

**FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM**

October 17, 2003

Local Provider Education and Training (Carrier and DMERC)

Addendum 3

The Local Provider Education and Training (LPET) program is designed to support medical review by educating those providers who demonstrate erroneous claims-submission behaviors affected by local medical review policies (LMRPs), coverage, coding, and medical review related billing issues. LPET also provides proactive education to address issues that emerge from the analysis of medical review data and information. The Medical Review (MR) program drives all LPET activity. As such, all LPET activity is a response to issues identified through the analysis of medical review findings, information from the various operational areas of the carrier, and data from various sources. The ultimate goal of the LPET program is the continual reduction in the national claims payment error rate. Carriers and DMERCs evaluate all of the information, prioritize the issues, and then design educational interventions that best address identified problems.

Unlike Provider Communication (PCOM) activities that address Medicare's national issues, LPET education is always a response to the local provider's claim submission patterns and information needs. The LPET program is intended to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. Teaching providers how to submit claims accurately, assures correct payment for correct services rendered. To meet this goal, contractors are required to use various media such as print, Internet, telephone, and in-person contacts. In-person contacts include one-on-one meetings as well as group conferences.

The FY 2004 LPET program requires contractors to consider the method in which the educational activity may be delivered. In FY 2003, the LPET program required carriers and DMERCs to determine the educational focus for the subject matter. For example, carriers and DMERCs were required to plan and report Proactive Local Educational Meetings or Provider-Specific Education related to a particular medical review issue. However, many educational activities delivered in FY 2003 were not solely medical review related. To more closely fuse LPET to medical review, contractors now must plan and report educational activity by mode of delivery. By considering educational modes rather than subject focus, carriers and DMERCs can more easily allow the identified problem to become the focus of the educational activity.

Methodology

In FY 2004, Medicare provides instructions for the MR and LPET programs through two Budget and Performance Requirements (BPRs) documents: the MR BPRs and the LPET BPRs. The BPRs require carriers and DMERCs to design a MR/LPET strategy. Carriers

and DMERCs are expected to design one MR/LPET strategy document that will satisfy the MR/LPET strategy requirements for both BPRs. The BPRs provide instructions for the LPET program and MR/LPET strategy. Please refer to the instructions in the MR BPRs for additional guidance in strategy design. Carriers and DMERCs that conduct LPET activities at multiple sites must have a system in place that allows workload and funding to be tracked separately for each individual MR activity site. These intermediaries may develop only one MR/LPET strategy; however site-specific problem identification, prioritization, funding, and workload must be addressed in the strategy and reported with the Interim Expenditure Report (IER) in the remarks section of CAFM II for each activity code (PIM Chapter 1, Section 2f).

The MR/LPET strategy must address identified medical review issues, educational activities, projected goals, and the evaluation of educational activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take precedence. The initial step in designing the MR/LPET strategy requires carriers and DMERCs to gather and analyze information and data from various sources. The carrier must develop methods of communication with various operational areas that interact with medical review. Information collected as a result of communication with the carriers' and DMERCs' other operational areas includes, but is not limited to, trends in appeals and provider inquiry. Data collection should include, but is not limited to, the data analysis of medical review, and information obtained from PCOM, inquiries, and data from the review of claims.

After information and data is gathered and analyzed, the carrier must develop and prioritize a medical review problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR and LPET activities. Once a problem list is created, the carriers and DMERCs must develop educational activities using the philosophy of Progressive Corrective Action (PCA) to address each problem. Carriers and DMERCs must consider resources and the scope of each identified medical review issue, when prioritizing their problem list. The methods and resources used for the MR and LPET interventions depend on the scope of the problems identified and the level of education needed to successfully address the problems.

The carrier and DMERCs must develop multiple tools to effectively address the local Medicare providers' wide-ranging educational needs. The MR/LPET strategy must include achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems. In addition, as problems are successfully addressed, the MR/LPET strategy must incorporate processes for follow-up that ensure appropriate resolution of the issue. As issues are resolved, the carriers and DMERCs should continue to address other issues identified on the problem list.

The MR/LPET strategy must include a section that describes the process used to monitor spending in each activity code. The process must ensure that spending is consistent with the allocated budget and includes a process to revise or amend the plan when spending is

over or under the budget allocation. In addition, the strategy must describe how workload for each activity code is accurately and consistently reported. The workload reporting process must also assure proper allocation of employee hours required for each activity.

Finally, the MR/LPET strategy must include a mechanism utilized to monitor and improve the accuracy and consistency of the LPET staff's responses to specific inquiries regarding MR related coverage and coding issues, whether they are submitted in writing or by telephone. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

Clinical expertise is required to educate providers concerning coverage, coding, and billing issues related to medical review. In FY 2003, educational interventions were performed at the direction of the MR manager, clinicians, and by specially trained non-clinical staff working under the direction of the clinicians. Educational interventions may continue to be performed in the same manner for FY 2004. However, contractors should begin to incorporate more clinicians and fewer 'specially trained non-clinical staff' in their LPET program.

Budget Considerations

Carriers and DMERCs must consider various elements when planning their LPET budget. For example, contractors should explain how they plan to allocate for provider educational activities between LPET, PCOM, and Benefit Integrity (BI). LPET subjects or issues include LMRPs and local coverage, coding, and billing issues as identified by the medical review process. BI subjects include fraud and abuse and benefit integrity. PCOM issues include subjects of national scope or impact. While there are fundamental differences between the LPET, PCOM, and BI programs, we understand that there may be circumstances when it would be feasible to provide educational events that encompass the scope of more than one of these programs. For any functions such as seminars, conventions, or conferences that address LPET subjects, as well as PCOM and/or BI issues, the proportional share of the cost of that function to be allocated to LPET, is equal to the percentage of time related to addressing LPET issues, multiplied by the cost of the function. For example, the proportional share of the cost of a seminar to be allocated to LPET is equal to the percentage of the seminar related to addressing issues other than PCOM subjects, multiplied by the cost of the seminar (e.g., if it costs \$4,000 to arrange and conduct a seminar containing 75 percent MR and 25 percent national coverage information, then the LPET cost would be \$4,000 multiplied by 0.75 or \$3,000, with the remaining \$1,000 charged to PCOM). This methodology for allocating costs also applies to other general, all-purpose provider education tools or materials such as regularly scheduled bulletins/newsletters. The costs for developing, producing and distributing bulletins should be allocated proportionally, according to the percentage of time spent on each subject in the bulletin between LPET, PCOM, and BI.

Each carrier will be given a specified maximum budget for LPET activities. Carriers and DMERCs must identify the appropriate budget and workload, for each activity code

within the constraints of their budgets. Carriers and DMERCs are not permitted to charge providers/suppliers for educational activities and training materials planned for in the MR/LPET strategy. However, carriers and DMERCs may assess fees for educational activities delivered at a non-Medicare contractor sponsored event specifically requested by specialty societies or associations. In addition, although carriers and DMERCs are mandated to supply providers with a paper copy of their bulletin at no cost, upon request, carriers and DMERCs may assess a fee to cover costs if the provider requests additional copies. Any monies collected must be reported as a credit in the applicable activity code and accompanied with a rationale for charging the fee. The fees must be fair and reasonable. Revenues collected from discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities.

Activity Codes

Business processes are defined for each LPET activity code and are included in the Activity Based Costing (ABC) Dictionary (Attachment 2 to the BPRs). To accurately capture costs, the LPET ABC Dictionary must be utilized as a guide when reporting workloads. Identify only those costs associated with each activity code definition in order to assure the integrity of the ABC process. Carriers and DMERCs will negotiate workload based upon a set-funding amount.

Discontinued LPET Activity Codes

In FY 2004, CMS will no longer support reporting of the following activity:

- 24101 - Provider-Specific Education
- 24102 - Comparative Billing Report Education
- 24103 - Education of Identified Service Specific Errors
- 24104 - Proactive Local Education Meetings
- 24106 - Frequently Asked Questions re: Local Education Issues
- 24107 - Bulletin Articles/Adv. Regarding Local Education
- 24108 - Analysis of Information
- 24112 - LPET Workload Management
- 24113 - Comprehensive Educational Interventions
- 24115 - Scripted Response Documents on Local Issues

New LPET Activity Codes

In FY 2004, carriers and DMERCs must begin reporting the following activities:

- 24116 - One-on-One Provider Education
- 24117 - Education Delivered to a Group of Providers
- 24118 - Education Delivered via Electronic or Paper Media

New LPET Miscellaneous Code

Budget Approval Requirements

Negotiations with the CMS Regional Office (RO) budget and MR staff's will concern the MR/LPET strategy and the individual elements in the strategy. CMS RO budget and MR staff's retain the authority to restrict carriers' and DMERCs' funding amounts for LPET, if their methodology or selection of activities for reducing the claims payment error rate is not problem focused, outcome driven, and related to medical review issues.

Under the Government Performance and Results Act (GPRA), CMS has a goal to reduce the Medicare fee-for-service national paid claims error rate to five percent. Carriers and DMERCs are not required to establish a baseline error rate, or calculate a carrier-specific error rate to be judged against the GPRA goal. The Comprehensive Error Rate Testing Program (CERT) will eventually provide the baseline measurements.

Budget requests must be accompanied by an MR/LPET strategy that includes the following:

- A listing of information and data used to identify medical review problems;
- A listing of identified medical review issues;
- An educational plan to address each issue;
- Outcome goals;
- An evaluation process that assesses the efficiency and effectiveness of educational activity and measures progress towards goals;
- A system that allows for follow-up of resolved issues once goals have been met and the concurrent shifting of focus and resources to the next issue on the list;
- A list of employees identified by job title and qualification (e.g., RN, LPN, specially trained staff);
- The number of FTEs for each activity code - include direct cost and qualification (e.g., RN, LPN, specially trained staff);
- A process to monitor spending in each activity code - include a process to revise or amend the plan when spending is over or under the budget allocation;
- A workload reporting process that assures accuracy and consistency;
- A mechanism utilized to monitor and improve the accuracy and consistency of the LPET staff's responses to written and telephone inquiries regarding coverage and coding issues; and
- The following chart (for budget planning purposes, no entry should be made in shaded areas).

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Manual Reviews				
21007	Data Analysis				
21100	PSC Support Services				
21206	Policy Reconsideration/Revision				
21207	MR Program Management				
21208	New Policy Development				
21210	MR Reopenings of N102 Claims and Claims with Late Documentation				
21220	Complex Manual Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				

21222	Postpay Complex Manual Review				
LOCAL PROVIDER EDUCATION AND TRAINING (LPET)					
24116	One-on-One Provider Education				
24117	Education Delivered to a Group of Providers				
24118	Education Delivered via Electronic or Paper Media				

Activity Code Definitions

One-on-One Provider Education (Activity Code 24116)

Carriers and DMERCs must develop One-on-One Provider Education in response to coverage, coding, and medical review related billing problems, verified and prioritized through the review of claims and the analysis of information provided by various sources. As these contacts are directly with the provider, clinical expertise is required to conduct this activity. One-on-One Provider Education includes face-to-face meetings, telephone conferences, videoconferences, letters, and electronic communications (e-mail) directed to a single provider in response to specific medical review findings. Carriers and DMERCs choose the type of one-on-one educational activity based on the level of coverage, coding, and medical review related billing errors identified. For a moderate problem, the carrier may choose to educate a provider via telephone conference. For more severe problems, or a problem that was not resolved through a telephone conference, a face-to-face meeting may be more appropriate. For all one-on-one contacts, carriers and DMERCs must supply the provider with a written explanation of the problem and directions on how to correct the errors. It is imperative that the written explanation be very specific to the provider's identified errors or aberrant billing problems. While one-on-one provider education is likely to correct most coverage, coding and medical review billing errors, it may be necessary for carriers and DMERCs to provide additional remedial education if the provider's billing pattern continues to demonstrate aberrancies.

Report the costs associated with One-on-One Provider Education in Activity Code 24116. Include the cost of developing the written material. Written materials, or electronic communications to providers during a One-on-One Provider Education, should **not** be reported in Education Delivered via Electronic or Paper Media, Activity Code 24118. Activity Code 24116, One-on-One Provider Education, must capture the one-on-one contact between the carrier and provider, and the written materials or electronic communication used to facilitate the one-on-one education. Included in this activity code would be letters sent to a provider that specifically addresses the medical review findings and instructions to correct the errors. Any contacts to providers made solely by paper or computer, without specifically addressing an individual provider, should not be reported here.

For One-on-One Provider Education, Activity Code 24116, Workload 1 is the number of educational contacts. Report the number of providers educated in Workload 2. . If a provider sends a representative(s) on his behalf to a one-on-one educational contact, count the number of provider(s) not representative(s) to whom the educational activity was directed.

Education Delivered to a Group of Providers (Activity Code 24117)

Carriers and DMERCs may determine that certain issues are best addressed by administering education to groups of providers. To remedy wide spread service-specific aberrancies, carriers and DMERCs may elect to educate a group of providers, rather than provide one-on-one contacts. Other subjects more appropriately addressed in a group setting include, but are not limited to, proactive seminars regarding medical review topics, educational interventions related to a group of services that combine for a comprehensive benefit (e.g., psycho therapy services) and local provider educational needs presented by new coverage policies. This activity is not to be used to educate providers on issues of national scope. Activity Code 24117, Education Delivered to a Group of Providers, is designed to educate groups of local providers only. Group education related to national, broader issues, is captured in PCOM, Activity Code 25104.

Education Delivered to a Group of Providers may include seminars, workshops, and teleconferences. A differentiating factor between Education Delivered to a Group of Providers and Education Delivered via Electronic or Paper Media is live interaction between educator and providers. A computer module with the capacity to educate many providers simultaneously would not be captured here, but would be captured under Education Delivered via Electronic or Paper Media. The determining factor is that there is not spontaneous, live interaction, between educator and providers, with the computer module.

Report the costs associated with Education Delivered to a Group of Providers in Activity Code 24117. Report the number of group educational activities in Workload 1. Report the number of providers educated in Workload 2. If a provider sends a representative(s) on his behalf to a group education activity, count the number of provider(s) not representative(s) to whom the educational activity was directed.

Education Delivered via Electronic or Paper Media (Activity Code 24118)

Carriers and DMERCs may elect to provide education via electronic or paper media. Do not report here an electronic tool or a paper document developed and utilized as an adjunct to One-on-One Provider Education (Activity Code 24116), or Education Delivered to a Group of Providers (Activity Code 24117). Instead, report education delivered solely by electronic or paper media that does not involve the facilitation or interpretation of a live educator. A comparative billing report issued to an individual provider during a one-on-one educational activity that included instructions on curing aberrant practices is an example of a paper tool used by the educator, and therefore would not be captured here. It would be included in the One-on-One Provider Education (Activity Code 24116) because it was an adjunct paper tool. A written letter composed by an educator containing specific instructions to an individual provider would also be considered One-on-One Provider Education. However, comparative billing reports issued to specialty groups upon request, or posted on the Web as a means to illustrate patterns, would be captured here.

Carriers and DMERCs are required to maintain a Web site and a Local Medical Review Policy (LMRP) list-serv (per FY 2003 BPRs, if CR 2466 is not issued - PIM Chapter 1, Section 5.9). Included in this category are developing and disseminating medical review bulletin articles and disseminating LMRPs. Carriers and DMERCs are required to disseminate LMRPs or a summary of the LMRP, via list-serv and post the full body text of the LMRP on their Web sites. Carriers and DMERCs are required to make them available in hard copy upon request. Carriers and DMERCs may assess a fee to providers who request more than one copy. In addition, Carriers and DMERCs are required to submit to CMS those articles/advisories/bulletins that address local coverage/coding and medical review related billing issues (PM 02-098). Frequently asked questions (FAQs) are part of Education Delivered via Electronic or Paper Media as well. Carriers and DMERCs are required to update them quarterly and post them to their Web sites. Carriers and DMERCs are encouraged to develop FAQ systems that allow providers to search FAQ archives and subscribe to FAQ updates, similar to the LMRP list-serv. CMS requires contractors to forward all articles and FAQs to CMS per the instructions in PM 02-098. Another example of Education Delivered via Electronic or Paper Media, includes, but is not limited to, scripted response documents to LMRPs and coverage review questions to be utilized by the customer service staff.

Report the costs associated with Education Delivered via Electronic or Paper Media in Activity Code 24118. Report the total number of educational documents developed for use in non-interactive educational interventions in Workload 1. Report the number of CBRs developed in Workload 2 (do not include CBRs developed for Activities in 24116 and 24117). Report the number of articles/advisories/bulletins developed in Workload 3.