Medicare Program Integrity Manual

Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity (BI) Programs

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Table of Contents

(Rev. 264, 08-07-08)

Transmittals for Chapter 1

1.1- Introduction

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

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 protect the Medicare Trust Fund from fraud, waste and abuse. 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 (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment regional carriers (DMERCs) shall follow the entire PIM for medical review functions as they relate to their respective roles and areas of responsibility to medical review (MR).

Part A and B Medicare administrative contractors (A/B MACs) and durable medical equipment Medicare administrative contractors (DME MACs) shall follow the PIM to the extent outlined in their respective statements of work. Program safeguard contractors (PSCs) and durable medical equipment program safeguard contractors (DME PSCs) shall follow the PIM to the extent outlined in the umbrella program safeguard contractor statement of work and in their respective task order statements of work. The PSC, in partnership with CMS, shall be proactive and innovative in finding ways to enhance the performance of PIM guidelines.

There are three types of entities with which Medicare contracts to review, and process claims. From this point forward, the term “contractors” shall refer to all of the following, unless otherwise noted:

- Affiliated contractors (ACs), which include FIs (including RHHIs), carriers, and DMERCs,

- Medicare administrative contractors (MACs), which include A/B MACs and DME MACs, and

- Program safeguard contractors (PSCs), which include A/B pscs and DME PSCs.

The PIM supports the Government Performance Results Act (GPRA) and OMB's Program Assessment Rating Tool (PART). The GPRA requires contractors to reduce the error rates as identified in the chief financial officer's (CFO) audit and developed through the comprehensive error rate testing (CERT) program.

The CMS’ national objectives and goals as they relate to medical review are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical review of claims; and 3) Collaborate

with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse. In order to ensure these objectives are being met, CMS has developed the S.P.A.C.E. Program to evaluate contractor performance. The S.P.A.C.E. acronym identifies the following key components of this evaluation strategy:

- **Self-Assessment** (Certification Package for Internal Controls (CPIC)**:** This is a self-certification process in which a contractor performs a risk assessment to identify and select particular business function areas to thoroughly evaluate and find areas for improvement.

- **Performance Oversight** (Statement of Auditing Standards (SAS 70) Audit): The SAS-70 is a process currently utilized by Medical Review (MR) and other CMS components for contractor performance oversight. This performance oversight program utilizes the skills and expertise of independent auditors to complete a performance audit. The audit takes approximately four months to complete and the contractor's performance during the most recent two quarters of the fiscal year are evaluated. There are two types of SAS-70 audits. Type I audits determine if essential internal controls are in place. Type II audits determine if the internal controls are effective. Medical review internal control objectives can be found in chapter 7 of the Medicare Financial Management Manual. The internal control objectives reflect CMS' requirements for an effective medical review operation.

And

- **Comprehensive Error Rate Testing** (CERT): CERT is a CMS program that measures a contractor's payment error rate. The S.P.A.C.E. program considers a contractor's CERT score in conjunction with SAS-70 audit findings and CPICs when making an overall determination of a contractor's educational need.

- **Educational Training Program**: Regional office (RO) or central office (CO) staff may recommend an educational intervention for a contractor based on findings from a SAS-70 audit, problems with a contractor's medical review (MR) Strategy, or for other concerns the RO or CO staff may have. A problem-focused educational interaction between CMS staff (RO & CO) and a contractor is based on potential or current areas of contractor vulnerability.

The PIM requirements form the basis of CMS' S.P.A.C.E. Program oversight. The PIM serves as the foundation upon which MR internal control objectives are developed. These internal control objectives are the criteria against which the contractor is evaluated when performing a self-assessment and/or during the SAS 70 Audit. The PIM also serves as written guidance for contractor evaluation under the Comprehensive Error Rate Testing Program, which serves to ensure that contractors are exercising accurate, and defensible decision making on medical reviews.

Both MR and the BIU use data analysis as the foundation for detection of aberrant billing practices. Through data analysis, the MR unit determines the extent of the problem and the potential threat to the Medicare Trust Fund. The most egregious problems are selected

for validation by probe review. The results of the probe review will determine whether the problem is an unintentional error by the billing entity that will be pursued by the MR unit; or potentially fraudulent, which is pursued by the BIU; or determined not to be a problem.

The purpose of this chapter is to describe the MR 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. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Contractors may perform MR functions for all claims appropriately submitted to a Medicare fiscal intermediary (FI), Medicare carrier, Part A and B Medicare administrative contractor (A/B MAC), and durable medical equipment Medicare administrative contractor (DME MAC).

Quality improvement organizations (QIOs) will no longer be performing the majority of utilization reviews for Acute Inpatient Prospective Payment System (IPPS) hospital and long-term care hospital (LTCH) claims. The review of acute IPPS hospital and LTCH claims (which, for the purposes of this section, also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) is now the responsibility of the A/B MACs or the FIs. An exception occurs when a provider requests a higher-weighted DRG review from the QIO. The QIO will continue to perform those reviews. QIOs will also continue to perform reviews related to quality of care and expedited determinations.

Contractors shall include claims for which they are responsible in doing data analysis to plan their medical review strategy. Amendments to plans and strategies shall be made as needed if analysis indicates adjustment of priorities.

1.1.3 - Quality of Care Issues

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Potential quality of care issues are not the responsibility of the contractor MR unit, but are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. Contractors should refer quality of care issues to the *QIO.* See chapter 3.1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

1.2 - The Medicare MR Program

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The MR program is designed to promote a structured approach in the interpretation and implementation of Medicare policy. The CMS makes it a priority to automate this process; however it may require the evaluation of medical records to determine the medical necessity of Medicare claims. The goal of the contractor's MR program is to participate in reducing the contractor's claims payment error rate by identifying, through analysis of data and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and by taking the necessary action to prevent or address the identified vulnerabilities.

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.

The CMS contracts with carriers, fiscal intermediaries (FIs), program safeguard contractors (PSCs), and Medicare Administrative Contractors (MAC) to perform MR functions: analyze data, write local coverage determinations (LCD), review claims, and educate providers. 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 LCD requirements, or any requirements other than data analysis.

1.2.1 - Goal of MR Program

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Under GPRA, CMS has a goal to reduce the Medicare fee-for-service paid claims error rate. Contractors are not required to establish a baseline error rate or calculate a contractor specific error. The CERT Program will provide the baseline measurements.

The goal of the MR 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:

- Proactively identify potential MR related 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) (IOM Pub.100-08, 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; (IOM Pub.100-08, chapter 3, describes these actions in further detail.)

- Place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinician) of MR findings and making appropriate referrals to provider outreach and education (POE), and PSC benefit integrity (BI) units; and

- Publish LCDs 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 IOM Pub. 100-08, chapter 4, section 4.16, 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 IOM Pub.100-08, 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. See IOM Pub. 100-08, chapter 4, §2.1. Contractors shall take action commensurate with the error made. Contractors shall evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction. See IOM Pub. 100-08, chapter 3, §3.1.

1.2.2 - MR Manager

(Rev. 203, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

An effective MR program begins with the strategies developed and implemented by senior management staff. Contractors must name an MR point of contact referred to as

the MR manager who 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 the development, oversight and implementation of the contractor's MR Strategy, Strategy Analysis Report (SAR) and quality assurance process. In addition, the MR manager shall have the primary responsibility for ensuring the timely submission of the MR strategy and SAR. For the PSC, the MR manager shall be designated as key personnel in the PSC SOW.

1.2.3 - Annual MR Strategy

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

Each fiscal year, the contractors shall develop and document a unique annual MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The MR strategy shall detail identified MR issues, activities, projected goals, and the evaluation of activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the MR strategy. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. CERT is only a pointer and cannot be relied upon as a single source of information. Contractors should use their internal data to verify that the CERT findings are (or are not) currently problems of sufficient magnitude to be included in their MR strategy in the appropriate priority. Other problems identified from other sources may be of higher priority, but contractors must review the CERT findings in terms of their own data and MR activities. Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and provider outreach and education POE.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR activities. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop MR interventions using the PCA process (IOM Pub 100-8, chapter 3, section 14) to address each problem.

The methods and resources used for MR interventions depend on the scope and severity of the problems identified and the action needed to successfully address the problems. For example, if initial MR actions such as an MR notification letter to the provider and placement on prepayment review are insufficient to improve the provider's billing accuracy, a priority referral to POE for potential intervention may be necessary.

Alternately, if on initial probe, a medium or high priority problem is identified, MR may determine that the initial issuance of probe result letter is insufficient, and a priority referral to POE, and/or more intensive medical review corrective actions may be required. A priority referral is an indication to the POE department that this is a problem which MR has determined will likely require further educational intervention. If, through communication with POE, it is determined that MR intervention and POE educational efforts have not effectively resolved the problem, a referral to the PSC BI unit may be indicated.

In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR strategy and reflected in the SAR. If resources allow, an MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address identified problems for the local Medicare providers. The MR strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of activities designed to resolve targeted medical review problems. These evaluation methods will be dependent upon effective communication between the MR and POE departments. MR shall work with POE to develop an effective system of communication regarding the disposition of problems referred to POE. Within MR, a system shall be used to track referrals to POE, follow-up communication with POE, and MR interventions used to address identified problems. The PSC shall include what information is required in the referrals to POE within the AC or MAC JOA.
As problems are addressed within MR or referred to POE, the MR department shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information gathered through communication with POE to determine a more progressive course of action, such as increase in prepay MR, priority referral to POE, or referral to BI in cases of suspected fraud. Effective tracking of MR and POE efforts to resolve identified problems is integral to development of any case referred for potential investigation by the PSC (See PIM, chapter 4, section 4.3). As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The MR strategy shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) *and Medicare administrative contractors (MACs)* shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the CMS analysis, reporting, and tracking (ART) system.

In each element of the MR strategy, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In addition, the contractor shall have in place procedures for continuous quality improvement. Quality improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported. Examples of actions which might be listed in the intervention list include, but are not limited to service-specific probes, notification letters, POE priority referrals, and automated denials based on LCDs.

Figure 1

FY 200_ Medicare Medical Review Strategy

Contractor Name:
Contractor Number:
Contractor MR site location(s):

Data Analysis Plan:
Prioritized Problems: **(1)**
(2)
(3)
Intervention Plan: **(1)**
(2)
(3)
Follow up Plan: **(1)**
(2)
(3)
Program Management:

- **Workload management process**
- **Cost allocation management process**
- **Staffing & Resource management process**
- **CMS Mandates**
- **PSC support**

Budget and Workload Chart:

Staffing Chart:

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR consults with POE to ensure that duplicate efforts are not being undertaken or consistently being

overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

1.2.3.1 - Data Analysis and Information Gathering

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The Data Analysis Plan shall list the data resources used in developing the strategy and the MR process. Examples of helpful resources include national database reporting systems, internal claims reports, provider feedback, team meetings with appeals and provider inquiry, SADMERC data, provider tracking tools to identify potential coverage and coding problems, CERT data, SAS 70 findings, benefit integrity (BI) information, and any additional data developed by the contractor. The data analysis plan shall list the data resources and processes used in development of the MR strategy.

Quality Assurance:

For quality assurances purposes, the contractor shall develop a process that includes frequent review of data and how the information is used. For example, establish a committee that routinely reviews data results. Document committee members' job titles, qualifications and contract operational areas they represent. Describe the log system or tracking system utilized for data analysis and how this information was developed via meetings and/or brainstorming. The contractor can use the CERT findings to demonstrate how well the contractor is performing their data analysis.

1.2.3.2 - Problem Identification & Prioritization

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR is not focusing on problems that are being addressed by the POE unit or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

1.2.3.3 - Intervention Planning

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

To address the problems identified in the MR strategy, the contractor shall design a comprehensive plan of interventions. Interventions may involve projected medical review of claims, referral of providers to POE or the PSC BI unit, edit modifications and development or revisions of LCDs.

Quality Assurance:

The contractor shall include a quality assurance element in each intervention that checks for effectiveness and progress towards the specified goal. The QA component shall include a projected goal, a timeline to achieve the goal, and an element to assess effectiveness of the intervention and progress towards the stated goal. Examples of QA for interventions include, but are not limited to, tests for edit effectiveness, post-test of educational interventions, claims review after an educational intervention, systematic reviews of LCDs, etc. Finally, the QA component shall include a determination of whether the problem has been resolved or a more progressive course of action is required.

1.2.3.4 - Program Management

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

The MR program management encompasses managerial responsibilities inherent in managing the MR program, including: development, modification, and periodic reporting of MR strategies and quality assurance activities; planning monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS MR instructions.

Quality Assurance:

The contractor shall describe in detail the quality improvement process. Include the processes employed to assure accuracy and consistency in the reporting of spending, workload and staffing levels. The contractor shall address how to maintain accuracy in decision-making (inter-reviewer reliability) and response to provider inquiries. In addition, the contractor shall describe the system for the review and evaluation of the MR strategy.

1.2.3.5 - Budget and Workload Management

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

In order to effectively determine appropriate budget levels and accurately predict workload, the contractor shall complete the following chart (omitting the shaded areas) for each strategy developed. Note that this chart is only for the purposes of developing an MR strategy. Contractors are expected to report workloads and costs associated with all CAFM II activity codes and assigned workloads. *PSCs and MACs* shall not report cost and workload using the CAFM II system. Instead, the PSC shall report cost and workload in the CMS ART system.

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	MR Program Management				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				

NOTE: When submitting the Interim Expenditure Report (IER), all defined workloads shall be entered.

In addition:

- The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code. Contractors may perform automated, routine, and complex prepayment review and post-payment reviews. Contractors shall determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration shall be given to 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.

– The contractor shall automate as much review as possible. For those types of review that cannot be automated, the contractor shall be able to justify why they cannot

be automated. Only in those instances where reviews cannot be automated and does not require clinical judgment shall the contractor conduct routine reviews.

– The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall MR program for the contractor. For the PSCs that perform some medical review functions, they shall be involved with the development of the MR strategy.

- The contractor shall identify the process for determining when the contractor will develop or revise LCD.

1.2.3.6 - Staffing and Workforce Management

(Rev. 229, Issued: 11-23-07, Effective: 04-01-08, Implementation: 04-07-08)

Contractors shall complete and include the following chart to project the number of full-time-equivalent (FTE) employees, their job titles and qualifications.

CAFM II Code	FTE	Description & Qualifications
21001		
21002		
21007		
21010		
21206		
21207		
21208		
21220		
21221		
21221/01 (DMERCs only)		
21222		

The contractor shall submit a MR strategy each fiscal year *via the MR system located at CMS's Local Coverage Systems Portal Web site.* The MR strategy shall be updated as required. *MAC contractors shall submit a MR strategy within 30 days after contract award and thereafter 30 calendar days prior to option year award.*

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 - Contractor Medical Director (CMD)

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

Contractors who perform medical review must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for

extended periods. Waivers for very small contractors may be approved by the CO. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy. All clinicians 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 LCDs; 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 LCDs and internal MR guidelines:
    - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
    - Determining when LCDs are needed or must be revised to address program abuse;
    - Assuring that LCDs 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 LCDs 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, Associate 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.

1.5 - Maintaining the Confidentiality of MR Records

(Rev. 174, Issued: 11-17-06, Effective: 10-01-06, Implementation: 10-06-06)

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.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R264PI	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
R229PI	11/23/2007	Medical Review Strategy and Strategy Analysis Report	04/07/2008	5760
R220PI	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
R203PI	05/25/2007	Strategy Analysis Report	07/02/2007	5519
R174PI	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
R170PI	11/03/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
R163PI	09/29/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
R136PI	02/01/2006	Contractor Medical Director Requirements	03/01/2006	4105
R118PI	08/12/2005	Various Benefit Integrity (BI) Clarifications	09/12/2005	3896
R107PI	04/08/2005	Updated Chapter 1 to Reflect Changes in Program Requirements	05/09/2005	3754
R099PI	01/21/2005	Waivers Approved by the Regional Office (RO) by Replacing Regional Office with Central Office (CO)	02/22/2005	3646
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R065PI	01/30/2004	Requirement Removal of Fiscal Intermediary Medical Review on Long Term Care Hospitals	03/02/2004	2905
R040PI	05/16/2003	Local Provider Education and Training Program	05/16/2003	2466
R033PI	11/01/2002	FY 2003 Budget Performance Requirement Revisions	11/01/2002	2407
R025PI	04/25/2002	Types of claims for which Contractors are Responsible	07/01/2002	2122
R024PI	04/05/2002	Removes the LMRP and related sections from Chap 1 and moves to Chap 13	10/01/2002	2061
R021PI	02/28/2002	Inpatient Hospital Claims for Which Contractors are Responsible for Performing MR	04/01/2002	1969
R019PI	02/08/2002	Benefit Integrity Unit Security Requirements	02/08/2002	1907
R017PI	12/12/2001	Reorganizes chapter 3, sections 4, 5, and 6	04/01/2002	1891

		and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.		
R016PIM	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732
R014PIM	09/26/2001	Local Medical Review Policy (LMRP) Format and Submission/Requirements	10/01/2001	1859
R010PIM	09/17/2001	Timeframe for Contractor Advisory Committees (CAC) Meetings	10/17/2001	1744
R009PIM	07/30/2001	LMRP Process	NA	1021
R008PIM	07/11/2001	Replaces PIM Chapter 1, Sections 2, 2.1, and sections 2.3 up through and including 2.3.4.	07/11/2001	1485
R006PIM	05/24/2001	Maintaining the Confidentiality of MR Records	05/24/2001	1581
R003PIM	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
R001PIM	06/2000	Initial Release of Manual	NA	931