CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 111

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: MAY 2, 2005

Change Request 3812

SUBJECT: Revising the FISS Shared System

I. SUMMARY OF CHANGES: The CMS has established two programs to monitor the accuracy of the Medicare Fee-for-Service (FFS) program: The comprehensive error rate testing program (CERT) and the hospital payment monitoring program (HPMP). The national paid claims error rate is a combination of error rates calculated by the CERT contractor and HPMP with each component representing about 50 percent of the error rate. The CERT program calculates the error rates for carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs); HPMP calculates the error rate for the quality improvement organizations (QIOs).

Strong outcome-oriented performance measures are a good way to assess the degree to which a government program is accomplishing its mission and to identify improvement opportunities. The *Improper Medicare Fee-for-Service Payments Report* for fiscal year 2004, describes the performance measurement process for the Medicare FFS Program.

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates from 1996 to 2002. OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that carriers/DMERCs/FIs/QIOs erroneously paid). To better measure the performance of the carriers/DMERCs/FIs and to gain insight about the causes of errors, CMS decided to calculate a number of additional rates. The additional rates include a provider compliance error rate (which measures how well providers prepared claims for submission) and contractor-specific paid claims error rates (which measure how accurately each specific carrier/DMERC/FI/QIO made claims payment decisions).

The CMS calculated the Medicare FFS error rate and improper payment estimate using a methodology the OIG approved. This methodology includes:

- Randomly selecting a sample of approximately 160,803 claims submitted in calendar year 2003
- Requesting medical records from providers that submitted the claims in the sample
- Reviewing the claims and medical records to see if the claims complied with Medicare coverage, coding, and billing rules
- Assigning errors to claims paid or denied incorrectly
- Classifying relevant providers as non-responders

- Treating non-response claims as errors
- Having the carriers/DMERCs/FIs send providers overpayment letters for claims that carriers/DMERCs/FIs overpaid.

One of the rates needed for this report is the provider compliance error rate. This rate is based on how the claims looked when they first arrived at the carrier/DMERC/FI – before the carrier/DMERC/FI applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the carrier/DMERC/FI is educating the provider community since it measures how well providers prepared claims for submission. The CMS calculated the numbers as a gross number by subtracting CERT determined correct payments form how claims looked when they arrived and dividing that sum by total dollars paid. This error rate is quantified in dollars. The CMS currently cannot calculate this rate for FIs because CMS does not get information on how claims looked when they arrived at FIs as part of FI reporting. The CMS does get information on how claims looked when they arrived at carriers and DMERCs and CMS can therefore calculate this rate for carriers and DMERCS.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 03, 2005

IMPLEMENTATION DATE : October 03, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R/N/D	Chapter/Section/SubSection/Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

One-Time Notification Attachment

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

Attachment – One-Time Notification

Pub. 100-08	Transmittal: 111	Date: May 2, 2005	Change Request 3812

SUBJECT: Revising the FISS Shared System

I. GENERAL INFORMATION

A. Background: The CMS has established two programs to monitor the accuracy of the Medicare Fee-for-Service (FFS) program: The comprehensive error rate testing program (CERT) and the hospital payment monitoring program (HPMP). The national paid claims error rate is a combination of error rates calculated by the CERT contractor and HPMP with each component representing about 50 percent of the error rate. The CERT program calculates the error rates for carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs); HPMP calculates the error rate for the quality improvement organizations (QIOs).

Strong outcome-oriented performance measures are a good way to assess the degree to which a government program is accomplishing its mission and to identify improvement opportunities. The *Improper Medicare Fee-for-Service Payments Report* for fiscal year 2004, describes the performance measurement process for the Medicare FFS Program. The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates from 1996 to 2002. OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that carriers/DMERCs/FIs/QIOs erroneously paid). To better measure the performance of the carriers/DMERCs/FIs and to gain insight about the causes of errors, CMS decided to calculate a number of additional rates. The additional rates include a provider compliance error rate (which measures how well providers prepared claims for submission) and contractor-specific paid claims error rates (which measure how accurately each specific carrier/DMERC/FI/QIO made claims payment decisions).

The CMS calculated the Medicare FFS error rate and improper payment estimate using a methodology the OIG approved. This methodology includes:

- Randomly selecting a sample of approximately 160,803 claims submitted in calendar year 2003
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- Classifying relevant providers as non-responders
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One of the rates needed for this report is the provider compliance error rate. This rate is based on how the claims looked when they first arrived at the carrier/DMERC/FI – before the carrier/DMERC/FI applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the carrier/DMERC/FI is educating the provider community since it measures how well providers prepared claims for submission. The CMS calculated the numbers as a gross number by subtracting CERT determined correct payments form how claims looked when they arrived and dividing that sum by total dollars paid. This error rate is quantified in dollars. The CMS currently cannot calculte this rate for FIs because CMS does not get information on how claims looked when they arrived at FIs as part of FI reporting. The CMS does get information on how claims looked when they arrived at carriers and DMERCs and CMS can therefore calculate this rate for carriers and DMERCS.

B. Policy: CMS Government Performance and Results Act (GPRA) goal requires CMS to decrease the Provider Compliance Error Rate as follows:

- In 2005, CMS will set the baseline for FIs.
- In 2005, decrease the Provider Compliance Error Rate 20% over the 2004 level.
- In 2006, decrease the Provider Compliance Error Rate 20% over the 2005 level (25.2% gross for providers who submitted claims to carriers; 19.7% gross for providers who submitted claims to DMERCs).
- In 2007, decrease the Provider Compliance Error Rate 20% over the 2006 level.
- In 2008, decrease the Provider Compliance Error Rate 20% over the 2007 level.

The CMS cannot meet this goal because FIs are unable to report how the claims looked when they first arrived at FI – before the FI applied any edits or conducted any reviews.

II. BUSINESS REQUIREMENTS

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3812.1	The FISS shared system maintainer shall revise the CERT shared system module to enter for each claim in the CERT sample the claim level covered charge amount (FISS field FSSCPDCL-REV-COV-CHRG-AMT) into the Medicare Initial Allowed Charge field (format 9(7) v99) in positions 429 through 437 of the CERT claims resolution file in time for contractors to begin reporting the revised data on October 3, 2005.					X				
3812.2	Data Centers operating the FISS shared system shall install the revised CERT shared system module developed in requirement 1 in time to begin reporting revised data on October 3, 2005.									
3812.3	Contractors using the FISS shared system shall insure that the revised CERT shared system module developed in requirement 1 begins to operate in time that all CERT claims resolution files submitted after October 3, 2005, contains a claims level covered charge amount in the first Medicare Initial Allowed Charge field on each record.	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
1	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 3, 2005 **Implementation Date: October 3, 2005** **Pre-Implementation Contact(s):** John Stewart (410) 786-1189 **Post-Implementation Contact(s):** John Stewart (410) 786-1189	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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