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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2466

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
1	TOC		
1	5		

Red italicized font identifies new material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 16, 2003
IMPLEMENTATION DATE: May 16, 2003

Medicare contractors only: these instructions should be implemented within your current operating budget.

Chapter 1, Section 5, Local Provider Education and Training (LPET) Program, provides overview of LPET program and lists LPET activities.

Medicare Program Integrity Manual

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

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(Rev. 40, 05-16-03)

5- Local Provider Education and Training (LPET) Program –(Rev. 40, 05-16-03*)*

- *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 **L**PET Strategy, **L**PET QIP plan, **L**PET 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 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 thes 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 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*				
***L**PET 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 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 approval and CO (LPET@cms.hhs.gov).

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