

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 231</b>	<b>Date: JANUARY 4, 2008</b>
	<b>Change Request 5761</b>

**SUBJECT: NPI Number for Medical Review**

**I. SUMMARY OF CHANGES:** 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.

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: APRIL 1, 2008**

**IMPLEMENTATION DATE: APRIL 7, 2008**

*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**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	2/2.2/Data Analysis

**III. FUNDING:**

**SECTION A: For Fiscal Intermediaries and Carriers:**

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.

**IV. ATTACHMENTS:**

**Business Requirements Manual Instruction**

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

# Attachment - Business Requirements

Pub. 100-08	Transmittal: 231	Date: January 4, 2008	Change Request: 5761
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**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	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
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	D M E	F I	C A R R I E R	R H I	Shared-System Maintainer				OTH ER



## 2.2 – Data Analysis

*(Rev. 231, Issued: 01-04-08, Effective: 04-01-08, Implementation: 04-07-08)*

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.*