CMS Medicare Manual System
Pub. 100-8 Program Integrity

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

Transmittal 47 **Date: JULY 25, 2003**

CHANGE REQUEST 2517

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
2	2		
3	5.4		
Exhibits	1		

Red italicized font identifies new material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 8, 2003
IMPLEMENTATION DATE: August 8, 2003
Medicare contractors only: These instructions should be implemented within your current operating budget.

Chapter 2, §2 - Data Analysis - Changes PRO to QIO. Changes HCFA to CMS. Deletes redundant bullet.

Chapter 3, §5.4 - CMS Mandated Edits - Describes how contractors should handle claims suspended for manual coverage and coding review by a CMS mandated edit. Adds HHA demand claims to the list of CMS mandated edits for intermediaries.

Exhibit 1 - Definitions – Is modified to include a definition of demand bill or demand claim.

2 – Data Analysis - (Rev. 47, 07-25-03)

Data analysis is a tool for identifying potential *claim payment* errors. Data analysis *compares* claim information and other related data (e.g., the provider registry) to identify

potential errors and/ or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or in the aggregate. Data analysis is an integrated, on-going component of MR and BI activity.

The MR and fraud units *frequently* analyze the same claims data to detect potential errors. It is wasteful to duplicate the downloading and basic arraying of data when a single request and format serve the needs of both units. Therefore, MR and fraud units *should* coordinate data requests and analysis results.

The contractor's ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. Contractors should use research and experience in the field to develop new approaches and techniques of data analysis. Ongoing communication with other government organizations (e.g., *QI*Os, the State Medicaid Agencies, fiscal intermediaries, carriers and the DMERCs) concerning new methods and techniques should occur.

Analysis of data should:

- Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;

- Establish baseline data to enable the contractor to recognize unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;

- Identify where there is a need for LMRP;

- *Identify* claim review strategies *that* efficiently prevent or address potential errors (e.g., prepayment edit specifications or parameters);

- Produce innovative views of utilization or billing patterns that illuminate potential errors; and

- *Identify* high volume or high cost services that are widely overutilized. This is important because these services *do not* appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk.

This data analysis program must involve an analysis of national data furnished by *CMS* as well as review of internal billing utilization and payment data to identify potential errors.

The goal of the contractors' data analysis program is to identify *provider billing practices and services* that pose the greatest financial risk to the Medicare program.

Contractors must document the processes *they use* to implement their data analysis program and provide the documentation upon request.

In order to implement a data analysis program, the contractor must:

- Collect data from sources such as:
    - Historical data, e.g., review experience, denial data, provider billing problems, provider cost report data, Provider Statistical and Reimbursement (PS&R) data, billing data, Common Working File (CWF), data from other Federal sources, i.e., *QI*O, other carriers and fiscal intermediaries (FIs), Medicaid; and
    - Referrals from internal or external sources (e.g., provider audit, fraud and abuse unit, beneficiary, or other complaints);
- Conduct data analysis to identify potential errors; and
- Institute ongoing monitoring and modification of data analysis program components *through the QIP*.

5.4 – CMS Mandated Edits - (Rev. 47, 07-25-03)

In past years, CMS created mandated edits that suspend certain claims for manual coverage and coding review. However, more recently, CMS has given the contractors the discretion to prioritize workload to effectively lower the error rate. CMS is now in the process of removing such mandated coverage and coding review edits from CWF, pricer, grouper, fee schedules, etc.

Effective January 1, 2003, contractors may override CMS mandated edits that suspend for manual coverage and coding review without performing review if one or more of the following conditions apply:

- *The contractor does not have MR responsibility for the claim, or*
- *The contractor's data analysis/priority setting/ MR strategy does not indicate this service is a problem in their jurisdiction, or*
- *It is not a SNF (excluding swing beds) or HHA demand bill (these demand bills must be reviewed).*

Exhibit 1 - Definitions

(Rev. 47, 07-25-03)

A

Abuse

Billing Medicare for services that are not covered or are not correctly coded.

B-C

Carrier

The Carrier is an entity that has entered into a contract with HCFA to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). Durable Medical Equipment Regional Carriers (DMERCs) are those carriers that *CMS* has designated to process DME, *prosthetic, orthotic and supply* claims.

Centers for Medicare & Medicaid Services (CMS)

CMS administers the Medicare program. *CMS*'s responsibilities include managing contractor claims payment, fiscal audit and/or overpayment prevention and recovery and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery.

Contractor

Contractor includes all intermediaries, carriers, DMERCs, RHHIs, and PSCs.

Closed Case

A FID case shall be closed when all fraud development activities are concluded by the contractor and law enforcement. Cases shall be closed even if the contractor is aware that the provider is actively making payments, or is in offset, or if a settlement decision has been reached and the contractor is unaware of the monetary amount being recouped.

D-E

Department of Justice (DOJ)

Attorneys from DOJ and the United States Attorney Offices have, under the memorandum of understanding, the same direct access to contractor data and records as OIG and the FBI. (See Chapter 1, §5.1.1) DOJ is responsible for prosecution of fraud civil or criminal cases presented.

Demand Bill or Demand Claim

A demand bill or demand claim is a complete, processable claim that must be submitted promptly to Medicare by the physician, supplier or provider at the timely request of the beneficiary, the beneficiary's representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary's subrogee. A demand bill or demand claim is requested usually, but not necessarily, pursuant to notification of the beneficiary (or representative

or subrogee) of the fact that the physician, supplier or provider expects Medicare to deny payment of the claim. When the beneficiary (or representative or subrogee) selects an option on an advance beneficiary notice that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill or claim must be submitted.

F

Federal Bureau of Investigation (FBI)

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding (see PIM Exhibits, §2.1), the FBI has direct access to contractor data and other records to the same extent as OIG.

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

G-H

I

Inpatient hospital claims

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. For benefit integrity purposes, claims for inpatient hospital services, hospital "swing" bed services, hospital-based ASC services, and procedures on the ASC list (see PIM Chapter 6) performed in the hospital outpatient hospital setting are reviewed by *Quality Improvement* Organizations, not intermediaries.

Intermediary

The intermediary is a public or private agency or organization that has entered into an agreement with *CMS* to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional Home Health Intermediaries (RHHIs) are those FIs that HCFA has designated to process Medicare claims received from Home Health and Hospice providers.

J-K-L

Local Medical Review Policy (LMRP)

LMRPs are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

M

Misrepresentation

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

N

Noncovered (Not Covered)

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

O

Office of Audit Services (OAS)

OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs, and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

Office of Civil Fraud and Office of Administrative Adjudication (OCFAA)

The OCFAA is responsible for coordinating activities that result in the negotiation and imposition of CMPs, assessments, and other program exclusions. It works with the Office of Investigations, Office of Audit Services (OAS), *CMS*, and other organizations in the development of health care fraud and exclusion cases.

Office of Inspector General (OIG)

The OIG investigates suspected fraud or abuse and performs audits and inspections of *CMS* programs. In carrying out its responsibilities, OIG may request information or assistance from *CMS* and its contractors, including *QIOs*. The OIG has access to *CMS*'s files, records, and data as well as those of *CMS*'s contractors. The OIG investigates fraud, develops cases, and has the authority to take action against individual health care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. The OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;

- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;

- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;

- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;

- Collecting and analyzing Medicare contractor and State Medicaid agency-produced information on resources and results; and,

- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. The OIG/OI investigates allegations of fraud or abuse whether committed by contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

The OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCFAA for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any state health care programs as defined under §1128(h) of the Social Security Act (the Act);or

- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

Offset

Withholding payment from a provider of an established, non-Medicare overpayment

P

Peer Review Organizations

The Peer Review Improvement Act of 1982 established the Utilization and Quality Control Peer Review Organization (PRO) program. The (*CMS*) contracts with independent physician organizations in each State to administer the PRO program. Their purpose is to ensure that the provisions of the Act are met. Under their contracts with *CMS*, PROs are required to review the medical services provided to Medicare beneficiaries in settings such as acute care hospitals, specialty hospitals, or ambulatory surgical centers.

The PRO program is intended to ensure that medical care furnished to Medicare beneficiaries is medically necessary and reasonable, is provided in the most appropriate setting, and meets professionally accepted standards of quality.

Program Safeguard Contractor (PSC)

The PSC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a single contract.

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, DMERCs, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization

See Peer Review Organizations

Recoupment

Withholding payment from a provider of an established, Medicare overpayment.

Suspension of payment differs from offset and recoupment in that, at the time payment is suspended, the amount of the overpayment is not yet known. Once an overpayment amount is established, the overpayment is recovered by first applying the payments that were suspended and then by initiating other recoupment procedures.

Reliable Information

Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists; for example, that claims are or were false or were submitted for non-covered or miscoded services. Reliable information of fraud exists if the following elements are found:

- **The allegation is made by a credible person, a credible source**. The source is knowledgeable and in a position to know. The source experienced or learned of the alleged act first hand, i.e., saw it, heard it, read it, etc. The source is more credible if the source has nothing to gain by not being truthful. The source is competent; e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source;

- **The information is material**. The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable. An example would be instructions handwritten by the provider delineating how to falsify claim forms;

- **The act alleged is not likely the result of an accident or honest mistake.** For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes but is not limited to the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed;

- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made;

- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this;

- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior;

- Corroboration from provider employees (official and unofficial whistle blowers);

- Other sources, such as prepayment and postpayment review of medical records; or

- Recommendations for suspension by OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or *CMS*, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

S

Services

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42 CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

Suspension of Payment

Suspension of payment is defined in the regulation span class="line">42CFR 405.370 as "the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists." In other words, contractors have received, processed and approved claims for a provider's items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

T-U-V-W-X