CMS Manual System

Pub. 100-08 Medicare Program Integrity

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

Transmittal 71 **Date: APRIL 9, 2004**

CHANGE REQUEST 3030

I. SUMMARY OF CHANGES: The Program Integrity Manual (PIM) chapters on medical review (MR) and benefit integrity (BI) were revised to apply to Program Safeguard Contractors (PSCs) as well as Medicare contractors that have not transitioned their MR and BI work to a PSC. Acronyms such as PRO, HCFA, and SVRS were changed to QIO, CMS, and statistical sampling for overpayment estimation respectively. This revision incorporates Change Request 2342, which was not communicated and replaces the current PIM in its entirety except for Chapter 10.

NEW/REVISED MATERIAL - EFFECTIVE DATE: MAY 10, 2004.
***IMPLEMENTATION DATE: MAY 10, 2004**.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 1
R	Chapter 2
R	Chapter 3
R	Chapter 4
R	Chapter 5
R	Chapter 6
R	Chapter 7
D	Chapter 8
R	Chapter 9
R	Chapter 11
R	Chapter 12
R	Chapter 13
R	Exhibits

***III. FUNDING:**
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment – Business Requirements

Pub. 100-8	Transmittal: 71	Date: April 9, 2004	Change Request 3030

SUBJECT: PIM Revisions

I. GENERAL INFORMATION

A. Background: The Program Integrity Manual (PIM) was revised to require Program Safeguard Contractors (PSCs) to follow the PIM to the extent outlined in their respective task orders. Contractors who have not transitioned their BI or MR work to a PSC are still required to follow the PIM. The PIM was also updated to change, add, and clarify various instructions. Also, Chapter 4 of the PIM was changed to pertain to benefit integrity instructions only. Therefore, section numbers in Chapter 4 were changed due to the addition and transfer of instructions and to reflect a 4 preceding all sections. Additionally, all other chapters except Chapter 10 were changed to reflect the chapter number preceding the section number. Acronyms such as PRO, HCFA, and SVRS were changed to QIO, CMS, and statistical sampling for overpayment estimation respectively.

B. Policy: For Proof of Delivery, 42 CFR 424.57, and other CFR citations specified in the PIM.

C. Provider Education: For Proof of Delivery, the DMERCs shall inform affected suppliers by posting either a summary or relevant portions of the instruction on their Web site within 4 weeks. Also, DMERCs shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected suppliers, they shall use it to notify subscribers that information about Proof of Delivery is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3030.1	The process by which the PSC notifies the AC of a suspension of payment shall be documented in the JOA.	PSC
3030.2	PSCs and Medicare contractor BI units recommend to the AC that payment be suspended through the installation of suspension of payment edits.	PSCs and Medicare Contractor BI Units
3030.3	PSCs and Medicare contractor BI units shall	PSCs and Medicare

	perform the necessary medical review on suspensions of payment.	Contractor BI Units
3030.4	PSCs shall only perform the necessary medical review for suspensions that they initiate.	PSCs
3030.5	For suspensions imposed for failure to furnish requested information, contractors shall recommend that the RO, (for PSCs, the GTL, Co-GTL, and SME) waive prior notice requirements for failure to furnish information requested by the contractor that is needed to determine the amounts due the provider.	PSCs and Medicare Contractor BI Units
3030.6	If the RO, GTL, Co-GTL, and SME waive the prior notice requirement, contractors shall send the provider notice concurrent with implementation of the suspension, but no later than 15 days after the suspension is imposed.	PSCs and Medicare Contractor BI Units
3030.7	Contractors should consult with their RO (for PSCs, the GTL, Co-GTL, and SME) when resources would be better utilized by determining what percentage of claims in a universe of suspended claims are payable through use of statistical sampling procedures.	PSCs and Medicare Contractor BI Units
3030.8	Contractors shall use the principles of statistical sampling found in the PIM to determine what percentage of claims in a given universe of suspended claims are payable.	PSCs and Medicare Contractor BI Units
3030.9	The process by which the PSC notifies the AC of a recommendation for a payment suspension extension shall be documented in the JOA.	PSCs and Medicare Contractor BI Units
3030.10	When the suspension expires or is lifted early, contractors must dispose of the suspension within a reasonable time period.	PSCs and Medicare Contractor BI Units
3030.11	PSCs and Medicare contractors shall ensure that releases of information to law enforcement are compliant with the HIPAA Privacy Rule, Privacy Act of 1974, and any other federal privacy requirements.	PSCs and Medicare Contractor BI Units
3030.12	Affiliated contractors (ACs) and Medicare contractors shall perform the following for complaint screening: complaint screening	ACs and Medicare Contractors

	for both initial screening and second level screening; acknowledging complaints that are not potential fraud and abuse; downloading complaints from the OIG Hotline, and referring any potential fraud and abuse complaints to the PSC or Medicare contractor BI unit.	
3030.13	ACs and Medicare contractors shall be responsible for entering and updating complaints into the Harkin Grantee Tracking System (HGTS).	ACs and Medicare Contractors
3030.14	PSCs and Medicare contractor BI units shall acknowledge complaints received by the AC and Medicare contractor, refer complaints that are not potential fraud and abuse back to the appropriate AC or Medicare contractor unit; or investigate complaints that are potential fraud and abuse.	PSCs and Medicare Contractor BI Units
3030.15	PSCs and Medicare contractor BI units shall be responsible for communicating updates to the AC and appropriate Medicare contractor BI unit on Harkin Grantee complaints; and they shall update valid cases in the OIG Hotline Database.	PSCs and Medicare Contractor BI Units
3030.16	PSCs and Medicare contractor BI units shall file complaints in the investigation file.	PSCs and Medicare Contrator BI Units
3030.17	PSCs and Medicare contractor BI units shall define investigations as the analysis performed on both proactive and reactive leads in an effort to substantiate the lead or allegation as a case.	PSCs and Medicare Contractor BI Units
3030.18	Files/documents shall be retained for 10 years. However, files/documents shall be retained indefinitely and shall not be destroyed if they relate to a current investigation or litigation/negotiation; ongoing Workers' Compensation set aside arrangements, or documents which prompt suspicions of fraud and abuse of overutilization of services. This will satisfy evidentiary needs and discovery obligations critical to the agency's litigation interests.	PSCs and Medicare Contractor BI Units
3030.19	PSCs and Medicare contractor BI units should use data analysis as part of their investigative method.	PSCs and Medicare Contrator BI Units

3030.20	PSCs and Medicare contractor BI units shall discuss any patterns of potential fraud with the OIG/OI at the onset of the investigation.	PSCs and Medicare Contractor BI Units
3030.21	PSCs and Medicare contractor BI units shall define a case in accordance with the revised definition in the PIM.	PSCs and Medicare Contractor BI Units
3030.22	For PSCs, only ACs shall issue demand letters and recoup overpayments.	PSCs and ACs
3030.23	PSCs shall provide necessary documentation to the AC to initiate IRP payment.	PSCs and ACs
3030.24	PSCs shall work with the AC via the JOA to disburse the IRP reward check.	PSCs and ACs
3030.25	PSCs and Medicare contractor BI units shall ensure that the FID captures information on investigations, cases, and payment suspensions.	PSCs and Medicare Contractor BI Units
3030.26	All available information shall be entered into the FID as an investigation concurrent with or within 15 days after immediate advisement and shall be converted to a case if OIG accepts it.	PSCs and Medicare Contractor BI Units
3030.27	Investigations shall be entered into the FID within 15 days of the start of the investigation.	PSCs and Medicare Contractor BI Units
3030.28	The minimum initial data entry requirements into the FID for an investigation shall be by Tab as specified in the PIM.	PSCs and Medicare Contractor BI Units
3030.29	Once a case has been referred to the OIG or other law enforcement agency, the investigation/worksheet shall be saved as a case within 15 days of referral.	PSCs and Medicare Contractor BI Units
3030.30	For payment suspensions, the information shall be entered into the FID Suspension Module no later than the effective date of the suspension.	PSCs and Medicare Contractor BI Units
3030.31	Updates should be entered as necessary into the FID for investigations.	PSCs and Medicare Contractor BI Units
3030.32	FID cases shall be updated at least every 3 months after initial entry, and the appropriate tabs shall be updated.	PSCs and Medicare Contractor BI Units
3030.33	If information is added to the worksheet during the investigation phase, it shall be saved in the FID as a worksheet.	PSCs and Medicare Contractor BI Units
3030.34	The first update following the initial entry	PSCs and Medicare

	of the suspension in the FID shall be made within one month; the second update shall be made within two months. Thereafter, the amount being withheld and other pertinent information on the suspension shall be updated in the suspension module every two months, until the suspension is removed.	Contractor BI Units
3030.35	When a payment suspension is removed, this information shall be entered into the payment suspension module within 15 days of removal.	PSCs and Medicare Contractor BI Units
3030.36	For suspensions under unlimited extension, updates shall be made every three months.	PSCs and Medicare Contractor BI Units
3030.37	If the PSC or Medicare contractor BI unit does not hear back from the OIG within 90 days and repeated attempts to find out the status have been unsuccessful, then the case shall be referred first to the FBI and if the FBI declines to another law enforcement agency with interest in the case.	PSCs and Medicare Contractor BI Units
3030.38	If subsequent referral to the FBI and other law enforcement agency is not acted upon within 45 days, the case shall be closed in the FID.	PSCs and Medicare Contractor BI Units
3030.39	An investigation shall be closed if it becomes a case (i.e., it is referred to OIG, DOJ, FBI, or AUSA), if it is referred back to the AC or to another PSC due to an incorrect referral or misrouting, or if it is closed with administrative action.	PSCs and Medicare Contractor BI Units
3030.40	An active FID case shall be closed when law enforcement has ended all its activity on the case (whether through successful resolution of the case or otherwise) and no further action will be required of the PSC or Medicare contractor BI unit by law enforcement.	PSCs and Medicare Contractor BI Units
3030.41	After a case has been closed, all administrative actions shall be documented in the Case Information and Action tabs of the closed FID case as they occur.	PSCs and Medicare Contractor BI Units
3030.42	Prior to a referral to law enforcement and within 60 days of identifying the necessity for administrative action, the PSC or Medicare contractor BI unit shall consult with law enforcement prior to taking	PSCs and Medicare Contractor BI Units

	administrative action. If law enforcement is unwilling to render a decision on administrative action, the PSC shall consult with the GTL, Co-GTL, and SME and the Medicare contractor BI unit shall contact the RO.	
3030.43	For FID tracking purposes, the PSC and Medicare contractor BI unit shall make any additional entries, based upon administrative or other actions taken, or, in the alternative, shall reopen the same FID case at some future time if the OIG, FBI, or other law enforcement agency accepts the case.	PSCs and Medicare Contractor BI Units
3030.44	If the OIG formally declines a referral and does not itself refer the case to the FBI, the PSC or Medicare contractor BI unit shall refer the case first to the FBI and then to another law enforcement agency if the FBI declines the case.	PSCs and Medicare Contractor BI Units
3030.45	If a new payment suspension has been imposed on a provider that was already the subject of an earlier payment suspension, a new payment suspension shall be entered in the FID.	PSCs and Medicare Contractor BI Units
3030.46	The prior (now inactive) suspension, however, shall be cross-referenced in the Contact/Narrative Information tab-Suspension Narrative section.	PSCs and Medicare Contractor BI Units
3030.47	For investigations, cases, and suspensions, it shall not be considered a duplicate investigation, case, or suspension if multiple PSCs or Medicare contractor BI units enter investigations, cases, or suspensions for the same provider as the subject of an investigation, case, or suspension.	PSCs and Medicare Contractor BI Units
3030.48	If a new investigation or case is initiated on a provider that was already the subject of a closed investigation or case, a new investigation shall be opened.	PSCs and Medicare Contractor BI Units
3030.49	If a new payment suspension has been imposed on a provider that was already the subject of an earlier payment suspension, a new payment suspension shall be entered into the FID.	PSCs and Medicare Contractor BI Units
3030.50	Membership in the FID User's Group is	PSCs and Medicare

	voluntary and open to all Users.	Contractor BI Units
3030.51	The AC or Medicare contractor second-level screening staff shall develop aggregate reports available to the Harkin Grantee state project coordinators every 6 months with a copy to CMS.	AC and Medicare Contractor Second Level Screening Staff
3030.52	Each AC and Medicare contractor shall designate a person in the second level screening staff to input the complaint into the HGTS database located on the Metaframe system.	AC and Medicare Contractor Second Level Screening Staff
3030.53	When a PSC offers and develops a consent settlement, the AC shall administer the settlement.	PSCs and ACs
3030.54	The PSC and Medicare contractor BI unit shall communicate with the AC or Medicare contractor staff responsible for processing voluntary refunds to obtain information on voluntary refund checks received.	PSCs, Medicare Contractor BI Units, and ACs
3030.55	The PSC and Medicare contractor BI units shall perform an investigation on any voluntary refunds where there is suspicion of inappropriate payment if a provider is under active investigation.	PSCs and Medicare Contractor BI Units
3030.56	Should the PSC or Medicare contractor BI unit receive a voluntary refund check in error, the PSC shall coordinate the transfer of voluntary refund checks to the AC through the JOA, and the Medicare contractor BI unit shall transfer the check to the appropriate Medicare contractor staff.	ACs and Medicare Contractor BI Units
3030.57	For PSCs, voluntary refund checks shall be processed and deposited by the AC.	PSCs and ACs
3030.58	PSCs and Medicare contractor BI units shall develop appropriate administrative action prior to the elapsing of the 90 days, but withhold final action until after consulting appropriately with a the OIG or other law enforcement agencies when taking such measures.	PSCs and Medicare Contractor BI Units
3030.59	PSCs and Medicare contractor BI units shall forward two copies of the referral and fact sheet to the OIG.	PSCs and Medicare Contractor BI Units
3030.60	PSCs and Medicare contractor BI units should recommend administrative and/or civil sanctions (including exclusions) to the	PSCs and Medicare Contractor BI Units

	OIG where law enforcement has declined the case.	
3030.61	In order to support cases of program abuse and quality of care issues, the PSC or Medicare contractor BI unit must document a long-standing pattern of care where educational contacts have failed to change the abusive pattern.	PSCs and Medicare Contractor BI Units
3030.62	PSCs shall not recommend payments to the AC, Medicare contractor BI units shall not recommend payments to the appropriate unit within the Medicare contractor, and ACs and Medicare contractors shall not make payment on any excluded individual or entity for items or services furnished, ordered, or prescribed in any capacity on or after the effective date of the exclusion, except in certain cases.	PSCs, Medicare Contractors, and ACs
3030.63	Contractors shall use the MED to determine whether a physician/practitioner/provider or other health care supplier seeks approval as a provider of services in the Medicare/Medicaid programs is eligible to receive payment, and to ensure that sanctioned providers are not being inappropriately paid.	PSCs, ACs, and Medicare Contractors
3030.64	Referral Process to CMS. If the provider fails to take corrective action and continues to remain non-compliant, the AC shall make a referral to the PSC who shall forward it to the GTL, Co-GTL, and SME, and CMS CO.	ACs and PSCs
3030.65	Suppliers shall maintain proof of delivery documents in their files for 7 years.	Suppliers
3030.66	Proof of delivery documentation shall be made available to the DMERC upon request.	Suppliers
3030.67	For patients that are residents of a nursing facility, suppliers should obtain copies of necessary documentation from the nursing facility (upon request) to document receipt of the DMEPOS item by the beneficiary.	Suppliers
3030.68	Suppliers or anyone else having a financial interest in the delivery of an item shall not sign or accept an item on behalf of a beneficiary.	Suppliers
3030.69	For supplies delivered directly by the	Suppliers

	supplier, the date of signature on the delivery slip shall be the date the supply was received by the beneficiary.	
3030.70	Suppliers shall contact the beneficiary prior to dispensing refills.	Suppliers
3030.71	Supplier contact with beneficiaries regarding refills should not take place sooner than approximately 7 days prior to delivery/shipping date.	Suppliers
3030.72	If the shipping service is utilized, the supplier's records should reference the delivery service's package identification number, the identification of the beneficiary and their address, and the delivery date.	Suppliers
3030.73	For shipping services or mail order, the supplier shall use the shipping date as the date of service on the claim.	Suppliers
3030.74	Suppliers should not deliver refills sooner than approximately 5 days prior to the end of usage.	Suppliers
3030.75	Supplies delivered to beneficiaries in a hospital, nursing facility, or home shall only be delivered up to 2 days prior to the patient's anticipated discharge and shall be for subsequent use.	Suppliers
3030.76	For DMEPOS delivered in a hospital/nursing facility setting, the date of service shall be the date of discharge and the Place of Service shall be 12 (patient's home).	Suppliers
3030.77	No billings shall be made for items on the days the beneficiary was receiving training or fitting in hospital/nursing facility or prior to discharge.	Suppliers
3030.78	DMERCs shall allow for the processing of claims for refills prior to the beneficiary exhausting his/her supply.	DMERCs
3030.79	PSCs and Medicare contractor BI units shall identify and initiate actions to recover payments with a billed date of service that is after the beneficiary's date of death.	PSCs and Medicare Contractor BI Units
3030.80	PSCs shall forward the identified overpayments to the AC for recoupment.	PSCs and ACs
3030.81	The PSC shall develop a JOA with the AC.	PSCs and ACs

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirements #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirements #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

D. Contractor Financial Reporting/Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: May 10, 2004 **Implementation Date:** May 10, 2004 **Pre-Implementation Contact(s):** Kimberly Downin and Debbie Skinner **Post-Implementation Contact(s):** Kimberly Downin and Debbie Skinner	**These instructions shall be implemented within your current operating budget**

Medicare Program Integrity Manual

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(Rev. 71, 04-09-04)

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Medicare Program Integrity Manual

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

Table of Contents

(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.

Medicare Program Integrity Manual

Chapter 2 – Data Analysis

Table of Contents

(Rev. 71, 04-9-04)

2.1 – Identifying Potential Errors - Introduction

(Rev. 71, 04-09-04)

This chapter specifies resources and procedures contractors must use to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively evaluate potential errors and not take administrative action unless they have verified the error and determined that the error is a high enough priority to justify the action. (See Reliable Evidence in *PIM* Exhibit 4.)

2.2 – Data Analysis

(Rev. 71, 04-09-04)

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 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., QIOs,

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;
- Identify high volume or high cost services that are being 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; and
- *Identify program areas and/or specific providers for possible fraud investigations.*

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 goals of the contractors' data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

Contractors must document the processes use*d* 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., QIO, other carriers and fiscal intermediaries (FIs), Medicaid; and
    - Referrals from internal or external sources (e.g., provider audit, *BI* unit, beneficiary, or other complaints);
- Conduct data analysis to identify potential errors;

- Institute ongoing monitoring and modification of data analysis program components through the QIP.

2.2.1 – Data Analysis to Detect Potential Errors or Potential Fraud *(Rev. 71, 04-09-04)*

The data sources that contractors use will depend upon the issue(s) being addressed and the availability of existing data. Some of the more obvious provider information that may be used include:

- Types of providers;
- Volume of business;
- Volume (or percentage) of Medicare/Medicaid patients;
- Prevalent types of services;
- Location;
- Relationships to other organizations;
- Types of ownership;
- Previous investigations by the fraud unit;
- Size and composition of staff;
- Administrative costs;
- Claims history; and
- Other information needed to explain and/or clarify the issue(s) in question.

Systematic data analysis requires contractors to have in place the hardware and software capability to profile providers in aggregate, by provider type, by common specialties among providers, or individually. Specific requirements are described in PIM Chapter 2 §*2*.2.4.2 – Document Data Strategy.

Where possible, the selection of providers should show a representative grouping, in order to accurately reflect the extent of program losses.

2.2.1.1 – Resources Needed for Data Analysis *(Rev. 71, 04-09-04)*

Contractors must have available sufficient hardware, software, and personnel with analytical skills to meet requirements for identifying problems efficiently and developing and implementing corrective actions. If carriers and intermediaries are unable to employ staff with the qualifications/expertise to aid in an effective analysis, they may use other entities (e.g., universities, consultants, other contractors) who can provide the technical

expertise needed. The following are minimum resource requirements for conducting data analysis.

A – Data Processing Hardware

Adequate equipment for data analysis includes facilities to process data (i.e., mainframes and personal computers) and to store data (i.e., tape drive, disk drives, etc.). Upgrading current resources (i.e., mainframe computers, shared systems, etc.) or the purchase of new capabilities (i.e., microcomputer workstations or subcontracts for computer services) may provide additional processing capabilities. In addition, contractors must have telecommunication capabilities to interact with the *CMS* Data Center.

B – Data Processing Software

CMS provides contractors with software to allow communication with the *CMS* Data Center. Contractors may wish to develop or acquire additional software that allows for analysis of internal data or other data obtained from the *CMS* Data Center. Contractors should have internal software to support the analyses of data to meet program goals.

C – Personnel

Contractors must have staff with appropriate training, expertise and skills to support the application of software and conduct systematic analyses and clinical evaluation of claims data. *CMS* strongly encourages contractors to have staff with clinical expertise (e.g., registered nurses) and a mix of skills in programming, statistics, and data analysis (e.g., trending and profiling of providers/codes).

Contractors must also employ staff that have training *in* develop*ing* analytical and sampling strategies for overpayment projections.

*2.*2.2 – Frequency of Analysis

(Rev. 71, 04-09-04)

Contractors must have at least 18 months of data to track patterns and trends. The contractors must, at a minimum, compare the current 6-month period to the previous 6-month period to detect changes in providers' current billing patterns and to identify trends in new services. Summary data or valid samples can be used when dealing with very large volumes of data.

*2.*2.3 – Sources of Data

(Rev. 71, 04-09-04)

A – Primary Source of Data

Claims data is the primary source of information to target abuse activities. Sources of claims data are:

- National Claims Data – Contractors should utilize the reports accessible from *Health Care* Customer Information System (HCIS). Carriers utilize the *CMS* Data Center's Part B Extract Summary System (BESS), especially the Focused Medical Review (FMR) reports, which show comparative utilization ratios by code, carrier, and specialty. Intermediaries must use national data where available. National data for services billed by *Skilled Nursing Facilities* (SNFs) and home health agencies (HHAs) is available at the *CMS* Data Center; and
- Contractor Local Claims Data – Local data should be compiled in a way to identify which providers in the contractor's area may be driving any unusual utilization patterns.

B – Secondary Sources of Data

Contractors should consider other sources of data in determining areas for further analysis. These include:

- OIG and *General Accounting Office* (GAO) reports;
- Fraud alerts;
- Beneficiary and provider complaints;
- Referrals from the *QIO*, other contractors, *CMS* components, Medicaid fraud control units, Office of the U.S. Attorney; or other federal programs;
- Suggestions provided directly or implicit in various reports and other materials produced in the course of evaluation and audit activities, e.g., contractor evaluations, State assessment, *CMS*-directed surveys, contractor or State audits of providers;
- Referrals from medical licensing boards;
- Referrals from the CAC;
- Information on new technologies and new or clarified benefits;
- Provider cost reports (Intermediaries);
- Provider Statistical and Reimbursement (PS&R) System data (Intermediaries);
- Enrollment data;
- Common Working File (CWF);
- Referrals from other internal and/or external sources (e.g., statistical analysis DMERC, MR, intermediary audit staff or, carrier quality assurance (QA) staff); and

- Any other referrals.

While the contractor should investigate reports from the GAO, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, the *Medicare Fraud Information Specialist* (MFIS)*/PSC network*, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not be used as a main source for leads on fraud cases.

*2.*2.2.4 – Steps in the Analysis Process
(Rev. 71, 04-09-04)

*2.*2.2.4.1 – Determine Indicators to Identify Norms and Deviations
(Rev. 71, 04-09-04)

Contractors should develop indicators *that will be* used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends and the most significant abnormalities or trends. Examples of indicators or variables are:

- Standard deviations from the mean;
- Percent above the mean or median;
- Percent increase in charges, number of visits/services from one period to another.

*2.*2.2.4.2 – Document Data Strategy
(Rev. 71, 04-09-04)

While *CMS* is deliberately not prescriptive in terms of the technical details of how contractors reach data analysis goals, contractors are expected to develop the most sophisticated and effective methods and procedures to meet these goals and will be held accountable for effective reports, procedures, and outcomes.

2.3 – Sources of Data for PSCs
(Rev. 71, 04-09-04)

Medicare contractor BI units must follow PIM Chapter 2, §2.2. The following instructions in this section apply to PSCs only.

The PSCs' approach for combining claims data (Fiscal Intermediary, Regional Home Health Intermediary, Carrier, and Durable Medical Equipment Regional Carrier data) and other data to create a platform for conducting complex data analysis shall be documented in their Information Technology Systems Plan. By combining data from various sources, the PSC will present an entire picture of a beneficiary's claim history regardless of where the claim was processed. The primary source of this data will be the

CMS National Claims History (NCH). The PSC shall be responsible for obtaining data for all beneficiaries for whom the AC(s) paid the claims.

PSCs are required to store at a minimum the most recent 36 months worth of data (including Part A, Part B, and DMERC) for the jurisdiction defined in their task order.

If the jurisdiction of the AC(s) is not defined geographically, the PSC shall obtain a complete beneficiary claims history for each unique beneficiary for whom the AC(s) paid a claim.

Example #1: The AC(s) jurisdiction being competed covers Maryland but includes a hospital chain with facilities in Montana. The PSC would request claims history from NCH for all claims paid by the AC(s).

Example #2: The AC(s) jurisdiction being competed covers Maryland, a beneficiary lives in Pennsylvania, and the beneficiary saw a doctor in Maryland. The PSC would request claims history from NCH for all claims paid by the AC(s).

PSCs will not be able to tap data from the Common Working File (CWF). The CMS Office of Information Services (OIS) has advised that this methodology for obtaining data will not be allowed.

PSCs may, if agreement and cooperation of the AC(s) are obtained, use data directly from the claims processing system of the AC(s), and then supplement the other data using NCH.

In developing this plan the PSCs shall address the above requirements and, at a minimum, establish read-only access to the AC's shared claims processing system(s) and access to the Part A, B, and D data available through the NCH for the jurisdictional area defined in the Task Order. The PSC shall also work with the AC(s) to obtain denial data and document the process for obtaining this data from the AC(s) in the Joint Operating Agreement.

The PSC must have the ability to receive, load, and manipulate CMS data. The data must also be maintained in accordance with CMS and Federal privacy laws and regulations as described in the CMS Data Use Agreement. For planning purposes, the PSCs should assume that there are 30 claims per HIC per year, on average. A claim record is about 1000 bytes. To calculate the storage space necessary, use the following formula:

#HICs X 30 claims X #years X 1000 = #bytes

The CMS Government Task Leaders (GTL) and PSC will need to complete:

- Data Use Agreement to give permission to receive privacy protected data.
- Data Request form to specify all data required by the PSC.
- HDC Application for HDC access and/or CMS systems' access to get access to the

data center and/or to specify which CMS systems the PSC will access.
- DESY system application form. (This is provided to the PSC post-award.)

Information on data files, including file layouts and data dictionaries, is available at http://cms.hhs.gov/data/purchase/default.asp.