Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-61 **Date: NOVEMBER 2, 2000**

CHANGE REQUEST 1338

SUBJECT: Comprehensive Error Rate Testing (CERT) Program – Requirements for Medicare Contractor Operations

Purpose

This document details how Part B Medicare contractors (i.e., carriers and DMERCs) will interact with the CERT Operations Center.

Background

The Health Care Financing Administration (HCFA), Office of Financial Management, Program Integrity Group, Division of Methods and Strategy has developed the CERT program to produce national, contractor specific, and benefit category specific paid claim error rates. The project will have independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers will medically review claims that are paid; claims that are denied will be validated to ensure that the decision was appropriate. The sampled claim data and decisions of the independent reviewers will be entered into a tracking and reporting database. The sampled claims will be followed through the system to their final disposition. The outcomes HCFA anticipates from this project are a national paid claims error rate, a claims processing error rate, a provider compliance rate, and a paid claims benefit specific error rate. The tracking database will allow HCFA to quickly identify emerging trends. CERT will enhance HCFA's ability to take appropriate corrective actions and can be used to better manage Medicare contractor performance. Another byproduct of the CERT program is a large database of independently reviewed claims that HCFA can use to test new software technologies such as data analysis tools or Commercial Off The Shelf (COTS) claims editing software.

HCFA will implement CERT in August 2000 at all durable medical equipment carrier (DMERC) sites. The goal is to implement CERT in October 2000 at all other VIPS Medicare System (VMS) users. HCFA will implement CERT in EDS contractor sites April 1, 2001. We will implement CERT in other locations depending on the availability of standard system programming time.

HCFA awarded a Program Safeguard Contractor (PSC) Task Order to DynCorp in May 2000. DynCorp will serve as the CERT contractor and will be responsible for the CERT Operations Center.

How to Contact and Make Submissions to the CERT Operations Center

If you have questions regarding this project or otherwise need to contact the CERT contractor, please contact the DynCorp management team at (804) 264-1778 (phone) or (804) 264-3268 (fax). The team is composed of the following individuals:

Laura Castelli, BSN, MPM, Project Director,
Ellen Cartwright, BSN, CCS, CCS-P, UMBI Manager,
William Johnson, M.D., Medical Director, and
Susan Toker, BSN, Lead Review Analyst.

The address of the CERT contractor is:

DynCorp
1530 E. Parham Road
Richmond, Virginia 23228

Overview of the CERT Process

The process begins at the Medicare contractor 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 processed 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 Medicare contractors. 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 Medicare contractor and matched to the Medicare contractor's claims history and provider files. A *Sampled Claims Resolution file,* a *Claims History Replica file* and a *Provider Address file* are created by the Medicare contractor 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. Reports identifying incorrect claim payment are sent to the appropriate contractor for follow-up.

Impact on Carriers and DMERCs

As CERT is implemented, HCFA will require carriers and DMERCs to support the CERT project as follows:

- Coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format (**Note:** These are changes to the standard system -- The sampling module will reside on a server in the HDC. Use of the sampling module will be under the supervision of the CERT Operations Center);
- Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered during the day;
- Provide the CERT contractor with all applicable materials (e.g., medical records) used to deny (in-part or total) or approve a sampled claim for medical review reasons or deny a sampled claim due to claims processing procedures. (HCFA expects the volume of such materials to be very low. The anticipated CERT sample is not expected to exceed 200 claims per month from each contractor. Generally, contractors will have to supply additional materials on 10% or less of those claims).
- Receive overpayment referrals and undertake appropriate collection action on cases in which the CERT contractor has determined an error has occurred;
- Provide the CERT contractor with the status and amounts of overpayments that you have collected within 10 working days of a CERT request;
- Process appeals stemming from the CERT project, e.g., CERT decisions appealed by providers or beneficiaries;
- Provide the CERT contractor with the status of appeals and final decisions on appeals within 10 working days of a CERT contractor request;
- Provide answers to the CERT contractor on the status of claims that were identified in the sample but, for which, there is no indication that the claim has been adjudicated; and
- Provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.

The CERT contractor will discuss the results of its review with the Medicare contractor to insure that all information available for review has been considered. As applicable, the CERT contractor will refer claims they have determined to be potentially fraudulent to the Medicare contractor.
Carriers and DMERCs random review requirements contained in the Budget Performance Requirements will be eliminated when CERT is implemented for the contractor.

Impact on Carrier and DMERC Standard Systems

The Carrier and DMERC Standard Systems will be required to create and transmit four files and receive and process one file. The formats for these files for carrier and DMERC standard systems are described in Attachment 1.

Claims Universe file

The carrier and DMERC Standard System will be required to create a daily *Claims Universe file*, which will be transmitted daily to the CERT Operations Center. The file will be processed through a sampling module residing on the server at the HCFA Data Center (HDC) to which you send the *Claims Universe file*. The *Claims Universe file* must contain all claims, except adjustments, that have entered the carrier and DMERC standard claims processing system on any given day. Any claim should be included only once and only on the day that it enters the system.

Sampled Claims Transaction file, Sampled Claims Resolution file and Claims History Replica file

The carrier and DMERC Standard System will periodically receive a *Sampled Claims Transaction file* from the CERT Operations Center. This file will include claims that were sampled from the daily *Claims Universe files.* The carrier and DMERC Standard System will be required to match the *Sampled Claims Transaction file* against the standard system claims history file to create a *Sampled Claims Resolution file* and a *Claims History Replica file.* The *Claims History Replica file* will be a dump of the standard system claims history file in the Standard System format. These files will be transmitted to the CERT Operations Center. The *Sampled Claims Resolution file* will be input to the CERT claim resolution process and the *Claims History Replica file* will be added to the Sampled Claims History Replica database. If a claim identified on the *Sampled Claims Transaction file* is not found on the standard system claims history file no record should be created for that claim.

Provider Address file

The names and addresses of the billing providers must also be transmitted in a separate file to the CERT Operations Center along with the *Sampled Claims Resolution file*. The *Provider Address file* will contain the mailing information for each billing provider on the *Sampled Claims Resolution* file for all claims, assigned and non-assigned, which contain the same provider number on all claims lines. Each unique provider should be included only once on the *Provider Address file.*

Assumptions and Constraints

- Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.
- Files must be transmitted to the CERT Operations Center via CONNECT:Direct.
- HCFA will provide Medicare contractors with dataset names for all files that will be transmitted to the CERT Operations Center.
- The CERT contractor will provide the Medicare contractors with the dataset names with which the *Sampled Claims Transaction file* will be transmitted.
- Medicare contractor files that are rejected will result in a call from the CERT Operations Center indicating the reason for rejection. Rejected files must be corrected and retransmitted.
- Standard System contractor will provide a data dictionary of the Claims Replica file to the CERT contractor in preparation for CERT implementation of CERT and will provide updates as necessary.

Clarification and Specification of CERT Requirements

The information presented to this point reiterates information contained in Change Request 1173. Below are details on how those requirements should be implemented.

1. *Coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format.*

The CERT contractor will request the information described in items 2, 5 through 7, 12, 14, and and 15 through letters or e-mail to the CERT point of contact of each Medicare contractor. Medicare contractors are required to provide responses in electronic format as described in Attachment 1. Responses should be made within 5 working days of a request.

2. *Submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims processed during the day.*

   Use the *Claims Universe file* format from Attachment 1 for this transmission. You should use CONNECT:Direct to transmit the files. Target files for the transmission will be defined in information provided to technical contacts by the CERT contractor.

   Each Medicare contractor in phase 1 of CERT has identified a HDC User ID they will use to transmit the files. Please notify the CERT contractor at the address included in the "**How to Contact and Make Submissions to the CERT Operations Center"** section above of any user ID changes or additions. Medicare contractors in phases 2 and 3 should provide HDC User IDs to the CERT Operations Center at least 30 days before their first report is due.

3. *Provide the CERT contractor with all applicable materials (e.g., medical records) used to deny (in-part or total) or approve a sampled claim for medical review reasons or deny a sampled claim due to claims processing procedures.*

   The CERT contractor will request the additional information in written form. The CERT contractor will include a checklist of items required for each record in each request. The requests will be batched by month. Medicare contractors must return the requested information to the CERT Operations Center at the address specified in the "**How to Contact and Make Submissions to the CERT Operations Center"** section above.

4. *Receive overpayment referrals and undertake appropriate collection action on cases in which the CERT contractor has determined an error has occurred.*

   The CERT contractor will make referrals in writing. The referrals will be batched by month.

5. *Provide the CERT contractor with the status and amounts of overpayments that you have collected within 10 working days of a CERT request.*

HCFA anticipates two types of requests: an initial request and follow-up requests. The initial request will require the submission of all claims data for claims included in the CERT sample. The CERT contractor will require information in all three formats listed below for that submission. The follow-up requests will be for claims that either the Medicare contractor has denied or for which the CERT contractor has questioned payment of one or more items on the claim."

Requests for updates will be transmitted electronically via e-mail in the format specified in the *Sampled Claims Transaction file* section of Attachment 1. Responses should be made using Network Data Mover (NDM) in the formats provided for *Sampled Claims Resolution file, Claims History Replica file, and Provider Address file* contained in Attachment 1. Requests will be made monthly and will specify the format to be used for each record included in the request.

6. *Provide the CERT contractor with the status of appeals and final decisions on appeals within 10 working days of a CERT contractor request.*

   Requests for updates will be transmitted electronically via e-mail in the format specified in the *Sampled Claims Transaction file* section of Attachment 1. Responses should be made using NDM in the format provided for the *Sampled Claims Resolution file* in Attachment 1.

7. *Provide answers to the CERT contractor on the status of claims that were identified in the sample but, for which, there is no indication that claim has been adjudicated.*

Requests for status will be transmitted electronically via e-mail in the format specified in the *Sampled Claims Transaction file* section of Attachment 1. Responses should be made using NDM and the formats provided for the *Sampled Claims Resolution file* in Attachment 1.

8. *Provide clarification/coordination with the CERT contractor on issues arising as part of the CERT project.*

   A request that each Medicare contractor appoints a CERT point of contact is made at the end of this change request. That person will interact with the CERT contractor on all issues. Interactions may be in writing, through e-mail or fax, in person, or over the telephone. The CERT contractor will initiate all requests for clarifications through the CERT point of contact.

9. *The CERT contractor will discuss the results of its review with the Medicare contractor to insure that all information available for review has been considered As applicable, the CERT contractor will refer claims they have determined to be potentially fraudulent to the Medicare contractor.*

   A request that each Medicare contractor appoints a CERT point of contact is made at the end of this change request. That person will interact with the CERT contractor to request discussions of results of CERT contractor review. Interactions may be in writing, through e-mail or fax, in person, or over the telephone. The Medicare contractor CERT point of contact will initiate all requests for discussion with the CERT contractor.

10. *Carriers and DMERCs random review requirements contained in the Budget Performance Requirements will be reduced by an amount equal to the number of claims identified in the CERT sample.*

    The FY 2001 BPR indicates that once the contractor has implemented the CERT program it must cease its random review process. Since CERT will not be operational until the end of FY 2000, it is not practical to substitute CERT review for random review in FY 2000.

11. *Header and trailer records with zero counts must be created and transmitted in the event that a Medicare contractor has no data to submit.*

    This requirement applies only when the routine processing cycle does not run. For example, if the Medicare contractor routinely processes claims every other day, zero count records do not have to be submitted for days on which processing is not routinely done. To insure the CERT contractor knows when to expect records, HCFA requests that the Medicare contractor send a copy of their processing schedule, if they do not process claims every day, to the CERT contractor 10 working days before they are required to begin sending processed records or ten working days after receipt of this CR, whichever is later. Please send the list to the address listed in the "**How to Contact and Make Submissions to the CERT Operations Center"** section above.

12. *Files must be transmitted to the CERT Operations Center via CONNECT:Direct. With the exception of the Claims Universe File (See item 2 above) HCFA will provide Medicare contractors with target dataset names for all files that will be transmitted to the CERT Operations Center at a later date.*

13. *The CERT contractor will provide Medicare contractors with the dataset name they will use to label the Sampled Claims Transaction that will be transmitted to them by e-mail.*

    Transmittal of the Sampled Claims Transactions file will be handled via e-mail. Provide the CERT contractor with an e-mail address to which requests should be sent. Send the address to the CERT Operations Center at the address listed in the " **How to Contact and Make Submissions to the CERT Operations Center"** section above.

14. *Medicare contractor files that are rejected will result in a call from the CERT Operations Center indicating the reason for rejection. Rejected files must be corrected and retransmitted within 24 hours of notification.*

    Requests for retransmissions will be made to the CERT point of contact via telephone. Retransmissions should be made in one of the following formats included in Attachment 1 as appropriate:

    Claims Universe file
    Sampled Claims Resolution file,
    Claims History Replica file, and/or
    Provider Address file

    Retransmissions should be NDM'd to the data sets to be provided as described in items 2 and 12 above.

15. *Standard System contractor will provide a data dictionary of the Claims Replica file to the CERT contractor before implementation of CERT and will provide updates as necessary.*

    The data dictionary should be provided 10 working days after receipt of this Change Request. Send it in Microsoft Word 97 format to the CERT Operations Center at the address provided in the **" How to Contact and Make Submissions to the CERT Operations Center"** section above.

CERT Point of Contact at Medicare Contractors

Medicare contractors should provide the CERT contractor with the name, phone number, address, fax number, and e-mail address of a point of contact. Send the information to the CERT Operations Center at the address provided in the **"How to Contact and Make Submissions to the CERT Operations Center"** section above. The CERT point of contact will be the individual that the CERT contractor will notify of any changes in requirements or problems with CERT data. The point of contact will also initiate all non-routine communications from the Medicare contractor to the CERT contractor.

To announce the CERT program, we request that you include the language included in Attachment 2 in your next provider bulletin.

The *effective date* for this Program Memorandum (PM) is August 14, 2000, for DMERCs and October 31, 2000, for all Part B contractors that use the VIPS Standard System. The effective date for Medicare contractors using the Part B EDS System is April 1, 2001.

The *implementation date* for this PM is August 14, 2000, for DMERCs and October 31, 2000, for all Part B contractors that use the VIPS Standard System. The implementation date for Medicare contractors using the Part B EDS System is April 1, 2001.

Additional PMs will be released for the remaining standard systems with future effective/implementation dates.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 30, 2002.

If you have any questions, contact Wayne Slaughter on (410) 786-0038 or John Stewart on (410) 786-1189.

Attachments

ATTACHMENT 1

CERT Formats for Carrier and DMERC Standard Systems

File Formats

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 HCFA assigned number.
Validation: Must be a valid HCFA 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 13 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 HCFA assigned number.
Validation: Must be a valid HCFA 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:A Must be present if claim contains the same billing/pricing provider number on all lines. Otherwise move all zeores 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 - 13
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: Must be a valid HCPCS/CPT-4 code.
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	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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 HCFA 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 HCFA assigned number.
Validation: Must be a valid HCFA 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.
punctuation
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 Claim Record				
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
Claim Control Number	X(15)	10	24	Spaces
Beneficiary HICN	X(12)	25	36	Spaces
Beneficiary Name	X(30)	37	66	Spaces
Billing Provider Number	X(15)	67	81	Spaces
Claim ANSI Reason Code 1	X(6)	82	87	Spaces
Claim ANSI Reason Code 2	X(6)	88	93	Spaces
Claim ANSI Reason Code 3	X(6)	94	99	Spaces

Field Name	Picture	From	Thru	Initialization
Claim Entry Data	X(8)	100	107	Spaces
Claim Adjudicated Date	X(8)	108	115	Spaces
Line Item Count	S9(2)	116	117	Zeroes
Line Item 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**.**				
Performing Provider Number	X(15)	118	132	Spaces
Performing Provider Specialty	X(2)	133	134	Spaces
HCPCS Procedure Code	X(5)	135	139	Spaces
HCPCS Modifier 1	X(2)	140	141	Spaces
HCPCS Modifier 2	X(2)	142	135	Spaces
HCPCS Modifier 3	X(2)	144	145	Spaces
HCPCS Modifier 4	X(2)	146	147	Spaces
Number of Services	S9(3)	148	150	Spaces
Service From Date	X(8)	151	158	Spaces
Service To Date	X(8)	159	166	Spaces
Place of Service	X(2)	167	168	Spaces
Type of Service	X(2)	169	169	Spaces
Diagnosis Code	X(5)	170	174	Spaces
CMN Control Number	X(15)	175	189	Spaces
Submitted Charge	S9(9)v99	190	200	Zeroes
Medicare Initial Allowed Charge	S9(9)v99	201	211	Zeroes
ANSI Reason Code 1	X(6)	212	217	Spaces
ANSI Reason Code 2	X(6)	218	223	Spaces
ANSI Reason Code 3	X(6)	224	229	Spaces
ANSI Reason Code 4	X(6)	230	235	Spaces
ANSI Reason Code 5	X(6)	236	241	Spaces
ANSI Reason Code 6	X(6)	242	247	Spaces
ANSI Reason Code 7	X(6)	248	253	Spaces
Manual Medical Review Indicator	X(1)	254	254	Space
Resolution Code	X(3)	255	257	Spaces
Final Allowed Charge	S9(9)v99	258	268	Zeroes

DATA ELEMENT DETAIL

Claim Header Fields

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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: **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: **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: **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 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 GGRRRR where:
GG is the group code and RRRR 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.
Remarks: Format must be CCYYMMDD.
Requirement: Required.

Data Element: **Line Item Count**
Definition: Number indicating number of service lines on the claim.
Validation: Must be a number 01 - 13
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: Must be a valid HCPCS/CPT-4 code.
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: Must be greater than 0.
Remarks: N/A
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 B 99.
Requirement: Required.

Data Element: **Type of Service**
Definition: Code that classifies the service.
Validation: Must be a value in the range of 01 B 21 or 99.
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-9-CM diagnosis code.
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: N/A
Requirement: Required on DMERC claims, for services for which a CMN is required.

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: N/A
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 GGRRRR where:
GG is the group code and RRRR is the adjustment reason code
Requirement: ANSI Reason Code 1 must be present on all claims with resolutions of >DEN', >DEO', >RTP', >RED', or >REO'. Codes 2 B 7 should be sent if available.

Data Element: **Manual Medical Review Indicator**
Definition: Code indicating whether or not the service was manually medically reviewed.
Validation: Must be>Y' or blank.
Remarks: Set to >Y' if service was subjected to manual medical review, else blank.
Requirement: Required.

Data Element: **Resolution Code**
Definition: Code indicating how the contractor resolved the line.
Validation: Must be >APP', >DEN', >DEO', >RTP', >RED', or >REO'.
Remarks: APP = Approved as a valid submission
DEN = Denied for medical review reasons, or for insufficient documentation of
medical necessity.
RTP = Denied as unprocessable (return/reject)
DEO = Denied for non-medical reasons, other than denied as unprocessable.
RED = Reduced for medical review reasons or for insufficient documentation of
medical necessity.
REO = Reduced for non-medical review reasons.
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: N/A
Requirement: Required.

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	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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 HCFA assigned number.
Validation: Must be a valid HCFA 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

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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.
Validation: N/A
Remarks: N/A
Requirement: Required.

Data Element: **Provider Name**
Definition: Provider's billing name.
Validation: N/A
Remarks: This is the payee name of the billing/pricing 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 billing address.
Validation: N/A
Remarks: This is the payee address1of the billing/pricing provider.
Requirement: Required.

Data Element: **Provider Address 2**
Definition: 2nd line of provider's billing address.
Validation: N/A
Remarks: This is the payee address2 of the billing/pricing provider.
Requirement: Required if available.

Data Element: **Provider City**
Definition: Provider's billing city name.
Validation: N/A
Remarks: This is the payee city of the billing/pricing 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 payee state of the billing/pricing 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 payee zip code of the billing/pricing provider
Provide 9-digit zip code if available, otherwise provide 5-digit zip code.
Requirement: Required.

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	S9(9)	7	15	Zeroes

DATA ELEMENT DETAIL

Data Element: **Contractor ID**
Definition: Contractor's HCFA assigned number.
Validation: Must be a valid HCFA 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.

Attachment 2

Language for Inclusion in Provider Letter

In order to improve the processing and medical decision making involved with payment of Medicare claims, HCFA began a new program effective August 2000. This program is called Comprehensive Error Rate Testing (CERT) and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (DynCorp of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. DynCorp's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. HCFA will use the DynCorp findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. On a monthly basis, DynCorp will request a small sample of claims--approximately 200--from each contractor, as the claims are entered into their system. DynCorp will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement, in appropriate ways. Consequently, it is HCFA's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How else are providers and suppliers impacted by CERT?

Providers and suppliers of the sampled claims will be asked during the course of the DynCorp review, to provide additional information (e.g., medical records, certificates of medical necessity, etc.) for DynCorp staff to verify services billed were delivered, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information and the name of a contact person.

General questions regarding the CERT initiative may be directed to Laura Castelli, DynCorp Project Director for the CERT Program, at 804-264-1778. Otherwise, providers and suppliers will be contacted ONLY if their claim(s) is selected and additional information is required by DynCorp.