CMS Guidance Document

Department of Health &
Human Services (DHHS)

Pub 100-08 Medicare Program Integrity

Centers for Medicare &
Medicaid Services (CMS)

Executive Guidance Number 0164

Date: December 14, 2007

Planned Web Site Address http://www.cms.hhs.gov/manuals/

Release planned:

December 31, 2007

PROGRAM AREA: NPI Number

SUBJECT: NPI Number for Medical Review

APPLIES TO: Contractor specific

I. SUMMARY OF DOCUMENT: The shared system maintainer currently does not allow contractors the
ability to select claims using the NPI or legacy number. This change will allow contractors to use the NPI or
legacy number.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)

STATUS: R=REVISED, N=NEW, D=DELETED.

Status

CHAPTER/SECTION/SUBSECTION/TITLE

R

2/2.2/Data Analysis

III. CLEARANCES:

Clearance & Point of Contact (POC)

Name/Telephone/Component

Senior Official Clearance

Tim Hill, 410-786-5448/Director Office of Financial Management

Agency POC

Debbie Skinner, 410-786-7488/OFM/PIG/DMR

IV. TYPE (Check appropriate boxes for type of guidance)

Audit Guide

X

Change Request

HPMS

Joint Signature Memorandum/Technical Director Letter

Manual Transmittal/Non-Change Request

State Medicaid Director Letters

Other

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation
is being interpreted. If not applicable, indicate N/A]

Attachment - Business Requirements

Pub. 100-08

Transmittal:

Date:

Change Request: 5761

SUBJECT: NPI Number for Medical Review

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: This CR will modify medical policy logic to check both OSCAR number and NPI
numbers on the claim when medical policy parameters are established for specific provider numbers. This will
allow the FI to review claims by NPI and OSCAR.

B. Policy: Contractors should check OSCAR and NPI numbers on claims for specific provider numbers
when parameters are established for medical policy.

II. BUSINESS REQUIREMENTS TABLE

Use“Shall" to denote a mandatory requirement

Number

Requirement

Responsibility (place an “X” in each
applicable column)

A/B

MAC

DME

MAC

FI

CARRIER

RHHI

Shared-
System
Maintainers

OTHER

FISS

MCS

VMS

CWF

5761.1

Shared system maintainers shall allow contractors the ability to select claims using the NPI number as a criterion for medical review.

X

X

X

X

X

X

X

5761.2

Shared system maintainers shall allow contractors the ability to select claims using the legacy number as a criterion for medical review.

X

X

X

X

X

X

X

III. PROVIDER EDUCATION TABLE

Number

Requirement

Responsibility (place an “X” in each applicable column)

A/
B

DME

FI

CARR

RHHI

Shared-
System
Maintainers

OTHER

FISS

MCS

VMS

CWF

None.

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref

Requirement

Number

Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, 410-786-7489, Debbie.Skinner@cms.hhs.gov or Nancy Moore, 410-786-6974, Nancy.Moore@cms.hhs.gov

Post-Implementation Contact(s): Debbie Skinner, 410-786-7489, Debbie.Skinner@cms.hhs.gov or Nancy Moore, 410-786-6974, Nancy.Moore@cms.hhs.gov

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs) use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs), use the following statement:

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically
authorized by the contracting officer. If the contractor considers anything provided, as described above, to be
outside the current scope of work, the contractor shall withhold performance on the part(s) in question and
immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding
continued performance requirements.

2.2 – Data Analysis

(Rev.)

Data analysis is a tool for identifying potential claim payment errors. Data analysis compares claim information and other related data (e.g., the provider registry) to identify potential errors and/ or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or in the aggregate. Data analysis is an integrated, on-going component of MR and BI activity.

The contractor’s ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. Contractors should use research and experience in the field to develop new approaches and techniques of data analysis. Ongoing communication with other government organizations (e.g., QIOs, the State Medicaid agencies, fiscal intermediaries, carriers and the DME MACS) concerning new methods and techniques should occur.

Analysis of data should:

• Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;

• Establish baseline data to enable the contractor to recognize unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;

• Identify where there is a need for LCD;

• Identify claim review strategies that efficiently prevent or address potential errors

(e.g., prepayment edit specifications or parameters);

• Produce innovative views of utilization or billing patterns that illuminate potential errors;

• Identify high volume or high cost services that are being widely overutilized. This is important because these services do not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk; and

• Identify program areas and/or specific providers for possible fraud investigations.

This data analysis program must involve an analysis of national data furnished by CMS as well as review of internal billing utilization and payment data to identify potential errors.

The goals of the contractors' data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

Contractors shall document the processes used to implement their data analysis program
and provide the documentation upon request.

In order to implement a data analysis program, the contractor shall:

• Collect data from sources such as:

o Historical data, e.g., review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement (PS&R) data,
billing data, Common Working File (CWF), data from other Federal sources, i.e., QIO,
other carriers and fiscal intermediaries (FIs), Medicaid; and

• Referrals from internal or external sources (e.g., provider audit, PSC, beneficiary,
or other complaints);

• Conduct data analysis to identify potential errors;

• Institute ongoing monitoring and modification of data analysis program components through the QIP.

The shared system maintainer shall allow the contractors the ability to select claims
using the NPI or the legacy number (OSCAR or UPIN) as a criterion for medical review.