Medicare
Peer Review Organization Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 83 **Date: OCTOBER 5, 2000**

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NEW/REVISED MATERIAL--EFFECTIVE DATE: November 2, 2000

The title of Part 11 is changed from "Objectives" to "Payment Error Prevention Program (PEPP)" to clearly define your activities in this area.

Section 11000, Introduction, describes your statutory authority for determining whether payment should be made by Medicare.

Section 11005, Review Responsibilities to Handle Clinical Data Abstraction Center (CDAC) Referrals, instructs you to conduct individual case review of all cases referred by the CDACs and to report all review results into PROVantage.

Section 11010, Developing the Capacity to Estimate Local Payment Error Rates, informs you that to change behavior and reduce payment error rates, you must develop the capability to conduct pattern analysis of large data bases and conduct confirmatory case reviews.

Section 11015, Determining the Types of Errors and Developing the Interventions Necessary to Reduce or Eliminate Errors, instructs you to conduct analyses of the types of errors found within your State and develop appropriate interventions.

Section 11020, Developing, Applying, and Assessing the Effect of Interventions, instructs you to develop and apply interventions and then document the effectiveness of these interventions.

Section 11025, Collaborating With Provider and Practitioner Groups, instructs you to collaborate with the provider and practitioner community when developing criteria.

Section 11030, Collaborating Efforts With Federal and State Agencies and Other Medicare Contractors, instructs you to collaborate efforts with Federal and State agencies and Medicare contractors when engaging in PEPP activities.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

PART 11

PAYMENT ERROR PREVENTION PROGRAM (PEPP)

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Payment Error Prevention Program (PEPP)

11000. INTRODUCTION

Section 1154(a)(2) of the Social Security Act (the Act) requires you to determine, based on your review of services furnished by physicians and providers, whether payment should be made by Medicare. This requirement is fulfilled through a variety of activities, all of which are designed to reduce the percentage of Medicare dollars paid improperly for:

- Medically unnecessary or unreasonable care (see §1154(a)(1)(A));
- Inpatient care that could have been provided in a more economical setting (see §1154(a)(1)(C));
- Hospital actions that circumvent Medicare payment rules (see §1886(f)(2)); and
- Incorrect diagnostic information and/or inadequate documentation (see §§1154(a)(6) and 1866(a)(1)(F)).

HCFA will determine the inpatient payment error rate for each State. Your performance will be evaluated, in part, on the basis of reductions in this payment error rate. The sum of your efforts in identifying and reducing improper payments is the Payment Error Prevention Program (PEPP). The Clinical Data Abstraction Centers (CDACs) will be responsible for initially requesting and screening the medical records for the PEPP surveillance sample.

11005. REVIEW RESPONSIBILITIES TO HANDLE CLINICAL DATA ABSTRACTION CENTER (CDAC) REFERRALS

As part of their surveillance activities, the CDACs screen medical records for DRG validation and medical necessity. The medical reviews will be an initial screening using generic criteria conducted by a non-physician reviewer. As a result of this screening, cases are selected and forwarded to you for a complete case review. Upon receipt of cases from the CDAC, review these cases using the review procedures specified at Part 4.

NOTE: The PEPP support PRO (PEPSPRO) works with the CDACs to develop and refine medical review criteria applied by the CDACs to screen medical records. The purpose of this collaboration is to create consistent and reliable screening review criteria in order to make the review process consistent.

A. Medical Review.--You are required to make a full determination for each case. (See Part 4.) Forward payment adjustments to the intermediary(ies) for processing. Process any identified quality of care concerns following the review instructions at Part 4. Report the results of your review into PROVantage under SDPS.

B. DRG Validation.--Conduct a DRG validation on all records forwarded to you by the CDAC. It will be your responsibility to forward adjustments to the intermediary for processing. Report the results of your review into PROVantage.

C. Failure to Submit Medical Records.--Hospitals are expected to deliver the requested medical records within 30 days--whether for purposes of fulfilling your mandatory review requirements or for PEPP. The CDACs will generate a reminder within this 30-day period. For the medical records that were requested from hospitals but not received within 45 calendar days of the date of the initial request, the CDACs will mark those records as cancelled (not received) using the PRO Abstraction Tracking System (PATS). You must use the PATS to identify overdue records and issue a technical denial in accordance with the procedures outlined in Part 7.

NOTE: The only exception to these procedures applies to the approximately 60,000 records initially requested for purposes of setting a baseline for PEPP. For those records only, technical denials were not issued until 90 days after the initial request, but the rest of the procedures remain the same.

11010. DEVELOPING THE CAPACITY TO ESTIMATE LOCAL PAYMENT ERROR RATES

In order to change behavior and reduce payment error rates, it is necessary to first identify and characterize the behavior causing the errors. This is possible by first identifying errors that have occurred. To do this, you will need to develop the capability to conduct pattern analysis of large databases and conduct a case review (see §4550). The detection of payment errors can be accomplished with the use of epidemiological techniques. That is, it is possible to determine the relationship between an observed billing pattern and the occurrence of payment errors.

This relationship can be established either through work you conduct or from reports generated by outside agencies, most notably, the Office of Inspector General (OIG) and the General Accounting Office (GAO). You will need the capacity to conduct a thorough analysis of health care services in your State, with the emphasis on inpatient hospital services. It is expected that you will utilize both statistical and clinical expertise in this process. Because of the changing nature of health care and billing practices, this analysis must be routinely updated and reflect innovations that may occur from time to time. Your monitoring and assessment strategies must reflect these changes and be responsive to information that may indicate changes in error patterns resulting from genuine confusion, deliberate abuse or fraud.

A. Purposes.--You are to develop this capability for the purposes of:

- Conducting analyses that will form the basis of work plans for determining the nature and extent of any payment errors, required interventions and, at later stages, the basis of assessing impact from previous efforts;

- Meeting your statutory requirements to review specific categories of services, such as unnecessary admissions and up-coded DRG assignments; and

- Developing a profile of Medicare services in your State. You have full discretion to structure your analysis to best characterize your State's Medicare population, your local environment, and its unique blend of providers, physicians, and practitioners.

B. Data Sources.--Data sources for your analysis may include:

- Standard Data Processing System (SDPS) to access inpatient hospital claims data.

- Clinical Data Abstraction Centers (CDACs).

- HCFA Customer Information System (HCIS) to provide summary data on other provider and claim types. You may find these data helpful for comparing health care services in your State with national figures, with similar States, or with utilization trends over time. HCIS summary tables will also facilitate your ability to look at variations between providers on average length of stay, total charges, or diagnostic mix.

- Demographic and economic information from published sources to provide a context in which health services are delivered. The Health Care Financing Review's Statistical Supplement and HCFA's Internet site provide many useful statistics.

- o Summary certification or licensure data to describe provider groups or illustrate potential problem areas.

- o Minimum Data Set or Health Outcomes Survey, which report on the functional status of beneficiaries.

- o Your own mandatory reviews, including both quantitative and qualitative data (see §4550).

- o Supplemental data from payers, certification and accreditation agencies, or any other source that receives and evaluates complaints from the public.

- o Data from quality improvement projects which suggest PEPP issues, and may take the form of:

  - Aggregate information, such as a project in which 15 percent of cases reviewed had to be eliminated because the diagnosis was inaccurately coded; or

  - Observations from a single case.

- o Qualitative and anecdotal data (see NOTE below) to:

  - Illustrate trends or patterns;

  - Suggest issues for further exploration; or

  - Provide possible explanations for provider variation.

NOTE: These data may come from news media, published OIG studies, court records, beneficiary complaints, certification findings, or scientific and administrative literature. The source and nature of any specific piece of information should determine the amount of credence given. Examples of fraudulent practices gleaned from OIG investigations, which resulted in criminal convictions would be given more weight than a news report.

You are encouraged to continually seek, evaluate, and use additional data sources as one way to innovate PEPP.

11015. DETERMINING THE TYPES OF ERRORS AND DEVELOPING THE INTERVENTIONS NECESSARY TO REDUCE OR ELIMINATE ERRORS

Develop appropriate interventions and apply them to the results of your analysis.

A. General Analysis.--Conduct this analysis to identify trends and patterns suggestive of:

- o Inappropriate setting, unreasonable or medically unnecessary care;

- o Incorrect DRG assignments;

- o Premature discharges;

- o Inappropriate transfers; and

- o Insufficient or poor care.

A good deal of work has been done that allows you to make certain assumptions about the relationship between types of discharges and the occurrence of payment errors. For instance, the OIG has demonstrated that one-day stays have a higher incidence of unnecessary admissions when compared to discharges greater than one day. Therefore, it is reasonable to assume that a facility exhibiting a high proportion of one-day stays may also have a high proportion of unnecessary admissions.

You cannot determine that any one discharge is medically necessary and/or appropriate or not unless you review the medical record. In addition, an analysis of a number of one-day stays may help to determine whether there is a systemic problem with unnecessary admission. Further work in conjunction with the facility may determine the underlying cause.

First of all, this type of analysis will allow you to decide if an intervention is warranted and, if so, what type and to whom it should apply. You will seldom know at this stage whether significant trends or patterns exposed by your analysis represent unnecessary services, poor quality of care, fiscal impropriety, inadequate access to services, or evolving standards of acceptable health care practice. For this reason, treat this analysis and all reports and work plans based on it in a manner appropriate from all perspectives. (See Part 10, Confidentiality and Disclosure.)

B. Mandatory Analysis.--Conduct mandatory analysis for the following areas:

- o Unnecessary admissions (see §4255); and
- o Diagnostic information where it affects hospital reimbursement (see §4130, DRG Validation Review).

These types of errors were identified by OIG/Office of Audit Services (OAS) audit of the HCFA Financial Statement as the most prevalent errors for inpatient services. During the first year of your contract, conduct the necessary analyses to determine the extent and pattern of errors in these two areas. At the end of the first year of your contract, report to HCFA the results of these analyses, the steps or actions you have initiated or will initiate to reduce the occurrence of these errors, and the follow-up analysis you plan to undertake to document the effects of the interventions conducted.

The audit conducted by OAS presented the results of a national sample. It is therefore possible that your State may not exhibit a problem with unnecessary admission or DRG miscoding of an order of magnitude that requires a large-scale intervention effort on your part. If this is the case, support for this conclusion should be documented and presented in your first year report. Then you, in consultation with your project officer, will be free to consider other areas to investigate for potential payment errors. However, you still must document the decision to move on to other areas in your first year report.

C. Additional Areas for Analyses.--It is expected that payment errors for inpatient services will occur in other areas besides unnecessary admissions and DRG miscoding. Analysis for errors in these areas can be of the same form as the analysis in the mandatory areas. You have discretion to identify these areas, take the appropriate actions, and document the effects of the interventions in these areas.

1. Descriptive Statistics and Local Highlights.--Information about other areas with a potential for payment errors can be obtained from published sources and available summary data. This type of information is outlined in the Data Sources section.

2. External Perspectives.--Outside agencies can provide information as a result of their own activities. In particular, OIG and GAO produce reports every year that review and analyze aspects of Medicare payments. These reports, and the analytical approaches presented, can provide good insight into other areas that may be productive to review. In some cases, reproducing their analyses may uncover admission types with a high potential for masking unnecessary admissions; potentially inappropriate DRGs; or other areas with potential payment errors.

EXAMPLE: The State agency's director may provide a list of priority areas for the upcoming year, while surveyors may provide specific anecdotal accounts of potential PEPP topics in focus group sessions or through copies of survey documentation.

D. HCFA-Selected Analyses.--HCFA may direct you to conduct an analysis in one or more focus areas in your State. These focus areas may be broadly defined, allowing you to choose the data sources, time periods and statistical techniques, or HCFA may prescribe some or all details of the process. HCFA will use these analyses primarily to build national profiles of significant issues and to explore local variations.

11020. DEVELOPING, APPLYING, AND ASSESSING THE EFFECT OF INTERVENTIONS

A. Developing and Applying Improvement Methodologies As Interventions.--The same concepts and techniques that you use in conducting quality improvement projects are applicable to the use of interventions, with minor modifications. Improvement methodologies are appropriate where a substantial component of inappropriate provider activity arises from an apparent lack of knowledge about acceptable practice standards, proper coding, or correct billing procedures.

Improvement methods may be highly effective in provider groups with a solid history of good faith efforts to self-regulate. This approach may be less effective in providers with a history of compliance problems. Thus, the responsiveness to education of providers and practitioners you are dealing with will substantially influence the extent to which you can rely on educational feedback instead of reporting the violation to OIG under your authority, as specified at 42 CFR 1004.30.

NOTE: Evidence of fraud precludes use of improvement methodologies with involved providers or physicians. Do not proceed with any improvement process where fraud is implicated without consulting with both HCFA (through your project officer) and your intermediary.

1. Health Care Quality Improvement Program (HCQIP) Projects Versus Payment Error Prevention Program (PEPP) Projects.--There are distinctive differences between HCQIP projects and the use of improvement methodologies in PEPP.

a. Health Care Quality Improvement Program (HCQIP).--Providers collaborate in HCQIP on a voluntary basis. If a provider has more pressing internal issues, it may decline to participate in a specific HCQIP without penalty. If it participates but fails to demonstrate improvement on remeasurement, there are no consequences.

b. Payment Error Prevention Program (PEPP) Projects.--PEPP involves issues of unacceptable claims for reimbursement. A provider may not decline interest in conforming to standards of appropriate, reasonable, and medically necessary care. Claims must accurately report the diagnosis, procedures and services rendered, and beneficiary eligibility for coverage. The provider may accept your assistance or it may prefer to solve its own problems. However, your remeasurement is not optional for the providers/practitioners and failure to improve may have negative consequences in the form of denials/adjustments, imposition of corrective action plans, sanction recommendations, or referral to the State agency, OIG, State licensing authorities, the intermediary, or a carrier.

Improvement methodologies applied to PEPP are based on monitoring and enforcing compliance with established standards, as opposed to testing intervention methods to encourage optimal or benchmark performance on scientifically proven indicators. You are encouraged to consider all possible avenues to enhance compliance. For PEPP, you will be judged on reduction of the inpatient payment error rate, whether you act alone or in concert. It is not possible for any partner to claim success if overall compliance with Medicare standards remains poor.

2. Project Data Collection versus Case Review.--You request medical records from a provider either for case review or for data collection. The processes have different implications; thus, it is crucial that you know for which process you are requesting a record. You may issue a technical denial for failure to provide the record in either case.

a. Data Collection.--Data collection differs from case review in that only specific pieces of data are abstracted. No determinations are made, because the record is not evaluated using the full case review process. Consequently, the provider/practitioner does not have reconsideration or appeal rights to your data findings, nor is there a requirement for physician review of the record in order to abstract data.

b. Case Review.--When a medical record is subjected to case review, you may still elect to abstract data from it. You must follow the review procedures described in Part 4. You render a determination and, where necessary, you must issue denials and adjustments (see Part 7).

Data collection does not allow for denials or adjustments, however, making it less persuasive to reluctant providers and less certain in demonstrating measurable impact. Case review may be the only reasonable option where the number of cases is too small to legitimately document improvement on remeasurement. Both techniques have uses in PEPP.

NOTE: You are not restricted regarding your choice of data collection or case review by your initial analysis. You may elect to conduct data collection as a baseline, and later institute case review for nonresponsive providers. Likewise, you might initially choose case review to address an issue, but change to data collection later to more efficiently monitor continued compliance.

3. Other Interventions.--

a. Generalized Provider Education.--Educational efforts, whether narrowly focused on specific providers or widely broadcast, can have a dramatic impact on PEPP issues. It may be particularly popular with the health care community, and so you may experience considerable pressure to educate first and foremost in all focus areas. You must always consider whether education is appropriate before using this strategy. It is never appropriate to "educate" a potentially fraudulent provider without first consulting with your project officer and your intermediary.

Even where the suggestion of fraud is absent, billing must be dealt with in a suitable manner. It is imperative that you never create the misperception that it is acceptable for providers to continue improper practices until notified by your "education" that it is time to stop. It must remain clear that you are not the sole source of information on Medicare policy, and that providers bear the full responsibility for learning and abiding by all the rules applicable to the services they provide.

Equally important is that the general public views your educational efforts accurately as disseminating helpful information to honest providers, not warning unscrupulous ones to quietly move on to new abuses. Your status as a physician-sponsored or physician-access organization aids your credibility in the community, but it also requires that your choice of strategies be above reproach.

Education and information dissemination are tools that should be used frequently. The paramount goal is to ensure that Medicare pays correctly for care that is reasonable and necessary, of high quality, and accurately reported. Raising the level of knowledge among providers enhances claims accuracy in the most fundamental sense. Education will continue to be a core responsibility for the PRO program.

Engage in a multi-level educational approach when developing interventions to prevent payment errors. At one level, and with providers at low risk for payment errors, you should consider promoting voluntary compliance plans. Another level would include generalized education on proper billing techniques, appropriate care, and proper coding directed at classes of providers or practitioners. A final level would direct educational efforts at specific providers or practitioners.

b. Specific Topic Education.--As a result of an analysis of payment errors it may be determined that certain types of payment errors are not specific to individual providers or practitioners. For instance, proper coding for a specific DRG may not be well understood among a majority of providers in a State. It would be appropriate in this case to develop an intervention specific to the topic of proper DRG coding and directed at all providers or, at least, those in the majority previously identified. Similarly, all providers in a PRO area may benefit from a general education on proper billing in the Medicare program. These generalized approaches need to be documented and assessed.

c. Specific Provider Education.--The identification of payment errors by a specific provider require an individual educational approach. Providers that represent outliers will need to be approached with individual interventions. The intent is to change behavior and the intervention should be documented and assessed.

d. Promoting Voluntary Compliance Plans.--The OIG has published the "OIG Compliance Program Guidance for Hospitals" ([***Federal Register***], Vol. 63, No. 35, February 23, 1998, pages 8987-98). This publication responds to a desire on the part of many providers to protect their operations from fraud and abuse through the adoption of voluntary compliance programs. While directed at tailoring programs to avoid the occurrence of fraud and abuse, such programs can also assist providers in setting up the necessary internal controls to promote adherence to applicable billing guidelines. For those providers in your area that are considered at low risk of billing errors, you should consider assistance in establishing a compliance program, using OIG guidelines. You can then monitor the implementation of this plan by reviewing the recommended reports and verifying that the provider has implemented the plan. OIG contends that the placement and use of such plans assures that a provider is attempting to comply with program guidelines for proper billing practices.

You are in a unique position to promote the effective use of voluntary compliance programs, another tool available to you in your graduated approach to proactive elimination of payment errors.

Each PEPP activity does not necessarily represent an element of a graded or stepped approach to education. Nor do these different levels represent a sequence you must follow. Rather, these levels of effort suggest an intervention approach to a class of provider or problem you may detect in your analysis. Lack of success with one approach may indicate a need to try a second approach. However, a provider's continued failure to change behavior does not require you to always try another approach. At some point you will have to develop a case on a nonresponsive provider and make an appropriate intervention, such as a sanction referral, to your intermediary.

B. Estimating, Documenting, and Assessing Effect of Interventions.--The goal of the PEPP is to reduce the percentage of Medicare dollars which are improperly paid for inpatient services. Performance will be primarily evaluated against HCFA's measurement of the inpatient payment error rate in each State. The inpatient payment error rate will not be so comprehensive as to allow determination of the error rate for specific services, diagnostic groups, practitioners or providers within a single State; therefore, you will have to develop separate indicators to estimate the impact of your intervention efforts and you may choose to prioritize PEPP focus areas and strategies.

You need not use the same indicator of payment error rate that is to be used by HCFA. Intermediate indicators may suffice. To carry forward the earlier example, if it is borne out that a high proportion of one-day stays is associated with unnecessary admissions, especially in specific providers, then measuring this proportion subsequent to an intervention may suffice to demonstrate the effects of the intervention.

C. Information Requirements for PEPP Project Plan and Project Results Narrative Documents.--Document each intervention effort to assess its effectiveness and to help determine, at a national level, those practices that are more or less effective than others.

HCFA has identified the following three situations for reporting a PEPP project under one project number:

o Projects with Same Indicator.--If you are specifically focusing on, measuring, and conducting interventions on the same indicator for different facilities, this constitutes one project.

o Replicated Projects.--If you take a previously completed project and duplicate the project steps with a new group of facilities at a later point in time, this may be reported as a separate project.

o Projects with Same Intervention Plan (Same Component).--If you are conducting the same intervention plan with all facilities, this constitutes one project.

1. PEPP Project Plan.--For each intervention effort, complete a PEPP Project Plan. The elements listed below represent minimal requirements. Include whatever additional information is necessary to fully describe your effort.

a. Background.--This is a description of how you arrived at the need for the project. Explain how the topic came to your attention and describe the issues. Provide general descriptive information such as external agency perspectives, literature reviews, and specific statistics (e.g., State performance versus national performance, provider performance versus State performance, etc.). If you extrapolate based on results of existing studies, describe the methods you used.

b. Purpose.--Describe specifically what you hope to accomplish with the project. This should include both the process(es) that you intend to improve and the ultimate outcome that you plan to achieve. This should be quantifiable where possible.

c. Hypothesis.--The hypothesis is a statement of the question(s) that you hope to answer regarding the causes and potential prevention of payment errors. Hypotheses typically contain both a predictor and an outcome variable. They should be stated as specifically as possible and be easy to comprehend. Multiple hypotheses should be broken out individually rather than combined. Although further exploration may be needed to define the types and extent of PEPP issues, you should, at a minimum, have formed hypotheses about the nature of problems in each focus area. Your description of each hypothesis should be supported by citations or descriptions of the relevant policy, regulations, statutes, or standards involved. If you have anecdotal information that suggests a hypothesis, you may include it here or refer to it from the background information.

d. Methods for Assessing Performance.--Describe the methods by which you will monitor progress and estimate impact for each focus area.

1) Indicators and Performance Goals.--Specify which indicators you expect to impact and provide a detailed narrative description. Note that these may change in actual implementation due to shifting strategies or unforeseen developments.

2) Calculations and Goals.--Describe how you will calculate changes in the indicators, what the goals of the intervention effort are, and how you will measure success.

3) Data Sources and Collection Methods.--Describe each of the data sources that will be utilized (e.g., claims/administrative files, medical record review) in identifying the focus of the project and determining results. Indicate the specific data that will be obtained from each source. Describe how you will develop and pilot test data collection instruments, the methods used to assess data quality, and the methods for measuring data validity and reliability.

4) Data Analysis Methods.--Describe in detail your methods for analyzing data to assess the project impact on performance of the indicators. Identify any data analysis software that you plan to use.

e. Project Setting and Reach--Define the parameters of the intervention. This may include specific diagnostic codes, particular providers, and/or entire provider categories. It may be bounded by geography or by rural versus urban setting. You may choose to address the entire universe of events (e.g., all unnecessary right heart catheterizations in the State) or a subset (e.g., unnecessary right heart catheterizations in the top 10 providers, based on the percentage of claims). It is entirely appropriate to approach some topics on a statewide basis and others in a tightly focused manner.

f. Case Selection and Sampling.--Indicate the number of cases sampled and how they were selected for this project. Include a general classification of the inclusion and exclusion criteria within the sample. Identify any special subgroups that were uniquely sampled. Specify the time period used to select cases, being sure to define the time period for the baseline and/or remeasurement sample. Describe any statewide sampling that was done and the relationship between the statewide and provider specific samples. Describe any geographic units (i.e., counties) that were used to restrict the sample. (Note: Sampling does not refer only to projects involving review of medical records.)

g. Baseline Data Analysis.--Describe the results of baseline data analysis.

h. PRO Interventions.--

1) Development.--Describe your strategy and goals, the target audience, partners and collaborators, specific indicators (if different from project indicators), and your time lines. Specify targeted and statewide interventions. For those activities that involve collaboration with other partners, describe the specific activities that each partner will undertake. In your time lines establish a beginning, evaluation, and ending (if applicable) dates. If the intervention effort is continuous after a given start date, note this. To facilitate your work, you may include other dates such as case selection, case review, and improvement plan request dates.

2) Implementation.--Describe how you will implement the interventions (method of delivery), your communication strategy, and any pilot testing. Describe the communications strategy in detail, including what is being communicated (e.g., results of baseline data, compliance techniques), who is being targeted for the communications (e.g., compliance officer, financial officer, collaborator liaison), and how the messages will be conveyed (e.g., regional meetings, project workshops, newsletters).

3) Evaluation.--Describe your monitoring plan, how you will perform a process assessment to identify process changes occurring as a result of your intervention, and how you will modify your interventions based on results.

i. Additional Information.--Include any other information needed to fully describe your plans for each intervention.

2. PEPP Project Results.--Report the results of your PEPP project, including the following:

a. Data Collection/Case Review Findings and Analysis.--Describe the results of data collection activities and what your analysis revealed. This may include case review activities.

b. Remeasurement Findings.--Provide your remeasurement results by hospital or statewide group, or a combination of these, whichever is appropriate, and compare the results to your baseline data. Report the degree of improvement, reduction in rate, etc.

11025. COLLABORATING WITH PROVIDER AND PRACTITIONER GROUPS

Consult with the provider and practitioner community, as specified in §4510. In addition, consult with them to design appropriate interventions.

11030. COLLABORATING EFFORTS WITH FEDERAL AND STATE AGENCIES AND OTHER MEDICARE CONTRACTORS

Collaboration begins with communication. You must fully understand the jurisdictional authority, resource limitations, and routine work processes of each partner with which you will engage in PEPP efforts. Similarly, these partners must have realistic expectations of your abilities and limits.

The ability to work with different partners in a variety of ways does not create an automatic obligation to respond affirmatively to all requests (see §§9200ff.). Where you cannot resolve differences of opinion about your obligations as a PRO, the obligations of other agencies to you, or the best course of action on a specific issue, involve your project officer in the discussions. Collaboration with these other agencies will be important to their understanding of the nature of the PEPP.

You are not limited to collaborating with one agency at a time any more than you are obligated to involve any external partner where your own authority and resources are sufficient. Dialogue should occur early and continue as events unfold. Facilitating these discussions is one reason for forming a work plan.

You bring many potential contributions to the table, including the not-so-simple act of convening groups with different perspectives and responsibilities to examine common problems. You can provide data to educate and inform participants, define major issues, and guide development of an efficient plan. You may even find it productive to serve as a temporary "base" for complex operations, where collaborators are dispersed. The ability to join forces for common work without confusing distinct jurisdictions will take careful and constant attention, but the synergistic impact will make coalitions attractive options for dealing with extensive or pervasive problems.

A. Collaborating with OIG.--Three components within OIG are pertinent to PEPP, and you may find it useful to work with each on different occassions. These components include:

1. The Office of Investigations (OI).--OI develops cases involving civil and criminal violations of Federal law. Its investigators generally focus on specific providers and practitioners, ranging from a single legal entity to large corporations with multi-State provider holdings. This is the office within OIG that will accept fraud referrals and sanction recommendations. Its offices often request medical review determinations (see Part 9).

OI may want PRO physicians to provide medical expertise for court presentation as well as case development. Both you and OI should be clear on whether this is a potential part of your contribution before you begin collaboration. OI investigators are also an excellent source of information on investigative procedures and evidence gathering in general.

2. The Office of Audit Services (OAS).--OAS conducts both audits of specific providers and large scale audits focusing on specific program issues. This office has particular expertise in issues involving provider activity designed to defraud or abuse the Medicare program through cost reports.

3. The Office of Evaluations and Inspections (OEI).--OEI conducts studies on a variety of issues, often national in scope. They post these completed studies on OIG's Internet home page, which is an excellent information source. It is possible that you may find opportunities to work with OEI in a variety of ways (see §§9200ff.). You may share with them general clinical expertise and knowledge of Medicare policies and procedures.

B. Collaborating with Other Agencies.--

1. State Agencies.--HCFA contracts with State departments of health to conduct survey and certification of Medicare and Medicaid providers. Their authority in monitoring and enforcing quality of care in Medicare providers is complementary to yours, making it paramount that you coordinate your activities. The certification process and periodic onsite surveys provide State agencies with a wealth of data, both quantitative and qualitative. Certification files contain detailed information about provider characteristics, both self-reported by providers and recorded by State staff. Onsite surveys also create detailed documentation based on the surveyor's observations of compliance with certification requirements. Surveyors, by virtue of their training and field observations, are an excellent source of information on current local practices, emerging problems, and proven solutions.

Your ability to profile providers, provider types, or services using claims and other data can be invaluable in helping the State agency effectively target its resources. Where collaboration allows the agency to use its authority to monitor and enforce requirements that parallel your own requirements, it is in the best interests of both agencies.

2. Licensure and Accreditation Bodies.--State governments license a variety of providers and health care practitioners. In addition, national accrediting bodies provide an essential component to overseeing health care services. Beyond your obligations in 42 CFR Part 480, look for opportunities to work with these agencies or provide them with information that furthers your PEPP goals.

3. State Medicaid Agencies.--Although your statutory authority directs you to review Medicare services, Medicaid is another large purchaser of health care services. As such, it is a potential partner with interests and obligations similar to your own. Regulations at 42 CFR 480.133(a)(2)(ii)(A) and 480.137(b) allow you to provide confidential information to Medicaid regarding payment errors, including fraud and abuse.

Further, you may provide nonconfidential summary information to Medicaid about quality or program integrity issues identified in your work that may be similarly problematic in the Medicaid population. You should become familiar with your State's program and identify common ground with Medicare requirements. To the extent that you can develop parallel efforts, you will greatly amplify the message to providers to improve their practices.

Note, however, that information related to your quality improvement projects that identifies a particular provider is confidential information, even if in summary form, and must be handled accordingly (see 42 CFR 480.101(b)).

4. Intermediaries/Carriers/Regional Home Health Intermediaries (RHHIs)/ Durable Medical Equipment Regional Contractors (DMERCs).--Continue to report denials and adjustments based on individual case reviews to the intermediary in accordance with Parts 3 and 4. Provide determinations on cases referred to you by HCFA contractors, and report the results in a mutually acceptable manner. These are only the beginnings of the potential partnerships you may develop with these contractors. You may share data for joint analysis or provide summary analysis or case review data, which identify patterns of payment errors. Beyond identification of specific providers, this may be useful to payers for development or assessment of local medical policy, edits, pre-payment review criteria, or other processes. You must refer medical review determinations or data collection on Part A services, which result in denials of payment, to carriers for consideration in reviewing corresponding Part B physician services.

Become familiar with the organizational structure of payers, and recognize the ease or difficulty with which information flows between them. For example, intermediaries and carriers have fraud units, which may receive your referrals for development (see §§3953ff. of the Medicare Intermediary Manual, Part 3). These units are generally distinct from medical review units, which may collaborate with you on a variety of program integrity issues that do not constitute fraud. These units may be willing and able to engage in joint reviews where your combined authority is needed to fully address an issue. Some of these organizations have significant beneficiary or provider outreach and education departments that would also be willing to join forces on issues of mutual interest.