X(2)	1845	1846	Spaces
Value Amount 34	S9(8)V99	1847	1856	Zeroes
Value Code 35	X(2)	1857	1858	Spaces
Value Amount 35	S9(8)V99	1859	1868	Zeroes
Claim Final Allowed Amount	S9(8)V99	1869	1878	Zeroes
Claim Deductible Amount	S9(8)V99	1879	1888	Zeroes
Claim State	X(2)	1889	1890	Spaces
Claim Zip Code	X(9)	1891	1899	Spaces
Beneficiary State	X(2)	1900	1901	Spaces
Beneficiary Zip Code	X(9)	1902	1910	Spaces
Claim PWK	X(60)	1911	1970	Spaces
Patient Reason for Visit 1	X(7)	1971	1977	Spaces
Patient Reason for Visit 2	X(7)	1978	1984	Spaces
Patient Reason for Visit 3	X(7)	1985	1991	Spaces
Patient Reason for Visit 1 Version Indicator Code	X(1)	1992	1992	Spaces
Patient Reason for Visit 2 Version Indicator Code	X(1)	1993	1993	Spaces
Patient Reason for Visit 3 Version Indicator Code	X(1)	1994	1994	Spaces
Present on Admission/External Cause of Injury Indicator	X(37)	1995	2031	Spaces

Field Name	Picture	From	Thru	Initialization
External Cause of Injury 1	X(7)	2032	2038	Spaces
External Cause of Injury 2	X(7)	2039	2045	Spaces
External Cause of Injury 3	X(7)	2046	2052	Spaces
External Cause of Injury 4	X(7)	2053	2059	Spaces
External Cause of Injury 5	X(7)	2060	2066	Spaces
External Cause of Injury 6	X(7)	2067	2073	Spaces
External Cause of Injury 7	X(7)	2074	2080	Spaces
External Cause of Injury 8	X(7)	2081	2087	Spaces
External Cause of Injury 9	X(7)	2088	2094	Spaces
External Cause of Injury 10	X(7)	2095	2101	Spaces
External Cause of Injury 11	X(7)	2102	2108	Spaces
External Cause of Injury 12	X(7)	2109	2115	Spaces
External Cause of Injury 1 Version Indicator Code	X(1)	2116	2116	Spaces
External Cause of Injury 2 Version Indicator Code	X(1)	2117	2117	Spaces
External Cause of Injury 3 Version Indicator Code	X(1)	2118	2118	Spaces
External Cause of Injury 4 Version Indicator Code	X(1)	2119	2119	Spaces
External Cause of Injury 5 Version Indicator Code	X(1)	2120	2120	Spaces
External Cause of Injury 6 Version Indicator Code	X(1)	2121	2121	Spaces
External Cause of Injury 7 Version Indicator Code	X(1)	2122	2122	Spaces
External Cause of Injury 8 Version Indicator Code	X(1)	2123	2123	Spaces
External Cause of Injury 9 Version Indicator Code	X(1)	2124	2124	Spaces
External Cause of Injury 10 Version Indicator Code	X(1)	2125	2125	Spaces
External Cause of Injury 11 Version Indicator Code	X(1)	2126	2126	Spaces
External Cause of Injury 12 Version Indicator Code	X(1)	2127	2127	Spaces
Service Facility Zip Code	X(9)	2128	2136	Spaces
RAC adjustment indicator	X(1)	2137	2137	Spaces
Split/Adjustment Indicator	9(2)	2138	2139	Spaces
Referring Physician NPI	X(10)	2140	2149	Spaces
Referring Physician Last Name	X(16)	2150	2165	Spaces
Referring Physician Specialty	X(2)	2166	2167	Spaces
Claim Rendering Physician	X(2)	2168	2169	Spaces
Overpay Indicator	X(1)	2170	2170	Spaces
Overpay Code	X(3)	2171	2173	Spaces
Claim Demonstration Identification Number 2	X(2)	2174	2175	Spaces
Claim Demonstration Identification Number 3	X(2)	2176	2177	Spaces

Field Name	Picture	From	Thru	Initialization
Claim Demonstration Identification Number 4	X(2)	2178	2179	Spaces
Beneficiary MBI	X(11)	2180	2190	Spaces
MBI/HICN Indicator	X(1)	2191	2191	Spaces
Filler	X(10)	2192	2201	Spaces
Total Line Item Count	9(3)	2202	2204	Zeroes
Record Line Item Count	9(3)	2205	2207	Zeroes

Sampled Claims Resolution File
Sampled Claims Resolution Claim Line Item Group Record
*The following group of fields occurs from 1 to 450 times for the claim (depending on Total Line Item Count) and 1 to 75 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
Revenue center code	X(4)	2208	2211	Spaces
SNF-RUG-III code	X(3)	2212	2214	Spaces
APC adjustment code	X(5)	2215	2219	Spaces
HCPCS Procedure Code	X(5)	2220	2224	Spaces
HCPCS Modifier 1	X(2)	2225	2226	Spaces
HCPCS Modifier 2	X(2)	2227	2228	Spaces
HCPCS Modifier 3	X(2)	2229	2230	Spaces
HCPCS Modifier 4	X(2)	2231	2232	Spaces
HCPCS Modifier 5	X(2)	2233	2234	Spaces
Line Item Date	X(8)	2235	2242	Spaces
Line Submitted Charge	S9(8)V99	2243	2252	Zeroes
Line Medicare Initial Allowed	S9(8)V99	2253	2262	Zeroes
ANSI Reason Code 1	X(8)	2263	2270	Spaces
ANSI Reason Code 2	X(8)	2271	2278	Spaces
ANSI Reason Code 3	X(8)	2279	2286	Spaces
ANSI Reason Code 4	X(8)	2287	2294	Spaces
ANSI Reason Code 5	X(8)	2295	2302	Spaces
ANSI Reason Code 6	X(8)	2303	2310	Spaces
ANSI Reason Code 7	X(8)	2311	2318	Spaces
ANSI Reason Code 8	X(8)	2319	2326	Spaces
ANSI Reason Code 9	X(8)	2327	2334	Spaces
ANSI Reason Code 10	X(8)	2335	2342	Spaces
ANSI Reason Code 11	X(8)	2343	2350	Spaces
ANSI Reason Code 12	X(8)	2351	2358	Spaces
ANSI Reason Code 13	X(8)	2359	2366	Spaces
ANSI Reason Code 14	X(8)	2367	2374	Spaces
Manual Medical Review Indicator	X(1)	2375	2375	Spaces
Resolution Code	X(5)	2376	2380	Spaces

Field Name	Picture	From	Thru	Initialization
Line Final Allowed Charge	S9(8)V99	2381	2390	Zeroes
Line Cash Deductible	S9(8)V99	2391	2400	Zeroes
Special Action Code/Override Code	X(1)	2401	2401	Zeroes

Units	S9(7)v999	2402	2411	Zeroes
Rendering Physician NPI	X(10)	2412	2421	Spaces
Rendering Physician Last Name	X(25)	2422	2446	Spaces
National Drug Code (NDC) field	X(11)	2447	2457	Spaces
National Drug Code (NDC)	S9(7)v999	2458	2467	Spaces
National Drug Code (NDC) Quantity Qualifier	X(2)	2468	2469	Spaces
Line PWK	X(60)	2470	2529	Spaces
Line Rendering Physician specialty	X(2)	2530	2531	Spaces
Prior Authorization Program	X(4)	2532	2535	Spaces
Unique Tracking Number (UTN)	X(14)	2536	2549	Spaces
Prior Authorization Affirmed	X(1)	2550	2550	Spaces
Filler	X(4)	2551	2554	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.

Data Element: Record Number
Definition: The sequence number of the record. A claim may have up to six records.
Validation: Must be between 1 and 6
Remarks: None 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 the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the MAC or shared system changed the claim control number during processing, enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: For all records in the resolution file, the Original Claim Control must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

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

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

Data Element: Beneficiary Last Name
Definition: Last Name (Surname) of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name
Definition: First (Given) Name of the beneficiary
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial
Definition: First letter from Beneficiary Middle Name
Validation: N/A
Remarks
: N/A
Requirement: Required

Data Element: Beneficiary Date of Birth
Definition: Birth date of the beneficiary
Validation: Must be a valid date
Remarks: MMDDCCYY on which the beneficiary was born
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 used to identify the billing/pricing provider or supplier.
Validation: Must be present
If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the first line of the claim.
Remarks: N/A
Requirement: Required for all claims

Data Element: Attending Physician UPIN
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 when available on claim record.

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 A/B MAC (A) or A/B MAC (B) and represents what CMS paid to the institutional provider, physician, or supplier, i.e. The Claim Paid Amount is the net amount paid after co-insurance and deductibles are applied.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim ANSI Reason Code 1-7
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.
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 shared 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 -30
Definition: The code that indicates a condition relating to an institutional claim that may affect payer processing
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: This field is left justified and blank filled.
Requirement: Required if there is a condition code for the bill.
Data Element: Type of Bill
Definition: A code indicating the specific type of bill (hospital, inpatient, SNF, outpatient, adjustments, voids, etc.). This 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 code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set
Remarks: N/A
Requirement: Required

Data Element: Principal Diagnosis
Definition: The current version of ICD--CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-- CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD--CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.
Requirement: Required

Data Element: Principal Diagnosis Version Indicator Code

Definition: The diagnosis version code identifying the version of ICD diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: With the exception of claims submitted by ambulance suppliers (specialty).

Requirement: Principal Diagnosis Version Code 1 is required for ALL claims.

Data Element: Other Diagnosis Code 1-24

Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be present during treatment.

Validation: Must be a valid ICD--CM diagnosis code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including The full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 24 additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Requirement: Required if available on the claim record.

Data Element: Other Diagnosis Version Indicator Code 1-24

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0

Remarks: N/A

Requirement: Principal Diagnosis Version Code 1 is required for ALL claims. Other Diagnosis version codes 1-24 should be submitted to correspond to claim level diagnosis codes 1-24.

Data Element: Principal Procedure and Date

Definition: The ICD--CM code that indicates the principal procedure performed during the period covered by the institutional claim. And the Date on which it was performed.

Validation: Must be a valid ICD--CM procedure code

- CMS accepts only CMS approved ICD--CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD--CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD--CM, Volume 3, procedure code, including the full number of digits (five forICD-9-CM, seven for ICD-10-CM).

Remarks: The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

- The date applicable to the principal procedure is shown numerically as CCYYMMDD in the "date" portion.

Requirement: Required for inpatient claims.

Data Element: Principal Procedure Version Indicator Code
Definition: The version code identifying the version of ICD procedure code submitted.
Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A
Requirement: Principal Procedure Code Version Code is required for ALL claims containing a Principal Procedure.

Data Element: Other Procedure and Date 1-24
Definition: The ICD-CM code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.
Validation: Must be a valid ICD-CM procedure code

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- The procedure code shown must be the full ICD-CM, Volume 3, procedure code, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM).

Remarks: The date applicable to the procedure is shown numerically as CCYYMMDD in the "date" portion.
Requirement: Required if on claim record.

Data Element: Other Procedure Code Version Indicator Code 1-24
Definition: The ICD-CM diagnosis version code identifying the version of procedure code submitted
Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A
Requirement: Principal Procedure Version Code is required for ALL claims. Other Procedure version codes 1-24 should be submitted to correspond to other procedure code 1-24.

Data Element: Claim Demonstration Identification Number
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the first populated demonstration field.
Requirement: Required for all claims involved in a demonstration project

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

Data Element: Action Code
Definition: Indicator identifying the type of action requested by the intermediary to be taken on an institutional claim.
Validation: Must be a valid action code.
1 = Original debit action (includes non-adjustment RTI correction items) – it will always be a 1 in regular bills.
2 = Cancel by credit adjustment – used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3.
6 = Force action code 2.
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present.
9 = Payment requested (used on bills that replace previously-submitted benefits- refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)
Remarks: N/A
Requirement: Required

Data Element: Patient Status
Definition: This code indicates the patient's status as of the "Through" date of the billing period.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required for providers using HIPAA standard transactions

Data Element: Claim Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation: Must be present
- If multiple taxonomy codes are associated with a provider number, provide the first one in sequence.

Remarks: N/A
Requirement: Required when available.

Data Element: Medical Record Number
Definition: Number assigned to patient by hospital or other provider to assist in retrieval of medical records.
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Patient Control Number
Definition: The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment.
Validation: N/A
Remarks: N/A
Requirement: Required if available on claim record

Data Element: Attending Physician NPI
Definition: NPI assigned to the Attending Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Attending Physician Last Name
Definition: Last Name (Surname) of the attending physician.
Validation: Must be present

Remarks: N/A
Requirement: Required when available on claim record

Data Element: Operating Physician NPI
Definition: NPI assigned to the Operating Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Operating Physician Last Name
Definition: Last Name (Surname) of the operating physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Claim Rendering Physician NPI
Definition: NPI assigned to the claim rendering physician (mapped from 2310D from the 837I version 5010A2).
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Claim Rendering Physician Last Name
Definition: Last Name (Surname) of the claim rendering physician (mapped from 2310D from the 837I version 5010A2).
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: Date of Admission
Definition: The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
Validation: Must be a valid date
Remarks: Format date as CCYYDDD
Requirement: Required if on claim record.

Data Element: Type of Admission

Definition: The code indicating the type and priority of an inpatient admission associated with the service on an intermediary claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure.
Remarks: N/A
Requirement: Required on inpatient claims only.

Data Element: Source of Admission
Definition: The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set Code Structure (For Emergency, Elective, or Other Type of Admission)
Remarks: N/A
Requirement: Required when entered on the claim record.

Data Element: DRG (Diagnosis Related Group)
Definition: The code identifying the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Validation: Must be valid per the DRG DEFINITIONS MANUAL
Remarks: N/A
Requirement: Required if available on the claim record

Data Element: Occurrence Code and Date 1-30
Definition: Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks:

- Event codes are two alpha-numeric digits, and dates are shown as eight numeric digits (MM-DD-CCYY)
- When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value codes, if there is another payer involved.

Requirement: Required if available on claim record

Data Element: Value Codes and Amounts 1-35
Definition: Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim.
Validation: Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks:

- The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00).
- Negative amounts are not allowed except in the last entry.
- Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter.
- Some values are reported as cents, so refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in

ascending numeric sequence.

- Use the first line before the second, etc.

Requirement: Required if available on claim record

Data Element: Claim Final Allowed Amount
Definition: Final Allowed Amount for this claim.
Validation: N/A
Remarks: The Gross Allowed charges on the claim. This represents the amount paid to the provider plus any beneficiary responsibility (co-pay and deductible)
Requirement: Required

Data Element: Claim Deductible Amount
Definition: Amount of deductible applicable to the claim.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim State
Definition: 2 character indicator showing the state where the service is furnished.
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Claim Zip Code
Definition: Zip code of the physical location where the services were furnished.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: Beneficiary State
Definition: 2 character indicator showing the state of beneficiary residence.
Validation: Must be a valid USPS state abbreviation
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Zip Code
Definition: Zip code associated with the beneficiary residence.
Validation: Must be a valid USPS zip code.
Remarks: N/A
Requirement: Required

Data Element: PWK Filler
Definition: PWK space -- use to be determined
Validation: N/A
Remarks: N/A
Requirement: Required when available on claim.

Data Element: Patient Reason for Visit 1-3
Definition: An ICD--CM code on the institutional claim indicating the beneficiary's reason for visit.
Validation: Must be a valid ICD-CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes,

including the full number of digits (five for ICD-9-CM, seven for ICD-10- CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 3 conditions responsible for the patient's visit.

Requirement: For OP claims, this field is populated for those claims that are required to process through OP PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

Data Element: Patient Reason for Visit Version Indicator Code 1-3

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code submitted.

Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0'

Remarks: N/A

Requirement: Patient Reason for Visit Version codes must be submitted to correspond to patient reason for visit codes 1-3.

Data Element: Present on Admission/External Cause of Injury Indicator

Definition: The code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

Validation: Position 1 for Principle Diagnosis, positions 2-25 for the 24 Secondary Diagnosis for the Present on Admission (POA) Indicator, Positions 26 – 37 for the 12 External Cause of Injury.

Remarks: N/A

Requirement: Required

Data Element: External Cause of Injury Diagnosis Codes 1-12

Definition: The ICD-CM code used to identify the external cause of injury, poisoning, or other adverse effect.

Validation: Must be a valid ICD--CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10- CM) where applicable.

Remarks: Report the full ICD-CM codes for up to 12 conditions resulting from external causes.

Requirement: Required if available on the claim record.

Data Element: External Cause of Injury Version Indicator Code 1-12

Definition: The ICD-CM diagnosis version code identifying the version of diagnosis code identified as external cause of injury.

Validation:

- Version ICD9 use Version Code '9'

- Version ICD10 use Version Code '0

Remarks: N/A
Requirement: External Cause of Injury version codes 1-12 should be submitted to correspond to external cause of injury diagnosis codes 1-12.

Data Element: Service Facility Zip Code
Definition: Zip Code used to identify were the service was furnished.
Validation: Must be a valid Zip Code
Remarks: N/A
Requirement: Required, if available on claim record.

Data Element: RAC Adjustment Indicator
Definition: Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).
Validation: 'R' identifies a RAC-requested adjustment
Remarks: N/A
Requirement: Required when RAC adjustment indicator was furnished to CWF.

Data Element: Split/Adjustment Indicator
Definition: Count of number of adjustments (with different DCNs) of the claim that are included in the resolution file.
Validation: '0' is used when only one DCN associated with the sampled claim is included in the resolution file.

When the resolution file contains multiple adjustments associated with a single claim, this field will provide a count of records.

- When the resolution file contains 2 DCNs related to a single claim, one of the records would contain a split/adjustment indicator of 1 and the second record would contain a split/adjustment indicator of 2.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.

CERT recognizes that Part A claims are not split. For Part A this field will identify adjustments only.
Requirement: Required when the resolution file contains multiple versions of a single claim.

Data Element: Referring Physician NPI
Definition: NPI assigned to the Referring Physician—the physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
Validation: N/A
Remarks: Enter zeros if there is no referring physician
Requirement: Required when available on the claim record
NOTES:

- Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- Ordering physician - is a physician or, when appropriate, a non- physician practitioner who orders non-physician services for the patient.

Data Element: Referring Physician Last Name

Definition: Last name of the referring physician.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider
Requirement: Required when available on the claim record.

Data Element: Referring Physician Specialty
Definition: Code indicating the primary specialty of the referring physician.
Validation: N/A
Remarks: Enter zeros if the referring physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Claim Rendering Physician Specialty
Definition: Code indicating the primary specialty of the claim rendering physician.
Validation: N/A
Remarks: Enter zeros if the rendering physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Overpay Indicator
Definition: Code indicating whether or not an overpayment exists on an OIG or *UPIC* tracked adjustment claims.

Validation:

- Y indicates an overpayment exists on an OIG or *UPIC* claim
- N indicates an overpayment does not exist on an OIG or *UPIC* claim.
- Default value is blank for claims that are not OIG or *UPIC* tracked claims.

Remarks: This field is populated only when there is a value present in the FSSCIDRP-OVERPAY-CODE field
Requirement: Required when available on the claim record.

Data Element: Overpay Code
Definition: Code that identifies an overpayment on an OIG or *UPIC* tracked adjustment claim.
Validation: Any of the user-defined values present in the online parm PRMOIGAA, PRMOIG00 through PRMOIG20 records.
Remarks: This field is populated only when the claim is an OIG or *UPIC* tracked adjustment claim.
Requirement: Required when available on the claim record.

Data Element: Claim Demonstration Identification Number 2
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the second populated demonstration field.
Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 3
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes
Remarks: This field contains the value from the third populated demonstration field.
Requirement: Required when available on the claim

Data Element: Claim Demonstration Identification Number 4
Definition: The number assigned to identify a demonstration project.
Validation: Must be numeric or zeroes.

Remarks: This field contains the value from the fourth populated demonstration field.
Requirement: Required when available on the claim.

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string
- Different, visibly distinguishable from HICN/RRB numbers
- Contain no more than 2 consecutive numbers
- Contain no more than 2 consecutive alphabetic characters
- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z)
- Must not contain lowercase letters
- Must not contain any special characters

Remarks: Do not include hyphens or spaces
Requirement: Required

Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI
Validation:
M = MBI submitted on the claim
H = HICN submitted on the claim
Remarks: N/A
Requirement: Required

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
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 - 100
Remarks: N/A
Requirement: Required

<u>Claim Line Item Fields</u>

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.
Must be a valid code as listed in Pub 100-4, Medicare Claims Processing Manual, Chapter 25, Completing and Processing CMS-1450 Data Set.
Remarks: Include an entry for revenue code '0001'
Requirement: Required

Data Element: NF-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.

This field may contain a HIPPS code. If a HHPPS HIPPS code is down coded, the down coded HIPPS will be reported in this field.

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 if present on claim record

Data Element: HCPCS Procedure Code or HIPPS Code
Definition: The HCPCS/CPT-4 code that describes the service or Health Insurance PPS (HIPPS) code.
Validation: Must be a valid HCPCS/CPT-4 or HIPPS code
Remarks: Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs

When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF
PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the 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, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXYY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without co-morbidity. The 'B' in front of the CMG is defined as with co-morbidity for Tier 1. The 'C' is defined as co-morbidity for Tier 2 and 'D' is defined as co-morbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

Requirement: Required if present on claim record

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

Data 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 shared system

Data Element: Line Submitted Charge
Definition: Actual charge submitted by the provider or supplier for the service or equipment
Validation: N/A
Remarks: This is a required field. CR3997 provided direction on how to populate this field if data is not available in the claim record.
Requirement: Required

Data Element: Line Medicare Initial Allowed Charge
Definition: Amount Medicare allowed for the service or equipment before any reduction or denial.
Validation: Must be a numeric value.
Remarks: This is a required field. Use the value in FISS field FSSCPDCL-REV-COV-CHRG-AMT to populate this field (per CMS Change Request 3912).
Requirement: Required

Data Element: ANSI Reason Code 1-14
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: G is the group code and RRRRRR is the adjustment reason code.
Requirement: Report all ANSI Reason Codes included on the bill.

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 MAC's history file. The review must require

professional medical 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 MAC'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 MAC resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the MAC'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 MAC'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 MAC's history file. The review must require professional medical 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 MAC'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', 'REO', 'DENAM', 'REDAM','INACT'.

Remarks:

Resolution Code	Description
APP	Approved as a valid submission without manual medical review.

APPAM	Approved after automated medical review
APPMR	Approved after manual medical review routine
APPMC	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENAM	Denied after automated medical review
DENMR	Denied for medical review reasons or for insufficient documentation of medical necessity, 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)
REDAM	Reduced after medical review
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.
INACT	Claim is inactive as identified by “I” Status

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: Cash Deductible
Definition: The amount of cash deductible the beneficiary paid for the line item service.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Special Action/Override Code
Definition: Code used to identify special actions taken in determining payment of this line item.
Validation: Must be valid
Remarks: N/A
Requirement: Required

Data Element: Units
Definition: The total number of services or time periods provided for the line item.
Validation: N/A
Remarks: Zero filled to maintain the relative position of the decimal point. The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers. For example if the number of units is 10, this field would be filled as 0000010000.
Requirement: Required

Data Element: Rendering Physician NPI
Definition: NPI assigned to the Rendering Physician.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: Rendering Physician Last Name
Definition: Last Name (Surname) of the rendering physician.
Validation: Must be present
Remarks: N/A
Requirement: Required when available on claim record

Data Element: National Drug Code (NDC) field
Definition: To be assigned at a later date.
Validation: N/A
Remarks: Left justify
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity Qualifier
Definition: To be assigned at a later date.
Validation: Must be present.
Remarks: N/A
Requirement: Required when available on claim record.

Data Element: National Drug Code (NDC) Quantity
Definition: To be assigned at a later date.
Validation: Must be present.
Remarks: Zero filled to maintain the relative position of the decimal point. For example, if the number of units is 10, this field would be filled as 0000010000.
Requirement: Required when available on claim record.

Data Element: PWK Filler
Definition: PWK space -- use to be determined.
Validation: N/A
Remarks: N/A
Requirement: Required when available on claim

Data Element: Rendering Physician Specialty
Definition: Code indicating the primary specialty of the rendering physician.
Validation: N/A
Remarks: Enter zeros if the rendering physician specialty is not available
Requirement: Required when available on the claim record.

Data Element: Prior Authorization Program Indicator

Definition: Prior Authorization Program Indicator issued by CMS to identify to which PA program the service belongs

Validation:
- Four character alphanumeric
- The first character identifies the line of business
  - A for Part A,
  - B for Part B,
  - D for DME,
  - H for Home Health and Hospice
- Followed by a three digit number.

Remarks: N/A

Requirement: Required for claims containing services subject to a prior authorization program.

Data Element: Unique Tracking Number (UTN)

Definition: Unique Tracking Number (UTN) assigned to the prior authorization request for the service or item.

Validation: UTN shall be 14 characters and use the following format:
- First two characters = MAC identifier (e.g., RR for Railroad, 0F for Jurisdiction F, 05 for Jurisdiction 5, etc.).
- Third character = line of business (e.g., A for Part A, B for Part B, D for DME, H for Home Health and Hospice).
- Remaining numerical characters = a unique sequence number assigned by the Shared System.

Remarks: N/A

Requirement: Required for claims containing services covered by an affirmed prior authorization.

Data Element: Prior Auth Affirmed

Definition: Code to identify if the prior authorization for the service(s) on this line was affirmed.

Validation:
- Y indicates the prior authorization was affirmed.
- N indicates the prior authorization was not affirmed.
- Default value is blank for claims that are not part of prior authorization demonstration.

Remarks: N/A

Requirement: Required for claims containing services subject to prior authorization in the state where the service was furnished.

Data Element: Filler

Definition: Additional space -- use to be determined

Validation: N/A

Remarks: N/A

Requirement: Required

Claims Resolution File

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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file.
Validation: Claim Resolution files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
F = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'.
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

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

Claims Provider Address File

Claims 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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 7/1/2016
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Provider Address Date
Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file
Remarks: Format is CCYYMMDD. May use shared system batch processing date
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	Spaces
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Sequence Number	X(1)	9	9	Spaces
Provider Number	X(15)	10	24	Spaces
Provider Name	X(60)	25	84	Spaces
Provider Address 1	X(25)	85	109	Spaces
Provider Address 2	X(25)	110	134	Spaces
Provider City	X(15)	135	149	Spaces
Provider State Code	X(2)	150	151	Spaces
Provider Zip Code	X(9)	152	160	Spaces
Provider Phone Number	X(10)	161	170	Spaces
Provider Phone Number Extension	X(10)	171	180	Spaces
Provider FAX Number	X(10)	181	190	Spaces
Provider Type	X(1)	191	191	Spaces
Provider Address Type	9(3)	192	194	1
Provider E-mail Address	X(75)	195	269	Spaces
Provider Federal Tax number or EIN	9(10)	270	279	Zeroes
Filler	X(16)	280	295	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file
Validation: Claim Provider Address files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor included in the file
Validation: Must be ‘A’ or ‘R’.

Where the TYPE of BILL, 1st position = 3, Contractor Type should be ‘R’.

Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be ‘R’.
All others will be contractor type ‘A’.

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 Medicare to identify the provider
Validation: N/A
Remarks: Left justify
Requirement: Required

Data Element: Provider Name
Definition: Provider's name
Validation: N/A
Remarks: This is the business name associated with the provider number. 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 first line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Address 2
Definition: Second line of provider’s address
Validation: N/A
Remarks: This is the line of the address associated with the provider number indicated in the record.
Requirement: Required for all Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider City
Definition: Provider’s city name
Validation: N/A
Remarks: This is the city of the provider number
Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider State Code
Definition: Provider's state code
Validation: Must be a valid state code
Remarks: This is the state associated with the address of the provider number.

Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Zip Code
Definition: Provider's zip code
Validation: Must be a valid postal zip code
Remarks: This is the zip code associated with the address furnished for the provider number identified in this record.

- Provide 9-digit zip code if available, otherwise provide 5-digit zip code.

Requirement: Required for Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider Phone Number
Definition: Provider's phone number
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Phone Number Extension
Definition: Provider's phone number extension
Validation: Must be a valid phone number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Fax Number
Definition: Provider's fax number
Validation: Must be a valid fax number
Remarks: N/A
Requirement: Required if available

Data Element: Provider Type
Definition: 1=Billing Provider Number (OSCAR)
2=Attending Physician Number (UPIN)
3=Operating Physician Number (UPIN)
4=Other Physician Number (UPIN)
5=Billing Provider NPI
6=Attending Physician NPI
7=Operating Physician NPI
8=Rendering Physician NPI
Validation: Must be 1-8.
Remarks: This field identifies the type of provider number whose name, address, phone number and identification information are included in the record.
Requirement: Required

Data Element: Provider Address Type
Definition: The type of Provider Address furnished.
Validation: 1 = Master Address (FISS)
2 = Remittance Address (FISS)
3 = Check Address (FISS) (APASS)
4 = MSP Other Address (FISS)
5 = Medical Review Address (FISS) (APASS)
6 = Other Address (FISS) (APASS)
7 = Chain Address (APASS)
8 = Correspondence Address
9 = Medical Record Address

Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855A. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855A. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained.

Requirement: Required Billing Provider Numbers. Furnish as available for other types of provider numbers.

Data Element: Provider E-Mail Address
Definition: Provider's e-mail address.
Validation: Must be a valid e-mail address.
Remarks: N/A
Requirement: Required if available.

Data Element: Provider Federal Tax Number or EIN
Definition: The number assigned to the billing provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).
Validation: Must be present
Remarks: N/A
Requirement: Required for all Billing Provider Numbers. For all other types of provider numbers, the tax number is required when available

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

Claims Provider Address File
Claims 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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	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
NOTE: For A/B MAC (A) and A/B MAC (HHH), when multiple workloads share a single processing environment, the Contractor ID will reflect the roll-up Contractor ID specified by CMS.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 10/1/2007 did not contain this field.
Codes:
B = Record Format as of 10/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 10/1/2012
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor included in the file
Validation: Must be 'A' or 'R'
Where the TYPE of BILL, 1st position = 3, Contractor Type should be 'R'.
Where the TYPE of BILL, 1st/2nd positions = 81 or 82, contractor Type should be 'R'.
All others will be contractor type 'A'.
Remarks: A = A/B MAC (A) only
R = A/B MAC (HHH) only or both A/B MAC (A) and A/B MAC (HHH)
Requirement: Required

Data Element: Number of Records
Definition: Number of provider address records on this file
Validation: Must be equal to the number of provider address records on the file
Remarks: Do not count header or trailer records
Requirement: Required

Exhibit 36.2

(Rev. 726, Issued: 06-16-17, Effective: 10-01-17, Implementation: 01-02-18 - For VMS and MCS for Business Requirements 11 through 22 and 22.1; 10-02-17 - For FISS)

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'
Record Version Code	X(1)	7	7	Spaces

Contractor Type	X(1)	8	8	Spaces
Universe Date	X(8)	9	16	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file.
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Universe Date
Definition: Date the universe of claims entered the shared system.
Validation: Must be a valid date not equal to a universe date sent on any previous claims universe file.
Remarks: Format is CCYYMMDD.
- Shared System logic may use shared system batch processing date as long as the date is not equal to the universe date sent on any previous claims universe file.

Requirement: Required

Claims Universe File
Claims Universe Claim Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	"2"
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	Spaces
Billing Provider NPI	X(10)	36	45	Spaces
Claim Submitted Charge Amount	S9(7)v99	46	54	Zeroes
Claim Demonstration Number	X(2)	55	56	Spaces
Claim State	X(2)	57	58	Spaces
Beneficiary State	X(2)	59	60	Spaces
Billing Provider Specialty	X(2)	61	62	Spaces
Beneficiary MBI	X(11)	63	73	Spaces
HICN/MBI Indicator	X(1)	74	74	Spaces
Filler	X(3)	75	77	Spaces
Line Item Count	9(2)	78	79	Zeroes

Claims Universe File
Claims Universe Claim Line Item Detail Record
*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

Field Name	Picture	From	Thru	Initialization
Performing Provider Number	X(15)	80	94	Spaces
Performing Provider Specialty	X(2)	95	96	Spaces
HCPCS Procedure Code	X(5)	97	101	Spaces
From Date of Service	X(8)	102	109	Spaces
To Date of Service	X(8)	110	117	Spaces
Line Submitted Charge	S9(7)v99	118	126	Zeroes
Performing Provider NPI	X(10)	127	136	Spaces

DATA ELEMENT DETAIL

<u>Claim Header Fields</u>

Data Element: Contractor ID
Definition: Contractor's CMS assigned number
Validation: Must be a valid CMS contractor ID
Remarks: N/A
Requirement: Required
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

Data Element: Record Type
Definition: Code indicating type of record
Validation: N/A

Remarks: 2 = claim record
Requirement: Required
Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim.
Validation: The required format for the Claim Control Number is different for each claim type.
DME: must be 15 digits with a leading 1 as filler.
Part B: must be 15 digits, with two leading zeros as filler.
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 NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required.

Data Element: Claim Submitted Charge Amount
Definition: The total submitted charges on the claim (the sum of line item submitted charges).
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Claim Demonstration Number

Definition: Also known as Claim Demonstration Identification Number. The number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: N/A
Requirement: Required when available on claim.

Data Element: Claim State
Definition: State abbreviation identifying the state in which the service is furnished.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).
Remarks: When services on a single claim are furnished in multiple states, enter the state identifier for the first detail line.
Requirement: Required for all Part B Claims. For DME claims, required if available.

Data Element: Beneficiary State
Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).
Remarks: N/A
Requirement: Required, when available.

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

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string.
- Different, visibly distinguishable from HICN/RRB numbers.
- Contain no more than 2 consecutive numbers.
- Contain no more than 2 consecutive alphabetic characters.
- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z).
- Must not contain lowercase letters.
- Must not contain any special characters.

Remarks: Do not include hyphens or spaces.
Requirement: Required

Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI.
Validation:
M = MBI submitted on the claim
H = HICN submitted on the claim
Remarks: N/A
Requirement: Required

Data Element: Filler
Definition: Additional space -- use to be determined
Validation: N/A
Remarks: N/A
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 NSC or MAC to identify the provider who performed the service or the supplier who supplied the medical equipment.
Validation: N/A
Remarks: Enter the PIN of the performing provider. When several different providers of service or suppliers are billing on the same claim, show the individual PIN in the corresponding line item.
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

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

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

Data Element: Line 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: Performing Provider NPI
Definition: NPI assigned to the Performing Provider.
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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type

Definition: Type of Medicare Contractor
Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

Claims Transaction File
Claims Transaction 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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Transaction Date	X(8)	9	16	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Transaction file
Validation: Claim Transaction files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be ‘B’ or ‘D’

Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Transaction Date
Definition: Date the Transaction File was created
Validation: Must be a valid date not equal to a Transaction date sent on any previous claims Transaction file.
Remarks: Format is CCYYMMDD. May use shared system batch processing date.
Requirement: Required

Sampled Claims Transaction File
Sampled Claims Transaction File Detail Record

Field Name	Picture	From	Thru	Initialization
Contractor ID	X(5)	1	5	Spaces
Record Type	X(1)	6	6	'2'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Claim Control Number	X(15)	9	23	Spaces
Beneficiary HICN	X(12)	24	35	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file.
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.

Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared system to uniquely identify the claim.
Validation: N/A
Remarks: Reflects the Claim Control Number selected from the Claim Universe file in the sampling process.
Requirement: Required

Data Element: Beneficiary HICN
Definition: Beneficiary’s Health Insurance Claim Number
Validation: N/A
Remarks: Reflects the Beneficiary HICN on the claim record selected from the Claim Universe file in the sampling process
Requirement: Required

Claims Transaction File
Claims Transaction 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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	17	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file.
Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:

B = Record Format as of 7/1/2007
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

Claims Resolution File
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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Resolution Date	X(8)	9	16	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file.
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010

D = Record Format as of 7/1/2016
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor
Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Resolution Date
Definition: Date the Resolution Record was created.
Validation: Must be a valid date not equal to a Resolution date sent on any previous claims Resolution file.
Remarks: Format is CCYYMMDD. May use shared system batch processing date.
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”
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Assignment Indicator	X(1)	9	9	Spaces
Mode of Entry Indicator	X(1)	10	10	Spaces
Original Claim Control Number	X(15)	11	25	Spaces
Claim Control Number	X(15)	26	40	Spaces
Beneficiary HICN	X(12)	41	52	Spaces
Beneficiary Last Name	X(60)	53	112	Spaces
Beneficiary First Name	X(35)	113	147	Spaces
Beneficiary Middle Initial	X(1)	148	148	Spaces
Beneficiary Date Of Birth	X(8)	149	156	Spaces
Billing Provider Number	X(15)	157	171	Spaces
Referring/Ordering UPIN	X(6)	172	177	Spaces
Claim Allowed Amount	S9(7)v99	178	186	Zeroes
Claim ANSI Reason Code 1	X(8)	187	194	Spaces
Claim ANSI Reason Code 2	X(8)	195	202	Spaces
Claim ANSI Reason Code 3	X(8)	203	210	Spaces
Claim Entry Date	X(8)	211	218	Spaces
Claim Adjudicated Date	X(8)	219	226	Spaces
Beneficiary Gender	X(1)	227	227	Spaces
Billing Provider NPI	X(10)	228	237	Spaces
Referring/Ordering Provider NPI	X(10)	238	247	Spaces
Claim Paid Amount	S9(7)v99	248	256	Zeroes
Beneficiary Paid Amount	S9(7)v99	257	265	Zeroes
Claim Diagnosis Code 1	X(7)	266	272	Spaces

Field Name	Picture	From	Thru	Initialization
Claim Diagnosis Code 1Version Indicator Code	X(1)	273	273	Spaces
Claim Diagnosis Code 2	X(7)	274	280	Spaces
Claim Diagnosis Code 2Version Indicator Code	X(1)	281	281	Spaces
Claim Diagnosis Code 3	X(7)	282	288	Spaces
Claim Diagnosis Code 3Version Indicator Code	X(1)	289	289	Spaces
Claim Diagnosis Code 4	X(7)	290	296	Spaces
Claim Diagnosis Code 4Version Indicator Code	X(1)	297	297	Spaces
Claim Diagnosis Code 5	X(7)	298	304	Spaces
Claim Diagnosis Code 5Version Indicator Code	X(1)	305	305	Spaces
Claim Diagnosis Code 6	X(7)	306	312	Spaces
Claim Diagnosis Code 6Version Indicator Code	X(1)	313	313	Spaces
Claim Diagnosis Code 7	X(7)	314	320	Spaces
Claim Diagnosis Code 7Version Indicator Code	X(1)	321	321	Spaces
Claim Diagnosis Code 8	X(7)	322	328	Spaces
Claim Diagnosis Code 8Version Indicator Code	X(1)	329	329	Spaces
Claim Diagnosis Code 9	X(7)	330	336	Spaces
Claim Diagnosis Code 9Version Indicator Code	X(1)	337	337	Spaces
Claim Diagnosis Code 10	X(7)	338	344	Spaces
Claim Diagnosis Code 10Version Indicator Code	X(1)	345	345	Spaces
Claim Diagnosis Code 11	X(7)	346	352	Spaces
Claim Diagnosis Code 11Version Indicator Code	X(1)	353	353	Spaces
Claim Diagnosis Code 12	X(7)	354	360	Spaces
Claim Diagnosis Code 12Version Indicator Code	X(1)	361	361	Spaces
Claim Zip Code	X(9)	362	370	Spaces
Claim Pricing State	X(2)	371	372	Spaces
Beneficiary Zip Code	X(9)	373	381	Spaces
Beneficiary State	X(2)	382	383	Spaces
Claim Demonstration Number	X(2)	384	385	Spaces
RAC Adjustment Indicator	X(1)	386	386	Spaces
Split/Adjustment Indicator	X(2)	387	388	Spaces
Facility NPI	X(10)	389	398	Spaces
Claim PWK	X(60)	399	458	Spaces
Claim Demonstration Identification Number2	X(2)	459	460	Spaces
Claim Demonstration Identification Number3	X(2)	461	462	Spaces
Claim Demonstration Identification Number4	X(2)	463	464	Spaces

Field Name	Picture	From	Thru	Initialization
Beneficiary MBI	X(11)	465	475	Spaces
HICN/MBI indicator	X(1)	476	476	Spaces
Line Item Count	9(2)	477	478	Zeroes
Filler	X(32)	479	510	Spaces

Sampled Claims Resolution File
Sampled Claims Resolution Line Item Detail Group
*The following group of fields occurs from 1 to 13 times (Depending on Line Item Count).
*From and Thru values relate to the 1st line item

Field Name	Picture	From	Thru	Initialization
Performing Provider Number	X(15)	511	525	Spaces
Performing Provider Specialty	X(2)	526	527	Spaces
HCPCS Procedure Code	X(5)	528	532	Spaces
HCPCS Modifier 1	X(2)	533	534	Spaces
HCPCS Modifier 2	X(2)	535	536	Spaces
HCPCS Modifier 3	X(2)	537	538	Spaces
HCPCS Modifier 4	X(2)	539	540	Spaces
Number of Services	S9(7)v999	541	550	Zeroes
Service From Date	X(8)	551	558	Spaces
Service To Date	X(8)	559	566	Spaces
Place of Service	X(2)	567	568	Spaces
Type of Service	X(1)	569	569	Spaces
Diagnosis Code	X(7)	570	576	Spaces
Line Diagnosis Code Version Indicator Code	X(1)	577	577	Spaces
CMN Control Number	X(15)	578	592	Spaces
Line Submitted Charge	S9(7)v99	593	601	Zeroes
Line Medicare Initial Allowed	S9(7)v99	602	610	Zeroes
ANSI Reason Code 1	X(8)	611	618	Spaces
ANSI Reason Code 2	X(8)	619	626	Spaces
ANSI Reason Code 3	X(8)	627	634	Spaces
ANSI Reason Code 4	X(8)	635	642	Spaces
ANSI Reason Code 5	X(8)	643	650	Spaces
ANSI Reason Code 6	X(8)	651	658	Spaces
ANSI Reason Code 7	X(8)	659	666	Spaces
Manual Medical Review Indicator	X(1)	667	667	Space
Resolution Code	X(5)	668	672	Spaces
Line Final Allowed Charge	S9(7)v99	673	681	Zeroes
Performing Provider NPI	X(10)	682	691	Spaces
Performing Provider UPIN	X(6)	692	697	Spaces
Miles/Time/Units/Services Indicator Code	X(1)	698	698	Spaces
Line Deductible Applied	S9(7)v99	699	707	Zeroes
Line Co-Insurance	S9(7)V99	708	716	Zeroes
Line Paid Amount	S9(7)v99	717	725	Zeroes
Line MSP Code	X(1)	726	726	Spaces
Line MSP Paid Amount	S9(7)v99	727	735	Zeroes
Line Pricing Locality	X(2)	736	737	Spaces

Field Name	Picture	From	Thru	Initialization
Line Zip Code	X(9)	738	746	Spaces
Line Pricing State Code	X(2)	747	748	Spaces
Ambulance Point of Pick up Zip	X(9)	749	757	Spaces
Ambulance Point of Drop Off Zip Code	X(9)	758	766	Spaces
Line PWK	X(60)	767	826	Spaces
Prior Authorization Program	X(4)	827	830	Spaces
Unique Tracking Number (UTN)	X(14)	831	844	Spaces
Prior Authorization Affirmed Indicator	X(1)	845	845	Spaces
Filler	X(6)	846	851	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file.
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 7/1/2016
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
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: The Claim Control Number the shared system assigned to the claim in the Universe file. This number should be the same as the claim control number for the claim in the Sample Claims Transactions file, and the claim control number for the claim on the Universe file. If the shared system had to use a crosswalk to pull the claim because the MAC or shared system changed the claim control number during processing,
enter the number the shared system used to look up the number needed to pull all records associated with the sample claim.
Validation: Must match the Claim Control Number identified in the Sampled Claims Transaction File.
Remarks: N/A
Requirement: Required

Data Element: Claim Control Number
Definition: Number assigned by the shared 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 Last Name
Definition: Last Name (Surname) of the beneficiary.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary First Name
Definition: First (Given) Name of the beneficiary.

Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Beneficiary Middle Initial
Definition: First letter from Beneficiary Middle Name.
Validation: N/A
Remarks: N/A
Requirement: Required when available

Data Element: Beneficiary Date of Birth
Definition: Date on which beneficiary was born.
Validation: Must be a valid date
Remarks: MMDDCCYY on which the beneficiary was born.
Requirement: Required

Data Element: Billing Provider Number
Definition: Number assigned by the National Supplier Clearinghouse (NSC) or MAC to identify the billing/pricing provider or supplier.
Validation: Must be present. Use the same requirements as for Item 33 in HCFA 1500.

- Enter the PIN, for the performing provider of service/supplier who is not a member of a group practice.
- Enter the group PIN, for the performing provider of service/supplier who is a member of a group practice.
- Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.
- If the same billing/pricing provider number does not apply to all lines on the claim, enter the Billing provider number that applies to the performing provider on the first line of the claim.

Remarks: N/A
Requirement: Required

Data Element: Referring/Ordering UPIN
Definition: UPIN assigned to identify the referring/ordering provider.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider.

- Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient.

Requirement: Required when available on the claim record.

Data Element: Claim Allowed Amount
Definition: Final Allowed Amount for this claim.
Validation: N/A
Remarks: The total allowed charges on the claim (the sum of line item allowed charges)

Requirement: Required

Data Element: Claim ANSI Reason Code 1-3
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 shared 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: Beneficiary Gender
Definition: Gender of the Beneficiary.
Validation: M=Male
F=Female
U=Unknown
Remarks: N/A
Requirement: Required

Data Element: Billing Provider NPI
Definition: NPI assigned to the Billing Provider.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Referring/Ordering Provider NPI
Definition: NPI assigned to the Referring/Ordering Provider.
Validation: N/A
Remarks: Enter zeros if there is no referring/ordering provider.

- Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient.

Requirement: Required when available on the claim record.

Data Element: Claim 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: Amount of payment made from the Medicare trust fund for the services covered by the claim record.
Requirement: Required

Data Element: Beneficiary Paid Amount
Definition: Amount paid by Beneficiary to the provider.
Validation: N/A
Remarks: N/A
Requirement: Required if available.

Data Element: Claim Diagnosis Code 1-12
Definition: The ICD-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
Validation: Must be a valid ICD-CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks:

- These fields should be left justified and space filled. For instance if the primary diagnosis on the claim is five positions long, this field should contain the diagnosis with 2 spaces at the end.
- With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:
    - Ambulance supplier (specialty 59)—amb
    - Independent Clinical Lab (specialty 69)--lab

Requirement: Claim Diagnosis 1 is required for ALL claims.
Claim diagnosis codes 2-12 should be submitted if contained on the claim record. Enter spaces for the diagnosis code fields that are not populated on the claim record in the Shared Processing System.

Data Element: Claim Diagnosis Version Indicator Code 1-12
Definition: The ICD--CM diagnosis version code identifying the version of diagnosis code submitted.
Validation:

- Version ICD9 use Version Code ‘9’

- Version ICD10 use Version Code '0'
- May be blank for claims billed by ambulance and independent laboratory suppliers.

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures.

Requirement: Claim Diagnosis Version Code 1 is required for ALL claims, except those billed by ambulance and independent laboratories. Claim diagnosis version codes 2-12 should be submitted to correspond to claim level diagnosis codes 2-12.

Data Element: Claim Zip Code

Definition: Zip Code used to identify were the service was furnished.

Validation: Must be a valid Zip Code

- This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.

Remarks: For DME MAC Claims use the zip code for beneficiary residence.
For Part B Claims, use the zip code identified in item 32 of the HCFA 1500, except in the listed situations.

- For ambulance services, identify the zip code where the patient was picked up.
- If the service was furnished in the patient's home, use the zip code from the patient's home address.
- For electronic claims, if multiple zip codes are identified enter the zip code for the line with the highest allowed amount. (If this logic is too cumbersome to implement, we can live with enter the zip code from the first line).

Requirement: Required

Data Element: Claim Pricing State

Definition: State where services were furnished.

Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).

Remarks: Furnish the state associated with the Claim Zip Code.

Requirement: Required

Data Element: Beneficiary Zip Code

Definition: Zip Code associated with the beneficiary residence.

Validation: Must be a valid Zip Code

- This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.

Remarks: Use the zip code for beneficiary residence.

Requirement: Required

Data Element: Beneficiary State

Definition: State abbreviation identifying the state in which the beneficiary resides.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).
Remarks: N/A
Requirement: Required

Data Element: Claim Demonstration Number
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: Must be populated with the value from the first populated demonstration number on the claim.
Requirement: Required on every claim processed under a CMS demonstration project.

Data Element: RAC Adjustment Indicator
Definition: Indicator used to identify RAC requested adjustments, which occur as a result of post-payment review activities done by the Recovery Audit Contractors (RAC).
Validation: 'R' identifies a RAC-requested adjustment
Remarks: N/A
Requirement: Required when RAC adjustment indicator was furnished to CWF

Data Element: Split/Adjustment Indicator
Definition: Count of number of splits/replicates/adjustments (with different claim control numbers (ICN/CCN)) of the sampled claim that are included in the resolution file.
Validation: '00' is used when only one claim control number (ICN/CCN) associated with the sampled claim is included in the resolution file.
When the resolution file contains multiple adjustments/splits/replicates associated with a single claim, this field will provide a count of records.

- For example, if the file contains the original, replicate and adjustment claims, one record would have an indicator of 01, one record would have an indicator of 02, and the third record would have an indicator of 03.

Remarks: This indicator does not apply when multiple records are submitted for a single claim record because of size restrictions.
This field is right justified and zero filled.
Requirement: Required when the resolution file contains multiple versions of a single claim.

Data Element: Facility NPI
Definition: The NPI of the facility at which the service was performed.
Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record.

Data Element: PWK
Definition: Space reserved for future use.

Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record.

Data Element: Claim Demonstration Number 2
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: Must be populated with the value from the second populated demonstration number on the claim.
Requirement: Required when present on claim.

Data Element: Claim Demonstration Number 3
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID.
Remarks: Must be populated with the value from the third populated demonstration number on the claim.
Requirement: Required when present on claim

Data Element: Claim Demonstration Number 4
Definition: This element is also known as the Claim Demonstration Identification Number. It is the number assigned to identify a demonstration Project. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
Validation: Must be a Valid Demo ID
Remarks: Must be populated with the value from the fourth populated demonstration number on the claim.
Requirement: Required when present on claim

Data Element: Beneficiary MBI
Definition: Beneficiary's Medicare Beneficiary Identifier
Validation: Comply with CMS Standards

- 11-character, fixed length alpha-numeric string.
- Different, visibly distinguishable from HICN/RRB numbers.
- Contain no more than 2 consecutive numbers.
- Contain no more than 2 consecutive alphabetic characters
- Must limit the possibility of letters being interpreted as numbers (i.e., alphabetic characters [A…Z]; excluding S, L, O, I, B, Z).
- Must not contain lowercase letters.
- Must not contain any special characters.

Remarks: Do not include hyphens or spaces.
Requirement: Required
Data Element: HICN/MBI Indicator
Definition: Indicator that identifies if the provider submitted the claim with a HICN or MBI.
Validation:
M = MBI submitted on the claim
H = HICN submitted on the claim
Remarks: N/A
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

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

<u>Claim Line Item Fields</u>

Data Element: Performing Provider Number
Definition: Number assigned by the shared 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: Must be a valid Provider Specialty per IOM 10.4 ch26 10.8.
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

Data Element: HCPCS Modifier 1-4
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: Zero filled to maintain the relative position of the decimal point. The last three positions should contain the value to the right of the decimal in the number of services. Put a zero in the last three positions for whole numbers. For example if the number of units is 10, this field would be filled as 0000010000.
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: Must be a valid ICD-CM diagnosis code.

- CMS accepts only CMS approved ICD-CM diagnostic and procedural codes. The CMS approves only changes issued by the Federal ICD-CM Coordination and Maintenance Committee.
- Diagnosis codes must be full ICD-CM diagnoses codes, including the full number of digits (five for ICD-9-CM, seven for ICD-10-CM) where applicable.

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories

enter a diagnosis only for limited coverage procedures. Since this is a required field, resolution records for claims billed by Ambulance suppliers and independent clinical laboratories must include the following filler information when the diagnosis is not otherwise available:

- Ambulance supplier (specialty 59)—amb
- Independent Clinical Lab (specialty 69)--lab

Requirement: Required

Data Element: Line Diagnosis Code Version Indicator Code
Definition: The ICD--CM diagnosis version code identifying the version of diagnosis code submitted.
Validation:

- Version ICD9 use Version Code '9'
- Version ICD10 use Version Code '0
- May be blank for claims billed by ambulance and independent laboratory suppliers.

Remarks: With the exception of claims submitted by ambulance suppliers (specialty type 59), all claims submitted on HCFA 1500 by physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-CM code number and code to the highest level of specificity for the date of service. Independent laboratories enter a diagnosis only for limited coverage procedures.
Requirement: Diagnosis Version Code is required for ALL lines, except those billed by ambulance and independent clinical laboratory suppliers.

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

Data Element: Line 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: Line 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.

- Use MPFDB, Clinical Lab FS, Ambulance FS, ASC FS, drug and injectable FS, or DME fee schedule as appropriate.

Requirement: Required

Data Element: ANSI Reason Code 1-7
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: 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 MAC's history file. The review must require professional medical 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 MAC'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.
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 MAC resolved the line.

Automated Review (AM): An automated review occurs when a claim/line item passes through the MAC'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 MAC'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 MAC's history file. The review must require professional medical 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 MAC'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', 'REO', 'DENAM', 'REDAM', 'DELET', or 'TRANS',

Remarks:

Resolution Code	**Descriptio**
APP	Approved as a valid submission without manual medical review.
APPAM	Approved after automated medical review
APPM	Approved after manual medical review routine
DENAM	Approved after manual medical review complex. If this code is selected, set the Manual Medial Review Indicator to 'Y.
DENMR	Denied after automated medical review
	Denied for medical review reasons or for insufficient documentation of medical necessity, manual medical review routine
	Denied for medical review reasons or for insufficient

Resolution Code	Descriptio
	Review Indicator to 'Y.'
DEO	Denied for non-medical reasons, other than denied as unprocessable.
RTP	Denied as unprocessable
REDA	(return/reject) Reduced after
M REDM	medical review Reduced for medical review reasons or for
R	insufficient documentation of medical necessity, manual medical review routine
REDM C	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.' Reduced for non-medical review reasons.
DEO	Claim deleted from processing system—AC maintains record of claim on system

Requirement: Required

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

Data Element: Performing Provider NPI
Definition: NPI assigned to the Performing Provider.
Validation: N/A
Remarks: N/A.
Requirement: Required for providers that use HIPPA standard transactions.

Data Element: Performing Provider UPIN
Definition: Unique Physician Identifier Number (UPIN) that identifies the physician supplier actually performing/providing the service.
Validation: N/A
Remarks: N/A
Requirement: Required, when available

Data Element: Miles/Time/Units/Services Indicator
Definition: Code indicating the units associated with services needing unit reporting on the line item for the Part B claim.
Validation: Must be a valid Indicator as identified in IOM 10.4 ch26 10.10.

0- No allowed services
1- Ambulance transportation miles
2- Anesthesia Time Units
3- Services

4- Oxygen units
5- Units of Blood

Remarks: N/A
Requirement: Required

Data Element: Line Deductible Applied
Definition: Amount of deductible applied for this service or equipment.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Line Co-Insurance Amount
Definition: Amount of co-insurance due for this service or equipment.
Validation: N/A
Remarks: N/A
Requirement: Required

Data Element: Line Paid Amount
Definition: Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.
Validation: N/A
Remarks: This represents the MAC's value of the claim after co-pays and deductibles.
Requirement: Required

Data Element: Line MSP Code
Definition: Code indicating primary payor for services on this line item.
Validation: A-Working Aged
B-ESRD
D-No-Fault
E-Workers' Compensation
F-Federal (Public Health)
G-Disabled
H-Black Lung
I-Veterans
L-Liability
Remarks: N/A
Requirement: Required, when contained on the claim record.

Data Element: Line MSP Paid Amount
Definition: The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).
Validation: N/A
Remarks: Amount paid by Primary Payer
Requirement: Required, when contained on the claim record.

Data Element: Line Pricing Locality
Definition: Code denoting the MAC-specific locality used for pricing this claim.

Validation: Must be a valid pricing locality.

- Enter '00' for claims priced at a statewide locality.

Requirement: Required

Data Element: Line Zip Code
Definition: Zip Code used to determine claim pricing locality.
Validation: Must be a valid Zip Code
This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Remarks: For DME Claims use the zip code for beneficiary residence.
For Part B Claims, use the zip code identified in item 32 of the HCFA 1500, unless the service was furnished in the patient's home. If the service was furnished in the patient's home, use the zip code from the patient's home address.
Requirement: Required

Data Element: Line Pricing State
Definition: State where services were furnished.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).
Remarks: Furnish the state associated with the Line Zip Code.
Requirement: Required

Data Element: Ambulance Point of Pick-up Zip Code
Definition: Zip Code identifying the ambulance point of pick up.
Validation: Must be a valid Zip Code.
Remarks: This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Requirement: Required for ambulance claims

Data Element: Ambulance Drop Off Zip Code
Definition: Zip Code identifying the ambulance drop off point.
Validation: Must be a valid Zip Code.
Remarks: This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
Requirement: Required for ambulance claims

Data Element: PWK
Definition: Space reserved for future use.
Validation: N/A
Remarks: N/A
Requirement: Required when available on the claim record

Data Element: Prior Authorization Program Indicator
Definition: Prior Authorization Program Indicator issued by CMS to identify to which PA program the service belongs

Validation: Four character alphanumeric

- The first character identifies the line of business
  - A for Part A,
  - B for Part B,
  - D for DME,
  - H for Home Health and Hospice
  - Followed by a three digit number

Remarks: N/A

Requirement: Required for claims containing services subject to a prior authorization program.

Data Element: Unique Tracking Number (UTN)

Definition: Unique Tracking Number (UTN) assigned to the prior authorization request for the service or item.

Validation: For Prior Authorization Claims/services the UTN shall be 14 characters and use the following format:

- First two characters = MAC identifier (e.g. RR for Railroad, 0F for Jurisdiction F, 05 for Jurisdiction 5, etc.).
- Third character = line of business (e.g. A for Part A, B for Part B, D for DME, H for Home Health and Hospice).
- Remaining numerical characters = a unique sequence number assigned by the Shared System.

  For claims/services in the PMD Prior Authorization Project, the UTN shall be 14 characters and use the following format:
- First character = DME MAC identifier (e.g. A for Jurisdiction A, B for Jurisdiction B, etc.).
- Second and third characters = 00 (zero and zero).
- Remaining characters = a unique sequence number assigned by the Shared System.

Remarks: N/A

Requirement: Required for claims containing services covered by an affirmed prior authorization.

Data Element: Prior Auth Affirmed

Definition: Code to identify if the prior authorization for the service(s) on this line was affirmed.

Validation:
- Y indicates the prior authorization was affirmed.
- N indicates the prior authorization was not affirmed.
- Default value is blank for services that are not part of prior authorization demonstration.

Remarks: N/A

Requirement: Required for claims containing services subject to prior authorization in the state where the service was furnished.

Data Element: Filler

Definition: Additional space TBD.

Validation: N/A

Remarks: N/A

Requirement: None

Claims Resolution File
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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Claims	9(9)	9	1617	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
NOTE: For A/B MAC (B): When multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Resolution file.
Validation: Claim Resolution files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
D = Record Format as of 7/1/2016
E = Record Format as of 10/1/2017
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be ‘B’ or ‘D’
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

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

Requirement: Required

Claims Provider Address File
Claims 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'
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Address Date	X(8)	9	16	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Provider Address file.
Validation: Claim Provider Address files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Provider Address Date
Definition: Date the Provider Address File was created.
Validation: Must be a valid date not equal to a Provider Address date sent on any previous claims Provider Address file.

Remarks: Format is CCYYMMDD. May use shared system batch processing date.
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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Provider Number/NPI	X(15)	9	23	Spaces
Provider Name	X(60)	24	83	Spaces
Provider Address 1	X(25)	84	108	Spaces
Provider Address 2	X(25)	109	133	Spaces
Provider City	X(15)	134	148	Spaces
Provider State Code	X(2)	149	150	Spaces
Provider Zip Code	X(9)	151	159	Spaces
Provider Phone Number	X(10)	160	169	Spaces
Provider Phone Number Extension	X(10)	170	179	Spaces
Provider Fax Number	X(10)	180	189	Spaces
Provider Type	X(2)	190	191	Spaces
Provider Address Order	X(2)	192	193	Spaces
Provider Address Type	9(3)	194	196	Zero
Provider E-mail Address	X(75)	197	271	Spaces
Provider Federal Tax number or EIN	9(10)	272	281	Zeroes
Provider Taxonomy Code	9(10)	282	291	Zeroes
Provider License Number	X(16)	292	307	Spaces
Provider License State	X(2)	308	309	Spaces
Filler	X(25)	310	334	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
NOTE: For A/B MAC (B): when multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Claim Universe file.

Validation: Claim Universe files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required
Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Provider Number/NPI
Definition: Number assigned by the MAC/NSC or NPI agency to identify the 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 provider.
The provider name must be formatted into a business name for mailing (e.g. Roger A Smith M.D. or Medical Associates, Inc).
Where possible this should contain the Legal Business Name as carried in the Shared Processing System.
Requirement: Required

Data Element: Provider Address 1
Definition: 1st line of provider's address.
Validation: N/A
Remarks: This is the address1 of the 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 provider.
Requirement: Required if available

Data Element: Provider City
Definition: Provider's city name.
Validation: N/A
Remarks: This is the city of the provider's address.
Requirement: Required

Data Element: Provider State Code
Definition: Provider's state code.

Validation: Must be a valid state code.
Remarks: This is the state of the provider's address.
Requirement: Required

Data Element: Provider Zip Code
Definition: Provider's zip code.
Validation: Must be a valid postal zip code.
Remarks: This is the zip code of the provider's address. Provide 9-digit zip code if available, otherwise provide 5-digit zip code.
This field should be left justified and zero filled. When only a five digit zip code is carried in the Shared Processing System, this field will contain the five digit zip code followed by 4 zeros.
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.
Requirement: None

Data Element: Provider Phone Number Extension
Definition: Provider's telephone number Extension.
Validation: Must be a valid telephone number.
Remarks: This is the phone number.
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 provider.
Requirement: None

Data Element: Provider Type
Definition: 1=Billing/pricing provider number (Assigned by MAC or NSC).
2=Referring/ordering provider (UPIN)
3=Performing/rendering provider (Assigned by MAC or NSC)
4=Entity is both billing/pricing and performing/rendering provider
5=Entity is both referring/ordering and performing/rendering provider
6=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider)
7=Billing/pricing provider number (NPI)
8=Referring/ordering provider (NPI)
9=Performing/rendering provider (NPI)
10=Entity is both billing/pricing and performing/rendering provider (NPI)
11=Entity is both referring/ordering and performing/rendering provider (NPI)
12=Entity is all (billing/pricing AND referring/ordering AND performing/rendering provider) (NPI)

Validation: Must be a valid provider type.
Remarks: This field indicates for which provider number associated with a sampled claim the address information is furnished.
Requirement: Required

Data Element: Address Order
Definition: The order in which the records of provider addresses for the provider are entered into the provider address file detailed record. This field in combination with the Contractor ID, Provider number, and Provider. Type will make each record in the file unique.
Validation: Must be a valid number between 01 and 99
Remarks: This field indicated the order in which records containing the addresses for a provider are entered into the detail file. For instance, if there are three addresses for a provider, the record for the first address for that provider with contain an '01' in this field; and the record for the second address for that provider will contain a '02' in this field.
Requirement: Required

Data Element: Provider Address Type
Definition: The type of Provider Address furnished.
Validation: 1 = Practice Address (MCS)
Provider address (VMS)
2 = Pay To Address (MCS)
Payee Address (VMS)
3 = Billing Address (VMS)
4 = Correspondence Address
5 = Medical Record Address
Remarks: The first "address type" for each provider will always be a "1." Subsequent occurrences of addresses for the same provider will have the "address type" to correspond to the address submitted. When your files contain only one address for the provider, submit only one provider address record. Submit additional address records for a single provider number only when your files contain addresses that differ from the Master or Legal address.

- Correspondence Address—The Correspondence Address as indicated on the 855. This is the address and telephone number where Medicare can directly get in touch with the enrolling provider. This address cannot be that of the billing agency, management service organization, or staffing company.
- Medical Record Address—the Location of Patients' Medical Records as indicated on the 855. This information is required if the Patients' Medical Records are stored at a location other than the Master Address (practice location). Post Office Boxes and Drop Boxes are not acceptable as the physical address where patient's medical records are maintained

Requirement: Required

Data Element: Provider E-Mail Address
Definition: Provider's e-mail address

Validation: Must be a valid e-mail address
Remarks: N/A
Requirement: Required if available

Data Element: Provider Federal Tax Number or EIN
Definition: The number assigned to the provider by the Federal government for tax report purposes. The Federal Tax Number is also known as a tax identification number (TIN) or employer identification number (EIN).
Validation: Must be present.
Remarks: N/A
Requirement: Required for all provider numbers.

Data Element: Provider Taxonomy Code
Definition: The non-medical data code set used to classify health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee health care transaction.
Validation: Must be present
Remarks: If multiple taxonomy codes are available, furnish the first one listed.
Requirement: Required if available

Data Element: Provider License Number
Definition: The professional business license required to provide health care services.
Validation: Must be present
Remarks: N/A
Requirement: Required if available

Data Element: Provider License State
Definition: Identify the state that issued the providers professional business license.
Validation: Must be a valid 2 digit state abbreviation as defined by the United States Postal Service (USPS).
Remarks: N/A
Requirement: Required if available.

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

Claims Provider Address File
Claims 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’
Record Version Code	X(1)	7	7	Spaces
Contractor Type	X(1)	8	8	Spaces
Number of Records	9(9)	9	17	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
NOTE: For A/B MAC (B): When multiple workloads share a single processing environment, the Contractor ID will reflect the contractor ID of the primary workload.

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

Data Element: Record Version Code
Definition: The code indicating the record version of the Provider Address file.
Validation: Provider Address files prior to 7/1/2007 did not contain this field.
Codes:
B = Record Format as of 7/1/2007
C = Record Format as of 1/1/2010
Remarks: N/A
Requirement: Required

Data Element: Contractor Type
Definition: Type of Medicare Contractor.
Validation: Must be 'B' or 'D'
Remarks: B = A/B MAC (B)
D = DME MAC
Requirement: Required

Data Element: Number of Records
Definition: Number of provider records on this file.
Validation: Must be equal to the number of provider records on the file.
Remarks: Do not count header or trailer records.
Requirement: Required

Exhibit 37 - Office of Inspector General, Office of Investigations Data Use Agreement

(Rev. 176, Issued: 11-24-06, Effective: 12-26-06, Implementation: 12-26-06)

DUA #: _____

(to be completed by CMS Staff)

OFFICE OF INSPECTOR GENERAL, OFFICE OF INVESTIGATIONS DATA USE AGREEMENT

I, _____, representing the Office of Inspector General (OIG), Office of Investigations (OI), will observe the following in the use of the Centers for Medicare & Medicaid Services (CMS) files released to me:

A. Purpose: _____

B. The following CMS data file(s) is/are covered under this Agreement.

Description of Data/File	Year(s)	System of Record (to be completed by CMS Staff)

1. The files will be used only for purposes authorized by the Inspector General Act of 1978 or other applicable law.

2. No information in the files released to the OIG will be used or disclosed except in strict accordance with all applicable confidentiality laws and regulations. Where practicable and consistent with OIG oversight responsibilities, the OIG will notify CMS of files extracted or derived from these files are disclosed pursuant to Federal disclosure and confidentiality laws.

3. The information sought in this request is required to be produced to the Office of Investigations pursuant to the Inspector General Act 1978, U.S.C. App. The information is also sought by the OIG in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 164.501; 164.512(a); and 164.512(d).

4. _____ will be designated as custodian of these files and will be responsible for establishment and maintenance of security arrangements to prevent unauthorized use. If the custodianship is transferred within the organization, CMS will be notified.

5. No listings or information from individual records, with identifiers will be published or otherwise released outside of those deemed appropriate by OIG to perform the legal scope of OIG duties and responsibilities.

6. The OIG needs to retain these files for up to 10 years. CMS will contact the OIG representative at the end of 5 years to confirm either that data will be destroyed or that OIG has a continuing need for the data. CMS will document its tracking system to indicate OIG's need for retention or destruction.

OIG Representative- Printed:	Phone Number:	Email Address:	
Street Address:	City:	State:	Zip Code:
Signature:	Date:		
Name of Custodian of Files, If Different:	Phone Number:	E-mail Address:	
Street Address:	City:	State:	Zip Code:
CMS Representative- Printed:			
Signature:	Date:		

38 - Qualified Independent Contractor (QIC) Jurisdictions (as of March 2005

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Task Order	Contractor	Covered States
Part A EAST QIC	Maximus, Inc.	Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, Washington DC
Part A WEST QIC	First Coast Service Options, Inc. (FCSO)	Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, American Samoa
Administrative QIC (AD QIC)	Q2A	N/A-Administrative QIC does not process reconsiderations.

Exhibit 39 - Carrier Record Requirements

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Carrier Record Requirements

Field Number	Item	M.D.s/D.O.s Record	Other Doctor's Record
1.	Record Code	Required	Required
2.	Record Status	Required	Required
3.	Last Name	Required	Required
4	First Name	Required	Required
5.	Middle Name/Initial	Required	Required
6.	Name Suffix	Required	Required
7.	Street (Billing Address)	Required	Required
8.	City (Billing Address)	Required	Required
9.	State (Billing Address)	Required	Required
10.	ZIP Code (Billing Address/ show 9 digits)	Required	Required
11.	Street (Business Address)	Required	Required
12.	City (Business Address)	Required	Required
13.	State (Business Address)	Required	Required
14.	ZIP Code (Business Address/ show 9 digits)	Required	Required
15.	State Licensed In	Required	Required
16.	Physician/Health Care Practitioner State License number	Required	Required
17.	Date of Birth	Required	Required
18.	Medical School Graduated	Required	Required
19.	Medical School Year Graduated	Required	Required
20.	Date of Death	If Available	If Available
21.	Credentials	Required	Required
22.	Primary Specialty Code	Required	Required
23.	Primary Board Certification Indicator	If Available	If Available
24.	Secondary Specialty Code	If Available	If Available
25.	Secondary Board Certification Indicator	If Available	If Available
26.	Type of Sanction Code	If Available	If Available
27.	Effective Date of Sanction	If Available	If Available
28.	Number of Sanctioned Years	If Available	If Available
29.	Deactivate Resident/Intern Practice/Opt Out code	Required	Required
30.	Group Practice Indicator	Required	Required
31.	Physician/Health Care Practitioner Participation Indicator	Required	Required
32.	Tax Identification Number	Required	Required
33.	Carrier Provider Number	Required	Required
34	Registry's Assigned UPIN	N/A	N/A
35.	NHIC Number	N/A	N/A
36.	Incoming Carrier Number	Required	Required
37.	Registry Assigned Error Codes/ Notification Codes	Required	Required
38.	Record Validation Field	N/A	N/A
39.	Special Processing Indicator	N/A	N/A
40.	Special Processing Data	N/A	N/A

41. Individual Social Security Number Required *	N/A	Required
42. Filler		

N/A = Not Applicable on initial data submission
* Health Care Practitioners Only

Exhibit 40 - UPIN Carrier Record Layout

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

UPIN CARRIER RECORD LAYOUT

Fld. No.	Position	No. of Cols.	Item	Description	Comments
1.	001	1	Record Code 9	1 = Add 2 = Add Develop/Return 3 = Assigned UPIN 4 = Registry Usage 5 = MPIER Update 6 = Update Develop/Return 7 = Notifications	
2.	002	1	Record Status 9	1 = Medical Doctor 2 = Other Doctor 3 = Non Physician/ Practitioner 4 = Group Practice	
3.	003-022	20	Last Name X(20)	Physician/Health Care Practitioner's Professional Last Name. Valid Characters A-Z and Blanks.	Left justify Use Fields 3, 4, 5, and 6 for group name
4.	023-036	14	First Name X(14)	Physician/Practitioner's Professional First Name. Valid Characters A-Z and Blank.	Left justify
5.	037-042	6	Middle Name/Initial X(06)	Physician/Health Care Practitioner's Professional Middle Name or Initial. Valid Characters A-Z and Blank	Left justify
6.	043-045	3	X(03)	Name Suffix. Practitioner's Name Suffix Example: JR, SR, III.. Valid Characters A-Z and Blank.	Physician/Health Care Left justify
7.	046-070	25	Street X(25)	Billing Street Address	Left justify

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no info leave field blank

Fld. No.	Position	No. of Cols.	Item	Description	Comments
8.	071-085	15	City X(15)	City of Billing Address	Left justify
9.	086-087	2	State X(02)	State of Billing Address	Standard U.S. post office State abbreviations.
10.	088-096	9	ZIP Code 9(09)	ZIP Code of Billing Address	Must report 9 position zip code
11.	097-121	25	Street X(25)	Business Street Address The practice or physical site address.	Left justify
12.	122-136	15	City X(15)	City of Business Address	Left justify
13.	137-138	2	State X(02)	State of Business Address	Standard U.S. post office State abbreviations.
14.	139-147	9	ZIP Code 9(09)	ZIP Code of Business Address	Must report 9 position zip code.
15.	148-149	2	State Licensed or operating in X (02)	State in which the physician/Health Care Practitioner is Licensed or This Practice Setting.	Standard U.S. post office State abbreviations.
16.	150-161	12	Physician/ Health Care Practitioner State License/ Registration Number X (12)	The State License Number or Registration Number for this Practice Setting.	Right justify and precede with zeroes.
17.	162-169	8	Date of Birth 9(08)	(MMDDYYYY)	**
18.	169-173	5	Medical School Graduated Code X(05)	Medical School Code	Refer to Exhibit 3.
19.	174-177	4	Medical School Year Graduated 9(04)	(YYYY)	Year of Graduation

Fld. No.	Position	No. of Cols.	Item	Description	Comments
20.	178-185	8	Date of Death 9(08)	(MMDDYYYY)	**
21.	186-188	3	Credentials X (03)		MD= Medical Doctor DO=Doctor of Osteopathy CH=Chiropractor DDM=Doctor of Dental Medicine DDS=Doctor of Dental Surgery DPM=Podiatrist OD= Doctor of Optometry CSW=Clinical Social Worker PT=Physical Therapist CP=Clinical Psychologist CNA=Certified Nurse Anesthetist AA= Anesthesia Assistant NP= Nurse Practitioner OT= Occupational Therapist GRP= Group Practice (USE ONLY WITH RECORD STATUS 5) RNA=Certified Registered Nurse Anesthetist PSY=Psychologist PA= Physician Assistant RN= Registered Nurse LPN= Licensed Practical Nurse CNM= Certified Nurse Midwife MSC=Mammography Screening Center AMB=Ambulance Service Supplier IDF=Independent Diagnostic Screening facility CNS = Clinical Nurse Specialist AU= Audiologist PXS= Portable X-Ray Supplier IPL=Independent Physiological Laboratory
22.	189-190	2	Primary Specialty 9(02)	Specialty Code Code Specified in Part 4 of MCM §2207	
23.	191	1	Primary Board Certification Indicator X(01)	Y or N or U for Unknown	

Fld. No.	Position	No. of Cols.	Item	Description	Comments
24.	192-193	2	Secondary Specialty Code 9(02)	Secondary Specialty Code For This Practice Setting.	
25.	194	1	Secondary Board Certification Indicator X(01)	Y=Yes N = No U = Unknown	
26.	195	1	Type of Sanction Code X(01)	Refer to Exhibit 4	
27.	196-199	4	Effective Date of Sanction 9(06)	(MMYY) Windowing	
28.	200-201	2	Number of Sanctioned Yrs 9(02)	Length of Sanction 01-99	
29.	202	1	Deactivate Resident/Intern Practice Code X(01)	D=Deactivate R =Resident I =Intern P =Practice O =OPT Out	
30.	203	1	Group Practice Indicator 9(01)	1=Group 4 =Solo	
31.	204	1	Physician/ Health Care Practitioner/ Group Practice Participation Indicator X(01)	Y=Yes The participation N=No decision is the latest recorded.	
32.	205-218	14	Tax Identification Employer Identification no. X(14)	Any number Number you assigned which permits Identifying cross-referencing Records For One Individual	
33.	219-232	14	Carrier Provider Number X(14) (Use UPIN for Record Status 5 only)		The number you have provided the Physician/Practitioner for billing Medicare
Fld. No.	Position	No. of Cols.	Item	Description	Comments

34.	233-238	6	Registry's Number the Assigned UPIN Registry X(06)	Leave blank	This space reserved for UPIN assignment
35.	239-248	10	NHIC Number 9(10)	Exception Turnaround Numbering	Assigned by Registry and correction process
36.	249-253	5	Incoming Carrier Number 9(05)	CMS Contractor Number; Multi-state Contractor Use The Distinct Number of Each Jurisdiction.	
37.	254-268	15	Registry Assigned Error Codes Or Notification Codes X(15)	Leave blank	Used for Registry error resolution/auto notification
38.	269	1	Record Validation Field X(1)	Y=Yes N=No	Indicate that you have validated the record with State Licensure Board
39.	270	1	Special Processing X(1)		Used to indicate special processing record is being submitted.
				Acceptable Values: Y = Indicates additional settings being added. 1 = Indicates change to Providers Name.	Record Code "1" with UPIN Record Code “5” OLD LAST NAME in Field
40.	271-290	20	Special Processing Data X(20)		Used to cross check the change to a Provider’s name or Provider Number.
			Name Change	Include the Providers LAST name only as it appears on the MPIER prior to the change.	Record Code "5" Providers NEW name in Fields 3, 4, 5, 6. UPIN Field 34.
			Provider Number Change	Include the Carrier assigned Number as it appears on the MPIER prior to the change.	Record Code "5" includes the NEW provider Number in Field 33 UPIN in Field 34.
			Individual Social Security Number	Physician/Health Care Practitioner Personal SSN	Record returned To you will contain the 10 Digit UPIN
41.	292-301	10	10 X(10)	Physician/Health Care Practitioner/Group	Record will contain 10-digit UPIN
42	302-306	5	5 Digit X(5)	Filler	Return record

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no information leave field blank.

40.1 - Trailer Record Data Elements

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Fld. No.	Position	No. of Cols.	Item	Description	Comments
1.	001	1	Record Code 9(01)	9 = Trailer Record	
2.	002-006	5	Incoming Carrier Number 9(05)		CMS Contractor Number; Multistate Contractors Use The Distinct Number Of Each Jurisdiction
3.	007-014	6	File Creation9(06)	(MMDDYYYY) Month, Day, And Year Of File Creation.	
4.	015-029	15	Number of Records Sent 9(15)	Total Number Of Records On The File. Do Not Include The Trailer Record.	Right justified and precede with zeroes.
5.	030-306	273	Filler X(277)		

NOTE: For "9" numeric fields, show zeroes if blank. For all "X" alpha numeric fields, if no information leave field blank.

Exhibit 41.1 - List of Medical School in the U.S.

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

LIST OF MEDICAL SCHOOLS IN THE U.S.

ALABAMA
00102 University of Alabama School of Medicine, Birmingham, AL 3529
00104 Birmingham Medical College
00106 University of South Alabama College of Medicine, Mobile, AL 37788

ARIZONA
00301 University of Arizona College of Medicine, Tucson, AZ 85724

ARKANSAS
00401 University of Arkansas College of Medicine, Little Rock, AR 77205
00402 College of Physicians and Surgeons, Little Rock, AR 77205

CALIFORNIA
00501 Cooper Medical College, San Francisco, CA 94143
00502 University of California, San Francisco School of Medicine, San Francisco, CA 94143
00504 California Eclectic Medical College, Los Angeles, CA 90033
00505 Hahneman Medical College of the Pacific, San Francisco, CA 94305

00506 University of Southern California School of Medicine, Los Angeles, CA 90033
00507 College of Physicians and Surgeons of San Francisco, CA
00508 Oakland College of Medicine and Surgery
00509 College of Physicians and Surgeons, Los Angeles, CA 90024
00511 Stanford University School of Medicine, Palo Alto, CA 94305
00512 Loma Linda University School of Medicine, Loma Linda, CA 92350
00513 Pacific Medical College, Los Angeles
00514 University of California, UCLA School of Medicine, Los Angeles, CA 90024
00515 University of California, California College of Medicine, Irvine, CA 92717
00516 University of California, Irvine, California College of Medicine Irvine, CA 92717
00517 University of California, Irvine, California College of Medicine, Irvine, CA 92717
00518 University of California, San Diego School of Medicine, La Jolla, CA 92093
00519 University of California, Davis School of Medicine, Davis, CA 95616
00576 College of Osteo of the Pacific, Pomona, CA 91766

COLORADO
00702 University of Colorado School of Medicine, Denver, CO 80262
00705 Denver and Gross College of Medicine Denver, CO 80262

CONNECTICUT
00801 Yale University School of Medicine, New Haven, CT 06510
00802 University of Connecticut School of Medicine, Farmington, CT 06032

DISTRICT OF COLUMBIA
01001 George Washington University School of Medicine, Washington, DC 20037
01002 Georgetown University School of Medicine, Washington, DC 20007

01003 Howard University College of Medicine, Washington, DC 20059

FLORIDA
01102 University of Miami School of Medicine, Miami, FL 33101
01103 University of Florida College of Medicine, Gainesville, FL 32610
01104 University of South Florida College of Medicine, Tampa, FL 33612
01175 Southeastern College of Osteo Medicine, Miami, FL 33162

GEORGIA
01201 Medical College of Georgia, Augusta, GA 30912
01205 Emory University School of Medicine, Atlanta, GA 30322
01209 Georgia College of Eclectric Medicine and Surgery, Atlanta, GA 30314
01211 Atlanta College of Physicians and Surgeons, Atlanta, GA 30322
01212 Atlanta School of Medicine Atlanta, GA 31207
01218 Hospital Medical College Eclectric, Atlanta, GA 31207
01219 Southern College of Medicine and Surgery, Atlanta, GA 30314
01221 Morehouse School of Medicine, Atlanta, GA 31207
01222 Mercer University School of Medicine, Macon, GA 31207

HAWAII
01401 University of Hawaii John A. Burns School of Medicine, Honolulu, HI 96822

ILLINOIS
01601 Rush Medical College of Rush University, Chicago, IL 60612
01602 University of Chicago, Pritzker School of Medicine, Chicago, IL 60637
01604 The Hahneman Medical College and Hospital, Chicago, IL 60637
01605 College of Medicine and Surgery, Chicago, IL 60658
01606 Northwestern University Medical School, Chicago, IL 60611
01608 Bennett Medical College, Chicago, IL 60639
01609 Northwestern University Women Medical School, Chicago, IL 60637
01610 Chicago Homeopathic Medical College, Chicago, IL 60612
01611 University of Illinois at Chicago Health Science Center, Chicago, IL 60612
01613 Harvey Medical College, Chicago, IL 60637
01614 National Medical University, Chicago 60639
01615 Hering Medical College, Chicago, IL 60638

ILLINOIS
01616 Jenner Medical College, Chicago, IL 60637
01617 Illinois Medical College, Chicago, IL 60637
01618 Dunham Medical College, Chicago, IL 60637
01619 American Medical Missionary College, Battle Creek, Chicago, IL 60637
01622 Chicago College of Medicine and Surgery
01623 Dearborn Medical College, Chicago, IL 60637
01642 University of Health Sciences/ Chicago Medical School, North Chicago, IL 60064
01643 Loyola University of Chicago, Stitch School of Medicine, Maywood, IL 60153
01644 The General Medical College, Chicago, IL 60615
01645 Southern Illinois University School of Medicine, Springfield, IL 62708
01675 Chicago College of Osteopathy, Chicago, IL 60615

INDIANA
01705 Physiological Medical College of Indiana, Indianapolis, IN 46202
01708 Medical College of Indiana, Indianapolis, IN 46224
01709 Central College of Physicians and Surgeons, Indianapolis, IN 46223
01717 Eclectic Medical College of Indiana, Indianapolis, IN 46224
01718 Indiana Medical College, Indianapolis, IN 46224

INDIANA
01719 School of Medicine of Purdue University, Indianapolis, IN 46202
01720 Indiana University School of Medicine, Indianapolis, IN 4622

IOWA
01801 College of Physicians and Surgeons, Keokuk, IA 52632
01803 University of Iowa College of Medicine, Iowa City, IA 52242
01804 State University of Iowa College of Homeopathic Medicine, Iowa City, IA 52242
01806 Drake University College of Medicine, Des Moines, IA 50311
01808 Sioux City College of Medicine, Sioux City, IA 50312
01810 Keokuk Medical College, College of Physicians and Surgeons, Keokuk, IA 52632
01875 University of Osteopathic Medicine and Health Sciences, Des Moines, IA 50312

KANSAS
01902 University of Kansas School of Medicine, Kansas City, KS 66103
01903 Kansas Medical College, Topeka, KS 66606
01904 College of Physicians and Surgeons, Kansas City, KS 66110
01907 Western Eclectic College of Medicine and Surgery, Kansas City, KS 66102

KENTUCKY
02001 Kentucky School of Medicine, Louisville, KY 40292
02002 University of Louisville School of Medicine, Louisville, KY 40292
02004 Louisville Medical College, Louisville, KY 40292
02005 Hospital College of Medicine, Louisville, KY

KENTUCKY
02006 Louisville National Medical College, Louisville, KY 40292
02008 Southwestern Homeopathic Medical College and Hospital, Louisville, KY 40546
02009 Kentucky University Medical Department, Louisville, KY 40292
02011 Louisville Hospital Medical College, Louisville, KY 40292
02012 University of Kentucky College of Medicine Lexington, KY 40536

LOUISIANA
02101 Tulane University School of Medicine, New Orleans, LA 70112
02104 Flint Medical College of New Orleans University, New Orleans, LA 70112
02105 Louisiana State University School of Medicine in New Orleans, New Orleans, LA 70112
02106 Louisiana State University School of Medicine in Shreveport, Shreveport, LA 71130

MAINE
02201 Bowdoin Medical School, Brunswick-Portland ME 04003
02275 University of New England, College of Osteo Medicine, Biddeford, ME 04005

MARYLAND
02301 University of Maryland School of Medicine, Baltimore, MD 21201
02303 College of Physicians and Surgeons of Baltimore, Baltimore, MD 21201
02304 Baltimore Medical College, Baltimore, MD 21201
02305 Womans Medical College of Baltimore, Baltimore, MD 21201
02306 Baltimore University School of Medicine, Baltimore, MD 21201
02307 Johns Hopkins University School of Medicine, Baltimore, MD 21205
02308 Atlantic Medical College, Baltimore, MD 21201
02309 Maryland Medical College, Baltimore, MD 21201
02311 Maryland College of Eclectic Medicine and Surgery, Baltimore, MD 21201
02312 Uniformed Services University of the Health Sciences, Bethesda, MD 20014

MASSACHUSETTS
02401 Harvard Medical School, Boston, MA 02115
02405 Boston University School of Medicine, Boston, MA 02118
02406 College of Physicians and Surgeons, Boston, MA 02111
02407 Tufts University School of Medicine, Boston, MA 02111
02415 Middlesex University School of Medicine, Waltham, MA 02154
02416 University of Massachusetts Medical School, Worcester, MA 01605

MICHIGAN
02501 University of Michigan Medical School, Ann Arbor, MI 48109
02505 University of Michigan Homeopathic Medical School, Ann Arbor, MI 48209
02507 Wayne State University School of Medicine, Detroit, MI 48201
02508 Michigan College of Medicine and Surgery, Detroit, MI 48201
02512 Michigan State University College of Human Medicine, East Lansing, MI 48824
02576 Michigan State University College of Osteopathic Medicine, East Lansing, MI 48824

MINNESOTA
02604 University of Minnesota Medical School, Minneapolis, MN 55455
02605 Minneapolis College of Physicians and Surgeons
02607 University of Minnesota, Duluth School of Medicine, Duluth, MN 55812
02608 Mayo Medical School, Rochester, MN 55905

MISSISSIPPI
02701 University of Mississippi School of Medicine, Jackson, MS 39216
02702 Mississippi Medical College, Meridian, MS 39305

MISSOURI
02801 Missouri Medical College, St. Louis, MO 63110
02802 Washington University School of Medicine, St Louis, MO 63110
02803 University of Missouri, Columbia School of Medicine, Columbia, MO 65212
02805 Homeopathic Medical College of Missouri, St. Louis, MO 63141
02807 St. Louis College of Physicians and Surgeons
02808 Kansas City Medical College
02810 National University of Arts and Sciences Medical Department, St. Louis, MO 63110
02820 University Medical College of Kansas City Kansas City, MO 64111
02822 Ensworth Medical College, St. Joseph, MO 64507
02826 Kansas City Homeopathic Medical College

02828 Barnes Medical College, St. Louis, MO 63110
02830 Woman's Medical College, Kansas City, MO 63111
02833 Eclectic Medical University, Kansas City, MO 63111
02834 Saint Louis University School of Medicine, St Louis, MO 63104
02835 Southwest School of Medicine and Hospital, Kansas City, MO 63111
02843 Kansas City College of Medicine and Surgery
02844 Kansas City University of Physicians and Surgeons
02845 Mid West Medical College, Kansas City, MO (See 02843)
02846 University of Missouri, Kansas City School of Medicine, Kansas City, MO 64108
02878 The University of Health Sciences, College of Osteo Medicine, Kansas City, MO 64124
02879 Kirksville College of Osteopathic Medicine, Kirksville, MO 63501

NEBRASKA
03004 Lincoln Medical College, Eclectic, Lincoln, NE 68501
03005 University of Nebraska College of Medicine, Omaha, NE 68105
03006 Creighton University School of Medicine, Omaha, NE 68178
03007 Nebraska College of Medicine, Lincoln, NE 69508

NEVADA
03101 University of Nevada School of Medicine, Reno, NV 89507

NEW HAMPSHIRE
03201 Dartmouth Medical School, Hanover, NH 03756

NEW JERSEY
03305 UMDNJ-New Jersey Medical School, Newark, NJ 07103
03306 UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ 08854
03375 UMDNJ New Jersey School of Osteo Medicine, Camden, NJ 08103

NEW MEXICO
03401 University of New Mexico School of Medicine, Albuquerque, NM 87131

NEW YORK
03501 Columbia University College of Physicians and Surgeons, New York, NY 10032
03503 Albany Medical College of Union University, Albany, NY 12208
03506 State Univesity of New York at Buffalo School of Medicine, Buffalo, NY 14214
03508 State University of New York Downstate Medical Center, Brooklyn, NY 12203
03509 New York Medical College, Valhalla, NY 10595
03510 Bellevue Hospital Medical College, New York, NY 10016
03511 New York Medical College and Hospital for Women, New York 10025
03513 Eclectic Medical College of the City of New York
03515 State University of New York Health Science Center of Syracuse, Syracuse, NY 13210
03519 New York University School of Medicine, New York, NY 10016
03520 Cornell University Medical College, New York, NY 10021
03543 Fordham University School of Medicine, New York, NY 10027
03545 University of Rochester School of Medicine and Dentistry, Rochester, NY 14642
03546 Albert Einstein College of Medicine of Yeshiva University, New York, NY 10461
03547 Mount Sinai School of Medicine of City University of New York, New York NY 10029

03548 State University of New York at Stony Brook, School of Medicine, Stony Brook, NY 11794
03575 New York College of Osteo Medicine of New York Institute of Technology, Old Westbury, NY 11568

NORTH CAROLINA
03601 University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC 27514
03603 Leonard Medical School, Raleigh, NC 27604
03604 North Carolina Medical College, Charlotte, NC 28223
03605 Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, NC 27103
03607 Duke University School of Medicine, Durham, NC 27710
03608 East Carolina University School of Medicine, Greenville, NC 27834

NORTH DAKOTA
03701 University of North Dakota School of Medicine, Grand Forks, ND 58201

OHIO
03801 Medical College of Ohio, Cincinnati, OH 44115
03802 Eclectic Medical College, Cincinnati, OH 44115
03803 Starling Medical College, Columbus, OH 45210
03806 Case Western Reserve University School of Medicine, Cleveland, OH 44206
03808 Cincinnati College of Medicine and Surgery
03809 Miami Medical College, Cincinnati, OH 44106
03811 University of Wooster Medical Department, Cleveland, OH 44206
03819 Toledo Medical College
03823 Cleveland Medical College, Homeopathic Cleveland, OH 45210
03825 Ohio Medical University Columbus, OH 45210
03826 Cleveland Pulte Medical College
03840 Ohio State University College of Medicine, Columbus, OH 43210
03841 University of Cincinnati College of Medicine, Cincinnati, OH 45267
03843 Medical College of Ohio at Toledo, Toledo, OH 43699
03844 Northeastern Ohio Universities College of Medicine, Rootstown, OH 44272
03845 Wright State University School of Medicine, Dayton, OH 45401
03875 Ohio University of Osteo Medicine, Athens, OH 45701

OKLAHOMA
03901 University of Oklahoma College of Medicine, Oklahoma City, OK 73190
03905 Oral Roberts University School of Medicine, Tulsa, OK 74171
03979 Oklahoma College of Osteopathic Medicine and Surgery, Tulsa, OK 47127

OREGON
04001 Williamette University Medical Department, Salem, OR 97304
04002 Oregon Health Sciences University School of Medicine, Portland, OR 97201

PENNSYLVANIA
04101 University of Pennsylvania School of Medicine, Philadelphia, PA 19104
04102 Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA 19107
04107 Medical College of Pennsylvania, Philadelphia, PA 19129

04109 Hahnemann University College of Medicine, Philadelphia, PA 19102
04111 Medico Chirurgical College of Philadelphia, Philadelphia, PA 19102
04112 University of Pittsburgh School of Medicine, Pittsburgh, PA 15261
04113 Temple University School of Medicine, Philadelphia, PA 19140
04114 Pennsylvania State University College of Medicine, Hershey, PA 17033
04177 Philadelphia College of Osteopathic Medicine, Philadelphia, PA 191431

PUERTO RICO
04201 University of Puerto Rico School of Medicine, San Juan, PR 00936
04202 Ponce School of Medicine, Ponce, PR 00732
04203 Universidad Central del Caribe Escuela de Medicina, Cayey, PR 00633
04204 University De Ciencias Med San Juan Bautista, Hato Rey, PR 00917

RHODE ISLAND
04301 Brown University Program in Medicine, Providence, RI 02912

SOUTH CAROLINA
04501 Medical University of South Carolina College of Medicine, Charleston, SC 29425
04504 University of South Carolina School of Medicine, Columbia, SC 29208

SOUTH DAKOTA
04601 University of South Dakota School of Medicine, Vermillion, SD 57069

TENNESSEE
04701 University of Nashville Medical Department
04705 Vanderbilt University School of Medicine, Nashville, TN 37232
04706 University of Tennessee College of Medicine, Memphis, TN 38163
04707 Meharry Medical College School of Medicine, Nashville, TN 37208
04708 Memphis Hospital Medical College
04709 Chattanooga Medical College
04710 Lincoln Memorial University Medical Department, Knoxville, TN 37920
04711 University of the South Medical Department, Sewanee, TN 37375
04713 Knoxville Medical College
04714 University of West Tennessee College of Medicine and Surgery, Memphis, TN 37402
04715 College of Physicians and Surgeons, Memphis, TN 37208
04720 East Tennessee State University, Quillen-Dishner College of Medicine, Johnson City, TN 37614

TEXAS
04802 University of Texas Medical Branch at Galveston, Galveston, TX 77550
04803 Fort Worth School of Medicine
04804 Baylor College of Medicine, Houston, TX 77030
04805 Physiological Medical College of Texas, Dallas, TX 76203
04806 Southern Methodist University Medical Department, Dallas, TX
04807 Gate City Medical College, Dallas, TX 76204
04812 University of Texas Southwestern Medical School at Dallas, Dallas, TX 75235
04813 University of Texas Medical School at San Antonio, San Antonio, TX 78284
04814 University of Texas Medical School at Houston, Houston, TX 77225
04815 Texas Tech University Health Science Center School of Medicine, Lubbock, TX 79430

04816 Texas A & M University College of Medicine, College Station, TX 77843
04878 Texas College of Osteopathic Medicine, Lubbock, TX 79430

UTAH
04901 University of Utah School of Medicine, Salt Lake City, UT 84132

VERMONT
05002 University of Vermont College of Medicine, Burlington, VT 05405

VIRGINIA
05101 University of Virginia School of Medicine, Charlottesville, VA 22908
05104 Medical College of Virginia Commonwealth University School of Medicine, Virginia, Richmond, VA 23298
05106 University College of Medicine, Richmond, VA 23298
05107 Eastern Virginia Medical School, Norfolk, VA 23501

WASHINGTON
05404 University of Washington School of Medicine, Seattle, WA 98195
05415 Washington College of Physicians and Surgeons, Seattle, WA 98196

WEST VIRGINIA
05501 West Virginia University School of Medicine, Morgantown, WV 26506
05502 Marshall University School Medicine, Huntington, WV 25701
05575 West Virginia School of Osteopathic Medicine, Lewisburg, WV 24901

WISCONSIN
05602 Wisconsin College of Physicians and Surgeons, Milwaukee, WI 53226
05603 Milwaukee Medical College
05605 University of Wisconsin Medical School, Madison, WI 53706
05606 Medical College of Wisconsin, Milwaukee, WI 53226

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Exhibit 41.2 - Directory of Podiatric Medical Colleges

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

DIRECTORY OF PODIATRIC MEDICAL COLLEGES

30000	California College of Podiatric Medicine 1210 Scott St., San Francisco, CA 94120
30100	Dr. William M. Scholl School of College of Podiatric Medicine 1001 North Dearborn St., Chicago, IL 60610
30200	New York College of Podiatric Medicine 53 East 124th St., New York, NY 10035
30300	Ohio College of Podiatric Medicine 10515 Carnegie Ave., Cleveland, OH 44106
30400	Pennsylvania College of Podiatric Medicine Eighth at Rale St, Philadelphia, PA 19107
30500	Barry University School of Podiatric Medicine 11300 Northeast Second Ave., Miami Shores, FL 33161
30600	College of Podiatric Medicine and Surgery, University of Osteopathic Medicine and Health Sciences 3200 Grand Ave., Des Moines, IA 50312

Exhibit 41.3 - American Optometric Association Council on Optometric Education

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

List of Accredited Professional Optometric Degree Programs
June 1986

40000 University of Alabama in Birmingham
School of Optometry
Birmingham, AL 35292

40010 University of California
School of Optometry
Minor Hall
Berkley, Ca 94720

40020 Ferris State College
College of Optometry
Big Rapids, MI 49307
AMERICAN OPTOMETRIC ASSOCIATION
COUNCIL ON OPTOMETRIC EDUCATION

40030 University of Houston
College of Optometry
Houston, TX 77004
40040 Illinois College of Optometry
3241 South Michigan Avenue
Chicago, IL 60616

40050 Indiana University
School of Optometry
Bloomington, IN 47405

40060 Inter-American University of Puerto Rico
School of Optometry
San Juan, PR 00936

40070 University of Missouri
St. Louis, MO 63121

40080 University of Montreal
School of Optometry
Montreal, P.Q.
Canada H3C 3J7

40090 New England
College of Optometry
Boston, MA 02115

40100 Berkeley Northeastern State University
College of Optometry
Tahlequah, Ok 74464

40110 State University of NY
State College of Optometry
New York, NY 10010

40120 The Ohio State University
College of Optometry
Columbus, OH 43210

40130 Pacific University
College of Optometry
Forest Grove, OR 97116

40140 Pennsylvania College of Optometry
Philadelphia, PA 19141

40150 South California College of Optometry
Fullerton, CA 96231

40160 Southern College of Optometry
Memphis, TN 38104

40170 University of Waterloo
School of Optometry
Waterloo, Ontario
Canada N2L 3G1

Exhibit 41.4 - List of Chiropractic Schools in the U.S.

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

List of Chiropractic Schools in the U.S

Code	
50010	Adio Institute of Straight Chiropractic Levittown, PA 19056 Changed name to Pennsylvania College of Straight Chiropractic - (1984)
50020	Atlantic States Chiropractic Institute Brooklyn, NY 10021 Merged with Columbia Institute of Chiropractic
50030	Bebout College of Chiropractic Indianapolis, IN 46224
50040	Booker T. Washington Chiropractic College Kansas City, MO 66103 50050
50050	Logan College Oklahoma City, OK 73190 Formerly Carver-Denny Chiropractic College Merged with Logan College of Chiropractic - (1958)
50060	Los Angeles College of Chiropractic Formerly California Chiropractic College (1963) Los Angeles, CA 90024
50065	Central States College of Physiatrics and Chiropractic Eaton, OH 45320
50070	Canadian Memorial Chiropractic College Toronto, Ontario M4G 3E6 50080
50080	Chiropractic Institute of New York New York, NY 10022
50090	Crisco Chiropractic College (Proposed) Crisco, TX 77650

* Schools in business since 1950
**Schools not listed use code 5000

50100	Cleveland Chiropractic College Los Angeles, CA 90004
50110	Cleveland Chiropractic College Kansas City, MO 64131
50120	Columbia College of Chiropractic Baltimore, MD 21201
50130	Columbia College of Chiropractic Alameda, CA 94501
50140	Columbia College of Chiropractic and Naturopathy Sacramento, CA 95860
50150	Columbia Institute of Chiropractic New York, NY 10025
50160	Hollywood College of Chiropractic Hollywood, CA 90024
50170	Lafayette Institute Philadelphia, PA 19104
50180	Life Chiropractic College San Lorenzo, CA 94580
50190	Lincoln Chiropractic College Marietta, GA 30060
50200	Reaver School of Chiropractic Dayton, OH 45401
50210	Restview Chiropractic College University of Chiropractic Seattle, WA 98196
50220	San Francisco College of Chiropractic San Francisco, CA 94128 Formerly West Coast Chiropractic College; Name changed to Metropolitan College of Chiropractic - 1944
50230	Sherman College of Straight Chiropractic, Spartanburg, SC 29304
50240	Western States College of Chiropractic, Portland, OR 97230
50250	University of Pasadena, College of Chiropractic, Pasadena, CA 91108
50260	University of Natural Healing Arts, Denver CO 80262
50270	National College of Chiropractic, Lombard IL 60148
50280	New York Chiropractic College, Glen Head, NY 11545
50290	Northwestern College of Chiropractic, Bloomington, MN 55431

50300	Palmer College of Chiropractic – West, Sunnyvale, CA 94087
50310	Palmer College of Chiropractic, Davenport, IA 52803

Exhibit 42 - Sanction Codes

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

Sanction Codes *

CODE	DESCRIPTION
A - 1128(a)(1) -	Program-related conviction
B - 1128(a)(2) -	Conviction for patient abuse or neglect
C - 1128(b)(1) -	Conviction relating to fraud
D - 1128(b)(2) -	Conviction relating to obstruction of an investigation
E - 1128(b)(3) -	Conviction relating to controlled substances
F - 1128(b)(4) -	License revocation or suspension
G - 1128(b)(5) -	Suspension or exclusion under a Federal or State health care program
H - 1128(b)(6) -	(Formerly 1862(d)(1)(B) and (C)) - Excessive claims or furnishing of unnecessary or substandard items or services
I - 1128(b)(7) -	Fraud, kickbacks and other prohibited activities (including 1162(d)(1A))
J - 1128(b)(8) -	(Formerly 1128(b) - Entities owned or controlled by a sanctioned individual
K - 1128(b)(9)	Failure to disclose required information
L - 1128(b)(10) -	Failure to supply requested information on subcontractors and suppliers
M -1128(b)(11) -	Failure to provide payment information
N - 1128(b)(12) -	Failure to grant immediate access
O - 1128(b)(13) -	Failure to take corrective action
P - 1128(b)(14) -	Default on health education loan or scholarship obligations
Q - 1128Aa -	(Formerly 1128(c) - Imposition of a civil money penalty or assessment
R - 1156(b) -	(Formerly 1160) - PRO recommendation
U - -	UNKNOWN (Physician is sanctioned, but type of sanction unknown)

* If a physician has more than one sanction, show the code of the sanction with the longest duration.

Exhibit 43 - Carrier Transmittal Sheet

(Rev. 141, Issued: 02-24-06; Effective/Implementation: N/A)

A.

UPIN Carrier Data Transmittal

Deliver to:

1. Carrier Number:
2. *Name and Address of Carrier

UPIN Records Included in this Transmittal

---

3. Date Prepared:

4. Date Shipped:

B. 1 UPIN Data Records: Tape Diskette

Volume Serial Number: _____

_____

_____

_____

_____

_____

B. 2 Total Records

B. 3 Type Records:

Medical Doctor/D.O. Records

Other Doctor Records

C. 1

We have successfully processed the above file (no reel will be returned).

C. 2

We are unable to accept your UPIN Data Records. See below for information on reason for return.

Reason for return:

---

* Enter complete name and address of persons to whom all questions may be addressed.

Exhibit 44

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

Standard Core
Joint Operating Agreement
Between
RACs and *UPICs*

Recovery Audit Contractors (RACs)
Unified Program Integrity Contractors (UPICs)

Revision History Log

Version	Date	Changed By	Description of Change	Approval Required
V01				
V02				

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1. Introduction

1.1. Purpose of this JOA

This Joint Operating Agreement (JOA) is designed to promote cooperation between Recovery Audit Contractors (RACs) and the *Unified Program Integrity Contractor (UPIC)* by establishing and maintaining shared expectations for the interaction among these Parties to the JOA.

1.2. Parties

Parties to the JOA are identified in Appendix Z. Please see Section 2.5 below in this JOA for information regarding completion of this appendix.

1.3. Jurisdictions, Contacts, Roles, and Responsibilities

This information is provided in Appendices B and C. Section 2.2 below in this JOA describes the process for completion of these appendices. Please note that there are multiple tabs in these Microsoft (MS) Excel Workbook appendix files to facilitate use of this information.

1.4. Confidentiality

Given the nature of the work performed by the RAC and the *UPIC*, information contained within this JOA is to be shared only with members of the RAC, *UPIC*, and CMS teams.

1.5. Liability

Although both the RAC and *UPIC* each individually have a contractual relationship with CMS, there is no privity of contract between the RAC and the *UPIC*.

Each contractor will be indemnified and protected by limitations on liability according to the terms of its respective contract with CMS. In light of the provisions of each contractors current contracts with CMS and the constraints of law, no amendments to their respective contracts are made through this JOA with respect to indemnification or limitations on liability.

1.6. Funding

Nothing in this JOA will obligate any parties to perform any tasks that add significant cost and are outside current scope of work unless adequate funding for these tasks is received from CMS.

2. Document Maintenance

2.1. Standard Core JOA

The Standard Core JOA is established and maintained by CMS to apply standardized best practices for the interaction between the RAC and *UPIC* contractors. This Standard Core JOA is purposely designed so that it does not need to reflect contractor specific information, which is instead

contained in the JOA Appendix Documents. This JOA should not be modified from the standard without consulting with the TO COTRs.

2.2. JOA Appendices

List of Appendices – Appendix A lists all JOA appendices, identifies the name of the team responsible for collecting and incorporating updates, and briefly describes how each appendix is to be created and maintained.

Distributed Update Responsibilities – Appendix documents are separated to facilitate maintenance.

The Contact List, for example, is divided into separate files by team so that each team can make and distribute updates to their list without having to coordinate input from other teams. If a contractor holds multiple contracts with CMS and if this contractor wants a separate Contact List for each contract to facilitate updates by different teams, this is allowed. The multiple tabs within each Contact List Excel Workbook facilitate differentiation between multiple task orders on a single contract.

Use Across Multiple JOAs – The templates for these appendix documents, such as the Contact List templates, have been formatted so that they can be applied to multiple JOAs, eliminating the need to maintain similar/duplicate information across multiple JOAs.

Document Owner – The name of the individual person on each team who will update each appendix will be identified by that team at the top of each of their appendix documents. This facilitates identification of the person to whom updates should be sent.

Templates – CMS provides a standard template for each appendix which can be amended by each party if necessary to effectively convey the information for their team. To promote consistency, please apply the standard template to the greatest degree practical.

2.3. Required Roles

To promote proper direction of communication, each RAC and *UPIC* will identify, in its Contact List, a Primary and an Alternate for each of the following Required Roles:

- JOA POC – Joint Operating Agreement Point of Contact – This individual is responsible for serving as the lead contractor point of contact in establishing and maintaining the JOA content and in leading the resolution of any JOA-related issues that may arise.

- JOA Approver – One individual from the RAC and one individual from the *UPIC* will be identified to approve the JOA.

- Operational Lead – This individual is responsible for serving as the lead point of contact in performing ongoing operational work under the terms of the JOA. This standard title is used in the JOA because various teams use different titles for the individuals that they have serving in this role, and the JOA can not effectively incorporate all of those titles. Each party will identify their Operational Lead in their Contact List, and they are welcome to add in the Contact List any other appropriate titles for this individual as well.

2.4. Managing Change

Change Suggestions – Recommendations for updates to JOA documents are encouraged and are to be sent to the Document Owner.

Revision History – Each Document Owner is to identify changes to JOA documents in the Revision History Log.

Version Number – The version number is used to make sure that everyone is looking at the same version of a document. The Document Owner is to increment the JOA version number each time the JOA is sent out for approval. Multiple updates can be consolidated into the same version number. The version number is imbedded as the last characters (ex: V01) of each file name.

Process Note: In MS Excel, updates to the version number in the file name are automatically propagated to the top of each printed Excel document. In MS Word, select "File, Print Preview" when the version number in the file name is updated to cause the updated version number to be propagated from the file name to the top of the document.

2.5. Approval of Standard Core JOA

CMS Approval of All Versions of the JOA

- CMS will solicit input, make updates, distribute, and refine this Standard Core JOA as necessary. Through this cycle of change, CMS will have reviewed and approved all updates.

RAC and *UPIC* Approval of the First JOA

- CMS directs that all Parties to the JOA (the RAC and *UPIC*) are to sign (using hand written signature) the first jointly approved version of the JOA.

- To accomplish this, the JOA Approvers are to hand-write their signature on two copies of Appendix Z, the JOA Approval Form, which they are then to mail (one copy each) to the primary RAC JOA POC and *UPIC* TO COTR who are responsible for their retention and for providing a copy of these upon request.

- To facilitate communication of status, the JOA Approvers are also to send out an email to these individuals indicating that they have approved the JOA.

RAC and *UPIC* Approval of Ongoing Updates

- As CMS makes subsequent updates to the Standard Core JOA, CMS will advise contractors via Email if the new version is sufficiently changed to require approval. CMS will also update the last column of the Revision History table of the JOA to keep a record of which versions require approval.

- A hand written signature is not required for ongoing updates. Instead, an electronic signature (an electronic copy of the approver's signature) is to be used as the signature.

- To provide approval for ongoing updates, the JOA Approver is to fill out Appendix Z, paste in their electronic signature, and then send this completed document via email to the Primary and Alternate JOA POC for the RAC and *UPIC* TO COTR. The Primary JOA POCs and TO COTRs are responsible for retaining these emails and for providing a copy of these upon request.

No Approval Required on Appendix Updates – No approval is required on updates to the appendices.

Timing of Approvals – Parties are to provide approval within 10 business days of receipt of an updated Standard Core JOA. If parties have an issue with the JOA, they are to raise this issue within 10 business days. If no issues are identified before the end of this period, the JOA updates will be considered approved.

Distribution – Each JOA POC will disseminate information regarding the update within their organization.

3. Communication

Communication is a crucial component that will occur at multiple levels using multiple tools and techniques as described below.

3.1. JOA Checkpoint Meetings

Purpose – These meetings provide a forum for communication on topics of mutual interest among the Parties to the JOA. Topics will include a discussion of any issues with coordination among the parties the status of any changes to the JOA documents.

Location – These meetings will most often take place via conference call. In those instances where a RAC and a *UPIC* are located close enough to allow a short drive, some participants may join in-person.

Frequency – The meetings will occur at minimum on a quarterly basis for the first year after the signing of the first JOA and then at least semi-annually thereafter.

Meeting Dates – CMS representatives need to attend multiple of these meetings across contractors, so CMS will work with contractors to coordinate spreading of these meetings over time. At the conclusion of each meeting, the participants will determine mutually agreeable timing (and location where appropriate) for the next meeting; information that will then be confirmed via email. Changes will be communicated through the JOA POC via email.

Facilitation – Responsibility for facilitating the meeting will rotate between the RAC and the *UPIC*. This will include preparation of the agenda, providing a dial in number, facilitating the discussion, and capturing and distributing meeting minutes.

Meeting Minutes – Are to be distributed within five business days of the meeting and should clearly identify Action Items for review in the next meeting.

Participation – Invitees are to minimally include the applicable CMS COTRs and the Primary and Alternate JOA POC. The JOA POC will invite other participants as appropriate.

3.2. Other Workgroup Meetings

Purpose – In addition to the JOA Checkpoint meetings, the Parties to the JOA will interact on a regular basis in smaller workgroups to address specific needs.

Location, Timing, and Facilitation –Will be similar to the Checkpoint Meetings.

Formation – Recommendations for new workgroups should be considered at the JOA Checkpoint Meetings.

3.3. Issue Escalation and Resolution Process

Issues will be escalated if necessary for resolution via the following process:

1. Source – The RAC and the *UPIC* individuals identifying the issue will work with their counter-parts first to attempt to resolve the issue.

2. JOA POCs – If they are unable to come to a resolution, the matter will be brought to the attention of the RAC Contractor JOA POC and the *UPIC* JOA POC (identified in the Contractor Contact List Appendices).

3. Operational Leads – If they are unable to come to a resolution, the matter will be escalated to the RAC Operational Lead and the *UPIC* Operational Lead (identified in the Contractor Contact List Appendices).

4. CMS Contract Officer Technical Representatives (COTRs) – If they are unable to come to a resolution, the Operational Leads will bring the matter to the attention of the CMS COTRs (identified in the CMS Contact List Appendices).

5. JOA Alternative Dispute Resolution (ADR) Team – In the event the dispute between the RAC and the *UPIC* cannot be resolved, the issues will be directed in writing to the CMS RAC and *UPIC* Contracting Officers, Project Officers, and COTRs for resolution by the JOA ADR) team. The ADR team will issue a written determination to both the RAC and the *UPIC*.

Timing of Issue Escalation and Resolution – The speed with which issues are escalated and resolved will be dependent on the priority of the issue, with higher impact issues receiving quicker attention by all parties. As a general guideline, parties should endeavor to resolve or escalate an issue within 1-3 days of its receipt, or they should reply to all parties to advise them of the reasons for additional time needed for action.

3.4. Non-Compliance

If a party does not comply with a provision of the JOA, notification and resolution will take place as follows:

1. Notification – If a party does not comply with a provision of the JOA, the Operational Lead for that party will notify the Operational lead for the other party.

2. Resolution – A non-compliance is often one-time event with no significant impact which can often be quickly resolved and prevented in the future through the interaction of the Operational Leads. In these circumstances, escalation is not required.

3. Escalation – If a non-compliance creates an impact that either party feels requires escalation either for notification purposes or for issue resolution purposes, then the Operational Leads will notify the CMS COTRs. If necessary, the ADR process described above will be applied to achieve closure.

3.5. Communication Regarding CMS Changes

As part of ongoing operations, the RAC and the *UPIC* Contractor staff will both review documents received from CMS, including Transmittals, Program Memoranda, Change Requests and Notes. The RAC and the *UPIC* Contractor will continue to determine their own operational impact and will provide comments and escalate issues to CMS independently, as appropriate.

All issues that are determined to have an impact on any RAC or *UPIC* Contractor operations included in this JOA will be submitted to the RAC and *UPIC* JOA POCs for discussion at the next JOA Checkpoint Meeting, or sooner if appropriate.

3.6. Securing Email Information

CMS has indicated that it is not appropriate to send emails containing beneficiary or provider identifiers (including names and numbers) even if those identifiers are contained within a password-protected attachment. Each JOA Participant is responsible for obtaining, understanding, interpreting, and implementing its own policies and procedures regarding use of email containing beneficiary or provider identifiers. CMS Secure Email may be used to send protected information to CMS and other users of this email system. If Secure Email is not available, send this information via an encrypted CD through registered mail.

4. Identification and Action on Fraudulent Behavior

4.1. Identification and Notification of Fraud by the RAC

RAC Responsibility – When the RAC encounters an issue that meets the criteria of potential fraud, the RAC will notify the RAC PO who will forward this to the Director of the Division of Benefit Integrity Management Operations.

Indicators of Fraud – The following are indicators of fraud that must be reported to the RAC PO. The RAC should use their best judgment to determine if other findings may constitute fraudulent behavior. Section 6.2 of this Standard Core JOA provides information regarding training for the RAC staff to identify fraud.

- Submission of false claims
- Services being rendered by unlicensed individuals

- Ordered services being provided without a legitimate physician order
- Claims for beneficiaries or providers that are deceased
- Non-compliance with medical record requests

4.2. Coordination with Law Enforcement

The *UPIC* will interact with Law Enforcement related to potential fraudulent activity. The RAC must not contact Law Enforcement with fraud suspicions; they must contact the RAC PO. Law enforcement may contact the RAC with recovery inquiries but any other LE RFIs shall be referred by the RAC directly to the *UPIC*.

4.3. High Risk Areas

CMS may identify High Risk areas within a *UPIC* jurisdiction. These are areas that are known to have wide-spread fraud. The *UPICs* are required to take aggressive, rapid and innovative measures to curtail fraud in these areas and this may impact the RAC's ability to perform audits in these areas. The *UPIC* will have the ability, in High Risk Areas, to suppress providers in order to protect the *UPIC* and Law Enforcement's ability to identify, prevent and prosecute fraudulent activities.

5. Training

5.1. Training provided by the *UPIC*

Purpose – Fraud detection and awareness training will be provided to assist the RAC in identifying fraudulent behavior, including indicators that RAC staff should look for and examples of real fraud scenarios.

Audience – This training is designed for members of the RAC team.

Initial and Annual Training – The *UPIC* will provide this training at the start of working together as contractors and on at least an annual basis thereafter.

New Employee Training – The RAC will be responsible to provide this on-going training for new RAC employees throughout the year using the materials provided by the *UPIC*.

Participation Requirement – Training participation is required to at least one session per year to be provided by the *UPIC*. *UPICs* can rotate the responsibility for training and must avoid duplication across contracts.

Training on Changes – Additional training will be provided by the *UPIC* when substantive changes are identified in fraud detection and awareness.

Exhibit 44.1
(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)

Joint Operating Agreement

Between

XXX
In its capacity as the Supplemental Medical Review Contractor (SMRC)

And

XXX
In its capacity as the Unified Program Integrity Contractor XXX

Prepared by:
XXX

Revision History

Version	Date	Changed By	Description of Change	Signature Required

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1. Introduction

1.1-Purpose of the Supplemental Medical Review Contractor

The purpose of the SMRC is to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the Medical Review (MR) functions primarily for Medicare Fee-for-Service (FFS); other product line analysis is limited and may include Medicaid FFS, private and group health insurance lines of business and Prescription Drug Plan (Part D). One of the primary tasks will be conducting large volumes of nationwide MR as directed by the Centers for Medicare & Medicaid Services (CMS). The MR will be performed on Medicare FFS claims for Part A, Part B, and DMEPOS programs. These medical review activities will assess compliance with Medicare's coding, coverage, billing, and payment requirements and identify claims improperly paid. The SMRC will recommend recoupment and/or adjustment for claims identified as improperly paid. Having a centralized MR resource that can perform large volume of MR nationally shall allow for a timely and consistent execution of MR review, activities, and decisions. The SMRC shall select subject claims, perform research and/or data analysis, and conduct reviews in a manner that will minimize provider and supplier burden.

1.2-Purpose of the SMRC Joint Operating Agreement

The purpose of this no-cost Agreement is to set forth the terms and conditions pursuant to which the Parties will coordinate efforts to maintain consistency of the Medicare program in accordance with the provisions of their respective CMS contract ("CMS Contract"). The term of this Agreement shall commence on the Effective Date and continue until either Party's CMS Contract expires, or it is terminated by either Party upon thirty (30) days written notice to the other Party.

1.3-Scope

This Agreement is intended to serve as a framework for the collaborative measures the Parties will take to implement, maintain, and advance their mutually shared goal of preserving the integrity of the Medicare program; it is not intended to be a comprehensive description of the Parties' working relationship. This Agreement does not create any affirmative duties, rights or legal obligations between the Parties, nor does it give any person or entity their successors and permitted assigns, any right, remedy or claim in it. Each Party has a contractual relationship with CMS and each party shall be solely responsible to CMS for its performance under this JOA and the terms of this Agreement shall not alter or amend a Party's CMS Contract. If there are any conflicts between the terms of this Agreement and a Party's CMS Contract, the terms of the Party's CMS Contract shall take precedence. The terms of this Agreement shall be interpreted so as to resolve any conflict between it and a Party's CMS Contract, and, if necessary, this Agreement shall be amended to reconcile any unresolved conflict with a Party's CMS Contract.

1.4-Joint Operating Agreement Participants and Roles

The term "JOA Participants" refers to the SMRC, CMS, and Unified Program Integrity Contractor (UPIC).

1.4.1-Supplemental Medical Review Contractor's Role

The SMRC will perform research and analysis, MR, statistical sampling, and extrapolation. The SMRC will specifically include the following activities:

- Perform Medicare Part A and Part B (including DME) post payment MR in accordance with CMS instructions including expedited reviews. The list of providers will be sent via secure email provided in Section 4.3;
- For post payment medical review, develop and send a letter for the solicitation of medical records and supporting documentation needed to support the claims, when necessary;
- Perform claim re-reviews for claims reviewed initially by the SMRC;
- Perform statistical sampling and extrapolation to assess overpayment or potential overpayment(s) made on claims;
- Access the Recovery Auditor Data Warehouse (RDW) prior to selecting claims for review to ensure they are not excluded or suppressed;
- Upload all claim samples identified into the RDW;
- Review all services in accordance with the applicable statutes, CMS guidelines, and coverage requirements;
- Recommend claim denial for any claim when a provider fails to send medical records or supporting documentation;
- Maintain a tracking system to reflect and identify MR activities for all claims;
- Ensure coordination of efforts and prevent duplication of activities or interference with an existing investigation or corrective action plan;
- Ensure each MR is conducted by a Registered Nurse (RN);
- Ensure each coding review is conducted by a Certified Professional Coder (CPC) or Certified Coding Specialist (CCS) with an active certification;
- Ensure records are maintained confidentially in accordance with the Statement of Work (SOW) and applicable regulations;
- Participate in Administrative Law Judge (ALJ) hearings as a participant or party, as appropriate, to defend positions or provide testimony;
- Provide education on eligible claims to providers as requested for those claims reviewed by SMRC; and
- Participate in discussion periods with providers as requested for those claims reviewed by SMRC that are eligible for Discussion & Education (D&E).

The SMRC does not have responsibility for:

- Claims processing and adjudication activities;
- Performing redeterminations related to appealed initial determinations conducted by the SMRC; and
- Cost report audit activities.

1.4.2-Unified Program Integrity Contractor's Role

The UPICs role and responsibilities include:

- Fraud, waste and abuse investigations and program integrity related data analysis; and
- Pre and post payment claim review for program integrity purposes.

1.4.3-Centers for Medicare & Medicaid Services' Role

CMS' Contracting Officers' Representative (COR), Contract Specialist, and Contracting Officer have overall responsibility for the SMRC. The Contract Specialist and Contracting Officer, Office of Acquisitions and Grants Management (OAGM), in coordination with the COR, are the only persons authorized to:

- Enter into and commit or bind the government by contract for supplies and services;
- Accept nonconforming work or waive any requirement of the contracts;
- Authorize reimbursement to the contractor for any costs incurred during the performance of the contract; and
- Modify any term or condition of the contract (that is, make any changes in the SOW, modify or extend the period of performance, change the delivery schedule).

1.5-Liability

Each Party is indemnified and protected by limitations on liability according to the terms of its respective contract with CMS.

Except with respect to a breach of the confidentiality provision set forth in section 1.6 below, titled "Mutual Confidentiality", this JOA shall not be construed to give rise to any binding obligation, rights, duty or liability, of any kind whatsoever, of any Party to this JOA to any other party.

1.6-Mutual Confidentiality

The parties understand, acknowledge and agree that each party's inventions, discoveries, proprietary information and trade secrets are of critical importance to its ongoing operations and prospects. During the course of performing services for CMS according to their respective contracts, described above, the parties will likely have access to information that is confidential and proprietary to the other party. In addition, each party may create inventions, make discoveries, write software or code, develop file layouts, methodologies or processes, and create applications during the course of the parties' relationship.

Examples of proprietary information and trade secrets include, but are not limited to, discoveries, improvements, processes, developments, designs, know-how, data, file layouts, documentation, computer programs (including but not limited to all source code for those programs) and formulae.

Each Party agrees to hold the other party's Confidential Information to at least the same level of protection against unauthorized disclosure or use as the receiving party normally uses to protect its own information of a similar character, but in no event less than reasonable care.

Neither party shall disclose to any person in any manner, either before, during or after the term of this JOA, proprietary or trade secret information (as hereafter defined) except to the extent necessary for the performance of each party's duties under this JOA, or as required by CMS pursuant to each party's contract with CMS, as applicable. Each party shall not use proprietary/trade secret information of the other for any other purpose whatsoever. Each party agrees to cooperate with the other party, and to use its best efforts, to prevent the unauthorized disclosure, use or reproduction of any proprietary/trade secret information of the other.

Nothing in this Agreement shall prohibit or limit a party's use of information (including, but not limited to, ideas, concepts, know-how, techniques, and methodologies) (i) previously known to that party, prior to its receipt from the disclosing party, (ii) independently developed without use of the Confidential Information, (iii) acquired by it from a third party which was not, to the recipient's knowledge, under an obligation to the disclosing party not to disclose such information, or (iv) which is or becomes publicly available through no breach of this Agreement by the receiving party.

The obligation to protect Confidential Information shall survive the expiration or termination of this JOA.

1.7-Independent Contractors

The parties each recognize and agree that they are independent contractors. There is no privity of contract between these Parties. Nothing contained in this Agreement shall be construed to make any party an agent, servant, partner, employee of or joint venture of or with any other party. No party has the right or authority to interfere with or in any manner influence, direct or control the decision-making process, evaluations, judgments or reviews of any other. No party shall have any right or authority, whether express or implied, to assume or create any obligation, duty, or responsibility whatsoever on behalf of any other party.

1.8-Privacy

The parties agree that issues pertaining to the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule) published in April 2003 are covered by the two organizations' independent contracts with CMS.

When future privacy regulations are published, the two organizations will review that information and address any impact to joint processes in subsequent versions of the JOA. The parties agree that issues pertaining to the confidentiality, privacy, and security of Medicare data are covered by the two independent contracts with CMS.

1.9 Funding

Nothing in this JOA will obligate either party to perform any tasks that are outside the current scope of work, unless CMS directs such tasks and provides adequate funding.

2. Communication

2.1-Contact Information

Contact information for all parties is provided in Appendix A, Master Contact List.

2.2-Point of Contact Roles

To ensure that communication is properly directed, CMS, the UPIC and the SMRC will identify (in Appendix A, Master Contact List) representative(s) to serve as:

- **JOA Point of Contact (POC)**: Each party will designate a representative responsible for serving as the lead company/agency POC in establishing and maintaining the JOA content, and in leading resolution of any JOA-related issues that may arise. Additional information regarding maintenance of the JOA is included in Section 2.5, Maintenance of the JOA.
- **JOA Signatory**: Each party will designate a representative who is responsible for providing final approval and signature for updates to the JOA.
- **Information Technology (IT) POC**: Each party will designate a representative to act as a focal point for the exchange of information relevant to systems configuration, operation, and communications.

2.3-Joint Operating Agreement Meetings

The SMRC and UPIC will assess for and discuss any JOA updates during the monthly workgroup meetings. The SMRC and UPIC JOA meetings will provide a forum for communication among the SMRC and UPIC JOA participants. The SMRC COR and the UPIC COR are to be notified of all SMRC and UPIC JOA conference calls since they are optional participants.

2.4-Workgroup Meetings

Workgroups will be formed based on input from JOA Participants to provide focused attention on key topics. Changes in participants in the workgroups will not necessitate a change in the JOA. These workgroup meetings will take place by conference calls.

SMRC and UPIC Coordination Workgroup: On an ongoing basis, this workgroup will meet at least monthly on the same date/time each month to facilitate coordination of activities related, but not limited to, workload, re-reviews, discussion and education sessions, overpayments and appeals. In addition to this workgroup, representatives may interact, as needed, in smaller workgroups to focus on specific areas, such as overpayments and appeals.

Additional Meetings: The SMRC and UPIC JOA POC will schedule additional conference calls as requested by the JOA Participants.

Agenda: The SMRC JOA POC will distribute the Agenda to all members by e-mail in advance of the next meeting. The SMRC JOA POC will solicit Agenda items from SMRC and UPIC JOA participants approximately one week prior to the meeting. The meetings may include (along with other agenda items) high-level data analysis findings, statistical reports, recommendations, review activities, and action items.

Participation: Workgroup participation will include representation from CMS, the UPIC, and SMRC. At minimum, JOA Participants will include the UPIC Operations, UPIC JOA POC, SMRC Program Manager (PM), SMRC JOA POC, CMS SMRC COR/ACOR/BFL, and CMS UPIC COR/ACOR/BFLs and others as applicable.

JOA Improvements: Continuous improvement of the JOA will be an agenda item for discussion at each meeting. Additional information regarding initiating and controlling changes to the JOA is described in Section 2.5, Maintenance of the JOA.

Minutes: SMRC will take Minutes during each workgroup meeting and distribute them by

e-mail to all participants within ten business days of the meeting. SMRC will also track all action items in the minutes and report on them at each workgroup meeting.

2.5-Maintenance of the JOA

JOA POCs are invited to initiate continuous improvements to the JOA. Any such suggestions will be discussed at the next regularly scheduled JOA meeting or through special sessions as necessary.

Change Suggestions: All suggestions are to be sent to the SMRC JOA POC. Within seven business days, the SMRC JOA POC will distribute a draft to CMS and the UPIC JOA POCs. Feedback is to be provided within seven business days. The SMRC JOA POC will then distribute a final draft to CMS and the UPIC JOA POC. If no issues are identified within seven business days, the updates will be considered accepted. The SMRC JOA POC will disseminate information regarding the updates to CMS and the UPIC JOA POC annual reviews, 14 business days will be allowed to review changes and make updates for the annual JOA reviews.

Tracking Changes: Changes to the JOA are identified in the Change History Log on the second page of this document and are controlled by a version number in the upper right corner of each page of the document. Changes to the appendices to this document are also controlled by a version number in the lower left corner of each appendix.

Signature of JOA: For those changes to the body of the JOA that are determined by the SMRC CMS COR and BFLs to be significant (as identified in the Change History Log on the second page of this document), new approvals will be collected. Approvals are not necessary for changes to the appendices (such as the Appendix A, Master Contact List). Approval of the first JOA will adhere to the following procedure: All parties to the JOA are to sign the first jointly approved version of the JOA and subsequent changes using Appendix B, Joint Operating Agreement Approval Signature Form. Such signed documents will be distributed to the relevant POCs for the parties identified in Appendix A, Master Contact List.

2.6-Dispute Resolution Process

Disputes/issues will be escalated, if necessary, for resolution by the following process:

1. The SMRC and the UPIC counterparts will first attempt to resolve the issue.
2. If the SMRC and the UPIC counterparts are unable to come to a resolution, the matter will be brought to the attention of the SMRC JOA POC and the UPIC JOA POC (as identified in Appendix A, Master Contact List).
3. If the SMRC JOA POC and the UPIC JOA POC are unable to come to a resolution, the matter will be escalated to the SMRC PM and the UPIC Project Manager (as identified in Appendix A, Master Contact List).
4. If the SMRC PM and the UPIC Project Manager are unable to come to a resolution, the SMRC PM will bring this matter to the attention of the SMRC CMS COR and the UPIC Project Manager will bring this matter to the attention of the UPIC CMS COR (as identified in Appendix A, Master Contact List).
5. If the dispute between the SMRC and the UPIC cannot be resolved, the issues will be directed, in writing, to the CMS CORs and BFLs for resolution by a JOA Alternative Dispute Resolution Team.

2.7-Mailing Information

All information mailed between the UPIC and SMRC will be sent by delivery service (FedEx®, United Parcel Service of America [UPS®], or DHL Worldwide Express [DHL®]) and shipped to the addresses specified below:

UPIC Company Name
Attn: Department
Mailing Address
City, State Zip Code

The sender will e-mail the intended recipient a confirmation e-mail containing an inventory of the shipment contents, encryption information (if applicable), and tracking number of the package. The recipient will confirm receipt of the package upon arrival. Refer to Section 3.2, Systems, regarding security.

3. Systems

3.1-Data Files

The CMS has directed the SMRC to perform data analysis activities to support MR and overpayment extrapolation. These activities will require the SMRC to obtain data from various resources, including, but not limited to, CMS' One Program Integrity (One PI) Shared Systems database, CMS' National Claims History (NCH) database, and RDW. If data is needed from the UPICs, this will be discussed during the workgroup meeting.

3.2-Security

Each party agrees to adhere to the security requirements in the Business Partner System Security Manual (BPSSM). Both parties agree to work together on all aspects of security in the BPSSM, or as otherwise issued via Technical Direction Letter or other means by CMS, that require the joint cooperation of both parties. Mail and email exchanges containing Personally Identifiable Information (PII) will follow the requirements as outlined by the most current version of the ARS which states the PII must be secured in an attachment that has been zipped using FIPS 140-2 validated software (i.e. SecureZip). Each party further agrees to adhere to CMS JSM/TDL-09323 and CMS JSM/TDL-11141: Guidelines for Implementing the Centers for Medicare & Medicaid Services' (CMS) Revised Information Security Incident Handling and Breach Analysis/Notification Procedures.

4. Processes

4.1-Misdirected Communications

Misdirected communications may include written, e-mail, or facsimile inquiries received from providers. Unless otherwise addressed in this JOA, any misdirected communications will be forwarded to the appropriate party (SMRC or UPIC) following the process outlined in Section 2.7 Mailing Information.

4.2-Collaboration

The SMRC will send the UPIC file of providers/suppliers on review via email at xxxx@xxxxxx.xx

4.3-Ad Hoc Reports

Ad hoc reports may be requested by either the UPIC or SMRC via the Ad Hoc Request Form (Appendix C xxx). The completed form must be faxed or emailed to the appropriate JOA POC. All requests will be evaluated by the receiving contractor for approval based upon feasibility and cost of implementation. The receiving contractor may directly contact the requesting individual to clarify data requests as needed. The SMRC and UPIC JOA POCs or authorized individual will coordinate with the requestor when these reports are available.

4.4-Fraud Referral

The SMRC will document their findings in a standard format, and, when appropriate, refer the case to the Center for Program Integrity (CPI)/Unified Program Integrity Contractor (UPIC) for development through the current process in place with CMS. The SMRC will remain accessible to the referral agency to facilitate their investigation, and to prepare potential cases for litigation or prosecution. SMRC referrals to UPIC xx of potential fraudulent activities should be sent to the UPIC xx at: UPICxxLead@admedcorp.com

4.5-Process Improvement

Where appropriate and feasible, the parties will provide recommendations on process refinements. Such changes will be presented and approved through the process described in Section 2.5 regarding changes to the JOA.

Appendix A. Master Contact List

Table A-1. Supplemental Medical Review Contractor

POC Role	Representative	Contact Number	E-mail
JOA POC			
Project Manager			
MR Director			
Information Security Manager			
MR Manager			
Operations Manager			
Liaison, Hearing & Appeals Coordinator			

Table A-2. Unified Program Integrity Contractor xx

POC Role	Representative	Contact Number	E-mail
UPIC JOA POC			
UPIC Operations POC			
UPIC Appeals Manager			
UPIC Appeals Manager			
UPIC Overpayment team leader—Audit			
UPIC Overpayment team Leader—Recoupment			
UPIC POE Manager			
JOA Signatory			
JOA Signatory			

Table A-3. Centers for Medicare & Medicaid Services

SMRC COR			
SMRC ACOR/BFL			
Contracting Officer			
Contracting Specialist			

Appendix B. JOA Approval Signature Form

Company/Entity Name:
Signatory Name (Printed):
Signatory Signature: _____

Date: ____/____/____

Company/Entity Name:
Signatory Name (Printed):
Signatory Signature: _____
Date: ____/____/____

Company/Entity Name:
Signatory Name (Printed):
Signatory Signature: _____
Date: ____/____/____

Exhibit 45 – ***UPIC*** **Prepayment and Postpayment Notification Letter**
(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

DATE:
PROVIDER NAME:
PROVIDER ADDRESS:
PROVIER NUMBER:

UPIC NAME/*JURISDICTION*:
UPIC CONTACT/PHONE NUMBER:
UPIC ADDRESS:

Dear Provider Name:

As a Medicare contractor, the *Unified Program Integrity Contractor (UPIC)* is required by the Centers for Medicare & Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment. Specifically, as a (indicate *UPIC*), (write *UPIC* Name) is required to investigate situations of potential fraud, waste, and abuse.

Your claims have been selected for a comprehensive medical review of your billing for Medicare services pursuant to CMS' statutory and regulatory authority. You were selected for this review because our analysis of your billing data indicates that there may be aberrancies in your billing.

We have selected claims for services provided during the period_____through_____. You will subsequently receive a request for medical records, which will explain the specific documentation that is being requested. If you have any questions regarding the letter requesting medical records/documentation, please contact (*UPIC* Contact's Name) at (Phone Number of *UPIC* Contact).

Thank you for your prompt response to the request for medical records/documentation.

Exhibit 46.1 - MAC Unified Postpayment ADR Sample Letter

(Rev.557, Issued: 11-26-14, Effective: 12-29-14, Implementation: 12-29-14)

Date:

Reference ID:
Attention:
Address:

NPI:
PTAN:
Phone:
Fax:

Request Type & Purpose: Notification of Post-payment Probe Review and Request for Medical Records
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims1. As part of our effort to accomplish this goal, the Medicare Administrative Contractor (MAC) program will conduct a post-payment medical review of selected Medicare Part A claims.

Reason for Selection
As an A/B MAC, 'Review Contractor Name' is tasked with preventing inappropriate Medicare payments. This is accomplished through provider education, training, and the medical review of claims. 'Review Contractor Name' recently completed review of a sample of service-specific claims for HIPPS code XXXXX (1st or 2nd episode with 11 to 13 therapy visits). The calculated charge denial rate (CDR) for these claims was 100%. Refer to the enclosed Encrypted CD for the complete list of claims and denial reasons.

Action: Additional Documentation

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the MAC program. Providing medical records of Medicare patients to the MAC program does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request.
Case ID: 1212121

Patient Name	Date of Birth	HIC Number	Date of Service	Rendering Provider / Supplier	Claim ID	Procedure Code

When: mm/dd/yyyy
Please provide the requested documentation by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the requested information.

When the review is completed, you will be notified of the results. The CMS' goal is to complete the review and deliver the results to providers/suppliers within 60 days of the receipt of all medical records needed for the review.

---

1 Social Security Act Sections 1833(e), 1815(a), and 1842(p)(4)

Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by mm/dd/yyyy, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions

The documentation submitted for this review must be a copy of the patient's medical record for each encounter clearly identified for each requested beneficiary and the date of service. Providers/suppliers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.).

- Refer to the 'Supporting Documentation' attachment for a list of required supporting documentation to be submitted.
- Providers/suppliers must pay the cost of providing this documentation; it cannot be billed to CMS or the MAC program.
- The CMS encourages providers/suppliers to respond quickly.
- Please do not include Powers of Attorney, Living Wills, or Correspondence.
- During this review period and at all times, in order to receive payment, providers/suppliers must continue to submit claims for all services performed on a beneficiary.

Submission Methods
Providers/Suppliers may submit this documentation in any of the following ways:

Via postal mail or Encrypted CD/DVD:

1. Include a copy of the Post Pay request letter with your documents.
2. Complete the ADR Response Cover Sheet Form (enclosed) and place on top of the entire set of documents to be submitted.
    a. An image of the coversheet may be included with the CD/DVD or may be scanned as the first image seen within your CD/DVD.
3. When submitting responses for multiple claims, please make a copy of the enclosed Part A Post Pay ADR Response Separator Sheet and insert between the responses for each Document Control Number (DCN).
4. If the CD/DVD is password protected, send an email to John.Doe@Company.com and Jane.Doe@Company.com and include the package tracking number and password.
5. Mail to the following:

Regular Mail:		Overnight Mail:
Company Name		Company Name
Medical Review		Medical Review
Mail Code XXXX	OR	Mail Code XXXX
Post Office Box XXXXX		Street Address
City, State Zip Code		City, State Zip Code

Via fax to:

1. XXX-XXX-XXXX
2. Include a copy of the ADR letter with your documents.
3. Complete the ADR Response Cover Sheet Form (enclosed) and place on top of the entire set of documents to be faxed.

4. When submitting Post Pay ADR responses with multiple claims, make a copy of the enclosed Post Pay ADR Response Separator Sheet and insert between the responses for each Document Control Number (DCN).

Via Electronic Submission of Medical Documentation (esMD):

1. Include a copy of the Post Pay request letter with your documents.
2. Complete the ADR Response Cover Sheet Form (enclosed) and place on top of the entire set of documents to be sent.
3. When submitting Post Pay ADR responses with multiple claims, make a copy of the enclosed Post Pay ADR Response Separator Sheet and insert between the responses for each Document Control Number (DCN).
4. Convert all documents, including your cover sheets, to PDF.
5. Submit your documentation to your CONNECT-compatible gateway or HIH.
6. More information on esMD can be found at www.cms.gov/esMD

Questions

If you have any questions please contact XXXXXXXX at XXX-XXX-XXXX or via postal mail at the following:

Company Name
Street Address
City, State Zip Code

Sincerely,

A/B MAC Jurisdiction X Medical Review

Attachments / Supplementary Information

1. Encrypted CD with a listing of claims requiring medical documentation
2. Supporting Documentation Required List
3. ADR Response Cover Sheet Form
4. Separator Sheet Form

Exhibit 46.2 - DME MAC Unified Post-Payment ADR Sample Letter

(Rev. 884, Issued: 05-31-19, Effective Date: 08-30-19, Implementation Date: 08-30-19)

Letter Date:
Provider/Supplier Name
Provider/Supplier
Address City, State Zip

Case ID #:
NPI /Provider #:
PTAN:

Request Type & Purpose: New Request, Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims[1]. As part of our effort to accomplish this goal, the Medicare Administrative Contractor (MAC) program will conduct a post-payment medical review of selected Medicare DME claims.

Reason for Selection

In the xx quarter 20XX, "Supplier's Name" HCPCS code XXXXX claim volume was two or more standard deviations above the norm when compared to all suppliers billing HCPCS code XXXXX in Jurisdiction X. This high claim volume billed by a new supplier for a high dollar item is of concern to the DME MAC.

When services appear outside the norm, the DME MAC must verify whether the potential error(s) represent an unacceptable practice. The DME MAC is validating this concern by performing a post-payment review on ## randomly selected claims billed by "Supplier's Name".

ACTION: MEDICAL RECORDS REQUIRED

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. The Centers for Medicare & Medicaid Services DME MAC program has randomly selected one or more of your Medicare claims for review, and providers/suppliers are required to send supporting medical records when requested. Providing medical records of Medicare patients to the MAC program does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. Please refer to the Instructions Section below for a list of supporting documentation required.

---

[1]Social Security Act Sections 1833 [42 USC 1320c-5 (a) (3)]

Case ID: XXXXXXX

Patient Name	MBI	Date of Service	Claim ID	Procedure Code

When: MM/DD/YYYY

Please provide the requested documentation by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the requested information.

Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by mm/dd/yyyy, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions

- Submit supporting documentation from third parties (hospitals, nursing homes, suppliers etc.). Providers/suppliers are responsible for obtaining and providing the following documentation:
  - o Physician's notes within 30 days of initial date: mm/dd/yyyy
  - o Diagnostic Tests
- Submit the bar coded cover sheet with your submission (optional)
- Providers/suppliers must pay the cost of providing this documentation; it cannot be billed to CMS.

Submission Methods

Providers/suppliers may submit this documentation in any of the following ways:

- Via postal mail to:
  Company Name
  Company Address
  City, State Zip Code

- Via fax to: XXX-XXX-XXXX

- Via Electronic Submission of Medical Documentation (esMD):
  - More information on esMD can be found at www.cms.gov/esMD
  - When sending records via esMD, please include a CASE ID number in your file transmission

- Via Encrypted CD: See attachment for detailed instructions.

Questions

If you have any questions, please contact:

Contact Name
Department
Company Name
Contact Address
City, State Zip
Code
Office: XXX-XXX-XXXX
Toll Free: XXX-XXX-
XXXX Fax: XXX-XXX-
XXXX
Company Email
Address
Company Website

Sincerely,
DME MAC Jurisdiction X Medical Review

Attachments / Supplementary Information

1. Important Notices
2. Cover Sheet
3. Change of address information
4. Appeals process
5. Comparative Data
6. Encrypted CD Submission Process

Exhibit 46.3 – Recovery Audit Contractor (RAC) Unified Postpayment ADR Sample Letter

(Rev. 884, Issued: 05-31-19, Effective Date: 08-30-19, Implementation Date: 08-30-19)

Recovery Auditor logo

Region X
RAC

Date:

Reference ID:
Attention:
Address:

NPI:
PTAN:
Phone:
Fax:

Request Type & Purpose: Additional Documentation Required and Request for Medical Records

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce the improper payment of Medicare claims[8] The Recovery Audit Program, mandated by Congress has been developed to assist in accomplishing this goal.

Reason for Selection:

Your RAC, (insert name of RAC), is requesting additional documentation for the selected list of claims as part of a post-payment complex review approved by CMS. Providers/suppliers will receive a Review Results Letter after a claim determination has been made. If an improper payment (underpayment or overpayment) is identified, these claims will be sent to your Medicare Administrative Contractor (MAC) for adjustment.

Please refer to the enclosed Claims Selected for Review Spreadsheet for a list of selected claims.

Action: Additional Documentation

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to (insert RAC name). Providing medical records of Medicare

patients to (insert RAC name) does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request.

When: mm/dd/yyyy

Please provide the requested documentation by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the requested information.

When the review is complete, you will be notified of the results. (Insert RAC name)'s goal is to complete the review and deliver the results to providers/suppliers within 30 days of receipt of all medical records needed for the review.

Consequences

If the provider/supplier fails to send the requested documentation to (insert RAC's name) by mm/dd/yyyy, the provider's/supplier's MAC will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions

1. The documentation submitted for this review must be a copy. Do not submit original documentation.
2. A copy of this additional documentation request letter should be affixed to the documentation. Please bundle documents for each claim separately to enable us to ensure receipt of all requested documents.
3. Providers/suppliers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.).
4. Refer to the 'Supporting Documentation' attachment for a list of required supporting documentation to be submitted.
5. The RAC is required to reimburse providers for the submission of medical records for the following claim types: Acute Care Inpatient Prospective Payment System Hospital Claims, Long Term Care Hospital Claims, non-PPS institution, and practitioners.
6. If you meet the Medicare definition of one of these provider types, you will be reimbursed for the cost of providing copies of the additional documentation. Payment will be issued to you within 45 days of receiving the additional documentation.
7. For PPS Providers, payment will be in the amount of $0.12 per page, plus the cost of First Class postage, if mailed via USPS. For non-PPS Providers and practitioners, payment will be in the amount of $0.15 per page, plus the cost of First Class postage, if mailed via USPS. The amount per page, for the respective providers, will not exceed this quantity, and the maximum payment per medical record, submitted via mail, fax, CD/DVD shall not exceed $25.00. For medical records submitted electronically (via esMD), the "per page" amount will be the same as those previously noted. However, the maximum payment per medical record shall not exceed $27.00, including a $2.00 transaction fee.
8. Please do not include Powers of Attorney, Living Wills, Correspondence, or Prior Episodes of Care.
9. Requirements for submitting imaged documentation on CD or DVD can be found at

(insert RAC web address) or by calling the RAC's Call Center at XXX-XXX-XXXX.

Submission Methods

Providers/suppliers may submit this documentation in any of the following ways:

Via postal mail or Encrypted CD/DVD:

1. Include a copy of the ADR letter with your documents.
2. Mail to the following:

Regular Mail:

Company Name
Medical Review
Mail Code OR
Post Office Box
City, State Zip
Overnight Mail:

Company Name
Medical Review
Mail Code
Address
City, State Zip

Via fax to:

1. XXX-XXX-XXXX
2. Include a copy of the ADR letter with your documents.

Via Electronic Submission of Medical Documentation (esMD):

1. Include a copy of the ADR letter with your documents.
2. Submit your documentation to your CONNECT-compatible gateway or HIH.
3. More information on esMD can be found at www.cms.gov/esMD

Questions

If you have any questions please contact:

Recovery ~~Auditor~~ Audit Contractor Customer Service General Inquiry
XXX-XXX-XXXX
Address
City, State Zip

Sincerely, RAC Region X

Attachments / Supplementary Information

1. Claims Selected for Review Spreadsheet

Exhibit 46.4 – CERT Unified Post-payment ADR Sample Letter

(Rev. 884, Issued: 05-31-19, Effective Date: 08-30-19, Implementation Date: 08-30-19)

Provider Name
Address 1
Address 2
City ST 00000

Date:
Reference ID: CID#
NPI/ Provider #:
Phone:
Fax:

Request Type & Purpose: New Request, Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records[1]. The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

[1]Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986

When: mm/dd/yyyy

Please provide the requested documentation by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the requested information.

Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by mm/dd/yyyy, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Instructions

Specific information and instructions pertaining to the sampled claim and returning requested documents are shown on the following pages of this letter.
Please include the bar coded cover sheet with your submission.

Submission Methods

You may submit this documentation in any of the following ways:

- Via postal mail to:
  CERT Documentation Center
  1510 East Parham Road
  Henrico, VA 23228

- Via Fax to: 804-261-8100 or 443-663-2698
  1. Use the barcoded cover sheet as the only coversheet.
  2. Do not add your own cover sheet—this slows down the receipt and identification process
  3. Send a separate fax transmission for each individual claim.

- Via Electronic Submission of Medical Documentation (esMD):
  1. Include a CID# or Claim number and the barcoded cover sheet in your file transmission.
  2. Information on esMD can be found at www.cms.gov/esMD.

- Via CD:
  1. The images should be encrypted per HIPAA security rules.
  2. If encrypted, the password and CID# must be provided via email to CERTMail@admedcorp.com or via fax to 804-264-9764.
  3. Must contain only images in TIFF or PDF format

- Via Email Attachment:
  1. The email attachment(s) should be encrypted per HIPAA security rules.
  2. If encrypted, the password and CID# must be provided via phone to 888-779-7477 or via fax to 804-264-9764.
  3. Must contain only attachments in TIFF or PDF format.

Questions

If you have any questions, please contact:

CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

Office: 443-663-2699 or Toll Free: 888-779-7477
Fax: 804-261-8100

Sincerely,
Contact Name
Director, Payment Accuracy & Reporting Group
Office of Financial Management
Centers for Medicare & Medicaid Services

Attachments / Supplementary Information

1. Claim Information
2. Bar Coded Cover Sheet

Exhibit 46.5 – SMRC Unified Postpayment ADR Sample Letter

(Rev. 884, Issued: 05-31-19, Effective Date: 08-30-19, Implementation Date: 08-30-19)

SMRC

LOGO

Letter Date:

Provider/Supplier Name
Provider/Supplier Address City,
State Zip

Project ID Number:
NPI/PROVIDER #:
PTAN:

Request Type & Purpose: Notification of Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims.[10] As part of our effort to accomplish this goal, CMS has retained "Contractor Name" as the Supplemental Medical Review Contractor (SMRC) to conduct a medical record review of selected Part A and Part B claims. Additional information regarding this contract can be found at: 'website URL'.

Reason for Selection

Reason for Project for XXXX code(s):

- Service on Review - Short Description

This constitutes new and material evidence that establishes good cause for reopening the claim. Providing additional documentation for each claim is authorized by CMS and is being requested.

Action: Medical Records Required

Federal law[10] requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request.

When: mm/dd/yyyy

Please provide the requested documentation by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the requested information. Please note, you may

request an extension to submit the requested documentation, if your request is made by mm/dd/yyyy.

---

[10] Social Security Act Sections [42 USC 1320c-5(a) (3)], 1833 [42 USC 13951 (e)], and 42 CFR 405.980(b)

When the review is completed, you will receive a review results letter after a determination has been made. The results letter will stipulate if any underpayment(s) or overpayment(s) were identified.

Consequences

If you or your facility fail to send the requested documentation or request an extension by mm/dd/yyyy, the “Contractor Name” will initiate claims adjustments or overpayment recoupment actions with your Medicare Administrative Contractor for these undocumented services.

Instructions

- This agency does not reimburse providers/suppliers for the cost associated with copying of medical records from any setting. When records are requested, the expense of supplying medical records is a part of the administrative costs of doing business with Medicare. Therefore, invoices from record retention centers and copying agencies are not eligible for reimbursement.
- Refer to the ADR Claim List for selected claims.
- A copy of this request letter should be affixed to the documentation submitted.
- All documentation should be submitted within 45 days of the date of this notice.
- Please refer to the Submission Methods section below for additional information on document preparation and available submission methods.
- Refer to the enclosed SMRC Response Cover Sheet Form(s) for documentation requirements.

- Note:

  - Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a legible handwritten or electronic signature.
  - Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service(s) should be clearly identified on the submitted documentation. Documentation submitted in response to this request shall comply with these requirements.
  - This may require providers/suppliers to contact the hospital or other facility where services were provided to obtain signed progress notes, plan of care, discharge summary, etc.
  - If signature requirements are not met, the reviewer will conduct the medical review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that medical necessity for the service(s) billed has not been substantiated.
  - “Contractor name” recommends that providers review their documentation prior to submission and ensure that all medical record entries and orders are signed appropriately. For documentation with a missing, illegible or electronic signature, a signature log or signature attestation may be submitted additionally as part of the ADR response. For detailed guidance regarding Medicare signature requirements, refer to the Medicare Program Integrity Manual, Publication 100-08, Chapter 3 and Section 3.3.2.4.

Submission Methods

Providers/suppliers may submit the documentation in any of the following ways:

- Include a copy of the Post Pay request letter with your documents.
- Complete the SMRC Response Cover Sheet Form (enclosed) for each claim number requested and place on top of each set of documents to be submitted.
- When submitting Post Pay ADR responses with multiple claims, make a copy of the enclosed SMRC Response Cover Sheet Forms and send each set of documents separately for each claim number.

- Via fax to: XXX-XXX-XXXX
- Via Electronic Submission of Medical Documentation (esMD):
  - Convert all documents, including your cover sheets, to PDF.
  - Submit your documentation to your CONNECT-compatible gateway or HIH.
  - More information on esMD can be found at www.cms.gov/esMD
- Via postal mail or Encrypted CD/DVD
  - Image(s)s must be submitted in PDF or multi-page TIF format.
  - If the CD/DVD is password protected, send an email to "Email Address". Include the Project Number from this letter, the package tracking number and password.

Contractor Name and Mailing Address:

Questions

Thank you for your participation with this review. If you have any questions, please contact:

Office: XXX-XXX-XXXX

Sincerely,
Supplemental Medical Review Contractor ~~Program Manager~~

Attachments / Supplementary Information

1. SMRC Point of Contact Information
2. SMRC ADR Claim List
3. SMRC Response Cover Sheet Form(s)

Exhibit 47 – Program Integrity Unit Contacts within the State Medicaid Agency

State	POC	Phone	POC E-mail Address
Alabama	Jacqueline Thomas	(334) 242-5318	jacqueline.thomas@medicaid.alabama.gov
Alaska	Doug Jones	(907) 269-0361	doug.jones@alaska.gov
American Samoa	Sandra King Young	(684) 633-4818	sandrakingyoung@gmail.com
Arizona	Sharon Ormsby	(602) 417-4535	Sharon.Ormsby@azahcccs.gov
Arkansas	Elizabeth Thomas Smith	(501) 683-6404	Elizabeth.Smith@governor.arkansas.gov
California	Bruce Lim	(916) 440-7552	bruce.lim@dhcs.ca.gov
Colorado	Katherine Quinby	(303) 866-4940	katherine.quinby@state.co.us
Connecticut	John McCormick	(860) 424-5920	john.mccormick@ct.gov
Delaware	Linda Murphy	(302) 255-9801	linda.murphy@state.de.us
District of Columbia	Donald Shearer	(202) 698-2007	Donald.Shearer@dc.gov
Florida	Jennifer Ellingsen Fred Becknell	(850) 412-3977	Jennifer.Ellinsen@myflorida.com Fred.Becknell@myflorida.com
Georgia	Terri Kight	(404) 463-7437	tkight@dch.ga.gov
Guam	Theresa Arcangel (also SMD)	671-735-7282	theresa.arcangel@dphss.guam.gov

State	POC	Phone	POC E-mail Address
Hawaii	Shelley Siegman (Acting)	(808) 692-8095	ssiegman@medicaid.dhs.state.hi.us
Idaho	Lori Stiles	(208) 334-0653	stilesl@dhw.idaho.gov
Illinois	Bradley Hart	(217) 524-5105	bradley.hart@illinois.gov
Indiana	John McCullough	317-234-2129	John.Mccullough@fssa.IN.gov
Iowa	Rocco Russo	(515) 256-4632	rrusso@dhs.state.ia.us
Kansas	Krista Engel	(785) 296-7286	KEngel@kdheks.gov
Kentucky	Veronica Cecil	(502) 564-5472 ext 2253	Veronica.Cecil@Ky.gov
Louisiana	Ruth Kennedy Jen Steele (Deputy)	(225) 342-3032	Ruth.Kennedy@la.gov Jen.Steele@la.gov
Maine	Herb F. Downs	(207) 287-2778	Herb.F.downs@maine.gov
Maryland	Susan Steinberg	(410) 767-6039	Susan.Steinberg@maryland.gov
Massachusetts	Joan Senatore	(617) 348-5380	joan.senatore@state.ma.us
Michigan	MI Corp Email Account		dch-oig@michigan.gov
Minnesota	Jennifer Hasbargen	(651) 431-4356	jennifer.hasbargen@state.mn.us
Mississippi	Otis Washington, Jr.	(601) 576-4135	Otis.Washington@medicaid.ms.gov

State	POC	Phone	POC E-mail Address
Missouri	Jessica Dresner	(573) 751-3399	Jessica.Dresner@dss.mo.gov
Montana	Michelle Truax	(406) 444-4120	MTruax@mt.gov
Nebraska	Anne Harvey	(402) 471-1718	anne.harvey@nebraska.gov
Nevada	Tammy Moffitt	(775) 684-3623	Tammy.Moffitt@dhcfp.nv.gov
New Hampshire	Sherry Bozoian	(603) 271-8029	sbozoian@dhhs.state.nh.us
New Jersey	Elissa Smith	(609) 292-4350	Elissa.Smith@osc.state.nj.us
New Mexico	Everet Apodaca	(505) 827-3135	everet.apodaca@state.nm.us
New York	Corp. Email Account		Bmfa@omig.ny.gov
North Carolina	Rob Kindsvatter	(919) 814-0123	Rob.kindsvatter@dhhs.nc.gov
North Dakota	Dawn Mock	(701) 328-1895	dmock@nd.gov
Northern Mariana Islands	Helen Sablan	670-664-4884	chcmc@pticom.com
Ohio	Rachel Jones	N/A	Rachel.jones@medicaid.ohio.gov
Oklahoma	Kelly Shropshire	(405) 522-7131	Kelly.Shropshire@okhca.org
Oregon	Charles Hibner	(503) 378-8113	charles.hibner@state.or.us
Pennsylvania	Clint Eisenhower (Acting)	(717) 214-1942	ceisenhowe@pa.gov

State	POC	Phone	POC E-mail Address
Puerto Rico	Luz Cruz-Romero Ricardo Rivera Cardona	(787) 765-4044 (787) 474-3300 ext. 3003	luz.cruz@salud.pr.gov raivera@asespr.org
Rhode Island	Bruce McIntyre	(401) 462-0613	bruce.mcintyre@ohhs.ri.gov
South Carolina	Betty Jane (BJ) Church	(803) 898-2678	church@scdhhs.gov
South Dakota	Lori Lawson (Interim)	(605) 773-3495	Lori.Lawson@state.sd.us
Tennessee	Dennis J Garvey	(615) 507-6696	Dennis.J.Garvey@tn.gov
Texas	Stuart Bowen, Jr.	(512) 491-2051	Stuart.bowen@hhsc.state.tx.us
Utah	Noleen Warrick	(801) 538-6455	noleenwarrick@utah.gov
Vermont	Ron Clark (ret. 2/20/15) Leanne Miles (eff. 2/20/15)	(802) 879-5652 (802) 879-5964	ron.clark@state.vt.us Leanne.miles@state.vt.us
Virgin Islands	Renee Joseph-Rhymer	(340) 774-0930	Renee.JosephRhymer@dhs.vi.gov
Virginia	Louis Elie	(804) 786-5590	louis.elie@dmas.virginia.gov
Washington	Cathie Ott (Acting)	(360) 725-2116	cathie.ott@hca.wa.gov
West Virginia	Tammy G. Hypes	(304) 356-4885	Tammy.G.Hypes@wv.gov

State	POC	Phone	POC E-mail Address
Wisconsin	Alan White	(608) 266-7436	alan.white@dhs.wisconsin.gov
Wyoming	Mark Gaskill	(307) 777-2054	Mark.gaskill@wyo.gov

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10228PI	07/27/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08	08/27/2020	11884
R943PI	02/21/2020	Updates to Chapter 4 and Exhibit 8 in Publication (Pub.) 100-08	03/24/2020	11629
R902PI	09/27/2019	Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08	10/28/2019	11425
R884PI	05/31/2019	Update to Exhibit 46.2, 46.3, 46.4, and 46.5 in Publication (Pub.) 100-08	08/30/2019	11242
R867PI	02/22/2019	Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08	03/25/2019	11088
R863PI	02/12/2019	Local Coverage Determinations (LCDs	01/08/2019	10901
R857PI	01/30/2019	Local Coverage Determinations (LCDs)	01/08/2019	10901
R854PI	01/11/2019	Local Coverage Determinations (LCDs)	01/08/2019	10901
R829PI	10/03/2018	Local Coverage Determinations (LCDs)	01/08/2019	10901
R831PI	10/01/2018	Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08	10/01/2018	10849
R826PI	09/21/2018	Update to Chapter 4, Section 4.18.1.4 and Exhibit 16 in Publication (Pub.) 100-08	10/22/2018	10853
R823PI	08/31/2018	Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08- Rescinded and replaced by Transmittal 831	10/01/2018	10849
R780PI	03/16/2018	Update to Exhibit 16 - Model Payment Suspension Letters in Pub. 100-08	05/16/2018	10498
R726PI	06/16/2017	Comprehensive Error Rate Testing (CERT) File Layout for Social Security Number Removal Initiative (SSNRI)	10/02/2017	9835
R714PI	05/12/2017	Comprehensive Error Rate Testing (CERT) File Layout for Social Security Number Removal Initiative (SSNRI) – Rescinded and replaced by Transmittal 726	10/02/2017	9835
R675PI	09/09/2016	Update to Chapter 4, Pub. 100-08	12/12/2016	9426
R670PI	08/19/2016	Update of Payment Suspension Instructions	11/23/2016	9396
R660PI	06/29/2016	Comprehensive Error Rate Testing (CERT) program Treatment of Claims in the Prior Authorization Model	07/05/2016	9238

R637PI	02/05/2016	Comprehensive Error Rate Testing (CERT) program Treatment of Claims in the Prior Authorization Model – Rescinded and replaced by Transmittal 660	07/05/2016	9238
R617PI	10/09/2015	Update to Chapter 3 of Pub. 100-08	11/10/2015	9303
R558PI	11/26/2014	Update to the Program Integrity Manual (Pub. 100-08) Exhibit 36 - Overview of the Comprehensive Error Rate Testing (CERT) Process	12/29/2014	8859
R557PI	11/26/2014	Update to CMS Publication 100-08, Chapter 3, Section 3.2.3.4 (Additional Documentation Request Required and Optional Elements)	12/29/2014	8948
R548PI	10/17/2014	Deletion of Program Integrity Manual Exhibit 34	11/18/2014	8904
R485PI	08/21/2013	Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification	01/29/2013	8079
R446PI	12/28/2012	Program Safeguard Contractor (PSC) and Zone Program Integrity Contractor (ZPIC) Provider Notification – Rescinded and replaced by Transmittal 485	01/29/2013	8079
R360PI	12/10/2010	Corrective Action Reporting	01/12/2011	7241
R311PI	11/13/2009	Recovery Audit Contractors (RACs)	12/14/2009	6684
R264PI	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
R224PI	10/16/2007	Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier	12/03/2007	5043
R220PI	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
R213PI	06/29/2007	Various Benefit Integrity Revisions	07/30/2007	5630
R209PI	06/12/2007	Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier	07/02/2007	5044

R201PI	05/11/2007	Revise the Fiscal Intermediary Shared System (FISS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier - Replaced by Transmittal 224	12/03/2007	5043
R197PI	04/06/2007	Revise the VIPS Medicare System (VMS) and Medicare Contractor System (MCS) to Expand Files to Include a National Provider Identifier (NPI) for Each Legacy Provider Identifier - Replaced by Transmittal 209	07/02/2007	5044
R176PI	11/24/2006	Various Benefit Integrity (BI) Clarifications	12/26/2006	5368
R144PI	03/31/2006	Various Benefit Integrity (BI) Clarifications	05/01/2006	4247
R143PI	03/17/2006	Demand Letters	04/17/2006	3954
R141PI	02/24/2006	Modification to the UPIN Process	N/A	4191
R118PI	08/12/2005	Various Benefit Integrity (BI) Clarifications	09/12/2005	3896
R106PI	03/14/2005	Inclusion of Interventional Pain Management Specialists on Carrier Advisory Committee (CAC) Membership	04/04/2005	3721
R096PI	01/14/2005	Consent Settlements	02/14/2005	3626
R077PI	05/28/2004	Comprehensive Error Rate Testing (CERT) Requirements	06/28/2004	3229
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R067PI	02/27/2004	Comprehensive Error Rate Testing (CERT) Requirements	03/12/2004	2976
R047PI	07/25/2003	Definitions	08/08/2003	2517
R044PI	07/25/2003	Replacing Contractor MR Web Sites with Medicare Coverage Database	10/01/2003	2592
R032PI	10/22/2002	Harkin Grantee, Fraud Alerts	10/25/2002	2333
R023PI	03/18/2002	Adds New Exhibits	05/02/2002	1981
R017PIM	12/12/2001	Reorganizes chapter 3, sections 4, 5, and 6 and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.	04/01/2002	1891
R016PIM	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732

R014PIM	09/26/2001	Local Medical Review Policy (LMRP) Format and Submission/Requirements	10/01/2001	1859
R009PIM	07/30/2001	LMRP Process	NA	1021
R003PIM	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
R001PIM	06/2000	Initial Release of Manual	NA	931

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