Medicare Program Integrity Manual

Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

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(Rev. 425, 06-15-12)

Transmittals for Chapter 1

1.1- Overview of Program Integrity and Provider Compliance
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

Affiliated contractors (ACs) shall follow all sections of the PIM unless otherwise indicated.

Medicare administrative contractors (MACs), comprehensive error rate testing (CERT) contractors, recovery audit contractors (RACs), program safeguard contractor (PSCs) and zone program integrity contractors (ZPICs) shall follow the PIM as required by their applicable Statement of Work (SOW).

1.2 - Definitions
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

To facilitate understanding, the terms used in the PIM are defined in Exhibit 1.

1.3 – Medicare Improper Payment Reduction Efforts – Provider Compliance
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency that operates the Medicare program. Addressing improper payments in the Medicare fee-for-service (FFS) program is a top priority for the CMS. Preventing Medicare improper payments requires the active involvement of every component of CMS and effective coordination with its partners including various Medicare contractors and providers. CMS contracts with three types of contractors in its effort to fight improper payments in the Medicare FFS program:

- Comprehensive Error Rate Testing (CERT) contractors;
- Carriers, fiscal intermediaries and Medicare administrative contractors (MACs); and
- Recovery audit contractors (RACs).

1.3.1 - Types of Contractors
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. The CERT Contractors

The CMS implemented the CERT program which establishes error rates and estimates of improper payments that is compliant with the Improper Payment Information Act.

B. ACs and MACs

For the purpose of this manual, the term affiliated contractors or AC will be used to refer to carriers and fiscal intermediaries. ACs and MACs primarily use error rates produced by the CERT program and vulnerabilities identified through the RAC program to identify

where to target their improper payment prevention efforts. The ACs and MACs analyze their internal data to determine which corrective actions would be best to prevent the CERT- and RAC-identified vulnerabilities in the future. The CMS has determined that most improper payments in the Medicare FFS program occur because a provider did not comply with Medicare's coverage, coding, or billing rules. The cornerstone of the AC's and MACs' efforts to prevent improper payments is each contractors' Error Rate Reduction Plan (ERRP), which includes initiatives to help providers comply with the rules. These initiatives usually fall into one of three categories:

1. Targeted provider education to items or services with the highest improper payments,

2. Prepayment and postpayment claim review targeted to those services with the highest improper payments. In addition, in order to encourage providers to submit claims correctly, ACs and MACs can perform extrapolation reviews as needed, and

3. New or revised local coverage determinations, articles or coding instructions to assist providers in understanding how to correctly submit claims and under what circumstances the services will be considered reasonable and necessary.

See section 1.3.6, for information on quality of care and potential fraud issues.

C. RACs

Although CMS, ACs and MACs have undertaken actions to prevent future improper payments, it is difficult to prevent all improper payments, considering that more than 1 billion claims are processed each year. CMS uses the RAC program to detect and correct improper payments in the Medicare FFS program and provide information to CMS, ACs and MACs that could help protect the Medicare Trust Funds by preventing future improper payments.

1.3.2 - Improper Payment Prevention Goals

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

The CMS strives in every case to pay the right amount to a legitimate provider, for covered, correctly coded and correctly billed services, provided to an eligible beneficiary. To achieve the goal of lowering the error rate, CMS follows three parallel strategies:

- Preventing improper payments through ACs and MACs evaluating program vulnerabilities and taking the necessary action to prevent the identified vulnerabilities in the future

- Correcting past improper payments through postpayment claim review by the RACs

- Measuring improper payments and pinpointing the causes of improper payments by calculating service specific, provider type and contractor specific error rates by the CERT contractors

1.3.3 - Applicable Program Integrity Manual Sections
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

- The ACs shall follow all sections of the PIM unless otherwise indicated

- The MACs, CERT, RACs, PSCs and ZPICs shall follow the PIM to the extent outlined in their SOWs.

1.3.4 - Performance Metrics
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. AC MR Units Performance

The AC MR Units Performance is measured by:

- **Self-Assessment** (Certification Package for Internal Controls (CPIC)**:** This is a self-certification process in which an AC performs a risk assessment to identify and select particular business function areas to thoroughly evaluate and find areas for improvement. The PIM serves as the foundation criteria against which the AC is evaluated when performing a self-assessment.

- **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 AC 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 AC'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. MR internal control objectives can be found in Pub.100-06, Medicare Financial Management Manual, chapter 7. The internal control objectives reflect CMS' requirements for an effective MR operation. The PIM serves as the foundation criteria against which the AC is evaluated during the SAS 70 audit.

- **CERT**: CERT is a CMS program that measures a contractor's payment error rate.

The AC MR Units' performance is corrected by:

- **Educational Training Program**: Regional office (RO) or central office (CO) staff should recommend an educational intervention for an AC based on findings from a SAS-70 audit, problems with an AC'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 and CO) and an AC is based on potential or current areas of contractor vulnerability.

B. MAC MR Units Performance

The MAC MR Unit performance is measured by:

- **CERT**: CERT is a CMS program that measures a contractor's payment error rate.

- In addition, the MACs are measured by other measures listed in the MAC SOW.

C. RAC Performance:

One key measure of RAC performance is the RAC accuracy rate. CMS will produce a RAC accuracy rate for each RAC on an annual basis. These rates will be released to the public.

D. CERT Performance

The CERT performance metrics are listed in the contractors' SOW. One key measure of CERT performance is the timely production of the national error rate each year.

1.3.5 - Types of Claims for Which Contractors Are Responsible

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. ACs and MACs

The ACs and MACs should, at their discretion perform medical review functions for all claims appropriately submitted to them.

Although they will continue to perform a number of quality functions, 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 ACs and MACs. An exception occurs when a provider requests a higher-weighted diagnosis related group (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.

The ACs and MACs shall include claims for which they are responsible when performing data analysis to plan their medical review strategy. Amendments to plans and strategies shall be made as needed if analysis indicates adjustment of priorities.

B. CERT

The CERT review contractor is responsible for reviewing claims randomly selected by the CERT statistical contractor.

C. RACs

In general, RACs are responsible for reviewing claims where improper payments have been made or there is a high probability that improper payments were made.

1.3.6 - Quality of Care Issues and Potential Fraud Issues

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

- Potential quality of care issues are not the responsibility of the AC, MAC, CERT or RAC, PSC and ZPIC, but they are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. ACs, MACs, CERT, RACs, PSCs and ZPICs shall refer quality of care issues to the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. See chapter 3, section 3.1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

- Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action shall be initiated. At any time, evidence of fraud shall result in referral to the PSC/ZPIC for development. See chapter 4, section 4.18.3 for a discussion on benefit integrity interaction with QIOs.

1.3.7 - The Affiliated Contractor (AC) and MAC Medical Review Program

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

The MR program is designed to prevent improper payments in the Medicare FFS program. Whenever possible, ACs and MACs are encouraged to automate this process; however it may require the evaluation of medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing policies.

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 ACs and MACs 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, and 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.
- 42 CFR 421.400 for MACs.

The PSCs and ZPICs shall refer to chapter 4 for MR for BI purposes.

1.3.8 - Goal of AC and MAC MR Program

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

The goal of the AC and MAC MR program is to reduce payment error by preventing the initial payment of claims that do not comply with Medicare's with coverage, coding, payment, and billing policies. To achieve the goal of the MR program, ACs and MACs:

- Identify provider noncompliance with coverage, coding, billing, and payment policies 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). (chapter 2, describes these activities in further detail.);

- Take action to prevent and/or address the identified improper payment; (chapter 3, describes these actions in further detail.); and

- Place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinician) of review findings identified by the ACs or by the MACs and making appropriate referrals to provider outreach and education (POE), and PSCs and ZPIC.

1.3.9 – Provider Self Audits

(Rev. 425, Issued: 06-15-12, Effective: 07-16-12, Implementation; 07-16-12)

Providers may conduct self-audits to identify coverage and coding errors. The Office of Inspector General (OIG) Compliance Program Guidelines *can be found at http://oig.hhs.gov/compliance/compliance-guidelines/index.asp and the statistical guidelines in http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf (if statistical sampling is utilized during the audit).* ACs and MACs shall follow chapter 4, section 4.16, 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 ACs and MACs shall follow the procedures listed in chapter 3, section *3.2.1.* 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. Per chapter 4, section *4*.2.1, ACs and MACs shall take action commensurate with errors made. ACs and MACs shall evaluate the circumstances surrounding the errors and proceed with the appropriate plan of correction.

1.3.10 – Coordination Among Contractors

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Coordination among ACs, MACs, PSCs and ZPICs

The AC and MAC medical review (MR) staff shall coordinate and communicate with their associated PSC or ZPIC to ensure coordination of efforts and to prevent inappropriate duplication of review activities. At any time, suspicion of fraud should result in referral to the PSC or ZPIC for development.

B. Coordination among ACs, MACs and the RACs

See Pub. 100-06, Financial Management Manual, chapter 4, section 100.1-100.15, for a description of the coordination efforts between ACs, MACs and RACs. In addition, the ACs and MACs shall coordinate and communicate with RACs to get the specifics on RAC identified vulnerabilities for use in the AC's and MAC's data analysis and possible corrective actions.

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 - Medical Review Manager

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Contractors To Which This Section Applies

This section applies to ACs and MACs only.

B. General

An effective MR program begins with the strategies developed and implemented by senior management staff. Contractors shall 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, SAR, and quality assurance process. In addition, the MR Manager shall have the primary responsibility for ensuring the timely submission of required reports.

1.6 – Maintaining the Confidentiality of MR Medical Records and Documents

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Contractors to Which This Section Applies

This section applies to ACs, MACs, CERT and RACs.

B. General

Contractors shall maintain the confidentiality of all MR medical records and documents before, during, and after the MR process. Similarly, contractors that use a subcontractor(s) to perform MR, to store MR documents, and/or to transport MR documents, are responsible for ensuring that the subcontractor(s) maintains the confidentiality of the MR documents that it handles. This responsibility applies to all contact with these documents 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 documents. Thus, just as the contractor shall assure that the subcontractor maintain confidentiality itself, so too shall 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 documents, maintain confidentiality.

1.7 - Benefit Integrity

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Contractors to Which This Section Applies

This section applies to PSCs and ZPICs only.

B. General

In addition to reducing improper payments, CMS strives to protect the program from potential fraud. CMS contracts with program safeguard contractors (PSCs) and zone program integrity contractors (ZPICs) to identify and stop potential fraud.

The primary task of PSCs and ZPICs is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are identified. PSCs and ZPICs shall refer cases of potential fraud to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Office of Investigations (OI).

1.8 - Medical Review for Benefit Integrity (MR for BI)

(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Contractors to Which This Section Applies

This section applies to PSCs and ZPICs.

B. General

The goal of the MR for BI program is to address situations of potential fraud, waste, and abuse (e.g., looking for possible falsification).

Information on maintaining the confidentiality of MR documents can be found in this chapter, section 1.6.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R425PI	06/15/2012	Provider Self Audits	07/16/2012	7851
R313PI	11/20/2009	Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7	12/21/2009	6546
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	04/01/2002	1969

		MR		
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 and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.	04/01/2002	1891
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

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