Medicare Program Integrity Manual

Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity (BI) and Local Provider Education and Training (LPET) Programs

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(Rev. 71, 04-09-04)

1.1- Introduction

(Rev. 71, 04-09-04)

The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of *Program Integrity* (PI) is to pay claims correctly. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare & Medicaid Services (*CMS*) follows four parallel strategies in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and data analysis; 3) close coordination with partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

Fiscal Intermediaries and Carriers that have transitioned some or all of their MR work to a PSC (from this point forward, referred to as Affiliated Contractors or ACs) and Fiscal Intermediaries and Carriers that have not transitioned their MR work to a PSC (from this point forward, referred to as Medicare contractors) shall follow the entire PIM for medical review functions as they relate to their respective roles and areas of responsibility to MR. PSCs shall follow the PIM to the extent outlined in their respective task orders. The PSC, in partnership with CMS, shall be proactive and innovative in finding ways to enhance the performance of PIM guidelines.

The PIM also supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that contractors reduce the error rate identified in the Chief Financial Officer's (CFO) audit. Both the GPRA and

NPR instruct contractors to increase the effectiveness and improve the efficiency of medical review.

Both MR and the *BIU* use data analysis, the foundation for detection of potential errors. The results of development situations identified by data analysis determine whether a situation is an error, which is pursued by the MR unit or potentially fraudulent which, is pursued by the *BIU*, or neither.

The purpose of this chapter is to identify *MR* activities, purpose, functions, and requirements.

1.1.1- Definitions

(Rev. 71, 04-09-04)

To facilitate understanding, the terms used in the PIM are defined in Exhibit 1.

*1.*1.2 - Types of Claims for which Contractors are Responsible – *(Rev.)*

Contractors may perform MR functions for the following types of claims:

- All claims appropriately submitted to a carrier, *Durable Medical Equipment Regional Carrier* (DMERC), or Regional Home Health Intermediary (RHHI) and;
- All claims appropriately submitted to an intermediary including but not limited to:
    - Acute Care Inpatient *Prospective Payment System* (PPS) Hospital Swing Beds
    - Ambulatory surgical centers (hospital based)
    - Inpatient rehabilitation freestanding hospitals or excluded rehabilitation units of PPS hospitals
    - Inpatient critical access hospitals including swing beds
    - Inpatient psychiatric freestanding hospitals or excluded psychiatric units of PPS hospitals
    - All ESRD facilities (freestanding and hospital based).

Prior to implementing medical review in the above settings, contractors shall notify providers they may be subject to review. Contractors shall apply Progressive Corrective Action in review of these claims.

Due to the Quality Improvement Organizations performing reviews, Contractors shall not perform MR functions for:

- acute care inpatient PPS hospital (DRG) claims and,
- Long Term Care Hospital (LTCH) claims

Contractors shall include claims from the above settings in doing data analysis to plan their medical review strategy using the same criteria employed in other settings. Customer service and education plans should also be considered. Amendments to plans and strategies should be made as needed if analysis indicates adjustment of priorities.

As part of your annual review of *local medical review policy* (LMRP) in conformance with PIM Ch. *13*, Sec. *13.3* consider the need to modify your policies to apply to these settings. As in any setting, contractors shall provide educational opportunities to assure knowledge of applicable policies and appropriate billing procedures.

1.2- The Medicare MR Program

(Rev. 71, 04-09-04)

The statutory authority for the MR program includes the following sections of the Social Security Act (the Act):

- Section 1833(e) which states, in part "...no payment shall be made to any provider... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ...;"
- Section 1842(a)(2)(B) which requires contractors to "assist in the application of safeguards against unnecessary utilization of services furnished by providers ...; "
- Section 1862(a)(1) which states no Medicare payment shall be made for expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;"
- The remainder of Section 1862(a) which describes all statutory exclusions from coverage;
- Sections 1812, 1861, and 1832 which describe the Medicare benefit categories; and
- Sections 1874, 1816, 1842 which provide further authority.

The regulatory authority for the MR program rests in:

- 42 CFR 421.100 for intermediaries
- 42 CFR 421.200 for carriers

CMS contracts with carriers, fiscal intermediaries (FIs), and program safeguard contractors (PSCs) to perform MR functions: analyze data, write local medical review

policy, and review claims. All of these entities are referred to as Medicare "contractors." Not all Medicare contractors perform all MR functions. The contractor requirements listed in this manual apply to contractors who have responsibility for those particular functions. For example, if a contractor has a contract with CMS only to perform data analysis for all durable medical equipment, that contractor would not be required to comply with the LMRP requirements, or any requirements other than data analysis.

A -- Quality of Care Issues

Potential quality of care issues are not the responsibility of the MR unit*; they are* the responsibility of the *Quality Improvement Organization (QIO)*, State licensing/survey and Certification agency, or other appropriate entity in the service area. Contractors should refer quality of care issues to them. See *PIM* Chapter 3 §1 for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

B -- Goal of MR Program

The goal of the medical review program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR program, contractors:

- *P*roactively identify potential billing errors concerning coverage & coding made by providers through analysis of data (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data) (PIM Chapter 2 describes these activities in further detail);

- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent. (*PIM* Chapter 3 describes these actions in further detail.) *and;*

- *P*ublish local medical review policy to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute.

Providers may conduct self-audits to identify coverage and coding errors using the *Office of Inspector General* (OIG) Compliance Program Guidelines at http://www.os.dhhs.gov/oig/modcomp/index.htm. Contractors must follow PIM *Chapter 4, Section 4.18.4.1* in handling any voluntary refunds that may result from these provider self-audits.

Most errors do not represent fraud. Most errors are not acts that were committed knowingly, willfully, and intentionally. However, in situations where a provider has repeatedly submitted claims in error, the MR unit shall follow the procedures listed in

PIM Chapter 3 §*3*.1. For example, some errors will be the result of provider misunderstanding or failure to pay adequate attention to Medicare policy. Other errors will represent calculated plans to knowingly acquire unwarranted payment. Contractors are to take action commensurate with the error made. Contractors should evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction. See *PIM* Chapter 3§*3*.1.

C -- MR Manager

An effective MR program begins with the strategies developed and implemented by senior management staff. Contractors must name a MR point of contact that will act as the primary contact between the contractor and *CMS* concerning the contractor's MR program. The MR Manager will also have primary responsibility for oversight and implementation of the contractor's MR Quality Improvement Program *(QIP)* (eff. 10/01) and primary responsibility for ensuring the timely submission of the MR Strategy, and MR QI Program Report.

D - Annual MR Strategy and Report

Contractors are required to develop and document a unique annual MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the error rate. Under the Government Performance and Results Act (GPRA), CMS has a goal to reduce the Medicare fee-for-service paid claims error rate to 5 percent. Contractors are not requested to establish a baseline error rate or calculate a contractor specific error rate to be judged against the GPRA goal. The Comprehensive Error Rate Testing Program will eventually provide the baseline measurements.

When submitting the MR Strategy, the contractor shall:

- Complete the following chart *(do not complete shaded areas)*:

(PSCs do not use CAFM II activity codes)

CAFM II Activity Code	BUDGET	PROJECTED WORKLOAD		
		Workload 1	Workload 2	Workload 3
21001 Prepay automated				
21002 Prepay routine				
21201 Prepay complex manual probe sample				
21202 Prepay complex manual provider specific review				

21203 Prepay complex manual service specific review				
21007 Data analysis				
21208 New Policy Development				
21206 Policy Reconsideration				
21205 Postpay complex manual probe sample review				
21030 Postpay routine manual				
21031 Postpay complex manual provider specific review				
21032 Postpay complex manual service specific review				
21010 TPL Claims				
21100 PSC Support Services				
21207 MR workload management				
21209 Corporate Activities				

- Provide an employee list by job title, including the MR responsibilities for each job title. Indicate the number of *full time equivalents* (FTEs) that are associated with the direct costs for each job title by activity code.

- Identify the intended areas for focusing the contractor's MR resources. Explain how these were selected.

- Identify the processes that the contractor shall use to monitor spending in each MR activity code to ensure that spending is consistent with the allocated budget. Indicate how often this is monitored. This shall include the processes the contractor shall undertake to revise or amend the plan, when spending is over or under the budget allocation;

- Identify and describe processes that assure the accuracy and the consistency of reporting workload for each CAFM II Activity Code and assesses the proper allocation of FTE/hours that are required for each activity;

- Identify the data analysis process the contractor will employ to carry out the MR program. Identify by name your claims processing *shared* system and list any other system support you use (e.g., expert systems) and the MR function it performs.

- - Identify the process for determining when the contractor will develop or revise LMRP.

- Contractors may perform automated, routine, and complex prepayment review and postpayment reviews. Contractors should determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration should be provided for the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate. Explain your methods for determining the appropriate amount of review for each CAFM II Activity Code.

- Contractors should attempt to avoid bunching workload. Describe how you plan to evenly distribute workload.

- Only in those instances where reviews cannot be automated and review by a clinician is unnecessary, shall the contractor conduct routine manual reviews. Explain those types of review that you cannot automate and the reasons why they cannot be automated.

- DMERCs, budgets should include funds for activities associated with providing advance determinations of Medicare coverage (ADMC) for certain customized items of *durable medical equipment* (DME) (PIM Chapter 5, Section 5.7).

- An MR Strategy should be submitted with your budget request to the appropriate *regional office* (RO) *(for PSCs, the GTL, Co-GTL, and SME)* and *central office* (CO) (MROperations@cms.hhs.gov). This report is a description of the contractor's MR strategy and must, at a minimum, include a discussion of the MR strategy requirements listed above. The MR Strategy should be updated as needed. When an updated MR Strategy requires a *supplemental budget request* (SBR), the updated MR Strategy should be sent with the SBR to the RO *(for PSCs, the GTL, Co-GTL, and SME)* and CO (MROperations@cms.hhs.gov).

Beginning in October 2000, an MR Strategy should be submitted no later than November 1 to the appropriate RO *(for PSCs, the GTL, Co-GTL, and SME)* and CO (MROperations@cms.hhs.gov). This report is a description of the contractors' MR strategy and must, at a minimum, include a discussion of the MR strategy requirements listed above. Effective 10/01, the MR Strategy should be updated as needed and updated

MR Strategies should be sent with the budget request to the RO *(for PSCs, the GTL, Co-GTL, and SME)* and CO (MROperations@cms.hhs.gov).

E - Annual QIP and Report

Contractors must assure the implementation of an effective QIP. The QIP goals are to assure that the decisions are accurate *and* consistent and the Medical Review Strategy is being implemented efficiently and effectively. The contractor is responsible for identifying problems or potential problems with each QI process. In response to problems or potential problems identified, a contractor must formulate an intervention to address the problem/potential problem and evaluate the impact/effectiveness of the intervention. In FY 2000, the top five overall problems identified through the Contractor Performance Evaluation process were workload management, effective data analysis, edit development and evaluation of edit effectiveness, and accurate review decisions. As such, contractors, in formulating their QIPs should give special attention to these five areas.

At a minimum, contractor's MR QIP must:

- Establish Quality Improvement coordinators within the organization structure.

- Assure that all QI processes are written and catalogued together in a single manual.

- Include oversight of policy development.

- Assure accurate, consistent, and defensible decision-making by the MR staff, including employing physician participation in determining the accuracy of medical review decisions and regularly testing and improving inter-reviewer reliability.

- Include oversight of the data analysis process to ensure the contractor uses a variety of local and national data sources. The QIP should identify potential aberrant patterns with appropriate translation of findings into a prioritized review strategy. The QIP should consider PCA, MR, appeals, and reversal findings and trends when considering changes in methodologies and procedures.

- Establish written methods for conducting objective assessment of all MR functions.

- Validate the appropriateness of the MR process.

- Assure that the MR system has the capacity to draw on special expertise when necessary for conducting medical review/claim determinations.

- Assure the internal education efforts are effective and efficient.

- Assure provider education efforts are effective and efficient. (Remedial provider education is a MIP PET activity.)

- Demonstrate proficient management practices, with written policies and procedures that are up-to-date to address identified problems and appropriate remedial action. One way the contractors can assure proficient management procedures is to become ISO 9000 certified or to undergo a third party validation process. PSCs with task orders valued at $1million or more must obtain ISO certification.

- Include a process that assures the accuracy and the consistency of reporting workload for each CAFM II code and assess the proper allocation of FTE/hrs that are required for each activity.

Contractors must submit an updated QIP plan with their MR strategy and budget request.

To the extent that a contractor has a corporate QIP that meets all or some of the MR QIP requirements, the contractor need not duplicate these processes, but must include a detailed description of its corporate QIP processes in the QIP Report. Contractors must submit an updated QIP plan to assess and monitor their MR Strategy with their budget request. Contractors must submit a semi-annual QIP Report entitled "MR QI Program" to the RO *(for PSCs, the GTL, Co-GTL, and SME)* and CO (MROperations@cms.hhs.gov) no later than 30 days after the close of the 2nd and 4th quarters.

F - Reporting for Separate MR Sites

Contractors with multiple MR sites must separate*ly* track workload and funding for each site and report this data in the Remarks Section of CAFMII for each activity code.

1.3– Coordination of MR and Benefit Integrity (BI) Units

(Rev. 71, 04-09-04)

Refer to PIM Chapter 4, section 4.3.

1.4- Local Provider Education and Training (LPET) Program)

(Rev. 71, 04-09-04)

- While the medical review process assures appropriate claims payment through the review of claims, the LPET program assures appropriate claims payment through remedial and proactive provider education. The success of this goal is measured by the continual reduction in the national claims payment error rate. Inherent to that success is a comprehensive effort to educate healthcare providers on coverage

and coding principles to ensure correctly billed claims. Medical review findings drive the contractor's LPET efforts. Contractors analyze medical review findings, prioritize issues, design educational interventions that best address issues identified by medical review and administer education to the provider.

A. LPET Activities

Contractors must employ LPET activities to address providers' educational needs proactively, as well as remedial needs identified through the medical review process. Identified coverage, coding and medical review related billing and claims issues should be addressed by appropriate LPET activities.

The LPET activities may include:

1. Analysis of Information to Identify Local Education Needs

Contractors must identify LPET needs by analyzing information obtained from a wide variety of sources. At a minimum, contractors should analyze information obtained from medical claims review, medical review data analysis, PCOM data analysis and appeals.

2. LPET Workload Management

Workload management of local education activities includes the development of the LPET Strategy, LPET QIP plan, LPET staff development and training, workload determinations, and outcome measures.

3. Provider-Specific Education

Provider-specific education is one-on-one provider education. Contractors must initiate provider-specific education after coverage, coding, claims and medical review related billing problems have been verified and prioritized through the review of claims (see PIM Chapter 3, Section *3.*2). These educational contacts involve clinical experts and include face-to-face meetings, telephone conferences, or educational letters to address the provider's specific coding, coverage and medical review related claims and billing issues depending on the level of the error identified. For minor or moderate coverage, coding or medical review related claim and billing errors identified through the medical review process, the educational contact may be made through educational letters or telephone conferences. In the case of major errors identified through the medical review process, the contractor must provide the opportunity for a face-to-face meeting but, at a minimum, must provide educational services through teleconferencing. In all instances, contractors must supply written educational materials that address the provider's specific coverage, coding or medical review related claims or billing error. In no instance should the contractor issue general statements without addressing the provider's specific educational need. While provider-specific education may correct most coverage, coding claims and billing errors related to medical review in the first educational meeting, some providers may require additional remedial education contacts to provide further instruction.

4. Comparative Billing Report Education

Contractors can develop and issue comparative billing reports in 3 situations: (1) provider-specific reports for high utilization individuals, (2) provider- specific reports for individuals who have requested a report, and (3) service-specific reports.

a) Provider-specific reports for high utilization individuals.

To address potential over-utilization, contractors may give provider-specific comparative billing reports to those providers that demonstrate the highest utilization for the services they bill. These reports must provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the provider's billing pattern more clearly. When provider-specific reports are distributed, contractors must develop and provide specific written educational information concerning the billing report and the highest utilized services. Contractors may not offer the report without this required educational documentation. Contractors may NOT charge a fee for providing these reports.

b) Provider-specific or specialty-specific comparative billing reports for requestors.

In order to provide good customer service, contractors may give provider-specific reports to providers or provider associations who request such a report. Contractors may charge a fee for providing these discretionary reports. However, any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. The fees must be fair and reasonable. Revenues collected from these discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities. If contractors choose to make such reports available, contractors must describe on their website the mechanism by which a provider or provider association can request such a report and the fee for it.

c) Service-specific comparative billing reports.

When widespread problems are verified, contractors may post service-specific comparative billing reports to their Web sites. Contractors may NOT charge a fee for posting these reports.

5. Education of Identified Service-Specific Errors

Contractors must initiate education on identified service-specific errors when widespread service-specific coverage, coding and medical review related claims or billing issues are verified through the medical review process. Contractors must use LMRPs and other readily available materials, such as bulletins and Web site postings to provide widespread education for the specific service in question. Contractors are encouraged to solicit medical and specialty societies for assistance. Education of identified service-specific errors requires clinical expertise to assure the development of the appropriate educational

materials. Additionally, contractors may perform education of specific provider specialty groups that routinely submit claims for the service in question.

6. Comprehensive Educational Interventions

Contractors may provide comprehensive educational interventions for a specific-provider specialty (e.g., podiatry, cardiology or psychiatry) or specific benefit (e.g., partial hospitalization programs, ambulance services, durable medical equipment) in response to large-scale coverage/coding/medical review related billing and claim issues. These educational activities may be identified by the contractor or by *CMS*. Unlike education of identified service-specific errors, comprehensive educational interventions should be made available only to individual or small provider groups for pervasive coverage/coding/medical review related claims and billing issues throughout the provider specialty or benefit. These special projects require clinical expertise to develop a thorough educational program of the coverage, coding, and documentation requirements needed to assure the appropriate claims payment. Contractors should consider using sanitized claim and documentation examples, as well as examples of best practices in supporting their educational program.

7. Proactive Local Educational Meetings

Proactive local educational meetings include seminars, workshops, classes, and other face-to-face meetings, as well as other live interactive meetings like Webinars that educate and train providers regarding local medical review policies and coverage/coding/medical review related claim and billing considerations. Contractors must use clinical staff as a resource at proactive educational meetings. Additionally, contractors should address the local educational needs presented by new coverage policies, and bulletin articles/advisories concerning medical review considerations. Whenever feasible, contractors should collaborate in holding these events with interested groups and organizations as well as *CMS* partners in their service area. Whenever feasible, hold teleconferences to address and resolve inquires from providers as a method to maximize the number of providers reached.

Contractors may NOT charge a fee for providing these mandatory contractor initiated meetings. However, contractors may attend or sponsor provider-requested local education meetings at the contractors' discretion. Contractors may charge a fee for providing these discretionary services, however any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. The fees must be fair and reasonable. Revenues collected from these discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities.

8. Frequently Asked Questions Regarding Local Education Issues

Contractors must develop a web-based searchable response document in Q and A format of frequently asked questions regarding local medical review policies, coverage, coding

and Medical Review related claim and billing considerations. When providing the response to frequently asked questions, contractors must adhere to the requirements in the PIM concerning the publication of articles. At a minimum, the FAQ document must be updated quarterly.

9. Bulletin Articles/Advisories Regarding Local Education Issues

Contractors must develop bulletin articles/advisories and alerts concerning local medical review policies, coverage, medical review related billing, claims or coding considerations. Clinical staff must develop bulletin articles/advisories or alerts and must adhere to the requirements in the PIM concerning the publication of articles.

Beginning in 2003, contractors will be required to submit to *CMS* those articles/advisories that address local coverage/coding/medical review related claims and billing issues. Please refer to PM AB-02-098 for detailed instructions. Articles may include any newly developed educational materials, coding instructions, or clarification of existing policy or instruction. Contractors are encouraged to send bulletin articles/advisories to specialty societies for inclusion in their publications and Web sites. All newly created bulletins must be posted on the contractor's Web site where duplicate copies may be obtained by physician/suppliers. All bulletins must have either a header or footer that includes the following bolded language: " THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE *P*HYSICIAN/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO COST FROM OUR WEBSITE AT (INSERT CONTRACTOR WEBSITE ADDRESS)". Additionally, contractors are encouraged to send bulletin articles/advisories to specialty societies for inclusion in their publications and Web sites.

Physicians/suppliers should be encouraged to obtain electronic copies of bulletins and other notices through the contractor website. If physicians/suppliers are interested in obtaining additional paper copies on a regular basis, contractors are permitted to charge a fee for this. The fee for this subscription should be "fair and reasonable' and based on the cost of producing and mailing the publication. A charge may also be assessed to any physician/supplier who requests additional copies. However, any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. Revenues collected must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities.

Beginning 10/1/02, contractors will no longer be required to distribute full-text LMRPs to all providers via hardcopy. Instead, contractors can meet the LMRP notice requirement through the following process:

a.)Post the full text of the LMRP on their Internet web site (the date the LMRP is posted is considered the "notice date");

b.) Develop an LMRP LIST-SERV that allows providers to subscribe/unsubscribe from getting emails containing a summary or full-text of the LMRP;

c.) Publish in the bulletin a summary of the LMRP, the URL for the full text LMRP website, information regarding how to subscribe to the LMRP LIST-SERV, and information regarding how to obtain a hard copy of this LMRP by mail and telephone at no additional charge.

10. Scripted Response Documents on Local Education Issues

Contractors may develop scripted response documents that address LMRPs and coverage review questions to be utilized by the customer service staff. The customer service staff may use these documents to respond to coverage questions. Providers that continue to have questions concerning coverage should be directed to the CMD or the FAQ Web site in order to have their question fully addressed. Coding questions should continue to be addressed according to the instructions in MCM 4552 and will be funded from the provider inquiry budget.

B. LPET Staff

Clinical expertise is needed to educate providers concerning local medical review policies, coverage, coding, billing and claims issues related to medical review. The delivery and design of the educational interventions are performed at the direction of the MR manager and can be supported by specially trained non-clinical staff working under the direction of the clinicians.

C. LPET Methods

Contractors must use a wide range of tools, both reactively and proactively to address the educational needs of the provider community. Various media include print, Internet, telephone, in-person presentation in classrooms as well as other settings. The methods used for the design, promotion and dissemination of LPET educational programs as well as the share of resources committed to specific activities depend on the scope of the problems identified and the level of education needed to successfully address the problems. Contractors must develop multiple tools to effectively address Medicare provider's wide-ranging educational needs.

D. Annual LPET Strategy

Contractors are required to develop an LPET strategy to submit with their budget requests. Contractors with multiple LPET sites, defined by contractor number, must create an LPET strategy that incorporates the activities performed at each of their sites.

When submitting the LPET strategy, the contractor shall:

1. Complete the chart for selected activities. (NOTE: Blocked workload areas are not completed for planning purposes.)

ACTIVITY	CAFM II ACTIVITY CODE	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
Provider-Specific Education	24101				
Comparative Billing Report Education	24102				
Education of identified service specific errors	24103				
Proactive Local Educational Meetings	24104				
Frequently Asked Questions re: Local Education Issues	24106				
Bulletin Articles/Advisories Regarding Local Education Issues	24107				
Analysis of Information to Identify Local Educational Needs	24108				
LPET Workload Management	24112				
Comprehensive Educational Interventions	24113				
Scripted Response Documents on Local Issues	24115				

2. Identify, by job title and qualification (e.g., clinician, RN, LPN, specially trained staff), the number of FTEs for each CAFM II Activity Code and provide and employee list associated with direct costs.

3. Identify the intended areas for focusing the carriers LPET resources.

4. Identify the processes that the contractor shall use to monitor spending in each CAFM II Activity Code to ensure that spending is consistent with the allocated budget. This shall include the processes the contractor will undertake to revise or amend the plan when spending is over or under the budget allocation.

5. Identify the process that assures the accuracy and the consistency of reporting workload for each CAFM II Activity Code and assesses the proper allocation of FTE/hrs. required for each activity.

6. Identify the analysis of information process the contractor will employ in carrying out the LPET program.

Beginning in FY 2003, an LPET strategy must be submitted with the contractor's Budget Request and to the appropriate RO *(for PSCs, the GTL, Co-GTL, and SME)* budget, MR staff and CO (LPET@*cms*.hhs.gov). This report is a description of the contractor's LPET strategy and must, at a minimum, include a discussion of the LPET strategy requirements listed above. Because contractors' educational efforts may change throughout the year, effective October 2003, the LPET strategy may be revised as needed. Revised LPET strategies must be sent to the appropriate RO *(for PSCs, the GTL, Co-GTL, and SME)* for approval and CO (LPET@cms.hhs.gov).

E. Annual QIP Plan and Report

Contractors must develop a QIP that evaluates the performance of the LPET strategy. The QIP goal is to assure that the LPET strategy is being implemented efficiently and effectively. The LPET QIP may be combined with the MR QIP providing they are differentiated and identifiable.

Contractors must submit an updated QIP with their LPET strategy and budget request. Contractors must submit a semi-annual QIP report entitled "LPET QI Program" to the RO *(for PSCs, the GTL, Co-GTL, and SME)* and CO (LPET@cms.hhs.gov) no later than 30 days after the close of the 2nd and 4th quarters.

To the extent that a contractor has a corporate QIP that meets all or some of the LPET QIP requirements, the contractor need not duplicate these processes but must include a detailed description.

At a minimum, a contractor's LPET QIP must:

- Establish LPET QI coordinator within the organization structure. The LPET QI coordinator may be the same person as the MR QI coordinator.
- Assure that all LPET QI processes are written and catalogued together.
- Demonstrate proficient management. Contractors can assure proficient management procedures by becoming ISO 9000 certified, or by third party validation. Program Safeguard Contractors (PSC) with task orders valued at one

million dollars or more must obtain ISO certification. If a contractor is not ISO 9000 certified, the QIP must include up to date written policies and procedures that identify problems and guide appropriate remedial action.

- Include a process that assures the accuracy and the consistency of reporting workload for each CAFM II Activity Code and assess the proper allocation of FTE/hrs. required for each activity.
- Provide a mechanism to monitor and improve the accuracy and consistency of LPET staff's response to written and telephone inquiries regarding coverage and coding issues.
- Assure the appropriate and efficient use of educational tools and clinical expertise to achieve effective provider education.
- Include a method of analysis of information and the use of a variety of information sources in determining providers' educational needs.
- Articulate methods that conduct objective assessments, produce outcome measurements, and validate all LPET functions and processes. Examples include but are not limited to, survey instruments and pre and post- testing at meetings and seminars.

F. Reporting for Separate LPET Sites

Contractors with multiple LPET sites, as defined by contractor number, must track workload and funding for each site and report this data in the remarks section of CAFM II for each activity code.

G. LPET Deliverables

Report	**Due date(s)**	**Submitted to**
LPET Strategy Report	Submit with Budget Request	Regional Office LPET@cms.hhs.gov(must be submitted via the VP of Government Operations)
LPET Quality Improvement Program Plan	Submit with Budget Request	Regional Office LPET@cms.hhs.gov(must be submitted via the VP of Government Operations)
LPET Quality Improvement Program Report	May 1, 2003 November 1, 2003	Regional Office LPET@cms.hhs.gov
LPET Strategy Report Revision	As revisions are made	Regional Office LPET@cms.hhs.gov(must be submitted via the VP of Government Operations)

*1.*4.1 - MIP-PET Activities

(Rev. 71, 04-09-04)

Each Medicare contractor is to perform the following activities:

- Provide one-on-one feedback to individual providers/suppliers on specific problems identified through prepay and postpay MR. Use progressive corrective action in focusing your educational activities;
- Provide feedback to the larger provider/supplier community on widespread errors. Use data analysis and the results of MR to direct these educational activities;
- Provide general information about PI activities. This includes sharing of information on PI goals and processes with local medical societies, professional associations, and other provider/supplier organizations in order to reach as many providers/suppliers as possible;
- Issue bulletins and letters to providers/suppliers containing PI information. Unless specifically requested by the provider, eliminate special bulletins and letters to all providers/suppliers with no billing activity in the prior 12 months. Bulletins should be posted on contractor websites where duplicate copies may be obtained by providers/suppliers. (Refer to the Program Management-Provider Education and Training (PM-PET) section for posting instructions.) All bulletins/newsletters must have a header/footer that includes the following bolded language: **"THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. Additional copies may be downloaded from our website at (insert contractor website address).";**
- Assure prompt, accurate, and courteous replies to all incoming phone calls and letters seeking educational information, clarifications, etc.; and
- Promote interaction and coordination among the *benefit integrity unit (BIU)*, medical review unit, provider/supplier enrollment unit, etc. This interaction and coordination is essential in determining the appropriate training and education that is needed to provide proper feedback to both individual and groups of providers.

As time and funding permits, the following activities can be funded through MIP-PET.

- Provide remedial education to Administrative Law Judges (ALJs) about MIP-related policies and administrative procedures.
- Participate in presentations at fraud and abuse programs arranged by health care provider/supplier groups, *as requested*.
- Address medical/specialty groups to answer their issues and concerns.

- Prepare/distribute computer based training modules, videos, and other materials that address Medicare PI issues.

*1.*5 - Contractor Medical Director (CMD)

(Rev. 71, 04-09-04)

Contractors must employ a minimum of one FTE *contractor* medical director and arrange for an alternate when the CMD is unavailable for extended periods. Waivers for very small contractors may be approved by the RO. The CMD FTE must be composed of no more than two physicians. All physicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties are listed below.

Primary duties include:

- Leadership in the provider community, including:
    - Interacting with medical societies and peer groups;
    - Educating providers, individually or as a group, regarding identified problems or LMRP; and
    - Acting as co-chair of the Carrier Advisory Committee (CAC) (see PIM Chapter *13 §13.7.1.4* for co-chair responsibilities).
- Providing the clinical expertise and judgment to develop LMRPs and internal MR guidelines:
    - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
    - Determining when LMRP is needed or must be revised to address program abuse;
    - Assuring that LMRP and associated internal guidelines are appropriate;
    - Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
    - Selecting consultants licensed in the pertinent fields of medicine for expert input into the development of LMRP and internal guidelines;
    - Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
    - Providing the clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse; and
    - Serving as a readily available source of medical information to provide guidance in questionable situations.

Other duties include:

- Interacting with the CMDs at other contractors to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and
- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.

To prevent conflict of interest issues, the CMD must provide written notification to CO (MROperations@cms.hhs.gov) and RO *(for PSCs, the GTL, Co-GTL, and SME)*, as well as to the CAC, within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify their RO *(for PSCs, the GTL, Co-GTL, and SME)* of the type and extent of the practice.

*1.*6 - Maintaining the Confidentiality of MR Records

(Rev. 71, 04-09-04)

Contractors must maintain the confidentiality of all MR records before, during, and after the MR process. Similarly, contractors that use a subcontractor(s) to perform MR, to store MR records, and/or to transport MR records, are responsible for ensuring that the subcontractor(s) maintains the confidentiality of the MR records that it handles. This responsibility applies to all contact with these records by all parties and entities, however derived from the contractor. The responsibility is not limited or ended if the subcontractor allows an additional party or entity to have contact with these records. Thus, just as the contractor must assure that the subcontractor maintain confidentiality itself, so too must the contractor assure that the subcontractor similarly assures that any third party or other entity, such as a sub to the subcontractor, which has contact with the records, maintain confidentiality.