REQUEST FOR RECORDS DISPOSITION AUTHORITY	JOB NUMBER N1-440-09-11
To: NATIONAL ARCHIVES & RECORDS ADMINISTRATION 8601 ADELPHI ROAD COLLEGE PARK, MD 20740-6001	Date received 9-22-2009
1. FROM (Agency or establishment) Department of Health and Human Services	NOTIFICATION TO AGENCY
2. MAJOR SUBDIVISION Centers for Medicare and Medicaid Services (CMS)	In accordance with the provisions of 44 U.S.C. 3303a, the disposition request, including amendments, is approved except for items that may be marked "disposition not approved" or "withdrawn" in column 10.
3. MINOR SUBDIVISION	
4. NAME OF PERSON WITH WHOM TO CONFER: Vickie Robey, CMS Records Officer	5. TELEPHONE NUMBER: 410-786-7883
DATE: 03 NOV 10	ARCHIVIST OF THE UNITED STATES: [signature]

6. AGENCY CERTIFICATION

I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and that the records proposed for disposal on the attached 3 page(s) are not needed now for the business for this agency or will not be needed after the retention periods specified; and that written concurrence from the General Accounting Office, under the provisions of Title 8 of the GAO Manual for Guidance of Federal Agencies,

☒ is not required ☐ is attached; or ☐ has been requested.

DATE	SIGNATURE OF AGENCY REPRESENTATIVE	TITLE
09/22/2009	S:// Yvonne K. Wilson [Yvonne K. Wilson]	HHS Records Officer

7. ITEM NO.	8. DESCRIPTION OF ITEM AND PROPOSED DISPOSITION	9. GRS OR SUPERSEDED JOB CITATION	10. ACTION TAKEN (NARA USE ONLY)
	CMS Payment Quality Review System See attached.		

Attachment to SF-115, for CMS Electronic Systems Schedule

Payment Quality Review Systems (PQRS)

A collection of automated systems that supports the review of Medicare Program payments for medical goods and services. Quality review areas include, but may not be limited to overpayment, duplicate payment, fraud and abuse, monetary penalty tracking, and overall benefit savings. Includes but not limited to:

Fraud Investigation Database (FID) – FID is a nationwide data entry and reporting system run out of the CMS Data Center that allows CMS to monitor fraudulent activity and payment suspensions related to Medicare and Medicaid providers. FID captures information on investigations of potential Medicare or Medicaid fraud, fraud and abuse cases that have been referred to law enforcement and payment suspensions that have been imposed on Medicare providers. FID tracks fraud cases as they move through development to final disposition, as well as, provider payment suspensions from the imposition to removal, identifies emerging fraud issues on a national and regional level; improves the prevention and detection of fraud and abuse in the Medicare and Medicaid Programs; FID also provides reporting capabilities on the data captured in the system. Medicare contractors, Medicaid State Agencies, Law Enforcement Agencies, and CMS staff have access to FID.

Mistaken Payment Recovery Tracking System (MPARTS) – MPARTS is the conduit for maintaining a summary database to serve as a master control file for mistaken payment recoveries resulting from the IRS/SSA/CMS Data Match Project. The cycle begins with SSA producing a file of Medicare beneficiaries, by social security number. IRS then runs the SSA file against tax filings for a given year or years to link the SSN's of the beneficiaries and their spouses. SSA runs the IRS file against the Master Earnings File. The file is output to tape and sent to the Data Match contractor, who creates an extract file by sorting the number of employees per employer and computing the earliest potential Medicare secondary payer. The output files from this process are transmitted to the Data Match subcontractor who does all printing and mailings including an initial mailing to determine whether or not a particular employer needs to complete the Data Match questionnaire as well as the Data Match questionnaires/instructions. The output files from this process are transmitted to the Data Match subcontractor who performs data entry edits as the mailings are received. Output files of health insurance non-settled MSP records (HUSP) are created and send to the Medicare Common Working file. Detailed output files are retrieved by Medicare contractors who have responsibility for the claims workload. Medicare contractors research the potential mistaken payment amounts identified in any given cycle and adjust the amount where appropriate. Contractors then send demand letters with the adjusted amount to the responsible employer with a copy to the insurer. After the contractors send out the demand letters, they enter the amounts in the MPARTS on-line database. **(Superseded Disposition Authority: N1-440-01-05)**

Provider Overpayment Recovery (POR) System – POR is used to track overpayments of Medicare and Medicaid monies to hospitals, skilled nursing facilities, and other Part A entities. POR accepts overpayment information, such as the claim determination date, the initial overpayment balance and principal and interest collections and displaying the current balance due, the total principal amount recouped to date, and the total interest amount recouped to date. This data comes from the contractor's internal accounting systems and is entered into the CMS mainframe computer.

Physician/Supplier Overpayment Recovery (PSOR) System – PSOR tracks overpayments of Medicare and Medicaid monies to physicians and suppliers. PSOR accepts overpayment information, such as the claim payment date, the claim determination date, the initial overpayment balance and principal and interest

collections and displaying the current balance due, the total principal amount recouped to date, and the total interest amount recouped to date from the contractor's internal accounting systems and is entered into the CMS mainframe computer.

Recovery Management and Accounting System (ReMAS) – Identifies potential Medicare overpayments resulting from Medicare paying claims as primary or conditionally, while legally being a secondary payer to group health plans, liability insurers, workers' compensation carriers and class action liability settlements. ReMAS transfers verified overpayment information to the Health Integrated General Ledger Accounting System (HIGLAS). ReMAS provides case creation and tracking, letter generation, correspondence tracking and a standard reporting capability. ReMAS identifies Medicare Secondary Payer debt in a more timely manner; manages and controls MSP recovery cases in a centralized database; tracks all financial activity on the MSP case.

Data exchanges are with:

- CMS Data Center (Beneficiary, claim, provider (institutional and non-institutional))
- Common Working File Hosts (supplier date, online claim retrieval)
- HIGLAS (Accounts receivable, letter transactions)

System for MSP Automated Recovery and Tracking (SMART) – SMART tracks debts owed to the Medicare Trust Fund due to Group Health Plan (GHP) MSP overpayments. GHP MSP overpayments are claims that Medicare paid as the primary payer when the beneficiary meets the condition of Working Aged, End Stage Renal Disease, or Disability Under Age 65 and is covered by another Insurer under a GHP who should have paid as the primary. SMART receives GHP Case Information from ReMAS for the purpose of establishing Account receivables and issuing Demand Letters. The case information includes Employer debtor information, Insurer information and Paid Claim information, as well as, Beneficiary and Provider Information associated with the Paid Claims. Functions supported by SMART: generates and stores records of outgoing correspondence for reference of case activities, posting recoveries, adjusting and writing off account balances, establishing an audit trail of recoupment activities, generates CMS-mandated reports and letters, including CFO reporting and MSP Savings, referral of eligible debts to Treasury for collection.

MSP Automated Recovery and Tracking Initiative (MARTI) – Tracks debts owed to the Medicare Trust Fund due to Non-Group Health Plan (Non-GHP) MSP overpayment. Non-GHP MSP overpayments are claims that Medicare paid as the primary payer when liability, worker's compensation, malpractice, or no-fault insurance entitles should have paid as the primary payer. Functions supported by MARTI: Generating and storing a record of outgoing correspondence for reference of case activity, posting recoveries, adjusting and writing off account balances, establishing an audit trail of recoupment activities, generating CMS-mandated reports and letters, including COP reporting and MSP Savings; referral of eligible debts to Treasury for collection.

MARTI receives data from:

- ReMAS - Non-Group Health Plan (Non-GHP) case information for the purpose of establishing Account Receivables and issuing Demand Letters and other correspondence. Case information includes beneficiary information, beneficiary's attorney information, insurer information, when applicable, settlement information, and paid claims information as well as beneficiary and provider information associated with the paid claims. A case is created in MARTI by beneficiary and date of incident.

- Recovery Service Center System – Records by beneficiary with open correspondence for the purpose of preventing referral of debts to Treasury until the correspondence item(s) has been closed.

MARTI sends data to:

- United Systems of Arkansas – Non-GHP Case Account receivable information for the purpose of printing Demand Letters and other correspondence. The account receivable information includes, beneficiary information, to who the Demand letter is addressed when the beneficiary is the debtor, Attorney information, who receives a copy of the Demand Letter, and the claims used to arrive at the amount due on the receivable. The claims included in the Demand letter are limited to claims containing services provided as a result of the incident or injury.
- Debt Collection System – outstanding account receivable information for the purpose of referral of debt to the Treasury.

Payment Error Rate Measurement (PERM) System

PERM is a comprehensive, ongoing federal audit intended to measure how frequently errors occur when providers submit claims to states and when states pay those claims. PERM is designed to estimate the proportion of Medicaid payments made in error. The estimated payment error rate is calculated as the ratio of the dollar value of all inaccurate payments to the dollar value of the total payments. The dollar amounts of any errors identified (overpayments and underpayments) are tracked and used to calculate the final payment error rate. The state-specific estimates will be used to establish national payment error rates for Medicaid and SCHIP. States are required to reimburse CMS for payment errors identified. States will, in turn collect dollars in error from Providers.

Data resides on mainframe system and is maintained in compliance with all Federal laws and regulations and Federal, HHS and CMS policies and standards as they relate to information security and data privacy. SMART & MARTI data resides at the Birmingham Data Center. PERM data (including medical records) resides on CMS contractors' servers.

~~1a. Inputs – outgoing correspondence for reference of case activity, posting recoveries, account balances, recoupment activities, CMS-mandated reports and letters, including COP reporting and MSP Savings; eligible debts for collection; overpayment data from providers; Medicare Secondary Payer, Medicaid/CHIP claims data from States and medical records from Providers.~~

~~DISPOSITION: Temporary. Cut off annually. Delete/destroy 5 years after cutoff, or when no longer needed for Agency business, whichever is later.~~ (GRS 20, Item 2)

~~1b. - Master Files - outgoing correspondence for reference of case activity, recoveries, account balances,~~ audit trail of recoupment activities, CMS-mandated reports and letters, eligible debts ~~referred to~~ Treasury for collection; provider overpayments; MSP, Medicaid/~~CHIP claims~~ data, medical records from providers.

DISPOSITION: ~~Temporary. Cut off annually. Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later.~~

~~1c. Outputs~~

~~1c1. CMS Mandated Reports, Letters and Collection Referrals~~

Superseded by job / item number: DAA-0440-2015-0004-0001

Date (MM/DD/YYYY): 7/13/2017

~~DISPOSITION: Temporary. Cut off annually. Delete/destroy 10 years after cutoff or when no longer needed for Agency business, whichever is later.~~ (GRS 20, item 6)

~~1c2. Adhoc Reports~~

~~DISPOSITION: Temporary. Cut off annually. Delete/destroy 1 year after cutoff or when no longer needed for Agency business, whichever is later.~~ (GRS 20, item 16)