

# Bills Payment Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	<b>Perform EDI Oversight</b>	<p>The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM Part 2, Chapter 11, Section 2982</li> <li>• MIM, Part 3, Sections 3508-3508.6, 3601.1, .2, .3, 4, 3602.1, .2, .3 to the extent these manual ref were not overridden by one of the listed PMs.</li> <li>• PM AB-01-96</li> <li>• PM AB-02-020</li> <li>• PM AB-02-133</li> <li>• CR 2547</li> <li>• CR 2576</li> </ul>	<ol style="list-style-type: none"> <li>a. Obtain valid EDI and EFT agreements, provider authorizations for third party representation for EDI, and network service agreements. Enter that data into the appropriate provider-specific and security files, and process reported changes involving those agreements and authorizations</li> <li>b. Issue/control/update/monitor passwords and EDI billing/inquiry account numbers</li> <li>c. Sponsor providers and vendors to establish IVANS, other private network, and LU 6.2 connections</li> <li>d. Systems test with electronic providers/agents to assure compatibility for the successful exchange of data</li> <li>e. Submit EDI data, HIPAA implementation status, and submitter HIPAA testing status reports</li> <li>f. Monitor and analyze recurring EDI submission and receipt errors, and coordinate with the submitters and receivers when necessary to eliminate errors</li> <li>g. Investigate high provider eligibility query to claim ratios and initiate corrective action as needed</li> <li>h. Maintain a list on your web page of software vendors whose EDI software has successfully tested for submission of transactions to Medicare</li> <li>i. Provide support to providers on the use of the free/low cost billing software</li> <li>j. Provide basic support to providers on interpretation of transactions issued by Medicare</li> </ol>	

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11202	<b>Manage Paper Bills/Claims</b>	<p>All costs related to the receipt, control, and entry of paper bills and for maintenance of the standard paper remittance advice format. This activity encompasses tasks prior to and following the shared system process.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter VII (Bill Review, 3600ff)</li> <li>• Pending CR for updating of the standard paper remittance advice format</li> </ul>	<ul style="list-style-type: none"> <li>a. Receive, open, sort and distribute incoming bills/claims</li> <li>b. Assign control numbers and date of receipt</li> <li>c. Image paper claims and attachments</li> <li>d. Perform data entry (whether manual or electronic scanning)</li> <li>e. Identify claims that cannot be processed due to incomplete information (field or scrubber edits)</li> <li>f. Resolve field edit errors</li> <li>g. Return incomplete paper claims or paper claims that failed field edits to providers for correction and resubmission</li> <li>h. Re-enter corrected/developed paper claims adjustment actions</li> <li>i. Update the standard paper remittance advice format annually</li> </ul>	<p><b>Workload 1</b> is the difference between the total bills reported on the HCFA-1566, Page 11, Line 38, Column 1 minus the EMC bills reported in Line 38, Column 8.</p>

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11203	<b>Manage EDI Bills/Claims</b>	<p>Establish, maintain and operate the infrastructure for EDI and DDE for claims, remittance advice, status query, eligibility query and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, PC-Print software, and related tasks.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 2, Chapter 11, Section 2982</li> <li>• MIM, Part 3, Sections 3508-3508.6</li> <li>• MIM, Part 3, Sections 3601.1, .2, .3, .4</li> <li>• MIM, Part 3, Section 3602.1, .2, .3</li> <li>• MIM, Part 3, Section 3600.A to the extent these manual references were not overridden by one of the listed PMs</li> <li>• MIM, Part 1, Chapter 4, Section 1430</li> <li>• PM A-00-89</li> <li>• PM A-01-20</li> <li>• PM A-01-57</li> <li>• PM A-01-63</li> <li>• PM A-02-005</li> <li>• PM A-02-014</li> <li>• PM A-02-036</li> <li>• PM A-02-037</li> <li>• PM-A-02-069</li> <li>• PM-A-02-070</li> <li>• PM A-02-078</li> <li>• PM A-02-119</li> <li>• PM AB-01-29</li> </ul>	<ol style="list-style-type: none"> <li>a. Provide free billing software, PC-Print software, and upgrade once per year</li> <li>b. Alpha test and validate free billing and PC-Print software</li> <li>c. Assist with resolution of problems with telecomm protocols and lines, your software and hardware, and with the processing of magnetic tapes if supported to maintain connectivity with partners</li> <li>d. Maintain capability for receipt and issuance of transactions via DDE and in batches, for DDE and batch correction of edits, and submission of adjustments via DDE and batch</li> <li>e. Maintain EDI access, syntax and semantic edits at the front-end, prior to shared system processing</li> <li>f. Route edit and exception messages, claim acknowledgements, claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners; route EFTs; and receive 997 transactions from trading partners reporting errors in transactions</li> <li>g. Verify the validity of the EDI data received from electronic trading partners through selective audits and use of other verification tools</li> <li>h. Maintain back-end edits to assure remittance advices and query responses comply with the implementation guide requirements, and EFTs comply with the ACH or 835 requirements</li> <li>i. Create copy of EDI claims as received and</li> </ol>	<p><b>Workload 1</b> is reported on the HCFA-1566, Page 11, Line 38, Column 8.</p>

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		<ul style="list-style-type: none"> <li>• PM AB-02-054</li> <li>• PM AB-02-067</li> <li>• PM AB-02-133</li> <li>• PM AB-02-142</li> <li>• PM AB-02-166</li> <li>• PM AB-03-012</li> <li>• PM AB-03-026</li> <li>• CR 2538</li> <li>• CR 2576</li> <li>• Pending CR: adjustment of translators to report line item dates and HCPCS for outpatient claims.</li> </ul>	<p>have the ability to recreate each outgoing remittance advice and COB transactions</p> <p>j. Maintain audit trails to document processing of EDI transactions</p> <p>k. Translate transaction data between pre HIPAA and the HIPAA standard formats and the corresponding shared system flat files</p> <p>l. Update claim status and category codes, revenue codes, claim adjustment reason codes, remittance advice remark codes</p> <p>m. Bill third parties for electronic access to beneficiary eligibility data, maintain receivables for those accounts, and terminate third parties for non-payment</p>	

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11204	<b>Bills/Claims Determination</b>	<p>Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims payment processing systems, are reported under the Claims Determination activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment edits should be assigned to this activity.</p>	<ul style="list-style-type: none"> <li>a. Maintain fee schedule (local variations)</li> <li>b. Check for duplicates</li> <li>c. Identify claims that have to be resolved manually</li> <li>d. Re-enter corrected/developed claims (pending)</li> <li>e. Resolve edits on claims that cannot be processed (if possible)</li> <li>f. Maintain pricing software modules</li> <li>g. Update HCPCS, diagnostic codes and other code sets that impact pricing as needed</li> </ul>	<p><b>Workload 1</b> for adjudicated bills is the cumulative number of bills processed reported on the HCFA-1566, Page 1, Line 12, Column 1.</p>

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11205	<b>Run Systems</b>	The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: CPU costs for claims processing (including those associated with the application of MIP edits); validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs.	<ol style="list-style-type: none"> <li>a. Test releases</li> <li>b. Assign Data Center costs</li> <li>c. Purchase software/hardware</li> <li>d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks <i>(Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity)</i></li> <li>e. Manage change requests</li> </ol>	
11206	<b>Manage Information Systems Security Program</b>	<p>The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM).</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• BPSSM Section 2.2</li> <li>• BPSSM Section 3.1</li> <li>• BPSSM Section 3.2</li> <li>• BPSSM Section 3.3</li> <li>• BPSSM Section 3.4</li> <li>• BPSSM Section 3.5.1</li> <li>• BPSSM Section 3.5.2</li> </ul>	<ol style="list-style-type: none"> <li>a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM)</li> <li>b. Conduct an annual self-assessment using CAST (A-2 of the BPSSM)</li> <li>c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM)</li> <li>d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM)</li> <li>e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM)</li> <li>f. Prepare, review, update and test the</li> </ol>	

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		<ul style="list-style-type: none"> <li>• BPSSM Section 3.6</li> <li>• BPSSM Section 3.7</li> <li>• BPSSM Section 3.8</li> </ul>	<p>information technology systems contingency plan (Section 3.4 of the BPSSM)</p> <p>g. Conduct an Annual Compliance Audit and implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM)</p> <p>h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM)</p> <p>i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)</p>	
11207	<b>Manage TPAs to Accomplish Coordination of Benefits with Supplemental Payers and States</b>	<p>The costs associated with the solicitation and execution of agreements for the purpose of crossing paid claims data to health care insurers; continuation of activities related to the cross over Medicare paid claims data to their existing trading partners; and collection of fees.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 1, Chapter 6, Section 1601</li> <li>• PM AB-02-095</li> <li>• PM AB-03-066</li> </ul>	<p>a. Market, execute, and maintain CMS's Eligibility File-Based Standard Trading Partner Agreement (TPA) for COB Purposes</p> <p>b. Perform billing/collections functions for crossover activities</p> <p>c. Perform internal and external systems support and testing</p> <p>d. Maintain information to answer inquiries regarding crossover claims</p> <p>e. Resolve problems with trading partners and impacted providers</p> <p>f. Resolve COB processing problems (e.g., in matching data and transmitting files)</p>	<p><b>Workload 1</b> is the number of claims transferred as designated in the MIM 1361.10 (currently only reported on the FACP).</p> <p><b>Workload 2</b> is the number of TPAs executed in this fiscal year.</p>
11208	<b>Conduct Quality Assurance</b>	<p>The costs related to routine quality control techniques used to measure the competency and performance of claims processing personnel; quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems.</p>	<p>a. Review suspended/reopened claims for correct processing</p> <p>b. Review processed paper/EMC claims for accuracy</p> <p>c. Perform other QC sampling techniques for claims processing</p> <p>d. Perform QA on fee schedules maintenance and contractor systems</p>	

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11209	<b>Manage Outgoing Mail</b>	<p>The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock).</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Sections 3602.5, .7</li> <li>• MIM, Part 3, Section 3750</li> <li>• MIM, Part 3, Section 3703</li> <li>• PM A-00-23</li> <li>• PM A-00-36</li> <li>• PM AB-00-65</li> <li>• PM A-00-98</li> <li>• PM A-01-57</li> <li>• PM AB-01-124</li> </ul>	<ul style="list-style-type: none"> <li>a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks</li> <li>b. Mail requests for information (other than medical records or MSP) to complete claims adjudication</li> <li>c. Return unprocessable claims to providers</li> <li>d. Return misdirected claims</li> <li>e. Forward misdirected mail</li> </ul>	
11210	<b>Reopen Bills/Claims</b>	<p>The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, or the misapplication of reasonable charge profiles and screens, etc.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 8</li> </ul>	<ul style="list-style-type: none"> <li>a. Receive written inquiry or referral for reopening</li> <li>b. Control and image claim</li> <li>c. Research validity of issues related to the reopening</li> <li>d. Adjust claim as appropriate</li> <li>e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB)</li> <li>f. Refer to other areas if appropriate to the circumstances</li> <li>g. Document and maintain files for appropriate retrieval</li> </ul>	

# Provider/Supplier Enrollment Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks*	Workload
31001	<b>Provider Enrollment</b>	<p>Provider/supplier enrollment is a critical function to ensure only qualified healthcare organizations and entities are enrolled in the Medicare program. Healthcare organizations and entities must enroll with Fiscal Intermediaries (FIs), with whom they will do business, before receiving reimbursement for services furnished to Medicare beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of all of their information.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM Chapter 10 *</li> </ul>	<p>a. Distribute all enrollment applications or refer applicants to the CMS web site. (§2.2 and 23)</p> <p>b. Process initial applications (CMS 855A) from receipt to final recommendation to the State Agency and the Regional Office (RO), including verification of information and meeting CMS timeliness standards. (§ 1, 2, 10 - 12, 14 - 21, 25)</p> <p>c. Process and verify Changes of Ownership (CHOWs) within CMS timeliness standards. (§10)</p> <p>d. Process, verify and acknowledge changes of information via the CMS 855A within CMS timeliness standards. This includes stock transfers, additional location requests, provider-based and freestanding status changes. (§3,13)</p> <p>e. Process voluntary termination of billing numbers via the CMS-855A. (§10.1)</p> <p>f. Verify and document the FID, HIPDB, Qualifier.Net, etc. (§2.2)</p> <p>g. Image applications (i.e., for authorized and delegated official representative signatures) or maintain a hardcopy file to compare the signatures of the authorized representative and delegated official. (§2.2)</p> <p>h. Enter all application information into the Provider Enrollment, Chain, and Ownership System (PECOS) to include enrollment record information captured from in-house records when changes of information or tie-ins occur. (§2.2) (Transmittal A-02-079, Change Request 2296)</p> <p>i. Monitor Community Mental Health Centers (CMHCs) and deactivate non-billing CMHCs. (§11)</p> <p>j. Ensure staff is trained on enrollment requirements, procedures and techniques. (§2)</p> <p>k. Respond to all phone calls and miscellaneous letters concerning enrollment in the Medicare program.</p> <p>Provider enrollment-initiated educational projects</p>	<p><b>Workload 1</b> is the number of initial applications (CMS 855A) and buyer CHOWs received in a month.</p> <p><b>Workload 2</b> is the number of changes of information and seller CHOWs received in a month. This includes cases where an enrollment record can be made and those where only logging and tracking could be performed. You will get credit for a change whether you create an enrollment record or not.</p>

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			<p>should be charged to provider enrollment. Activities done in conjunction with the Provider Communications (PCOMM) group should be charged to the PCOMM line.</p> <p>(§22)</p> <p>l. Provide a link to the CMS web site from your contractor web site. (§23)</p> <p>m. Initiate special projects as necessary or as requested by CMS.</p> <p>n. Coordinate with other internal components (e.g., appeals, fraud unit, EFT processor, provider education/professional relations, ROs etc.). For EFTs, only charge provider enrollment for the mailing in the new provider packet and the verification of the bank account per MCM §3060 and §3488. (§2)</p> <p>o. Coordinate with other external components (e.g., OIG, Medicaid, FBI, Payment Safeguard Contractors (PSCs), State survey and certification agencies, etc.). When working with PSCs, the FI will charge their assistance to a PSC under one of the three designated workloads (see activity code 23201). Work not associated with one of these workloads is charged to provider enrollment. (§2)</p>	

# Appeals Fiscal Intermediary Activity Dictionary

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12090	<b>Part B Quality Improvement/ Data Analysis</b>	<p>All costs and workload associated with appeal quality improvement and data analysis.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PM AB-02-122</li> </ul>	<ol style="list-style-type: none"> <li>a. Identify reasons for full or partial reversals and dismissals</li> <li>b. Identify denials due to medical review edits</li> <li>c. Identify providers/suppliers with high review rates and high reversals</li> <li>d. Identify problems/issues that have the highest rate of appeal or reversal</li> <li>e. Identify percentage of each level of appeal that result in full reversals, partial reversals, and affirmations.</li> <li>f. Report on claims processing system errors, provider errors, and delayed documentation submission that result in denials and the potential affect on appeals review requests</li> <li>g. Forward the results of data analysis and any recommendations to appropriate components (e.g. Medical Review, Provider Education, etc.)</li> <li>h. Take corrective action as needed</li> <li>i. Perform Quality Control Checks as instructed in the PM.</li> <li>j. Create and maintain an effective system for internal feedback loops</li> <li>k. Submit reports to CMS as specified in official instructions</li> </ol>	
12110	<b>Part A Reconsiderations</b>	<p>All costs and workloads associated with conducting the first level of appeal following the initial determination of a Part A claim (reconsideration).</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• §1869 and §1816(f)(2)(A)(i) of the Act</li> <li>• 42 CFR §405.710-405.717</li> <li>• MIM, Part 3, Chapter 8, Section 3782</li> <li>• MIM, Part 3, Chapter 8, Section 3783</li> <li>• MIM, Part 3, Chapter 8, Section 3784</li> </ul>	<ol style="list-style-type: none"> <li>a. Receive reconsideration request in corporate mailroom and date stamp</li> <li>b. Assign contractor control number (CCN) to request</li> <li>c. Scan reconsideration request and other documentation as necessary</li> <li>d. Forward request to appropriate department and date stamp with department name</li> <li>e. Begin reconsideration case preparation, validate request, develop for an special circumstances as a result of validation (good cause, beneficiary consent, POA, Estate issues)</li> <li>f. Enter data as necessary into system/database</li> <li>g. Write and mail a reconsideration dismissal letter, if necessary, or</li> <li>h. Write and mail a reconsideration acknowledgement letter</li> <li>i. Obtain consultant/RN/specialist opinion as necessary</li> </ol>	<p><b>Workload 1</b> Reconsideration Request Cleared (claims) (CMS-2591, Line 7, Column 1)</p> <p><b>Workload 2</b> Reconsideration Requests Cleared (cases) (CMS-2591, Line 6, Column 1)</p>

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			<ul style="list-style-type: none"> <li>j. Write or call appellant to request additional documentation as necessary</li> <li>k. Make a determination about the reconsideration request</li> <li>l. Write and mail a reconsideration determination letter to appellant and cc other parties</li> <li>m. Request and receive written assurance from provider that payment has not been made prior to the decision</li> <li>n. If decision is partially or wholly reversed, effectuate decision (make payment) and close case</li> <li>o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request</li> </ul>	<b>Workload 3</b> Reconsideration Requests Reversed (cases) (CMS-2591, Line 11, Column 1)
12113	<b>Incomplete Reconsideration Requests</b>	<p>All costs and workloads associated with returning incomplete or unclear requests for reconsideration.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 8, §3782</li> </ul>	<ul style="list-style-type: none"> <li>a. Receive unclear or incomplete request from provider or state</li> <li>b. Return it with clarification of what is required for a reconsideration request</li> <li>c. Maintain a count of returned reconsideration requests and enter this count into CAFMII</li> </ul>	<b>Workload 2</b> Incomplete Reconsideration Requests (cases) (not currently captured on the CMS-2591)
12120	<b>Part A ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations</b>	<p>All costs associated with processing ALJ hearings, including receiving requests, preparing case files, and implementing ALJ decisions.</p> <p>All costs associated with processing DAB referrals, DAB requests and DAB effectuation.</p> <p><b>Reference:</b></p> <p><b>Part A ALJ requests and effectuations:</b></p> <ul style="list-style-type: none"> <li>• §1869 and §1816(f)(2)(A)(ii) of the Social Security Act</li> <li>• 42 CFR §405.720-405.722</li> <li>• MIM, Part 3, Chapter 8, §3785</li> </ul>	<p><b>For Part A ALJ requests and effectuations:</b></p> <ul style="list-style-type: none"> <li>a. Receive ALJ hearing request in corporate mailroom and date stamp it</li> <li>b. Assign a contractor control number to ALJ hearing request</li> <li>c. Scan ALJ hearing request and any other documentation, if applicable</li> <li>d. Forward ALJ hearing request to the appropriate department and dates stamp with department name</li> <li>e. Enter data as necessary into system/database</li> <li>f. Prepare and send ALJ hearing request acknowledgement letter</li> <li>g. Assemble ALJ hearing case file and make and maintain an exact copy</li> <li>h. Forward ALJ hearing case file to local OHA (ALJ)</li> <li>i. Receive and control ALJ hearing file and decision</li> <li>j. Review ALJ decision</li> </ul>	<p><b>Workload 1</b> ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 1)</p> <p><b>Workload 2</b> ALJ Hearing Requests Forwarded (cases) (CMS-2591, Line 56, Column 1)</p> <p><b>Workload 3</b> ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 1)</p>

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		<ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 8, Section 3786 and 3787</li> <li>• MIM, Part 3, Chapter 8, Section 3797</li> </ul> <p><b>Part A DAB referrals, requests for case files, and effectuations:</b></p> <ul style="list-style-type: none"> <li>• 42 CFR §405.724</li> <li>• MIM, Part 3, Chapter 8, Section 3786 and 3787</li> </ul> <p><b>Misc. Code: 12120/01 – Courier Service Fees</b> – All costs of using a courier service to forward requests for Part A ALJ hearing and case files.</p>	<ul style="list-style-type: none"> <li>k. Request and receive written assurance from provider that payment has not been made prior to ALJ decision (if whole or partial reversal)</li> <li>l. Compute the amount due to the appellant/party based on the ALJ decision (if whole or partial reversal)</li> <li>m. Enter data as necessary into system/database</li> <li>n. If no referral, effectuate ALJ decision</li> <li>o. Place documentation confirming payment has been made in case file, if applicable</li> <li>p. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</li> </ul> <p><b>For Part A DAB referrals, requests for case files, and effectuations:</b></p> <ul style="list-style-type: none"> <li>a. Prepare draft Agency Referral memo and case file, and forward to lead RO or</li> <li>b. Receive and control the appellant’s DAB review request or the DAB’s request for a case file</li> <li>c. Retrieve case file</li> <li>d. Copy any additional correspondence and make a copy of the original case file and maintain</li> <li>e. Send original case file to the DAB</li> <li>f. Effectuate DAB’s decision</li> <li>g. Enter case status information throughout the process of this activity and update as necessary</li> </ul>	
12141	<b>Part B Telephone Reviews</b>	All costs and workloads associated with conducting telephone reviews. Telephone reviews are those reviews that are requested by telephone and subsequently completed over the telephone.	<ul style="list-style-type: none"> <li>a. Take all pertinent information for review request over the telephone</li> <li>b. Determine if the review can be handled over the telephone</li> <li>c. Log Request into system and assign control number</li> <li>d. Enter data as necessary into system/database</li> <li>e. Conduct the review over the telephone and evaluate evidence/case history</li> <li>f. Make a review determination</li> <li>g. Write a review determination letter (if wholly or partially</li> </ul>	<b>Workload 1</b> Telephone Review Requests Cleared (claims) (not included in the CMS-2591)

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CAFM Code	Activity Name	Definition	Tasks	Workload
		<p><b>Misc. Code:</b> 12141/01 – <b>Dismissals/Withdrawals of Telephone Reviews</b> – All costs associated with processing telephone reviews that are dismissed or withdrawn.</p>	<p>unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable)</p> <p>h. Mail a review decision letter to parties</p> <p>i. If decisions partially or wholly reversed, effectuate decision</p> <p>j. Enter case status information throughout the process of this activity and update as necessary</p> <p>k. Maintain an accurate count of telephone reviews completed and reversed and enter this data into CAFMII</p>	<p><b>Workload 2</b> Telephone Review Requests Cleared (cases) (not included in the CMS-2591)</p> <p><b>Workload 3</b> Telephone Review Reversals (not included in the CMS-2591)</p> <p>Telephone Review Requests Dismissed or Withdrawn (not included in the CMS-2591)</p>
12142	<b>Part B Written Reviews</b>	<p>All costs and workloads associated with completing a written review. Written reviews are those reviews that are requested in writing and subsequently completed in writing.</p> <p><b>Misc. Code:</b> 12142/01 – <b>Dismissals/Withdrawals of Written Reviews</b> – All costs associated with processing written reviews that are dismissed or withdrawn.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• §1869 and §1842(b)(2)(B)(i) of the Social Security Act</li> <li>• 42 CFR 405.807 – 405.812</li> <li>• MIM, Part 3, Chapter 8, Section 3793</li> </ul>	<p>a. Receive written review request in corporate mailroom and date stamp request</p> <p>b. Assign contractor control number (CCN) to review request</p> <p>c. Scan review request and any other documentation, if applicable</p> <p>d. Forward review request to appropriate department and date stamp with department name</p> <p>e. Begin review case preparation and validate request</p> <p>f. Enter data as necessary into system/database</p> <p>g. Evaluate evidence and case history of review request</p> <p>h. Obtain consultant/RN/specialist opinion for review request, if necessary</p> <p>i. Write or call appellant to request additional documentation for the review, if necessary</p> <p>j. Receive, scan and control additional documentation for review, if necessary</p> <p>k. Make a determination about the review request</p>	<p><b>Workload 1</b> Written Requests Cleared (claims) (CMS-2591, Line 7, Column 5)</p> <p><b>Workload 2</b> Written Requests Cleared (cases) (CMS-2591, Line 6, Column 5)</p> <p><b>Workload 3</b> Written Requests Reversals (cases) (CMS-2591, Line 11, Column 5)</p>

# Appeals Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
			l. Write a review determination letter (if wholly or partially unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) m. Mail review determination letter to parties, if applicable n. If decision is partially or wholly reversed, effectuate decision (make payment) o. Enter case status information throughout the process of this activity and update as necessary, maintain/story case file for possible HO Hearing Request	Written Requests Dismissed or Withdrawn (cases) (CMS-2591 Line 10, Column 5)
12143	<b>Part B Incomplete Review Requests</b>	All costs and workloads associated with handling incomplete or unclear requests for review.  <b>Reference:</b> <ul style="list-style-type: none"> <li>MIM, Part 3, Chapter 8, Section 3793</li> </ul>	a. Receive unclear or incomplete request from provider or state b. Return it with clarification of what is required for a review request c. Maintain a count of all returned review requests and enter this count into CAFMII	<b>Workload 2</b> Incomplete Review Requests (cases) (not currently captured on the CMS-2591)
12150	<b>Part B Hearing Officer Hearings</b>	All costs and workloads associated with processing, and conducting on-the-record, telephone, and in-person Hearing Officer (HO) Hearings.  All costs and workloads associated with processing a dismissal/withdrawal of a Hearing Officer Hearing request.  <b>Reference:</b> <ul style="list-style-type: none"> <li>§1869 and §1842(b)(2)(B)(ii) of the Social Security Act</li> <li>MIM, Part 3, Chapter 8, Section 3794</li> </ul>	a. Receive HO hearing request in mailroom or by phone b. Assign contractor control number (CCN) to HO hearing request c. Scan HO hearing request and any other documentation, if applicable d. Forward HO hearing request to appropriate department and date stamp with department name e. Begin HO hearing case preparation and validate request f. Enter data as necessary into system/database g. Write and send an HO hearing acknowledgement letter h. Prepare the HO hearing case file i. Schedule the hearing j. Provide written notice of the hearing k. Pre-examine the HO hearing evidence l. Enter data as necessary into system/database m. Examine the applicable sections of the statutes, regulations, rulings, policy statements, general instructions and formal guidelines to prepare for the HO hearing	<b>Workload 1</b> HO Hearings Completed (claims) (CMS-2591, Line 7, Column 6)  <b>Workload 2</b> HO Hearings Completed (cases) (CMS-2591, Line 6, Column 6)  <b>Workload 3</b> Dismissals (cases) (CMS-2591, Line 10, Column 6)

# Appeals Fiscal Intermediary Activity Dictionary

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CAF Code	Activity Name	Definition	Tasks	Workload
			n. Travel o. Conduct the HO hearing p. Receive medical review for the HO hearing, if necessary q. Make a determination about HO hearing request r. Write and mail a HO hearing decision letter to appellant s. Effectuate the decision if whole or partial reversal t. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request	

# Appeals Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
12160	<b>Part B ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations</b>	<p>All costs and workloads associated with the processing of ALJ hearing requests, decisions and effectuations.</p> <p>All costs associated with processing DAB referrals, DAB requests and DAB effectuations.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• 42 CFR 405.855 and 42 CFR 405.856</li> <li>• MIM, Part 3, Chapter 8, Section 3797</li> </ul> <p><b>Misc. Code: 12160/01 – Courier Service Fee</b> – All costs of using a courier service to forward requests for Part B ALJ hearing and case files.</p>	<p><b>For Part B ALJ requests and effectuations:</b></p> <ol style="list-style-type: none"> <li>a. Receive written ALJ hearing and requests from the DAB for case files</li> <li>b. Assign contractor control number (CCN)</li> <li>c. Scan requests, referrals, and any other documentation, if applicable</li> <li>d. Forward ALJ hearing request to appropriate department and date stamp with department name</li> <li>e. Enter data as necessary into system/database</li> <li>f. Prepare and send an acknowledgement letter</li> <li>g. Assemble case file and make and maintain an exact copy of the file</li> <li>h. Forward case file to appropriate OHA location (for ALJ hearing requests), and send case files to the DAB as requested</li> <li>i. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</li> <li>j. Receive and control case file and decision</li> <li>k. Compute the amount due to the appellant/party based on the decision (if whole or partial reversal)</li> <li>l. Enter data as necessary into system/database</li> <li>m. Effectuate decision if whole or partial reversal (make payment)</li> <li>n. Place documentation confirming payment has been made in the case file, if applicable</li> <li>o. Place documentation confirming payment has been made in case file, if applicable</li> <li>p. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals</li> </ol> <p><b>For Part B DAB referrals, requests for case files and effectuations:</b></p> <ol style="list-style-type: none"> <li>a. Prepare draft Agency Referral memo and case file, and forward to lead RO within 30 days of the date of the ALJ decision</li> </ol>	<p><b>Workload 1</b> ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 5)</p> <p><b>Workload 2</b> ALJ Hearings Effectuated (cases) (CMS-2591, Line 56, Column 5)</p> <p><b>Workload 3</b> ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 5)</p>

# Appeals Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks	Workload
			<ul style="list-style-type: none"><li>b. Receive and control the appellant's DAB review request or the DAB's request for a case file</li><li>c. Retrieve case file</li><li>d. Copy any additional correspondence and make a copy of the original case file and maintain</li><li>e. Send original case file to the DAB</li><li>f. Effectuate DAB's decision</li><li>g. Enter case status information throughout the process of this activity and update as necessary</li></ul>	

## Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
13002	<b>Beneficiary Written Inquiries</b>	<p>All costs associated with answering beneficiary/Congressional questions through correspondence.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>MIM, Part 2, Chapter 11, Section 2958.B</li> </ul>	<p>a. Log/Control and stamp all written inquiries with receipt date in mailroom</p> <p>b. Answer Inquiry in writing, via telephone, or e-mail</p> <p>c. Send Response</p> <p>d. Maintain Quality Control Program for written policies and procedures</p> <p>e. Transfer misrouted correspondence</p> <p>f. Establish a correspondence Quality Control Program</p> <p>g. Perform continuous quality reviews of outgoing letters</p>	<b>Workload 1</b> is the cumulative inquiries as reported on the CMS-1566, Line 37, Beneficiary Column.
13003	<b>Walk-In Inquiries</b>	<p>All costs associated with answering questions from beneficiaries visiting the Medicare Contractor facility.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>MIM, Part 2, Chapter 11, Section 2958.C</li> </ul>	<p>a. Maintain sign-in sheets for walk-in individuals</p> <p>b. Keep records of contact by recording facts, questions, and responses given to individual</p> <p>c. Conduct inquiry interview</p> <p>d. Provide Medicare publications, as required</p>	<b>Workload 1</b> is the cumulative inquiries as reported on the CMS-1566, Line 36, Beneficiary Column.
13004	<b>Customer Service Plans</b>	<p>All costs associated providing beneficiary outreach and educational seminars, conferences and meetings for the contractor's entire geographic area and not limited to the local RO.</p>	<p>a. Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups</p> <p>b. Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries</p> <p>c. Conduct Medicare awareness training/education with appropriate Congressional staffs to resolve beneficiary issues with Medicare</p>	

# Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
13005	<b>Beneficiary Telephone Inquiries</b>	<p>All costs associated with answering beneficiary/Congressional questions over the telephone.</p> <p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response.</p> <p>All costs associated with planning/conducting training; and inputting/reviewing performance data.</p> <p>All costs associated with purchasing and maintaining telephone systems and equipment (e.g. IVRs)</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 2, Chapter 11, Section 2958.A</li> </ul>	<p>a. Answer telephones                      b. Completing internal paperwork                      c. Inputting data into the system                      d. Analyzing reports and data                      e. Mailing information requested                      f. Making follow-up calls                      g. Monitoring Call                      h. Completing Scorecard                      i. Inputting Scorecard                      j. Reviewing Scorecard with CSR                      k. Planning/conducting training for CSRs</p>	<p><b>Workload 1</b> is the cumulative inquiries as reported on the CMS-1566, Line 35, Beneficiary Column.</p>
13201	<b>Second Level Screening of Complaints Alleging Fraud and Abuse</b>	<p>Costs associated with screening second level inquiries of potential fraud and abuse that are closed for beneficiaries, ordering medical records for beneficiary inquiries that are closed, and sending the referral package to the PSC or Medicare fee-for-service contractor BIU. This also includes the costs associated with the referral package for provider inquiries of potential fraud and abuse.</p> <p>Workload associated only with beneficiaries.</p>	<p>The tasks below are associated with beneficiary inquiries only.</p> <p>a. Calls the beneficiary (CR 2719)                      b. Reviews claims history (CR 2719)                      c. Reviews provider correspondence files for educational/warning letters or contact reports that relate to similar complaints (CR 2719)                      d. Requests itemized billing statements, when necessary (CR 2719)                      e. Requests medical records, when necessary (CR 2719)                      f. Resolves complaints, whenever possible (CR 2719)                      g. Refers complaints that are not fraud and abuse</p>	<p><b>Workload 1</b> is the total number of second level screening inquiries that were closed for beneficiaries.</p> <p><b>Workload 2</b> is the total number of medical records ordered for beneficiary inquiries that were closed.</p> <p><b>Workload 3</b> is the total number of potential beneficiary fraud and abuse complaints identified and</p>

# Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks	Workload
		<p><b>Misc. Code: 13201/01 – Second Level of Complaints Alleging Fraud and Abuse by Providers</b> – Costs and workload associated with the referral package for provider inquiries of potential fraud and abuse.</p>	<p>to the appropriate staff within the contractor or PSC, if appropriate (CR 2719)                      h. Screens all Harkin Grantee complaints for fraud and abuse (CR 2719)                      i. Screens all OIG Hotline complaints for fraud and abuse (CR 2719)                      j. Develops the referral package for the PSC or Medicare fee-for-service contractor BIU on fraud and abuse complaints (CR 2719)                      k. Refers the referral package to the PSC or Medicare fee-for-service contractor BIU within 30 calendar days of receipt of the complaint in the AC mailroom, or within 30 calendar days of receiving medical records(CR 2719)                      l. Maintains statistics and reports, as required (CR 2719)</p>	<p>referred to the PSC or Medicare fee-for-service contractor BIU.</p>

# Provider Inquiries Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
33001	<b>Answering Provider Telephone Inquiries</b>	<p>All costs associated with answering provider questions over the telephone.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>MIM, Part 2, Chapter 11, §2959.C.1-4, MIM, Part 2, Chapter 11, §2959.C.6, MIM, Part 2, Chapter 11, §2959.C.9-12, MIM, Part 2, Chapter 11 §2959.D.1-3</li> </ul>	<p>a. Answering the phones timely                      b. Completing internal paperwork                      c. Inputting data into the system                      d. Analyzing reports and data                      e. Sending requested information                      f. Making follow-up calls                      g. Implementing a provider satisfaction survey                      h. Developing a contingency plan                      i. Developing an IVR quality assurance plan                      j. All costs associated with purchasing and maintaining telephone systems and equipment</p>	<p><b>Workload 1</b> is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column</p>
33014	<b>Provider Quality Call Monitoring</b>	<p>All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>MIM, Part 2, Chapter 11, section 2959.C.7-8.</li> </ul>	<p>a. Monitoring Calls                      b. Completing Scorecard                      c. Inputting Scorecard                      d. Reviewing Scorecard with CSR</p>	
33020	<b>Staff Development and Training</b>	<p>All costs associated with the training and development of provider inquiries staff.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>MIM, Part 2, Chapter 11, Section 2959.C.5.</li> </ul>	<p>a. Planning/conducting training for CSRs                      b. Attending CMS sponsored meetings, conferences, and train-the-trainer sessions related to provider customer service</p>	

## Provider Inquiries Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks	Workload
33002	<b>Provider Written Inquiries</b>	<p>All costs associated with answering provider questions through written correspondence.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 2, Chapter 11, section 2959.A. 1-3</li> <li>• MIM, Part 2, Chapter 11, section 2959.B.</li> </ul>	<ol style="list-style-type: none"> <li>a. Logging/Controlling and date stamping all written inquiries in the mail room</li> <li>b. Responding to a written inquiry in writing, via telephone, or via e-mail</li> <li>c. Mailing the response (if applicable)</li> <li>d. Maintaining a Quality Control Program for written policies and procedures</li> <li>e. Transferring misrouted correspondence</li> <li>f. Maintaining a correspondence Quality Control Program</li> <li>g. Performing continuous quality reviews of outgoing letters</li> </ol>	<p><b>Workload 1</b> is the number of provider written inquiries received by the contractor as reported on the CMS-1566, Line 37, Provider Column.</p>
33003	<b>Provider Walk-In Inquiries</b>	<p>All costs associated with answering questions from providers visiting the Medicare Contractor facility.</p>	<ol style="list-style-type: none"> <li>a. Maintain sign-in sheets for walk-in individuals</li> <li>b. Keep records of contact by recording facts, questions, and responses given to individual</li> <li>c. Conduct inquiry interview</li> <li>d. Provide Medicare publications, as required</li> </ol>	<p><b>Workload 1</b> is the cumulative inquiries as reported on the CMS-1566 Line 36, Provider Column.</p>

# Provider Communications (PCOM-PM) Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
14101	<b>Provider/Supplier Information and Education Website</b>	<p>All costs associated with maintaining an Internet web site that is dedicated to furnishing providers and suppliers with timely, accessible and understandable Medicare program information. This includes the costs associated with the development and maintenance of an internet web site.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965, A.7.b., 2004 BPR</li> </ul>	<p>a. Develop a website that is consistent with CMS requirements and website functionality</p> <p>b. Periodically review the Web site standards Guidelines for compliance</p>	<p><b>Workload 1</b> is the number of page views at the URL (root) level for your provider education web site.</p>
14102	<b>Electronic Mailing Lists/List Serv.</b>	<p>All costs associated with the development and maintenance of electronic list-servs.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965, A.7.b., 2004 BPR</li> </ul>	<p>a. Provide registrants via e-mail of important and time sensitive Medicare program information</p> <p>b. Notify registrants of the availability of contractor bulletins</p> <p>c. Ensure that list-serv accommodates all providers/suppliers</p>	<p><b>Workload 1</b> is the total number of contractor provider/supplier PCOM electronic mailing lists.</p> <p><b>Workload 2</b> is the total number of registrants on all the PCOM electronic mailing lists.</p> <p><b>Workload 3</b> is the total messages sent to registrants. (# of registrants of each listserv multiplied by the # of times used.)</p>

# Provider Reimbursement Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
16002	<b>Non-MSP Debt Collection/Referral</b>	<p>Recover overpayments</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>42 CFR 405.370</li> </ul>	<p>a. Promptly suspend payments to providers to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectable accounts</p> <p>b. Verify bankruptcy information for accuracy, timeliness, and coordinate with CMS/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds</p> <p>c. Record overpayments determined by functional areas timely</p> <p>d. Refer all eligible delinquent debt to Treasury within 180 days of the debt becoming delinquent. (Do not include MSP debt referral on this line)</p> <p>e. Promptly review all extended repayment plan requests. Coordinate with regional and central office on Extended Repayment Plans (ERPs) that are over 12 months</p> <p>f. Process overpayments recoupments</p>	<b>Workload 1</b> is the number of Extended Repayment Plans (ERPs) processed (approved or denied).
16003	<b>Interim Payment Control</b>	<p>Establish, review, and revise interim payments rates</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>42 CFR 413.64 (h)</li> <li>Provider Reimbursement Manual 15 Part 1</li> </ul>	<p>a. Closely monitor provider compliance with interim payment requirements, especially those providers reimbursed under the periodic interim payment (PIP) method of reimbursement, and terminate providers from PIP, when necessary</p> <p>b. Review/revise Graduate Medical Education (GME), Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), bad debt, organ acquisition, interim rates, etc.</p> <p>c. Review documentation requests for special payment status such as sole community and Medicare dependent hospital</p>	<b>Workload 1</b> is the number of provider interim rate reviews, including PIP reviews.
16004	<b>Reimbursement Report and File Maintenance</b>	<p>Maintain data reports and files for provider reimbursement</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>42 CFR Part 413 Program Memorandum 2197 under PM A-03-004</li> <li>Provider Reimbursement Manual 15 Part 1</li> </ul>	<p>a. Maintain accurate PPS Pricer Prov (provider specific) file</p> <p>b. Ensure an accurate System for Tracking Audit and Reimbursement (STAR) database is maintained, including ensuring that all information is properly entered and reported</p> <p>c. Maintain the Provider Statistical and Reimbursement (PS&amp;R) system including testing all system updates and ensuring data is reliable for cost report settlements</p> <p>d. Obtain cost reports from providers including issuance of cost report submission reminder letters, PS&amp;R reports, and demand letters</p> <p>e. Mass updates of cost to charge ratios</p>	

# Provider Reimbursement Fiscal Intermediary Activity Dictionary

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			<p>f. Generate and submit HCRIS files</p> <p>g. Update provider specific files for all payment factors (e.g., DSH, IME, CCR, etc.)</p> <p>h. Calculate and notify providers of applicable limits and caps (e.g. TEFRA, ESRD, Hospice, etc.)</p> <p>h. Answer information requests from CMS, OIG, DOJ, FBI, and GAO including FOIA requests related to reimbursement activities</p>	
16005	<b>Provider-Based Regulations</b>	<p>Carry out all functions related to making provider-based determinations.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• 42 CFR 413.65</li> <li>• CR 2411</li> </ul>	<p>a. Process all provider applications or attestations and review all applications or attestations for completeness and accuracy</p> <p>b. Make any necessary on-site visits</p> <p>c. Carry out random sample reviews of providers that have not submitted any attestations or applications</p> <p>d. Take any necessary review or audit steps needed to allow CMS to make final provider-based determinations</p>	<p><b>Workload 1</b> is the number of recommendations for approval made to the regional office (RO).</p> <p><b>Workload 2</b> is the number of recommendations for disapproval made to the RO.</p> <p><b>Workload 3</b> is the number of attestations received, but for which recommendations have not yet been made to the RO.</p>

# Medical Review Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21001	<b>Automated Review</b>	<p>When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See PIM Ch. 3 section 5.1 for further discussion of automated prepayment review.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM Chapter 3, Section 5.1</li> <li>• PIM Chapter 11, Section 1.3.1</li> </ul>	<ul style="list-style-type: none"> <li>a. Develop edits</li> <li>b. Implement edits</li> <li>c. Quality Assurance edits</li> <li>d. Generate denial letters if appropriate</li> </ul>	<p><b>Workload 1</b> is the number of claims denied in whole or in part.</p> <p><b>Workload 2</b> is the number of claims subjected to automated review, to the extent that contractors can report this.</p> <p><b>Workload 3</b> is the number of providers subjected to automated medical review, to the extent a contractor can report this.</p>
21002	<b>Routine Manual Reviews</b>	<p>Routine prepayment review requires the intervention of specially trained non-clinical MR staff.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM Chapter 3, Section 5.1</li> <li>• PIM Chapter 11, Section 1.3.2</li> </ul>	<ul style="list-style-type: none"> <li>a. Develop edits</li> <li>b. Implement edits</li> <li>c. Claim review</li> <li>d. Make determination</li> <li>e. Generate denial letter if appropriate</li> </ul>	<p><b>Workload 1</b> is number of claims reviewed.</p> <p><b>Workload 2</b> is number claims denied in whole or in part.</p> <p><b>Workload 3</b> is the number of providers subjected to routine review, to the extent a contractor can report this.</p>

# Medical Review Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21007	<b>Data Analysis</b>	<p>Data Analysis is the integrated and on-going comparison of claim information, claims data deviations from standard practice, and other related data to identify potential errors. This analysis can be a comparison of individual claim characteristics or in the aggregate of claims submissions.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM Chapter 2, Section 2</li> <li>• PIM Chapter 11, Section 1.4</li> </ul>	<ul style="list-style-type: none"> <li>a. Collect data</li> <li>b. Analyze data and compare</li> <li>c. Verify existence of errors</li> <li>d. Identify potential aberrance's</li> <li>e. Develop edit criteria</li> <li>f. Institute ongoing monitoring and modification of data analysis program components</li> <li>g. Develop and maintain trend reports over at least a two-year period</li> </ul>	
21010	<b>Third Party Liability (TPL) or Demand Bills</b>	<p>Demand bills are bills submitted by the SNF or a RHHI at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF and RHHI must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM Chapter 6, Section 1.1</li> <li>• PIM Chapter 11, Section 1.6</li> </ul>	<ul style="list-style-type: none"> <li>a. Select claims</li> <li>b. Claim review</li> <li>c. Request medical record and documentation</li> <li>d. Make determination</li> <li>e. Generate denial if appropriate</li> </ul>	<p><b>Workload 1</b> report the number of claims (TPL and demand bills) reviewed.</p> <p><b>Workload 2</b> report number of claims denied in whole of in part.</p> <p><b>Workload 3</b> report the number of demand bills. (PIM Ch. 11)</p>

# Medical Review Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21100	<b>Program Safeguard Contractors (PSC) Support Services</b>	Contractors must track and record costs associated with providing medical review related support to PSC.  <b>Reference:</b> <ul style="list-style-type: none"> <li>PIM Chapter 11, Section 1.8</li> </ul>	<ul style="list-style-type: none"> <li>a. Pulling medical records</li> <li>b. Photocopying medical records</li> <li>c. Mailing medical records</li> <li>d. Medical Review reconsideration</li> </ul>	
21206	<b>Policy Reconsideration/ Revision</b>	Contractors are to update Local Medical Review Policy (LMRP)  <b>Reference:</b> <ul style="list-style-type: none"> <li>PIM Chapter 11, Section 1.5.2</li> </ul>	<ul style="list-style-type: none"> <li>a. Determine need</li> <li>b. Develop draft LMRP change</li> <li>c. Solicit comment</li> <li>d. Compile comments</li> <li>e. Develop final policy</li> <li>f. Distribute policy</li> <li>g. Post LMRP on Website</li> </ul>	<p><b>Workload 1</b> report the total number of policies revised.</p> <p><b>Workload 2</b> report the total number of policies that required notice and comment.</p> <p><b>Workload 3</b> report total number of policies revised due to outside request (e.g., beneficiary or provider request.)</p>
21207	<b>MR Program Management</b>	MR Program Management encompasses managerial responsibilities inherent in managing the Medical Review and Local Provider Education & Training Programs, including development, modification and periodic reports of MR/LPET Strategies and quality assurance activities; planning, monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions.	<ul style="list-style-type: none"> <li>a. Develop and periodically modify Medical Review/LPET Strategy</li> <li>b. Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, Committee meetings, and periodic reports</li> <li>c. Evaluate edit effectiveness</li> <li>d. Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff</li> <li>e. Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus</li> </ul>	

# Medical Review Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		<b>Reference:</b> <ul style="list-style-type: none"> <li>PIM Chapter 11, Section 1.9</li> </ul>	when indicated f. Implement Medical Review instruction from Regional and/or Central Office g. Educate staff on Medical Review issues, new instruction, and quality assurance findings	
21208	<b>New Policy Development Activities</b>	Contractors are to create Local Medical Review Policy (LMRP).  <b>Reference:</b> <ul style="list-style-type: none"> <li>PIM Chapter 11, Section 1.5.1</li> </ul>	a. Determine need b. Develop draft LMRP change c. Solicit comment d. Compile comments e. Develop final policy f. Distribute policy g. Post LMRP on Website	<b>Workload 1</b> is the number of new policies that were presented for notice and comment.  <b>Workload 2</b> is the number of policies that became effective.  <b>Workload 3</b> is the number of Coverage Statements (National Coverage Decisions that do not require you to develop an LMRP) you published.
21210	<b>MR Reopenings of N102 Claims and Claims with Late Documentation</b>	Report the costs associated with Contractor MR staff re-processing denials returned from the formal appeals process.  <b>Note:</b> PIM Chapter 11 will be updated	a. Receive reopening request b. Review initial determination c. Request additional documentation (if needed) d. Make determination e. Communicate with provider/supplier	<b>Workload 1</b> is the number of reopening requests received.  <b>Workload 2</b> is the number of reopenings resulting in payment.  <b>Workload 3</b> is the number of providers requesting a reopening.

# Medical Review Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21220	<b>Complex Manual Probe Sample Review</b>	Reports all costs associated with prepay and postpay Complex Manula Probe Sample Review.	<ul style="list-style-type: none"> <li>a. Review data</li> <li>b. Select sample</li> <li>c. Request medical records/additional information</li> <li>d. Review claim</li> <li>e. Make determination</li> <li>f. Generate denial/demand letters, if appropriate</li> </ul>	<p><b>Workload 1</b> is the number of claims reviewed.</p> <p><b>Workload 2</b> is the number of claims denied in whole or in part.</p> <p><b>Workload 3</b> is the number of providers subjected to complex review as reported by the carrier and DMERC.</p>
21221	<b>Prepay Complex Manual Review</b>	Reports all costs associated with Prepay Complex Manual Review.	<ul style="list-style-type: none"> <li>a. Develop edits</li> <li>b. Implement edits</li> <li>c. Claim review</li> <li>d. Request medical records and additional documents</li> <li>e. Claim and Documentation Review</li> <li>f. Make determination</li> <li>g. Generate denial letters, if appropriate</li> </ul>	<p><b>Workload 1</b> is the number of claims reviewed.</p> <p><b>Workload 2</b> is the number of claims denied in whole or in part.</p> <p><b>Workload 3</b> is the number of providers subjected to complex review as reported by the carrier and DMERC.</p>
21222	<b>Postpay Complex Manual Review</b>	All costs associated with Postpay Complex Manual Review.	<ul style="list-style-type: none"> <li>a. Select claims</li> <li>b. Claim review</li> <li>c. Request medical records and additional documents</li> <li>d. Claim and Documentation review</li> <li>e. Make determination</li> <li>f. Generate overpayment demand letters, if appropriate</li> </ul>	<p><b>Workload 1</b> is the total number of claims reviewed on a postpayment basis.</p> <p><b>Workload 2</b> is the total number of claims denied in whole or in part.</p> <p><b>Workload 3</b> is the number of providers subjected to postpayment review as reported by contractors.</p>

# Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
22001	<b>MSP Bills/Claims Prepayment</b>	<p>All costs of activities associated to continued processing of a MSP claim after it enters the claims processing system, subsequent to initial claim entry, and activities necessary to aid in the processing of MSP Prepay-related Congressional hearings and appeals</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PM AB-03-016</li> <li>• PM AB-03-020</li> <li>• PM AB-03-024</li> <li>• PM AB-02-089</li> <li>• PM AB-02-107</li> <li>• PM AB-03-082</li> <li>• MIM, Part 3, Chapter 7, § 3682</li> <li>• PM AB-02-140</li> </ul>	<p>a. Resolve MSP claim edits occurring in the claim adjudication process within the standard systems and in response to CWF verification and validation Compare EOB/RA data attached to the MSP claim to HIMR/CWF data to identify the presence/absence of a CWF MSP Aux File record and to continue claim processing</p> <p>c. Contact the provider (for clarification- not development) if necessary, to avoid suspending the claim</p> <p>d. Add termination dates to MSP auxiliary records previously established on CWF with a “Y” validity indicator when no discrepancy exists in the validity of the CWF information and an active claim (simple terminations)</p> <p>e. Prepare a CWF Assistance Request to terminate a record only when a system problem exists or it fits existing CWF error codes/subject to the 6-month rule</p> <p>f. Work MSP suspended claims that have not processed through to final payment decision including: -Override a claim using conditional payment codes to process the claim as primary -Prepare an “I” record to accommodate an override -Determine to pay as primary or secondary or deny <i>-Follow up on COBC development/actions</i> -Address CWF Automatic Notices</p> <p>g. Complete MSP ECRS Inquiries and CWF Assistance Requests necessary to process the receipt of a claim through to payment or denial – Use C in the ECRS AC field.</p> <p>h. Follow up on prepay CWF Assistance Requests within designated timeframes</p> <p>i. Create “I” records when enough claim information exists to add a new CWF MSP Aux File record</p> <p>j. Process Congressional inquiries related to MSP Prepay functions and follow up with COBC within designated timeframes</p>	<p><b>Workload 1</b> is the number of MSP claim edits resolved in the claim adjudication and CWF verification and validation processes and the “I” records prepared, necessary to complete the processing of a claim.</p> <p><b>Workload 2</b> is the number of ECRS MSP Inquiries and CWF Assistance Requests transmitted to the COBC.</p> <p><b>Workload 3</b> is the number of MSP prepay Congressional and hearing requests processed, including follow up with the COBC.</p>

# Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks	Workload
22005	<b>MSP Hospital Audits/On-site Reviews</b>	<p>All costs of activities associated with the onsite review of hospitals, completion of reports and follow-up.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PM A-02-021</li> <li>• PM AB-03-082</li> <li>• MIM, Part 3, Chapter 7, Section 3693</li> </ul>	<p>a. Conduct on-site hospital reviews                      b. Prepare review reports to providers                      c. Conduct follow-up on corrective action plans with providers</p>	<p><b>Workload 1</b> is the number of completed on-site reviews when a provider report has been submitted.</p>
42002	<b>Liability, No-Fault, Workers' Compensation, Federal Tort Claim Act (FTCA)</b>	<p>All costs of activities associated with the identification and establishment of a MSP Recovery claim specific to the named activity.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 5, Section 3407 - 3420</li> <li>• MIM, Part 3, Chapter 7, Section 3600,</li> <li>• MIM Part 3, Chapter 9, Section 3899</li> <li>• PM AB-03-082)</li> </ul>	<p>a. Research Medicare paid claims to identify claims related to a pending settlement, judgment, or award                      b. Identify Medicare's conditional payment amount                      c. Issue subsequent conditional payment amount notices (when appropriate)                      d. Respond to all case related inquiries (includes congressional inquiries) prior to the demand.                      e. Issue inter-contractor notices (ICN) requests, as appropriate                      f. Respond to ICN requests                      g. Enter appropriate termination dates to CWF                      h. Calculate the Medicare recovery amount                      i. Issue recovery demand to appropriate individual or entity                      j. Coordinate with RO all pre-demand compromise requests                      k. Coordinate with CMS to effectuate FTCA recoveries                      l. Follow CMS directives for access to OSCAR, UPIN, &amp; NSC data                      m. Perform appropriate case related ECRS transactions. Use R in the ECRS AC field</p>	<p><b>Workload 1</b> is the number of recovery demand letters issued.</p> <p><b>Workload 2</b> is the number of <u>incoming Correspondence</u> plus the number of resultant ECRS transactions.</p> <p><b>Workload 3</b> is the number of notices of Medicare's conditional payment amount issued for cases which the contractor has lead responsibility plus the number of ICNs responded to for which you do not have lead responsibilities.</p>

# Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
42003	<b>Group Health Plan</b>	<p>All costs of activities associated with recovery of all Medicare mistaken payments specific to the named activity.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 5, Section 3400</li> <li>• MIM, Part 3, Chapter 7, Section 3600,</li> <li>• MIM, Part 3, Chapter 9, Section 3899</li> </ul>	<p>a. Install/run Data Match tapes</p> <p>b. Perform all Data Match and Non-Data Match history searches</p> <p>c. Develop &amp; issue recovery demand letters (Data Match, Non-Data Match and DPP demands, as well as, demands resulting from 42 CFR 411.25 notices) taking into account existing search parameters and tolerances, if any</p> <p>d. Check CWF prior to mailing of recovery demands, if contractors' systems will not recognize an existing termination date on an MSP record, to ensure valid MSP periods</p> <p>e. Respond to any pre-demand Data Match &amp; Non-Data Match incoming CORR related to a case</p> <p>f. Perform all MPARTS status code updates related to actions up to and through the issuance of a recovery demand</p> <p>g. Perform appropriate case related ECRS transactions. Use G in the ECRS AC field</p>	<p><b>Workload 1</b> is the number of GHP recovery demand letters issued.</p> <p><b>Workload 2</b> is the number of MSP post payment case related ECRS transactions performed.</p>

# Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

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CAFM Code	Activity Name	Definition	Tasks	Workload
42004	<b>MSP General Inquires</b>	<p>All costs of activities associated to MSP CORR that is <u>not case or active claim specific</u>.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 5, Section 3400</li> <li>• MIM, Part 3, Chapter 7, Section 3600,</li> <li>• MIM, Part 3, Chapter 9, Section 3899</li> <li>• PM AB-03-082</li> <li>• PM (MSP General Inquiries Clarification)</li> </ul>	<p>a. Perform appropriate general (non-case related and non-active claim related) ECRS transactions, including those that may be necessary for voluntary refunds/unsolicited refunds. Use I in the ECRS AC field. Take action on non-active claim and non-case related letters (including voluntary refunds/unsolicited refunds), faxes, e-mails, or telephone inquiries</p> <p>b. Respond to one time inquiries for outreach materials which may include the reproduction of these materials (those not counted in 42006)</p> <p>c. Enter non-case related and non-active claim related CWF termination dates</p> <p>d. Respond to OBRA 93 requests not related to an existing debt</p>	<p><b>Workload 1</b> is the number of general MSP inquiries resolved. This includes OBRA 93 requests.</p> <p><b>Workload 2</b> is the number of non-case related &amp; non-active claim related ECRS transactions performed.</p> <p><b>Workload 3</b> is the number of one-time inquiries requesting outreach materials.</p>
42021	<b>Debt Collection/Referral</b>	<p>All costs of activities associated with the collection of all MSP debts and the referral of eligible delinquent MSP debt under the Debt Collection Act of 1996.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• MIM, Part 3, Chapter 5, Section 3400</li> <li>• MIM, Part 3, Chapter 7, Section 3600,</li> <li>• MIM, Part 3, Chapter 9, Section 3899</li> <li>• PM AB-00-11 (CR 899)</li> <li>• PM AB-01-24 (CR 1280)</li> <li>• PM AB-01-83 (CR 1538)</li> <li>• PM AB-02-102 (CR 2145)</li> <li>• PM AB-03-082(CR 2548)</li> </ul>	<p>a. Ensure proper recovery of MSP debts</p> <p>b. Respond and resolve all Corr or other inquiries regarding a debt</p> <p>Timely adjudicate and post checks received</p> <p>c. Review and respond timely to “Extended Repayment Plan” (ERP) requests and monitor ongoing ERPs</p> <p>d. Resolve all post demand 1870 waiver requests</p> <p>e. Validate debts using CWF and other available appropriate information before issuing the “Intent to Refer” (ITR) letter</p> <p>f. Issue ITRs to the appropriate individual or entity (includes the acknowledgement letters, and the preparation of CWF assistance requests &amp; ECRS inquiries)</p> <p>g. Resolve all Treasury Action form requests and perform appropriate recall actions, if necessary</p> <p>h. Perform appropriate debt related ECRS transactions (CWF assistance requests &amp; ECRS inquiries). Use D in the ECRS AC field.</p> <p>i. Refer delinquent debts, as appropriate to Treasury</p> <p>j. Take appropriate referral actions for all compromise or waiver of interest requests</p>	<p><b>Workload 1</b> is the number of responses to initial demand letters received from the debtor /agent.</p> <p><b>Workload 2</b> is the number of intent to refer to Treasury letters (ITRs) &amp; the number of responses received from ITRs. .</p> <p><b>Workload 3</b> is the number of referrals to Treasury plus the number of Treasury action forms received.</p>

# Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
			k. Develop/complete write-off – closed recommendation reports l. Update all appropriate systems that detail the progression of a debt (e.g. MPARTS, DCS, etc.) m. Ensure all MSP report detail are available and complete and can support reported figures (i.e., MSP savings)	

## Benefit Integrity Fiscal Intermediary Activity Dictionary (Non-PSC Support Services)

FINAL

CAFM Code	Activity Name	Definitions	Tasks	Workload
23001	Medicare Fraud Information Specialist (MFIS)	<p>Costs associated with MFIS activity</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM chapter 1, section 3.2.5.1 and chapter 2, section 4-4.5</li> <li>• PIM chapter 2 for specific look under tasks.</li> <li>•</li> </ul>	<ol style="list-style-type: none"> <li>a. Obtains and shares information on health care issues/fraud investigations (PIM chapter 1, section 3.2.5.1)</li> <li>b. Serves as a reference point for law enforcement and other organizations/agencies (PIM chapter 1, section 3.2.5.1)</li> <li>c. Coordinates and attends fraud related meetings/conferences (PIM chapter 1, section 3.2.5.1)</li> <li>d. Distributes Fraud Alerts and shares contractor findings on them (PIM chapter 1, section 3.2.5.1 and chapter 2, section 4-4.5)</li> <li>e. Works with CMS RO to develop and organize external programs and perform training (PIM chapter 1, section 3.2.5.1)</li> <li>f. Serves as a resource for CMS as necessary (PIM chapter 1, section 3.2.5.1)</li> <li>g. Helps develop fraud related outreach material (PIM chapter 1, section 3.2.5.1)</li> <li>h. Assists in preparation and development of fraud related articles for contractor newsletters/bulletins (PIM chapter 1, section 3.2.5.1)</li> <li>i. Serves as a resource for contractor training (PIM chapter 1, section 3.2.5.1)</li> <li>j. Attends 32 hours of training sessions on training skills, presentation skills, and fraud related training (PIM chapter 1, section 3.2.5.1)</li> </ol>	<p><b>Workload 1</b> is the number of fraud conferences/meetings coordinated by the MFIS.</p> <p><b>Workload 2</b> is the number of fraud conferences/meetings attended by the MFIS.</p> <p><b>Workload 3</b> is the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other CMS health care partners.</p>

## Benefit Integrity Fiscal Intermediary Activity Dictionary (Non-PSC Support Services)

FINAL

CAFM Code	Activity Name	Definitions	Tasks	Workload
23004	<b>Outreach and Training Activities</b>	All costs associated with fraud, waste, and abuse outreach and training activities for contractor staff and beneficiaries. Include costs associated with establishing and maintaining fraud, waste, and abuse outreach and training activities for beneficiaries and providers (excluding MFIS activities)	<ul style="list-style-type: none"> <li>a. Train non-BI staff on proper referral of complaints handled under BI (PIM chapter 2, section 3, 3.2.4)</li> <li>b. Initiates and maintains outreach activities with internal components as well as outside groups. (PIM chapter 1, section 3.2, 3.2.3.1, 3.2.5, 7.3)</li> <li>c. Completion of required fraud training for BI staff (PIM chapter 1, section 3.2.3)</li> <li>d. Provide law enforcement with training as needed (PIM chapter 2, section 3.2.3.1)</li> </ul>	<p><b>Workload 1</b> is the number of training sessions internal and external furnished only to the BI staff.</p> <p><b>Workload 2</b> is the number of face-to-face presentations by BI unit staff made to beneficiaries and providers.</p> <p><b>Workload 3</b> is the number of training sessions furnished by the contractor BI unit to non-BI contractor staff.</p>
23005	<b>Fraud Investigation Activities</b>	<p>Any costs associated with fraud investigation used to substantiate a case</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• PIM for specific look under task.</li> </ul>	<ul style="list-style-type: none"> <li>a. Identify program vulnerabilities (PIM chapter 1, section 3.2)</li> <li>b. Control, verify and document all investigations. (PIM chapter 1, section 3.2.4.1)</li> <li>c. Document all pertinent contacts, letters, decisions, discussions, etc. Retain records for 7 years (PIM chapter 2, section 3.3)</li> <li>d. Interview providers and beneficiaries (PIM chapter 2, section 3.4.2-3.4.4). )</li> <li>e. Conduct onsite reviews (PIM chapter 2, section 3.4.5).</li> <li>f. Determine patterns of fraud (PIM chapter 2, section 2.1)</li> <li>g. Issue Fraud Alerts (PIM chapter 2, section 4)</li> <li>h. Coordinate with Medical Review and other internal sources on fraud activities.</li> <li>i. Implement claim payment suspension (PIM chapter 3, section 9)</li> <li>j.. Review and evaluate cases to determine exclusion action (PIM chapter 3, section 11.2.2)</li> <li>k. Prioritization of investigations (PIM chapter 1, section 3.2.1)</li> </ul>	<p><b>Workload 1</b> is the number of investigations opened.</p> <p><b>Workload 2</b> Of the investigations in workload column 1, report how many were opened by contractor self-initiated proactive data analysis.</p> <p><b>Workload 3</b> is the total number of investigations closed (no longer requiring fraud investigation) and which were not referred to law enforcement.</p>

## Benefit Integrity Fiscal Intermediary Activity Dictionary (Non-PSC Support Services)

FINAL

CAFM Code	Activity Name	Definitions	Tasks	Workload
23006	<b>Law Enforcement Support</b>	<p>All BI costs and related data analysis for work done to support law enforcement.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>PIM chapter 1, section 7-7.1.2</li> </ul>	<p>a. Receive and respond to all law enforcement requests (PIM chapter 1, section 7-7.1.2)</p>	<p><b>Workload 1</b> is the number of law enforcement requests.</p> <p><b>Workload 2</b> is the number of requests discussed with the RO.</p> <p><b>Workload 3</b> is the number of BI law enforcement requests that require data analysis.</p>
23007	<b>Medical Review in Support of Benefit Integrity Activities</b>	<p>All costs associated with medical review (MR) in support of BI activities. The main goal of medical review is to change provider-billing behavior through claims review and education; therefore, any BI initiated review activity that does not allow for provider education or feedback must also be charged to this activity.</p>	<p>a. Review of claims by MR and BI (PIM chapter 1, section 4).</p> <p>b. Perform SVRS for overpayment estimation (PIM chapter 1, section 4)</p>	<p><b>Workload 1</b> is the number of cases in which the MR unit assisted the BI unit.</p> <p><b>Workload 2</b> is the number of claims reviewed by both the MR and BI unit for the BI unit.</p> <p><b>Workload 3</b> is the number of statistically valid random samples (SVRS) performed for overpayment estimation by MR in support of BI.</p>
23014	<b>Fraud Investigation Database (FID) Entries</b>	<p>All costs associated with FID entries.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>PIM</li> </ul>	<p>a. Entering new FID cases</p> <p>b. Updating FID cases</p> <p>c. Entering new payment suspension information</p> <p>d. Updating payment suspension information</p>	<p><b>Workload 1</b> is the total number of new cases entered into the FID.</p> <p><b>Workload 2</b> is the total number of cases updated in the FID.</p> <p><b>Workload 3</b> is the total number of new payment suspensions entered into the FID.</p>
23015	<b>Referrals to Law Enforcement</b>	<p>All costs associated with referrals to law enforcement.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>PIM, Chapter 3, section 10.1.4</li> </ul>	<p>a. Developing the referral package to law enforcement (PIM chapter, section 10.1.4).</p> <p>b. Fulfilling requests for additional information from law enforcement on the referrals they received (PIM)</p>	<p><b>Workload 1</b> is the total number of referrals to law enforcement.</p> <p><b>Workload 2</b> is the total number of</p>

# Benefit Integrity Fiscal Intermediary Activity Dictionary (Non-PSC Support Services)

FINAL

CAFM Code	Activity Name	Definitions	Tasks	Workload
				<p>law enforcement referrals requesting additional information by law enforcement.</p> <p><b>Workload 3</b> is the number of law enforcement referrals declined.</p>

## Benefit Integrity Fiscal Intermediary Activity Dictionary (PSC Support Services)

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
23201	<b>PSC Support Services</b>	<p>The services that the AC will provide to support the BI activities being performed by the PSC (PM)</p> <p><b>Misc.Code:</b> 23201/01 – <b>Miscellaneous PSC support services</b> - ACs record the total costs associated with miscellaneous PSC support services. ( e.g., training and meetings.)</p> <p><b>Misc. Code:</b> 23201/02 – <b>Non-Law Enforcement Complaint Development and Investigation Requests</b> - ACs record the total costs associated with requests (not law enforcement requests) that they fulfill to support the PSC in investigations.</p> <p><b>Misc. Code:</b> 23201/03 – <b>Law Enforcement Requests</b> - ACs record the total costs associated with PSC requests for support from the AC with law enforcement requests.</p>	<p>a. Prepare referral package</p> <p>b. Prepare/supply additional documentation at the request of the PSC</p>	<p><b>Workload 1</b> Report the total number of miscellaneous PSC support services.</p> <p><b>Workload 2</b> AC’s record the total number of requests (not law enforcement) they fulfill to support the PSC in investigations.</p> <p><b>Workload 3</b> Reports the total number of PSC requests for support from the AC with law enforcement requests.</p>

# Local Provider Education and Training (LPET) Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
24116	<b>One-on-One Provider Education.</b>	<p>Contractors must initiate provider one-on-one education in response to coverage, coding and medical review related billing problems identified, verified and prioritized through the analysis of information from various sources and the medical review of claims. These educational contacts require clinical expertise and include face-to-face meetings, telephone conferences, or letters and electronic communications to a provider that address the provider’s specific coding, coverage and billing issue. An individualized comparative billing report (CBR) included as part of a specific instructional letter to a specific provider would be considered part of a ‘one-on-one’ educational contact. The selected educational contacts depend on the level of the coverage, coding or billing error identified. For minor or moderate coverage, coding or billing errors, the educational contact may be made through telephone conferences or an individualized letter iterating the specific problems and cures and including an opportunity for the provider to engage in a teleconference or face-to-face contact. In the case of major coverage, coding or billing errors, the contractor must provide the opportunity for a face-to-face meeting or at a minimum provide educational services through teleconferencing. In all instances, contractors must supply educational materials to address the provider’s <u>specific</u> coverage, coding or billing error. In no instance should the contractor issue general coverage, coding or billing statements without addressing the provider’s specific educational need. While one-on-one provider education may correct most coverage, coding or billing errors in the first educational meeting, providers may require additional</p>	<ul style="list-style-type: none"> <li>a. Analyze Data</li> <li>b. Determine appropriate educational method based on scope of problem</li> <li>c. Develop/produce educational information</li> <li>d. Send letter, or electronic communication</li> <li>e. Make a telephone call</li> <li>f. Hold a meeting, i.e. teleconference, or face-to face contact</li> </ul>	<p><b>Workload 1</b> is the number of providers educated as a result of complex prepaids and postpay review.</p> <p><b>Workload 2</b> is the number of providers educated as a result of a probe.</p> <p><b>Workload 3</b> is the number of providers educated as a result of other medical review activity, i.e., data analysis, new provider education, etc.</p>

# Local Provider Education and Training (LPET) Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		remedial education contacts to provide further instruction on coverage, coding or billing requirements.		
24117	<b>Education Delivered to a Group of Providers</b>	<p>Education delivered to a group of providers include seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding local medical review policies, coverage, coding and billing considerations, and service or specialty specific issues. Clinical staff must be used as a resource. Additionally, group settings may be appropriate to address the local educational needs presented by new providers, new coverage policies and bulletin articles concerning medical review issues. Whenever feasible, contractors should collaborate education delivered to a group of providers with interested groups and organizations as well as CMS partners in their service area.</p> <p><b>Misc. Code:</b> 24117/01 - <b>Group Education Complex MR</b> - Report costs associated to educate a group of providers as a result of prepay and postpay complex review.</p>	<ul style="list-style-type: none"> <li>a. Analyze Data</li> <li>b Determine appropriate educational method based on scope of problem</li> <li>c. Gather resources, including clinical staff expertise, and develop/produce educational information</li> <li>d. Select focus groups or site visits/meetings. If feasible, collaborate with partner groups in holding events</li> <li>e. Hold educational meeting with the presence of clinical staff</li> </ul>	<p><b>Workload 1</b> is the number of providers educated as a result of a new or modified policy.</p> <p><b>Workload 2</b> is the number of providers educated as a result of a probe.</p> <p><b>Workload 3</b> is the number of providers educated as a result of other medical review activity, i.e., data analysis, and new providers.</p>
24118	<b>Education Delivered via Electronic or Paper Media</b>	<p>Education delivered solely via paper media or electronically, without any live interactions is included here. Contractors are required to maintain a website and list serv and adhere to instruction regarding them (PIM Chapter 1, Sec. 5.A.9 CR2466 to be issued.) Examples of this type of education include, but are not limited to, the development and dissemination of frequently asked questions (FAQs), scripted response documents. bulletin articles. LMRP postings.</p>	<ul style="list-style-type: none"> <li>a. Analyze Data</li> <li>b. Develop and disseminate web-based searchable FAQs</li> <li>c. Develop and disseminate bulletin articles</li> <li>d. Disseminate and post LMRPs</li> <li>e. Develop and disseminate CBRs</li> <li>f. Develop and disseminate other types of electronic or paper media education</li> </ul>	<p><b>Workload 1</b> is the number of educational projects, developed as a result of prepay and postpay complex medical review.</p> <p><b>Workload 2</b> is the number of educational</p>

# Local Provider Education and Training (LPET) Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		comparative billing reports (CBRs) issued for other than one-on-one provider education.		<p>projects, developed to be disseminated via paper media.</p> <p><b>Workload 3</b> is the number of educational projects, developed to be disseminated electronically.</p>

# Provider Communications (PCOM-MIP) Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
25103	<b>Create/Produce and Maintain Educational Bulletins</b>	<p>All costs associated with the development, production and dissemination of provider bulletins/newsletters.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965 A.5</li> </ul>	<p>a. Gather resources and information to use in developing bulletin</p> <p>b. Develop bulletin</p> <p>c. Publish bulletin</p> <p>d. Disseminate bulletin</p>	<p><b>Workload 1</b> is the total number of bulletin editions published.</p> <p><b>Workload 2</b> is the total number of bulletins mailed.</p>
25105	<b>Partner with External Entities</b>	<p>All costs associated with the establishment and maintenance of collaborative provider education efforts with external entities.</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• (To be added to Intermediary Manual)</li> </ul>	<p>a. Contact/communicate with external groups or organizations</p> <p>b. Work with external groups to foster and develop collaborative PET activities</p> <p>c. Obtain feedback on effectiveness and reach of partnering efforts</p>	<p><b>Workload 1</b> is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.</p>
25201	<b>Administration and Management of PCOM Program</b>	<p>All costs associated with administering and managing the provider communications program. Includes: research analysis and identification of provider education needs; planning of educational strategies, approaches, or efforts; training of staff in support education initiatives; and reporting of provider education activities and efforts.</p> <p>All costs associated with developing plans to outline the strategies, projected activities, efforts, and approaches that will be used in the forthcoming year to support physician/supplier education and training.</p>	<p>a. Develop and submit PSP Report</p> <p>b. Develop and submit Quarterly Activity Reports</p> <p>c. Develop and maintain a provider inquiry analysis program</p> <p>d. Tally and analyze claim submission errors</p> <p>e. Solicit and analyze provider feedback</p> <p>f. Hold periodic meetings with other contractor staff to ensure that issues raised by providers are being addressed through education</p> <p>g. Send at least one training representative to between 2-4 CMS-sponsored training events</p> <p>h. Development and research responses to provider referrals</p>	

# Provider Communications (PCOM-MIP) Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		<p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965 A.1, 2,3,11, 12 &amp; B.1.</li> </ul>		
25202	<p><b>Develop Provider Education Material and Information</b></p>	<p>All costs associated with the planning, design, research, writing and development of materials and information used to support provider education and training efforts. This includes work for new as well as substantially revised materials or information.</p> <p><b>Misc. Code:</b> 25202/01 - <b>Special Media</b> - for costs associated with preparation of special media.</p> <p><b>Reference:</b> (To be added to Intermediary Manual)</p>	<p>a. Plan materials b. Research needed information c. Design, layout materials d. Write, illustrate or revise material e. Duplicate materials f. Prepare special media educational presentations (discretionary)</p>	<p><b>Workload 1</b> is the number of special media efforts developed.</p>
25203	<p><b>Disseminate Provider Information</b></p>	<p>All costs associated with holding workshops seminars, classes and other provider education events or face-to-face meetings. (Does NOT include activities related to creation of bulletins or newsletters.)</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965 A.6, 8.</li> </ul>	<p>a. Hold workshops, seminars, classes and other face to face meetings b. Disseminate Medicare provider information or materials at other provider education events or opportunities</p>	<p><b>Workload 1</b> is the number of educational seminars, workshops, classes and face-to-face meetings held.</p> <p><b>Workload 2</b> is the number of attendees at your educational seminar workshops, classes and face-to-face training</p>

## Provider Communications (PCOM-MIP) Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
25204	<b>Management and Operation of PCOM Advisory Group</b>	<p>All costs associated with the management and operation of the PCOM Advisory Group (formerly the PET Advisory Group).</p> <p><b>Reference:</b></p> <ul style="list-style-type: none"> <li>• Intermediary Manual, Part 2, Chapter XI, Section 2965 A.4</li> </ul>	<p>a. Arrange PCOM Advisory Group meetings            b. Solicit and maintain membership            c. Obtain materials, supplies and equipment for meetings            d. Produce and distribute POM Advisory Group information (agenda, minutes, etc.)</p>	

# Audit Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
26001	<b>Provider Desk Reviews</b>	<p>Includes activities related to the cost report acceptance, tentative settlement, desk review and audit scoping.</p> <p><b>Reference:</b> MIM, Part 2, Chapter 1, 13.4 PRM 15, Part 1, Chapters 27-29</p> <ul style="list-style-type: none"> <li>• CR 1468</li> <li>• Uniform Desk Review Guidelines</li> </ul>	<p>a. Initial review to make sure the cost report is complete and acceptable</p> <p>b. Complete the Automated Desk Review (ADR)</p> <p>c. cursory review and initial tentative settlement determination</p> <p>d. Professional desk review including the resolution of issues via phone or letter</p> <p>e. The determination of whether a field audit is to be performed and if so the scope</p> <p>f. Review of updated PS&amp;R if cost report is not subjected to a field audit.</p> <p>g. Final review and approval of these procedures by a supervisor</p>	<p><b>Workload 1</b> is Line 2a of the CASR IER, the total number of units (cost reports) when the desk reviews are completed. Line 2a is the total of lines 3a and 4a.</p> <p><b>Workload 2</b> is Line 3a, the number of limited desk reviews.</p> <p><b>Workload 3</b> is Line 4a, the number of full desk reviews.</p>
26002	<b>Provider Audits</b>	<p>Include all activities after the desk review but prior to the settlement.</p> <p><b>Reference:</b> MIM 13.4, Part 2, Chapter 11 PRM 15, Part 1</p> <ul style="list-style-type: none"> <li>• CR 1468</li> </ul>	<p>a. Preliminary audit work including reviewing prior years workpapers</p> <p>b. Review of updated PS&amp;R if cost report is subjected to a field audit or focused review</p> <p>c. All on-site audit work and proposed audit adjustments</p> <p>d. The entrance and exit conference</p> <p>f. The preparation of the final audit adjustment report</p> <p>g. Final review of the results by the supervisor</p>	<p><b>Workload 1</b> is Line 6b of the CASR IER. Line 6b is the total of line 7b and line 8b.</p>
26003	<b>Provider Settlements</b>	<p>Includes all work performed after the desk review/focus review and field audit through the NPR issuance. Do not include any appeal or hearing work.</p> <p><b>Reference:</b> MIM 13.4 PRM 15 Part 1</p> <ul style="list-style-type: none"> <li>• CR 1468</li> </ul>	<p>a. Reworking/review of the cost report after audit</p> <p>b. Preparation and typing of all transmittal letters (NPR and Management Letter)</p> <p>c. Final review by the supervisor for approval</p> <p>d. Issuing the NPR</p>	<p><b>Workload 1</b> is Line 10a of the CASR IER, the number of cost reports settled.</p>

## Audit Fiscal Intermediary Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
26004	<b>Cost Report Reopenings</b>	Includes all work related to the reopening of a cost report.  <b>Reference:</b> MIM 13.4 PRM 15 Part 1 • CR 1468	a. Review of the request for reopening b. Review documentation from the provider and determine if there is any change in the settlement c. If necessary, re-settle the re-opened cost report	<b>Workload 1</b> is Line 13b of the CASR IER, the number of reopenings completed.
26005	<b>Wage Index Review</b>	Includes all activities related to wage index reviews.	a. Follow the most recent transmittal/Change Request containing detail procedures for wage index review tasks	<b>Workload 1</b> is a manual count of the number of hospital wage index reviews completed.
26010	<b>STAR Activities</b>	<b>NOTE: This code is not included in the BPRs section for Audit because it is exclusively used by Mutual of Omaha to account for all work performed on the maintenance and enhancement of the STAR system</b>  <b>Reference:</b> MIM 13.4 • STAR Procedures Manual	a. CMS will review and approve a yearly plan	

# Audit Fiscal Intermediary Activity Dictionary

## FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
26011	<b>PRRB and Intermediary Hearings</b>	<p>This code is now available to all FIs and includes all work performed on cost reports related to a provider's appeal.</p> <p><b>Reference:</b>  MIM 13.4  PRM 15 Part 1  <ul style="list-style-type: none"> <li>• CR 1468</li> </ul> </p>	<ol style="list-style-type: none"> <li>a. Prepare position papers</li> <li>b. Participate in meetings with providers including work performed relating to administrative resolutions</li> <li>c. Participate in any mediations with PRRB staff and with providers</li> <li>d. Prepare for board hearing and interact with BCBS attorneys</li> <li>e. Testify before PRRB</li> <li>f. Prepare any evidence for CMS attorney advisor if Administrator intervention to overturn board decision is necessary</li> </ol>	<p><b>Workload 1</b> – cases closed – include all cases closed resulting from administrative resolutions, hearings, mediation, withdrawals, etc.</p>