CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 904	**Date: June 8, 2011**
	Change Request 7272

Note to Contractors: Transmittal 841, dated January 21, 2011, is being rescinded and replaced by Transmittal 904, dated June 8, 2011 to correct errors in revenue code locations and the input file record length, as well as to highlight a change (addition of the rate field) that was not clearly identified in the original transmittal. All other information remains unchanged.

SUBJECT: Enhancements to the Recovery Audit Contractor (RAC) Mass Adjustment/Reporting Process in FISS

I. SUMMARY OF CHANGES: CMS directed enhancement of the existing RAC file-based mass adjustment/reporting process in FISS in July 2010; this CR makes further enhancements in response to a number of user concerns raised since implementation.

EFFECTIVE DATE: July 1, 2011
IMPLEMENTATION DATE: July 5, 2011

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 904	Date: June 8, 2011	Change Request: 7272

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SUBJECT: Enhancements to the Recovery Audit Contractor (RAC) Mass Adjustment/Reporting Process in FISS

Effective Date: July 1, 2011

Implementation Date: July 5, 2011

I. GENERAL INFORMATION

A. Background: The Recovery Audit Contractor (RAC) program began as a three-state demonstration project in 2005; Congress subsequently made the program permanent and directed CMS to expand it nationwide no later than January 2010. There are currently four RACs with jurisdictions paralleling those of the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)s.

RACs review past claims for potential improper payments, requesting and reviewing medical records when necessary to make appropriate determinations. Once an overpayment has been identified, the RAC forwards the claim information to the appropriate Fiscal Intermediary (FI), Carrier, A/B MAC, DME MAC or Regional Home Health Intermediary (RHHI) for adjustment, accounts receivable creation and eventual collection by provider check, offset or Treasury referral. Underpayment correction follows a similar process, ending with a check or electronic funds transfer to the affected provider/supplier.

Virtually all fee-for-service Medicare claims are subject to RAC review. Given the anticipated volume of RAC adjustments, CMS issued Change Requests (CRs) to direct enhancement of the existing RAC file-based mass adjustment/reporting process in the Fiscal Intermediary Shared System (FISS) and the creation of comparable processes in the Multi-Carrier System (MCS) and the ViPS Medicare System (VMS). These changes were implemented in April 2010 (CR 6554/MCS) and July 2010 (CRs 6928/FISS and 6943/VMS); this CR further enhances the FISS process in response to a number of user concerns raised since implementation.

B. Policy: The permanent RAC program was mandated under Division B, Title III, Section 302 of the Tax Relief and Healthcare Act of 2006. All references to the mass adjustment process in the business requirements table refer to the file-based process established under CR 6928, not the pre-existing online process.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility ("X" indicates the columns that apply)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7272.1	The mass adjustment input file layout shall accommodate rate fields, per FISS INFOMAN HPAR CR6928H7.						X				

Number	Requirement	Responsibility ("X" indicates the columns that apply)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7272.2	The mass adjustment input file layout shall accommodate attending, operating and other provider NPIs for claims where such identifiers are not already present, per FISS INFOMAN HPAR CR6928H8.						X				
7272.3	The mass adjustment input file layout shall accommodate up to 225 revenue code groups. RACs that identify improper payments in claims with more than five NCH segments shall submit those claims to the appropriate FI/RHHI/MAC for manual adjustment.	X		X		X	X				RACs
7272.4	FISS shall accommodate a RAC region indicator on the manual adjustment screens and shall utilize that indicator to direct errors, adjustment outcomes and transactions to the correct regional file, per FISS INFOMAN HPAR CR6928H4.						X				
7272.5	The mass adjustment process shall automatically insert "0" for covered days and cost report days, a calculated number of non-covered days based on the dates of service and/or values on the original claim, and appropriate values in any other day-related fields, if the RAC is denying an entire inpatient claim, per FISS INFOMAN HPAR CR6928H7.						X				
7272.6	The mass adjustment process shall bypass any edits based on claim/adjustment origin, per FISS INFOMAN HPAR CR6928H9.						X				
7272.7	Adjustments in a post-pay (x/B75xx) status/location, or any other statuses/locations that are eligible for recoupment/interest accrual, shall be reported on the RAC outcome reports per FISS INFOMAN HPAR CR6928HC. Recoveries against those adjustments shall be similarly reported on the RAC transaction reports.						X				
7272.8	The mass adjustment process shall be a scheduled nightly job that shall run whether or not an input file is present. Manual cycle requests shall no longer be required.						X				EDCs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility ("X" indicates the columns that apply)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
N/A											

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:
N/A	

Section B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact: LCDR Terrence Lew, USPHS (terrence.lew@cms.hhs.gov or 410-786-9213).

Post-Implementation Contact: ***Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.***

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs): No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs): The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

Revised FISS input files (header)

Field #	Field Name	Start	End	Length	Values/comments
1	File type	1	10	10	"FISS-INPUT"
2	Filler	11	11	1	
3	File format version	12	14	3	"***002***"
4	Filler	15	15	1	
5	Record count	16	21	6	Number of records in file, not including header; zero fill
6	Filler	22	22	1	
7	Record length	23	28	6	"***018065***"
8	Filler	29	29	1	
9	File creation date	30	37	8	"YYYYMMDD"
10	Filler	38	38	1	
11	Source ID	39	43	5	Workload ID of proposed adjustments
12	Filler	44	44	1	
13	Region	45	45	1	Region associated with originating RAC
14	Filler	46	***18065***	***18020***	

Note 1: All fields in all layouts are left justified/space filled unless otherwise indicated.

Note 2: Input and outcome files shall be space filled – record lengths will not vary with line counts.

Note 3: *Red/bold/italic* represents changes from the initial CR 6928 layout.

Revised FISS input files (content)

Field #	Field Name	Start	End	Length	Existing Layout (if applicable)	Comments
1	FI/RHHI/MAC workload number	1	5	5	FSSCRACC-CONTRACTOR-NO	At time of original processing; may differ from current number (i.e., Title XVIII vs. MAC)
2	HIC number/prefix/suffix	6	17	12	FSSCRACC-HIC-NO	
3	DCN	18	40	23	FSSCRACC-DCN	
4	Provider NPI	41	50	10	FSSCRACC-PROVIDER-NPI	
5	Provider OSCAR/CCN	51	63	13	FSSCRACC-MEDA-PROVIDER	
6	Claim start date	64	71	8	FSSCRACC-STMT-COV-FROM-DT-CYMD	
7	Claim end date	72	79	8	FSSCRACC-STMT-COV-TO-DT-CYMD	
8	Claim paid date	80	87	8	FSSCRACC-PAID-DT-CYMD	
9	Adjustment reason code	88	89	2	FSSCRACC-NEW-ADJ-REASON	"RI" (RAC)
10	Claim denial reason code	90	94	5	FSSCRACC-NEW-DEN-REJ-REASON	
11	Adjusted admission date	95	102	8	FSSCRACC-NEW-ADMIT-DT-CYMD	
12	Adjusted patient discharge status	103	104	2	FSSCRACC-NEW-DISCHRG-STATUS	
13	Adjusted discharge date	105	112	8	FSSCRACC-NEW-DISCHRG-DT-CYMD	
14	Adjusted DRG	113	115	3	FSSCRACC-NEW-DRG-NO	
15	Adjusted principal diagnosis	116	123	8	FSSCRACC-PRIM-DIAG	Seven diagnosis bytes (ICD-9 w/filler or ICD-10 eventually) plus a POA indicator in the eighth position per CR 5679.
16	Adjusted admitting diagnosis	124	131	8	FSSCRACC-ADMIT-DIAG	
17-66	Adjusted diagnosis/POA 1-25	132	331	200	FSSCRACC-DIAG-CODE(1-17)	Increase from 17 additional diagnoses on current layout
	Adjusted diagnosis			7		
	Adjusted POA indicator			1		
67	***Adjusted attending provider NPI***	***332***	***341***	***10***		
68	***Adjusted operating provider NPI***	***342***	***351***	***10***		
69	***Adjusted other provider NPI***	***352***	***361***	***10***		
70	Adjusted principal procedure	***362***	***368***	7	FSSCRACC-PRIN-PROC-CD	
71	Adjusted principal procedure date	***369***	***376***	8	FSSCRACC-PRIN-PROC-CYMD	
72-119	Adjusted additional procedures 1-24	***377***	***736***	360	FSSCRACC-PROC-CD-(1-5) FSSCRACC-PROC-CD-(1-5)-CYMD	Increase from 5 additional procedures on current layout
	Adjusted procedure			7		
	Adjusted procedure date			8		
120	Count of revenue codes	***737***	***740***	4	FSSCRACC-LINE-COUNT	

Revised FISS input files (continued)

Field #	Field Name	Start	End	Length	Existing Layout	Comments
121+	Revenue code 1-***225***	***741***	***18065***	***17325***		RAC to submit all revenue/ HCPCS/HIPPS codes, whether changed or not, including the 0001 summary line (total charges, covered charges and non-covered charges). ***Claims with 6+ NCH segments must be adjusted manually.***
	Revenue code			4	FSSCRACC-NEW-REV-CODE	
	HCPCS/HIPPS			5	FSSCRACC-NEW-HCPCS	
	Modifier 1			2	FSSCRACC-NEW-HCPCS-MOD(1)	
	Modifier 2			2	FSSCRACC-NEW-HCPCS-MOD(2)	
	Modifier 3			2	FSSCRACC-NEW-HCPCS-MOD(3)	
	Modifier 4			2	FSSCRACC-NEW-HCPCS-MOD(4)	
	Modifier 5			2	FSSCRACC-NEW-HCPCS-MOD(5)	
	Units			9	FSSCRACC-NEW-UNITS	NNNNNNNNN (no decimals)
	Rate			***9***		***NNNNNNDDD (implicit decimal)***
	Date of service			8		YYYYMMDD
	Revised charges			9		Nominal charges for revised allowable units (linear projection from original amount) Implicit decimal: NNNNNNNDD Note: RAC shall submit partial line denials as two separate lines, one with covered charges and one with non-covered charges.
	Revised covered charges			9		Estimate of covered amount based on allowable units; FISS to calculate exact amounts payable.
	Revised non-covered charges			9	FSSCRACC-NEW-NON-COVERED	Corresponding estimate of non-covered amount based on allowable units.
	Line denial reason code			5	FSSCRACC-NEW-LINE-REJ-REASON	

Example:

Original

Line Number	Revenue Code	HCPCS	Qty	Charges	Covered	Non-Covered
1	9999	12345	3	300	300	0
2	0001		3	300	300	0

Adjusted

Line Number	Revenue Code	HCPCS	Qty	Charges	Covered	Non-Covered
1	9999	12345	1	100	100	0
2	9999	12345	2	200	0	200
3	0001		3	300	100	200