

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

June 25, 2003

Medical Review (Intermediary)

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflect the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal, intermediaries must ensure that they pay the right amount for covered services, rendered to eligible beneficiaries, by legitimate providers. CMS follows four parallel strategies that assist us in meeting this goal:

- preventing inappropriate payments through effective enrollment of providers and beneficiaries;
- detecting program aberrancies through on-going data analysis;
- coordinating and communicating with our partners, including contractors, law enforcement agencies, and others; and
- reasonable and firm enforcement policies in accordance with the principles of Progressive Corrective Action (PCA).

Medical Review's primary mission is to reduce the claims payment error rate. The MR staff has a variety of tools to use in support of their mission. Primarily, MR reduces the error rate by identifying patterns of inappropriate billing, educating providers about Medicare coverage and coding requirements, and performing medical review.

For FY 2004, CMS is providing instructions for the MR and Local Provider Education and Training (LPET) programs through two BPRs documents: the MR BPRs and the LPET BPRs. These BPRs will provide instructions for the MR program and MR/LPET strategy. The BPRs require intermediaries to design a single MR/LPET strategy. Intermediaries are expected to design one MR/LPET strategy document that will satisfy the MR/LPET strategy requirements for both BPRs. Please refer to the instructions in the LPET BPRs for additional guidance in strategy design. Intermediaries that conduct MR 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 in the remarks section of CAFM II for each activity code (PIM Chapter 1, Section 2f). Negotiations with the RO budget and MR staff's will center on the strategy and the individual elements of the strategy. RO budget and MR staff's retain the authority to reduce contractor's funding amounts for MR strategies that are not detailed in their methodology, funding, or selection of activities for reducing the claims payment error rate.

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 intermediaries to gather and analyze information and data, from various sources. The intermediaries must develop methods of communication with various operational areas that interact with MR. Information collected as a result of communication with the intermediaries' 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, Provider Communications (PCOM), and data from the review of claims.

After information and data are gathered and analyzed, the intermediaries 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. Intermediaries must consider available resources and the scope of each identified medical review issue when prioritizing their problem list. Once a problem list is created, the intermediaries must develop MR and LPET interventions, using the philosophy of PCA, to address each problem. The methods and resources used for the MR interventions depend on the scope of the problems identified and the level of education needed to successfully address the problems.

The intermediaries must develop multiple tools to effectively address the local Medicare providers' variety of 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 issues are resolved, the MR/LPET strategy must incorporate processes for follow-up that ensure appropriate resolution of the issue. As issues are resolved, the intermediaries should continue to address the 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 MR staff's responses to specific inquiries regarding coverage and coding issues, whether they are written or by telephone. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

In addition to the review of claims, LPET is a critical tool in reducing the claims payment error rate. Therefore, contractors may need to supplement the LPET budget with MR funds. All MR education activities are funded through LPET.

In FY 2004, MR will continue to incorporate Activity Based Costing (ABC) in the budget process. ABC is a management reporting system that will allow the MR department to focus on the costs of the work activities, instead of concentrating on the standard cost centers associated with the traditional cost accounting structure. ABC identifies the all-inclusive business process for each activity, so that the total costs of the activity are fully visible to the MR manager. Business processes are defined for each MR activity code and are included as Attachment 1 to the BPRs. MR managers should identify only those costs associated with each activity code definition, in order to assure the integrity of the ABC process.

In addition to satisfying all requirements contained in the MR BPRs, intermediaries must carry out all medical review activities identified in the Program Integrity Manual (PIM) and in all relevant medical review Program Memoranda.

Submit a MR/LPET Strategy to the Regional Office and to the Central Office mailbox at *MRSTRATEGIES@cms.hhs.gov* with your Budget Request. Submit a quarterly strategy update that assesses the accomplishments of individual elements of the strategy, as well as other components of the MR/LPET process, at the end of each quarter, to the Regional Office and Central Office mailbox.

Activities in the MR BPRs will be reflected in updated PIM transmittals prior to the start of the fiscal year.

Discontinued MR Activities

In FY 2004, CMS will no longer fund the following activity:

CAFM II reporting for Activity Code 21030 - Routine Manual Postpay Review

CAFM II reporting for Activity Code 21031 - Complex Manual Provider-Specific Postpay Review

CAFM II reporting for Activity Code 21032 - Complex Manual Service-Specific Postpay Review

CAFM II reporting for Activity Code 21201 - Prepay Complex Manual Probe Sample Review

CAFM II reporting for Activity Code 21202 - Prepay Complex Manual Provider-Specific Review

CAFM II reporting for Activity Code 21203 - Prepay Complex Manual Service-Specific Review

CAFM II reporting for Activity Code 21205 - Postpay Complex Manual Probe Sample Review

CAFM II reporting for Activity Code 21209 - Corporate Activities

Continuing MR Activities

In FY 2004, intermediaries are expected to continue to perform the range of activities in the CMS PIM including, but not limited to, developing an MR/LPET strategy, performing data analysis, conducting probe reviews, performing the appropriate levels of prepayment and postpayment medical review; developing and revising Local Medical Review Policy (as appropriate), and supporting Program Safeguard Contractor activities.

New MR Activity

In FY 2004, intermediaries must begin performing the following activity:

Reporting for Medical Review Reopenings (Activity Code 21210)

Reporting for Complex Manual Probe Sample Review (Activity Code 21220)

Reporting for Prepay Complex Manual Review (Activity Code 21221)

Reporting for Postpay Complex Manual Review (Activity Code 21222)

Quantifiable MR Activities

Instructions for completing the following quantifiable MR activities can be found in the PIM, Chapter 11. Intermediaries must follow the instructions in the PIM when performing and reporting the costs and workloads associated with the following activities:

Automated Review (Activity Code 21001)

PIM Ch. 3, § 5.1; PIM Ch. 11, § 1.3.1

Routine Manual Prepay Reviews (Activity Code 21002)

PIM Ch. 3, § 5.1; PIM Ch. 11, § 1.3.2

Data Analysis (Activity Code 21007)

PIM Ch. 2, § 2; PIM Ch. 11, § 1.4

Third Party Liability (TPL) or Demand Bills (Activity Code 21010)

PIM Ch. 6, § 1.1; PIM Ch. 11, § 1.

Program Safeguard Contractor (PSC) Support Services (Activity Code 21100)

Contractors must track and record costs associated with providing support to PSC that support Medical Review. (e.g. working with the CERT contractor, or PSC doing MR or data analysis for MR). This activity code does not include providing support for the BI PSC. Charge these costs to Activity Code 23201.

PIM Ch. 11, § 1.8

Policy Reconsideration/Revision (Activity Code 21206)

PIM Ch. 11, § 1.5.2

MR Program Management (Activity Code 21207)

MR Program Management encompasses managerial responsibilities inherent in managing MR and LPET, including; development, modification, and periodic reporting of MR/LPET strategies and quality assurance activities; planning, monitoring, and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions.

Activity Code 21207 is designed to capture the costs of managerial oversight for the following tasks:

- Develop and periodically modify MR/LPET strategy;
- Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, committee meetings, and periodic reports;
- Evaluate edit effectiveness;
- Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff;
- Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus when indicated;
- Implement MR instruction from regional and/or central office; and
- Educate staff on MR issues, new instructions, and quality assurance findings.

PIM Ch. 11, § 1.9

New Policy Development (Activity Code 21208)

PIM Ch. 11, § 1.5.1

Medical Review Reopenings of N102 Claims and Claims with Late Documentation (Activity Code 21210)

When conducting a complex medical review on a claim, it is often necessary for contractors to send physicians, providers or suppliers additional documentation requests (ADRs). Generally, an ADR is made to assist the contractor in determining if payment of the claim is reasonable and necessary. Physicians, providers, or suppliers are given 45 days to respond to ADRs. If the ADR is not responded to in a timely manner, contractors must determine if the claim is reasonable and necessary based on the existing information. Since ADRs are generally sent only when the record contains little or no evidence to support paying the claim, failure to respond to an ADR usually results in a claim denial. These claim denials are issued with Remittance Advice Code N102 (“Denied due to failure to submit necessary medical documentation.”)

Many times, the documentation arrives after the 45-day period or the physician, provider, or supplier submits the requested documentation along with a request for an appeal of the claim denial. As a result, it is the Appeals Unit, rather than the MR Unit that reviews the requested documentation. We believe the MR Unit should have the first opportunity to examine the documentation they requested in the ADR and issue a revised determination based on that documentation.

Therefore, when an N102 claim denial is appealed and the documentation requested is received after the 45-day deadline, or is received with the appeal request, the MR Unit will review the requested documentation, as opposed to the Appeals Unit. The Appeals Unit will forward the file based on which unit issued the N102 denial (i.e., MR issued the denial, MR will receive the forwarded file and conduct the review).

In the workload section of Activity Code 21210, intermediaries must capture the number of reopening requests received in Workload 1, the number of reopening requests resulting in payment in Workload 2, and, to the extent possible, the number of providers requesting a reopening in Workload 3.

Complex Manual Probe Sample Review (Activity Code 21220)

Report all costs associated with prepay and postpay Complex Manual Probe Sample Review in Activity Code 21220. In the workload section of CAFM II, Activity Code 21220, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Prepay Complex Manual Review (Activity Code 21221)

Report all costs associated with Prepay Complex Manual Review in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the carrier and DMERC can report providers subjected to complex review, they should report this number as Workload 3.

Postpay Complex Manual Review (Activity Code 21222)

Contractors must report all costs associated with Postpay Complex Manual Review in Activity Code 21222. In the workload section of Activity Code 21222, contractors must report the total number of claims reviewed on a postpayment basis as Workload 1 and report the total number of claims denied in whole or in part as Workload 2. To the extent contractors can report providers subjected to postpayment review, they should report this number as Workload 3.

MEDICAL REVIEW DELIVERABLES

<i>Report</i>	<i>Due date(s)</i>	<i>Submitted to</i>
MR/LPET Strategy (Note: Contractors operating multiple MR/LPET sites are NOT required to submit separate reports; however, consolidated reports must clearly identify the costs and workloads attributable to each site)	Submit with Budget Request	Regional Office <i>MRSTRATEGIES</i> <i>@cms.hhs.gov</i> (must be submitted via the VP of Government Operations)
MR/LPET Strategy Update	Submit with quarterly IER (i.e. for FY 2004, January 20, April 20, July 20)	Regional Office <i>MRSTRATEGIES</i> <i>@cms.hhs.gov</i> (must be submitted via the VP of Government Operations)

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

Medicare Secondary Payer - Prepayment (Intermediary)

THESE REQUIREMENTS STAND ALONE AND SUPERSEDE PRIOR YEARS
BPRS.

The following Medicare Secondary Payer (MSP) Prepayment activities are listed by priority or program focus. Contractors should develop their FY 2004 MSP Prepayment budget by using the focused items outlined below. All remaining funds will be applied to ongoing MSP Prepayment workloads.

Instructions for workload reporting are included in the Activity Dictionary (Attachment 1 to these BPRs) and in Transmittal AB-03-082 (CR 2548). In general, MSP Prepayment activity workload includes all activities specific to bills on which you take some manual MSP action before the bill is paid.

These MSP actions are described in the Medicare Intermediary Manual (MIM), Sections 3400, 3600 and 3899, as well as the specific Program Memoranda (PM) identified below.

Transmittal AB-02-089 (CR 1529), dated June 28, 2002; Transmittal AB-02-107 (CR 2240), dated July 31, 2002; Transmittal AB-03-016 (CR 2552), dated February 7, 2003; Transmittal AB-03-020 (CR 1558), dated February 14, 2003; Transmittal AB-03-024 (CR 2074), dated February 28, 2003; Transmittal AB-03-082 (CR 2548), dated May 6, 2003; and MIM § 3693 as outlined below.

MSP Bills/Claims Prepayment (Activity Code 22001)

1. Resolve MSP edits occurring in the bill adjudication process including those from the Common Working File (CWF). This does not include edits resulting from bill entry activities or incomplete bills that must be returned to the provider.

No workload or costs associated to initial bill entry should be charged to the MSP Activity Code 22001. Bill payment activities include initial claim entry and must be reported in the Program Management, Bills/Claims Payment function.

A. Initial bill entry activities that should **not** be charged to MSP Activity Code 22001 are:

- Receipt, control of bills and attached Explanation of Benefits (EOB)/Remittance Advice (RA). Includes opening, sorting, date stamping, imaging, Control Number assignment, batching bills and activation of batches;
- Prepare batches for keying. Includes verification that all batches are accounted for and bills are in proper order within the batch;

- Key the entire MSP bill into the standard system to begin bills processing; and
- Resolve all bill entry edits.

B. Initial bill entry for a MSP bill is not complete, until payment information from the primary payer’s EOB/RA is keyed as part of the hard copy bill, bringing the hard copy MSP bill to the same status as the receipt of an MSP Electronic Media Claim (EMC) and preparing the bill for adjudication. Neither the hard copy bill nor the EMC should enter claim processing if the primary payment information is incomplete. The primary payment information is crucial in determining the appropriate amount Medicare should pay as the secondary payer, an amount calculated within the MSPPAY module during bill adjudication. The following list includes primary payer information that may be present on the EOB/RA or may need to be determined, then keyed, to complete entry of the hard copy bill into the standard system. All costs associated to these functions should be charged to Bills/Claims Payment.

Note: individual EOB/RAs may use different, but similar terms.

Actual Charges	Deductible
Provider Discount	Co-pay/Co-Insurance
Contract Write-off	Non-covered Services
Primary Payer Allowed Amount	Benefits Paid
Primary Payer Paid Amount	Covered Charges
Obligated to Accept as Payment in Full	Withhold

2. Perform bill determination activities necessary to process an MSP bill through to a final payment or non-payment decision.

Examples include: comparing EOB/RA bill data to HIMR/CWF data; overriding with conditional payment codes to pay primary; making primary, secondary or denial payment decisions; working suspended bills.

3. Congressional Inquiries and Hearings related to MSP Prepayment activities.

This includes contacting the designated Coordination of Benefits Contractor (COBC) consortia congressional representative, and coordinating, as necessary, for a consolidated prepay response and follow-up with the COBC, if applicable after five days. This also includes contact with the COBC consortia for the collection of information and/or documentation to respond to a hearing pertinent to MSP Prepayment activities.

4. Prepare “I” records and add termination dates to MSP CWF auxiliary records, as necessary, to complete the bill adjudication process.

Adding “I” auxiliary records to the CWF to process a bill, would include those that are necessary to accommodate an override for primary conditional payment and also, when sufficient bill information exists to add a new CWF MSP Aux File record and process a bill as secondary.

Simple terminations should be performed when the CWF MSP Aux file was previously established on CWF with a “Y” validity indicator and no discrepancy exists with information on the active bill.

5. Prepare Electronic Correspondence Referral System (ECRS) CWF Assistance Requests and ECRS MSP Inquiries necessary to process a bill through to a final payment or non-payment decision.

ECRS transmissions that are required to complete the processing of a bill should be reported here. If the ECRS transmission is a result of an inquiry and there is no active bill in process, see requirements under Activity Code 42004, General Inquiries, for proper reporting.

MSP Hospital Audits/On-site Reviews (Activity Code 22005)

Instructions: MIM §3693, PM A-02-021 (CR 2104)

Conduct on-site hospital reviews, complete audit reports to providers and CMS Regional Offices, and follow up, as necessary, with the providers. In FY 2004, funding will be designated for a minimum number of audits.

Desk audits performed at the Medicare contractor site are not included under this activity.

MSP Workload

MSP Prepayment workload is defined in PM 2548 and the ABC Dictionary.

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

Medicare Secondary Payer - Postpayment (Intermediary)

THESE REQUIREMENTS STAND ALONE AND SUPERSEDE PRIOR YEARS
BPRS.

The BPRs for FY 2004 will detail specific workload focus items in addition to ongoing Medicare Secondary Payer (MSP) Postpayment activities. Contractors should develop their FY 2004 MSP Postpayment budget by using the workload focus items outlined below. All remaining funds will be applied to ongoing MSP Postpayment workloads.

MSP activities are described in the ABC Dictionary (Attachment 2 to the BPRs), Medicare Intermediary Manual (MIM), Sections 3400, 3600 and 3899, as well as the specific Program Memoranda (PMs) identified below:

Transmittal AB-00-11 (CR 899), Transmittal AB-00-27 (CR 1142), Transmittal AB-00-107 (CR 1163), Transmittal AB-00-129 (CR 1460), Transmittal AB-01-24 (CR 1280), Transmittal AB-01-25 (CR 1558), Transmittal AB-03-082 (CR 2548) - Medicare Secondary payer (MSP) Prepayment and Postpayment Workload Reporting - Activity Code (AC) Definitions, CR 2697 - Bankruptcy PM (awaiting publication), CR 2729 - GHP Copies of Demands to Insurers/TPAs PM (awaiting publication), CR 2715 - ICN Process PM (awaiting publication) and CR 2745 - MSP Interest Issues (awaiting publication). Additionally, the 04/15/03, Joint Signature Memorandum titled "Clarification/ Reminder of Medicare Secondary Payer (MSP) Post Payment Activities for FY 2003 for Group Health Plan (GHP) Recoveries."

General Reminder: The BPRs will not override any post payment instructions where contractors have specific instruction for pending litigation, bankruptcy, etc.

Note: Contractors should not budget for CR 2664 Joint and Several PM.

The following MSP Postpayment activity codes are listed in order of workload focus priority. Contractors should budget for these focus workloads.

Group Health Plan (Activity Code 42003)

Contractors should refer to the 04/15/03 Joint Signature Memorandum titled "Clarification/ Reminder of Medicare Secondary Payer (MSP) Post Payment Activities for FY 2003 for Group Health Plan (GHP) Recoveries" for specific information regarding Data Match and Non-Data Match recovery processes. This memorandum places focus on the timely adjudication and posting of checks received within the financial reporting period. CMS understands that due to the receipt of checks near or at the end of the financial reporting period a limited number of these postings may not occur within the

same reporting period. Every effort should be made to post these checks within the same financial reporting period.

1. Fully implement and become current on the identification and initial demand letter process involving all Data Match cycle tapes. History search parameters should be from 10/1/00 forward. If the history search identifies potential GHP mistaken primary payments that equal or exceed \$1,000, the contractor must seek recovery. Prior to the mailing of an initial demand check CWF to determine the records validity to the proposed debt. The initial demand letter for Data Match GHP should be sent by certified mail. Upon issuance of the demand letter packages the contractors should provide a copy of the demand letter packages to the insurer/TPA associated with this debtor (employer). The copy to the insurer/TPA does not have to be sent by certified mail. The contractor should also obtain authorization from the debtor to allow the insurer/TPA to act as their agent in resolving the debt.
2. Fully implement and become current with the Non-Data Match GHP mistaken payment identification and initial demand letter process. History search parameters should be from 10/1/00 forward. If the history search identifies potential GHP mistaken primary payments that equal or exceed \$1,000, the contractor must seek recovery. Prior to the mailing of an initial demand letter check CWF to determine the records validity to the proposed debt. The initial demand letter for Non-Data Match GHP should be sent certified mailing. Upon issuance of the demand letter packages the contractors should provide a copy of the demand letter packages to the insurer/TPA associated with this debtor (employer). The copies do not have to be sent by certified mail. The contractor should also obtain authorization from the debtor to allow the insurer/TPA to act as their agent in resolving the debt.

Note: If the GHP on the original demand has a "union plan", the lack of CWF information for the debt is not a sufficient reason to invalidate the debt.

3. Acknowledge and respond to all correspondence within 45 calendar days from the date of receipt in the corporate mailroom or any other mail center location absent instructions to the contrary for a particular activity. Where there is a PM, manual provision, or other requirement, contractors are bound by that instruction. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.

Liability, No-Fault, Workers' Compensation and FTCA (Activity Code 42002)

1. If you are the lead contractor, respond to "Notice of Settlement" correspondence by obtaining updated amounts paid subsequent to your initial request for Medicare's conditional claim amounts. In the event the initial request for conditional payments (ICNs) resulted in the lead contractor having to send out ICN requests (i.e. greater than 18 months from the date of accident/injury/illness

in comparison to the date of lead notification), the updated conditional claim amounts may be gotten from checking CWF vs. sending out contractor ICNs, if less than 18 months have elapsed since the initial conditional claims were obtained from the non-lead contractors. Check CWF and obtain all information needed to calculate Medicare's actual claim. Make the demand for repayment once you determine Medicare's claim.

2. If you are not the lead contractor, respond to final ICN requests from the lead contractors within 15 calendar days, if the case is in a settlement status and the lead contractor cannot obtain total conditional claim amounts from checking CWF (i.e., 18 months have elapsed since the initial conditional claim amounts were obtained). Non-lead contractors have 30 days to respond to a notice of settlement, judgment or award ICN, if they had no prior ICN request made of them.
3. Contractors should initiate the identification and request for repayment of Medicare conditional payments specific to Liability, No Fault, and Workers' Compensation recovery claims.

Note: Contractor involvement and roles in FTCA casework has not changed from prior years.

4. Respond to ICN requests sent from lead recovery contractors within 45 calendar days, if the case is still in a pre-settlement status.
5. Acknowledge and respond to all correspondence within 45 calendar days from the date of receipt in the corporate mailroom or any other mail center location absent instructions to the contrary for a particular activity. Where there is a PM, manual provision, or other requirement, contractors are bound by that instruction. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.

Debt Collection/Referral (Activity Code 42021)

1. Adjudicate and post all checks to established debts as a priority. Goal is to post all checks to an established debt within the same quarterly reporting period.
2. Acknowledge and respond to all correspondence within 45 calendar days from the date of receipt in the corporate mailroom or any other mail center location absent instructions to the contrary for a particular activity. Where there is a PM, manual provision, or other requirement, contractors are bound by that instruction. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.
3. Refer all eligible debt to Treasury within required timeframes.

4. Upon issuance of the intent to refer letter, the contractor should provide a copy of the entire intent to refer package with all attachments to the insurer/TPA of the debtor (employer). The copies do not have to be sent by certified mail.

General Inquiries (Activity Code 42004)

1. Deposit checks and transmit ECRS MSP inquiries on all voluntary/unsolicited checks not associated with an existing case or debt in order to begin the development process at COBC.
2. Acknowledge and respond to all correspondence within 45 calendar days. Correspondence sent to the contractor as a carbon copy (cc) does not require any action.

MSP Outreach (Activity Code 42006)

Outreach will not be funded in FY 2004.

MSP Postpayment Workload is defined in PM 2548 and the ABC Dictionary.

Lead Contractors, by State, for MSP Liability Recoveries

Effective 03/2003

Note: The list set forth below applies except where CMS has designated a specific intermediary or carrier as the lead contractor or recoveries for a particular class or group of cases. See the end of this document for a current list of such designations.

Alabama 00010

Cahaba, Blue Cross And Blue Shield of Alabama
MSP Division, PO Box 12647, Birmingham, AL 35202

Alaska 00430

Premera Blue Cross
MSP, PO Box 2847, Seattle, WA 98111-2847

American Samoa 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93101-9140

Arizona 00030

Blue Cross and Blue Shield of Arizona
MSP, PO Box 37700, Phoenix, AZ 85069-7700

Arkansas 00020

Arkansas Blue Cross and Blue Shield
Medicare Services, PO Box 1418, Little Rock, AR 72203

California 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Colorado 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Connecticut 00308

Empire Medicare Services
Empire MCR Services, PO Box 4751, Syracuse, NY 13221-4751

Delaware 00308

Empire Medicare Services
Empire MCR Services, PO Box 4751, Syracuse, NY 13221-4751

District of Columbia 00190

Care First Blue Cross and Blue Shield of Maryland, Inc.
MSP, 1946 Greenspring Drive, Timonium, MD 21093-4141

Florida 00090

First Coast Service Options, Inc.
MSP, PO Box 44179, Jacksonville, FL 32231

Georgia 00101

Blue Cross Blue Shield of Georgia
MCR Division, PO Box 9048, Columbus, GA 31908-9048

Guam 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Hawaii 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Idaho 00350

Medicare Northwest
MSP, PO Box 8110, Portland, OR 97207-8110

Illinois 00131

AdminaStar Federal
MSP, 225 N. Michigan Avenue, 22nd Floor, Chicago, IL 60681-2912

Indiana 00130

AdminaStar Federal
MSP, 8115 Knue Road, PO Box 50408, Indianapolis, IN 46250

Iowa 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Kansas 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Kentucky 00160

AdminaStar Federal MSP
9901 Linn Station Road, PO Box 23711, Louisville, KY 40223

Louisiana 00230

Trispan Health Services
MSP, PO Box 23046, Jackson, MS 39225-3046

Maine 00180

Associated Hospital Service of Maine and Massachusetts
MSP, 2 Gannett Drive, South Portland, ME 04106

Maryland 00190

Care First of Maryland, Inc.
MSP, 1946 Greenspring Drive, Timonium, MD 21093-4141

Massachusetts 00181 (00180)

Associated Hospital Service of Maine and Massachusetts
MSP, 1515 Hancock Street, Quincy, MA 02169-5228

Michigan 00452

United Government Services
MCR Division/401 N. Michigan, PO Box 2019, Milwaukee, WI 53203

Minnesota 00320

Noridian Mutual Insurance Company
MSP, 4305 13th Avenue South, Fargo, ND 58103-3373

Mississippi 00230

Trispan Health Services
MSP, PO Box 23046, Jackson, MS 39225-3046

Missouri 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Montana 00250

Blue Cross and Blue Shield of Montana, Inc.
MSP, PO Box 5017, Great Falls, MT 59403

Nebraska 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Nevada 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

New Hampshire 00270

Anthem Health Plans of New Hampshire
MSP, 3000 Goff Falls Road, Manchester, NH 03101

New Jersey 00390

Riverbend
MCR Division/730 Chestnut Street, Chattanooga, TN 37402

New Mexico 00400

TrailBlazer Health Enterprises, LLC
MSP, PO Box 9020, Denison, TX 75021

New York 00308

Empire Medicare Services
MSP, PO Box 4751, Syracuse, NY 13221-4751

North Carolina 00382

Palmetto GBA
MSP, PO Box 3824, Durham, NC 27702

North Dakota 00320

Noridian Mutual Insurance Company
MSP, 4305 13th Avenue South, Fargo ND, 58103-3373

Northern Marianna Islands San Francisco 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Ohio 00332

AdminaStar Federal
PO Box 145482, Cincinnati, OH 45250-5482

Oklahoma 00340

Group Health Service of Oklahoma, Inc.
MCR Division/1215 S. Boulder, PO Box 3404, Tulsa, OK 74101

Oregon 00350

Medicare Northwest
MSP, PO Box 8110, Portland, OR 97207-8110

Pennsylvania 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Puerto Rico 57400, 00468

Cooperative de Seguros de Vida de Puerto Rico
MCR Division/PO Box 363428, San Juan, PR 00936-3428

Rhode Island 00370

Blue Cross and Blue Shield of Rhode Island
MCR Division/444 Westminster Street, Providence, RI 02903-3279

South Carolina 00380

Palmetto Government Benefits Administrators, LLC,
MCR Division/PO Box 100190, Columbia, SC 29202

South Dakota 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Tennessee 00390

Riverbend
MCR Division/730 Chestnut Street, Chattanooga, TN 37402

Texas 00400

TrailBlazer Health Enterprises, LLC
MSP, PO Box 9020, Denison, TX 75021

U.S. Virgin Islands 57400, 00468

Cooperative de Seguros de Vida de Puerto Rico
MCR Division, PO Box 363428, San Juan, PR 00936-3428

Utah 00350

Medicare Northwest
MSP, PO Box 8110, Portland, OR 97207-8110

Vermont 00270

Anthem Health Plans of New Hampshire
MSP, 3000 Goff Falls Road, Manchester, NH 03101

Virginia 00453

United Government Services
MSP, PO Box 12201, Roanoke, VA 24023-2201

Washington 00430

Premera Blue Cross
MSP, PO Box 2847, Seattle WA 98111-2847

West Virginia 00453

United Government Services
MSP, PO Box 12201, Roanoke, VA 24023-2201

Wisconsin 00450

United Government Services
MCR Division/401 N. Michigan, PO Box 2019, Milwaukee, WI 53203

Wyoming 00460

Blue Cross and Blue Shield of Wyoming
MCR Division, 4000 House Avenue, PO Box 908, Cheyenne, WY 82003

CMS designated lead contractors for specific groups/classes recoveries:

- Gel Implant Recoveries: *TrailBlazers (Ms Chinika Polk, Director, MSP Recoveries: 903-463-0668) and Cahaba, Alabama (Mr. Ward, Director: 205-220-2633 / Ms. Spencer, MSP Insurance Specialist: 205-220-4812)* (See below list for state by state responsibilities)

Trailblazers - AL, AR, AS, AK, AZ, CA, CO, ID, GA, GU, HI, KY, LA, MP, MS, MT, NC, ND, NM, NV, OK, OR, SC, SD, TN, TX, UT, WA, WY

Cahaba - CT, DC, DE, FL, IA, IL, IN, KS, MA, MD, ME, MI, MN, MO, NE, NH, NJ, NY, OH, PA, PR, RI, VA, VI, VT, WI, WV

- Bone Screw recoveries: *United Government Services, MSP, PO Box 9140, Oxnard, CA 93031-9140* (formally known as BCC was originally the lead contractor for AcroMed settlement recoveries; now the lead for all bone screw recoveries.)
- Diet Drug recoveries: *Cahaba Blue Cross and Blue Shield Alabama, MSP Division, PO Box 12647, Birmingham, AL 35202* (If Fed-Ex, use the following address: 450 Riverchase Parkway E, Birmingham, AL 35298)
- Sulzer Inter-Op Acetabular Shells for Hip Implants recoveries: *Chisholm Administrative Services, MSP Department, 1215 South Boulder, Tulsa, Oklahoma 74101*
- Sulzer Orthopedic & defective knee replacements recoveries: *Chisholm Administrative Services, MSP Department, 1215 South Boulder, Tulsa, Oklahoma 74101*

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

Benefit Integrity (Intermediary)

Contractor budget requests should ensure implementation of all program requirements in the Program Integrity Manual (PIM) and all applicable Program Memoranda (PM). The PIM, the ABC Dictionary (Attachment 1 to the BPRs) and applicable PMs should be referenced for instructions relating to the areas specified in this BPR.

CONTRACTORS WHO HAVE TRANSITIONED THEIR WORK TO A PSC:

Contractors who have transitioned their BI work to a PSC must only use the PSC Support Activity Code 23201, when providing support to the PSC. Since most contractors will have transitioned to a PSC by July 1, 2003, the vast majority of contractors will only use Activity Code 23201.

PSC Support Services (Activity Code 23201)

Affiliated Contractors (ACs) must keep a record of support services rendered to a PSC and report these services in the following workloads: report the total number of miscellaneous PSC support services (e.g., training and meetings to support the PSC) in Workload 1, report the total number of PSC requests (not law enforcement related) fulfilled by the AC to support the PSC in investigations in Workload 2, and report the total number of PSC requests for support from the AC with law enforcement requests in Workload 3. Additional PSC support work that does not fall into Workload 1, 2, or 3 must be reported under this general Activity Code 23201, and not counted in Workload 1, 2, or 3.

PSC Support Services - Miscellaneous PSC Support Services (Miscellaneous Code 23201/01)

ACs should report miscellaneous PSC support services (e.g., training and meetings to support the PSC) in Miscellaneous Code 23201/01.

PSC Support Services - Non-Law Enforcement Investigation Requests (Miscellaneous Code 23201/02)

ACs must keep a record of the number of requests (not law enforcement requests) they fulfill to support the PSC in investigations, and record the total costs in Miscellaneous Code 23201/02.

PSC Support Services - Law Enforcement Requests (Miscellaneous Code 23201/03)

ACs must keep a record of the number of PSC requests for support from the AC with law enforcement requests and record the total costs in Miscellaneous Code 23201/03.

CONTRACTORS WHO HAVE NOT TRANSITIONED THEIR BI WORK TO A PSC:

Contractors who have not transitioned to a PSC must include the following in their budget requests: CMS training requirements, the Quality Improvement (QI) program, and the maintenance of a secure environment.

In addition, contractors who have not transitioned to a PSC should provide the supporting documentation requested in Attachment A of the FY 2004 BPRs. Attachment A requests contractor specific narrative, workload, and cost data for FY 2003 and FY 2004.

Only contractors who have not transitioned their BI work to a PSC will use the activity codes listed below (23001-23015).

Medicare Fraud Information Specialist (MFIS) (Activity Code 23001)

Report all costs associated with MFIS activity in Activity Code 23001. This activity code applies only to contractors at which the RO has indicated an MFIS will be located. New MFIS positions and MFIS positions vacated will not be funded.

Report the number of fraud conferences/meetings coordinated by the MFIS in Workload 1; the number of fraud conferences/meetings attended by the MFIS in Workload 2; and the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other CMS health care partners in Workload 3.

Outreach and Training Activities (Activity Code 23004)

Include the costs associated with establishing and maintaining fraud, waste and abuse outreach and training activities for beneficiaries and providers (excluding MFIS activities).

Report all costs associated with fraud, waste and abuse outreach and training activities for contractor staff, providers, and beneficiaries in Activity Code 23004. Report the number of training sessions (internal and external) furnished only to BI staff in Workload 1, the number of face-to-face presentations by BI unit staff made to beneficiaries and providers in Workload 2, and the number of training sessions furnished by the contractor BI unit to non-BI contractor staff in Workload 3.

Note: 1) a training session is the presentation of a topic regardless of the number of attendees; 2) a training session which exceeds more than one day is counted as one session; and 3) the same training session which is repeated at a later date should be counted as a separate session.

Fraud Investigation Activities (Activity Code 23005)

Report any costs associated with fraud investigation used to substantiate a case in Activity Code 23005. Report the number of investigations opened in Workload 1. Of the investigations reported in Workload 1, report how many were opened by the contractor based on contractor self-initiated proactive data analysis in Workload 2. Report the total number of investigations closed (no longer requiring fraud investigation) and which were not referred to law enforcement in Workload 3.

Law Enforcement Support Activities (Activity Code 23006)

For work done to support law enforcement, report all BI costs and related data analysis costs in Activity Code 23006. Report the total number of law enforcement requests in Workload 1, report the number of requests discussed with the RO in Workload 2, and report the number of BI law enforcement requests that require data analysis in Workload 3.

Medical Review in Support of Benefit Integrity Activities (Activity Code 23007)

Report all costs associated with Medical Review in support of BI activities in Activity Code 23007. Because the main goal of Medical Review is to change provider billing behavior through claims review and education, any BI initiated review activity that does not allow for provider education or feedback, must also be charged to this activity code. Report the number of investigations that the MR unit assisted the BI unit within Workload 1, the number of claims reviewed by both the MR and BI unit for the BI unit in Workload 2, and the number of statistically valid random samples (SVRSs) performed for overpayment estimation by MR in support of BI in Workload 3.

Use of Extrapolation (Miscellaneous Codes 23007/01, 23007/02, 23007/03)

Contractors must keep a record of only BI work using miscellaneous codes in CAFM II for the following information: the number of consent settlements offered (Miscellaneous Code 23007/01), the number of consent settlements accepted (Miscellaneous Code 23007/02), and the number of SVRSs performed for overpayment estimation (Miscellaneous Code 23007/03). Report workload only for the above items.

FID Entries (Activity Code 23014)

Report all costs associated with FID entries and updates in Activity Code 23014.

Report the total number of new cases entered into the FID in Workload 1, report the total number of cases updated in the FID in Workload 2, and report the total number of new payment suspensions entered into the FID in Workload 3.

Referrals to Law Enforcement (Activity Code 23015)

Report all costs associated with referrals to law enforcement in Activity Code 23015
Report the total number of cases referred to law enforcement in Workload 1, report the total number of law enforcement referrals requesting additional information by law enforcement in Workload 2, and report the total number of law enforcement referrals declined in Workload 3.

Attachment A

**FY 2004 BENEFIT INTEGRITY (BI) SUPPORTING DOCUMENTATION
FOR INTERMEDIARIES**

Only contractors who have not transitioned their BI work to a PSC are required to submit the documentation requested on this attachment.

In addition to your CAFM II budget request, CMS is requesting supporting narrative to justify your FY 2004 budget request. Please provide the information requested below.

**Name of Contractor and Contractor Number
Fiscal Year 2004 Budget Request
Narrative and Supporting Justification**

I. Staffing/Function Requirements

- Explain the unit cost in Activity Code 23002 (Complaint Development). What functions are charged to this Activity Code?
- What new strategies and functions will you add in FY 2004; what results do you anticipate, and what will be the cost for the functions and strategies?
- Provide new BI staffing requirements in FY 2004 and the functions the staff will perform.
- Explain any significant changes in your staffing mix or FTE level from FY 2003 to FY 2004.

Note: The total number of FTEs requested in FY 2004 for this activity should equal the number of FTEs which are calculated from productive hours entered into CAFM II.

II. Subcontracts

- Provide the following information for each subcontractor exceeding \$25, 000 related to this line of your budget request (per Medicare contract, this excludes arrangements you may have with medical consultants to review Medicare claims, health care utilization or related services):
 - (1) the name of the subcontractor (please indicate if the subcontractor is another current Medicare contractor or a subsidiary of a Medicare contractor);
 - (2) a list of the functions the subcontractor will provide;
 - (3) the total cost you expect to incur during FY 2004, for this subcontract; and
 - (4) if available, the number of FTEs funded by this subcontract.

III. Other

- Include any additional budget narrative that supports your FY 2004 BI funding request.

- Include costs necessary to establish a secure environment as specified in the PIM, Chapter 1, Section 3.2.6.

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

Local Provider Education and Training (Intermediary)

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 intermediaries, and data from various sources. The ultimate goal of the LPET program is the continual reduction in the national claims payment error rate. Intermediaries evaluate all of the information, prioritize the issues, and then design educational interventions that best address the 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 intermediaries to determine the educational focus for the subject matter. For example, intermediaries 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, intermediaries 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 intermediaries to design a MR/LPET strategy. Intermediaries 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. Intermediaries 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). Negotiations with the RO budget and MR staff's will concern the strategy and the individual elements of the strategy. RO budget and MR staff's retain the authority to reduce contractor's funding amounts for MR strategies that are not detailed in their methodology, funding, or selection of activities for reducing the claims payment error rate.

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 intermediaries to gather and analyze information and data from various sources. The intermediaries must develop methods of communication with various operational areas that interact with medical review. Information collected as a result of communication with the intermediaries 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 gained from PCOM, inquiries, and data from the review of claims.

After information and data are gathered and analyzed, the intermediaries 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 intermediaries must develop educational activities using the philosophy of Progressive Corrective Action (PCA) to address each problem. Intermediaries 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 intermediaries 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 intermediaries 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 include 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 the 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 coverage and coding issues, whether they were 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. Beginning FY 2005, CMS will require in the design, development, and delivery of LPET educational activities, that contractors utilize a team of specialized professionals, led by a clinician.

Budget Considerations

Intermediaries must consider various elements when planning their LPET budget. For example, all provider inquiries concerning Healthcare Common Procedure Coding System (HCPCS) coding questions that get referred to the Contractor Medical Directors (CMD) or LPET staff are to be charged to the Provider Inquiry budget. Additionally, 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. Given the fundamental differences between the LPET, PCOM, and BI programs, there should not be educational events that encompass the scope of more than one of these programs. However, we understand that there may be circumstances when this does occur. For any functions such as general seminars, conventions, or conferences that address LPET subjects, as well as PCOM, 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 and the remaining \$1,000 would be 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 the time spent on each subject in the bulletin between LPET, PCOM, and BI.

Each intermediary will be given a specified maximum budget for LPET activities. Intermediaries must identify the appropriate budget and workload for each activity code within the constraints of their budgets. Intermediaries are not permitted to charge providers/suppliers for planned educational activities and training materials in the MR/LPET strategy. However, intermediaries may assess fees for educational activities delivered at a non-Medicare contractor sponsored event, specifically requested by specialty societies or associations. In addition, although intermediaries are mandated to supply providers with a paper copy of their bulletin at no cost, upon request, intermediaries may assess a fee to cover costs if the provider requests additional copies. All 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 1 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. Intermediaries 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, intermediaries 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

24117/01 - Education Delivered to a Group of Providers
- Associated Costs

Budget Approval Requirements

Negotiations with the CMS Regional Office (RO) budget and MR staff's will involve the MR/LPET strategy and the individual elements in the strategy. CMS RO budget and MR staff's retain the authority to reduce the intermediaries' funding amount 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. Intermediaries are not required to establish a baseline error rate or calculate an intermediaries-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 a 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 efficiency and effectiveness of educational activity and measures progress towards goals;
- A system that allows the 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 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 Prepay Reviews				
21007	Data Analysis				
21010	TPL or Demand Bills				
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				

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				
24117/01	Education Delivered to a Group of Providers - Associated Costs				
24118	Education Delivered via Electronic or Paper Media				

Activity Code Definitions

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

Intermediaries 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. Intermediaries 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, intermediaries 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, intermediaries 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 intermediaries 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 costs of developing the written materials. Written materials supplied, or electronic communications addressed 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 intermediaries and the provider and the written materials or electronic communication used to facilitate the one-on-one education. Reported activity would include 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 providers educated, as a result of complex prepay and postpay review. Workload 2 is the number of providers educated as a result of a probe. Workload 3 is the number of providers educated as a result of other medical review activity; i.e., data analysis, new provider education, etc. 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)

Intermediaries may determine that certain issues are best addressed by administering education to groups of providers. To remedy wide spread service-specific aberrancies, intermediaries 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 Partial Hospitalization Program (PHP), 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 that of 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 are not spontaneous, live interactions 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 providers educated as a result of a new or modified policy in Workload 1. Workload 2 is the number of providers educated as a result of probes. Workload 3 is the number of providers educated as a result of other medical review activity. 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 to a Group of Providers - Associated Costs (Miscellaneous Code 24117/01)

Report costs associated to educate a group of providers as a result of prepay and postpay complex review, in Miscellaneous Code 24117/01.

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

Intermediaries may elect to provide education via electronic or paper media. Do not report under this activity code, an electronic tool or a paper document developed and utilized as an adjunct to Education Delivered One-on-One, Activity Code 24116 or Education Delivered to a Group of Providers, Activity Code 24117. Education delivered solely by electronic or paper media that does not involve the facilitation or interpretation of a live educator would be reported under this activity code. 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.

Intermediaries are required to maintain a Web site and a Local Medical Review Policy (LMRP) list-serv. Included in this category are the development and dissemination of medical review bulletin articles and the dissemination of LMRPs. Intermediaries 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. Contractors are required to make them available in hard copy upon request. Intermediaries may assess a fee to providers who request more than one copy. In addition, intermediaries 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. Contractors are required to update them quarterly and post them to their websites. Intermediaries 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 number of educational projects, developed in whole or in part, as a result of prepay and post pay complex review in Workload 1. Workload 2 is the number of educational projects, developed in whole or in part, disseminated via paper media. Workload 3 is the number of educational projects, developed in whole or in part, disseminated electronically.

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS MEDICARE INTEGRITY PROGRAM

Provider Communications (Intermediary)

The Provider Communications (PCOM) Budget Performance Requirements (BPRs) initiatives for FY 2004, continue to be based on CMS' goal of giving those who provide service to beneficiaries, the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end, bill correctly. PCOM is driven by educating providers and their staffs, about fundamental Medicare programs, policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and by analyses of provider inquiries and claim submission errors.

Provider Communications uses mass media, such as print, Internet, satellite networks, and other technologies, face-to-face instruction, and presentations in classrooms and other settings, to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. The provider communications work using the Internet and electronic communications is funded through the Program Management (PM) budget.

PCOM staff should also consult with the Medical Review staff and the Contractor Medical Director to determine if PCOM is needed to address national educational activities, including national policies and national coverage/coding issues. Unlike Local Provider Education and Training (LPET), PCOM is generally not targeted to individual providers, but is instead designed to be broader in nature, plus have an additional focus on:

- New programs, policies and initiatives;
- Educating providers on significant changes to the Medicare program;
- Training and consulting for new Medicare providers; and
- Ongoing education of billing staff.

The Provider Communications instructions in the Intermediary Manual (Part 2, Chapter XI, Section 2965) represent the current requirements for intermediaries. These BPRs, and the companion PM-PCOM BPRs, identify the new and incremental work proposed for FY 2004. All new work requirements will be added to the Intermediary Manual.

Activity Based Costing (ABC) will again be used in the budget process for Provider Communications. The Provider Communications work components from the Manual and both PCOM BPRs, are grouped within and under the ABC definitions. (Reference the Activity Dictionary, Attachment 1, to the BPRs).

FY 2004 Funding Approach

For FY 2004, CMS will fund each contractor's level of effort to provide excellent educational services. Each contractor will be given a budget for PCOM activities. Based

on this budget, the contractor must develop a plan for conducting educational activities in their area.

Contractors should explain how they plan to allocate costs for provider education activities between PCOM, LPET, and Benefit Integrity (BI). LPET subjects or issues include, but are not limited to, medical review, LMRPs, and local coverage and coding issues related to medical review. BI subjects include fraud and abuse and benefit integrity. For any functions such as general seminars, conventions, or conferences that address PCOM subjects, as well as LPET and/or BI issues, the proportional share of the cost of that function to be allocated to PCOM is equal to the percentage of time related to addressing PCOM Medicare issues multiplied by the cost of the function. 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 subject contents of the bulletin between PCOM, LPET, and BI.

Note: The issuance and distribution of paper provider bulletins/newsletters, at least quarterly, as well as the related initiative for alternate electronic distribution begun in FY 2003, will continue in FY 2004. Contractors who have approved proposals for this initiative should recognize and use this in budgeting for this activity.

Following are the FY 2004 activities, their activity code numbers, and accompanying manual references for the ongoing work requirements included under the activity. The new PCOM BPRs activities and their descriptions are included under each activity.

Create/Produce and Maintain Educational Bulletins (Activity Code 25103)

Reference: Intermediary Manual, Part 2, Chapter XI, Section 2965 A.5.

New Requirements -

- Easy Identification of Bulletin Information

Providers should have easy access to relevant Medicare information that pertains to their particular type of practice. It is important to identify the information in your paper bulletin/newsletter, so that providers can easily and quickly find information of interest to them. As such, provide within the introductory table of contents, summary, or compilation or listing of articles/information, an indicator (word(s), icon, or symbol) that denotes whether the article/information is of interest to a specific provider audience(s) or is of general interest. This requirement may be disregarded if your introductory table of contents, summary, or article/information compilation is structured by specialty or provider interest groupings.

Workload

Workload 1 is the total number of bulletin editions published. Workload 2 is the total number of bulletins mailed.

Partner with External Entities (Activity Code 25105)

Reference: (Requirements listed below are to be added to the Intermediary Manual)

New Requirements -

- Collaborative/Partnering Efforts

Contractors should work toward establishing partnerships with external entities to help in disseminating Medicare provider information. These types of partnerships can expand the reach of your PCOM program and reduce the costs associated with PCOM activities. Partnering entities may be medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, providers can obtain Medicare program information through a variety of sources. Partnering or collaborative provider information and education efforts can include external entities:

- printing information in member newsletters;
- reprinting and distributing (free-of-charge) provider education materials;
- giving out provider education materials at organization meetings and functions;
- scheduling presentations or classes to or for members;
- posting provider information on their websites; and
- helping organizations develop their own Medicare provider education and training material.

In FY 2004, particular attention for this activity should be directed at local or regional hospital associations, alliances or groups, and medical centers.

Workload

Workload 1 is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.

Administration and Management of PCOM Program (Activity Code 25201)

Reference: Intermediary Manual, Part 2, Chapter XI, Section 2965 A.1, 2, 3, 11, 12, B.1.

New Requirements -

- Reporting of New Provider Education Material

Report the development of any new or significantly revised provider education or training material in Section 7 (Other Activities) of your Provider/Supplier Service Plan (PSP) Quarterly Activities Report. Evaluate products for potential use as national training products and designate as such. Nominated products should have the potential of being used in provider education efforts nationally, by CMS or by other Medicare contractors.

- Provider Technical Assistance Referral Program

Develop a technical assistance referral program that is designed to handle the more complex questions from providers that require substantive and technical experience beyond the scope of the routine questions handled by Customer Service Representatives. Designate and train contractor representatives to handle these non-routine questions. Types of questions handled by these staff may include requests for technical assistance, but should be unrelated to claims status or beneficiary eligibility inquiries. Representatives should be designated according to the significant or distinct provider groups serviced by the contractor.

- CMS Sponsored Provider Communications Training

Contractors must send at least one training representative to national CMS conferences, e.g., train-the-trainer conferences. Your representatives should be from the appropriate business function area, i.e., provider education/customer service, payment, claims processing, billing, or medical review. Your representatives will be responsible for training additional staff, which will then educate providers and provider staffs in their area.

Develop Provider Education Materials and Information (Activity Code 25202)

Reference: (Requirements listed below are to be added to the Intermediary Manual)

New Requirements -

- Produce Provider Education Material

As needed, develop and produce provider information and education materials that support your provider communications activities. (These materials do not include bulletins and newsletters.)

- Special Media Creation - Discretionary

As needed, develop and produce provider education products that use special media, i.e., videos, web/computer based training courses, audio tapes, CD ROMs, etc.

Workload

Workload 1 is the number of special media efforts developed.

Special Media Creation (Miscellaneous Code 25202/01)

Use Miscellaneous Code 25202/01 to report the costs associated with the preparation of special media.

Disseminate Provider Information (Activity Code 25203)

Reference: Intermediary Manual, Part 2, Chapter XI, Section 2965 A.6, 8.

New Requirements -

- Fundamentals of Medicare Billing Workshops

Contractors must conduct at least two workshops during the year, targeted to new Medicare providers and provider billing staff. These workshops should deal with fundamental Medicare policies, programs, and procedures, but should concentrate and feature information on the basics of billing Medicare.

- Website Promotion and Presentations

Actively promote and market your Medicare provider communications website. Contractors are to present information concerning how to find, navigate and fully use their Medicare provider education website. This information should be part of, or made available at, all your provider education and training workshops and seminars, training sessions with individual providers, and all other provider education events.

- Informing External Organizations About Training Events

In order that training events have maximum attendance, directly and routinely notify external groups, organizations, and other interested entities within your geographic service area, of upcoming provider education and training events, to promote and encourage attendance. Direct notification avenues include mail, telephone, and e-mail. Notifications should be made sufficiently in advance of the scheduled events to allow time for registration.

- Quarterly Provider Update Promotion

The Quarterly Provider Update (QPU) is a listing of the regulations and program instructions issued by CMS that impact Medicare providers. The QPU is maintained by CMS and available to providers through the CMS website. Providers may elect to join a CMS electronic mailing list, to be notified periodically of additions to the QPU. Promote the existence and usage of the QPU and the electronic mailing list to your

providers, through your provider communications avenues, e.g., your Medicare provider education website, bulletins/newsletters, provider workshops, presentations and events, and in your provider education materials.

Workload

Workload 1 is the number of educational seminars, workshops, classes and face-to-face meetings held. Workload 2 is the number of attendees at your educational seminars, workshops, classes and face-to-face meetings.

Management and Operation of PCOM Advisory Group (Activity Code 25204)

Reference: Intermediary Manual, Part 2, Chapter XI, Section 2965 A.4

New Requirements -

(No new/additional requirements in FY 2004)

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

Audit (Intermediary)

Each intermediary's budget is to furnish sufficient funding to complete all required activities in accordance with CMS instructions. As funds permit, intermediaries are to budget for planned audits and focus reviews based on CMS' audit priorities identified below. As part of Activity Based Costing (ABC), new codes have been added for cost report reopenings, wage/index, and Provider Reimbursement Review Board (PRRB)/Intermediary Hearings. The Activity Dictionary for Audit should be utilized to define the activities that should be included in each task. (See Attachment 1 of the BPRs).

General Instructions

- **Audit Quality** - Intermediaries must continuously strive to comply with all audit standards and instructions, especially those regarding audit techniques, implementation of adjustments, and the expansion of audits based on preliminary findings and managerial review. Each audit must address the issues identified for field review by properly performing all necessary audit steps and procedures, and documenting them in properly prepared and supervisory reviewed audit working papers.
- **Auditor Training** - In accordance with CMS Pub. 13-4, intermediaries are required to ensure that their audit staffs receive training and meet Continuing Education Standards. We suggest that the intermediary staffs, including supervisors, receive training in Medicare Principles of Reimbursement, work paper preparation, documentation of audits, and how to perform supervisory reviews. Audit supervisors and staff are required to receive 80 hours of training every 2 years, in order to comply with the revised Government Auditing Standards, which were effective January 1, 1989. During FY 2004, intermediaries are to ensure that these standards are met.
- Intermediaries must complete the Contractor Audit and Settlement Report (CASR), the Audit Selection Criteria Report (ASCR), and the Schedule of Providers Serviced (SPS), in accordance with the instructions contained in CMS Pub. 13-1, Chapter 2, Sections 1270 to 1274. Intermediaries must complete a supporting worksheet that shows the details of their calculation of all data shown on the CASR and the Provider Reimbursement Profile (PRP). Intermediaries are to use available time records to support the hours indicated. These data can be extracted from the System Tracking for Audit and Reimbursement (STAR) system, if necessary. The supporting worksheets are to be maintained in the intermediary's files for review or submission to CMS at a later date.

Provider Audit Priorities for FY 2004

The primary focus of audit is proper payment. Intermediaries should attempt to optimize the audit budgets by ascertaining risk, in conjunction with the CMS stated goals, and utilizing focused audits wherever possible. Specific attention should be given to new providers, bad debts, organ procurement costs, indirect and direct medical education (IME/GME), disproportionate share (DSH), Transitional Outpatient Payments (TOPs), and excluded units. This will allow intermediaries to optimize the funding available and impact more at risk program dollars.

Each contractor should consider the following priorities in determining workload and selecting providers for review/audit:

- The intermediary should continue to perform audits in connection with CR 2528, Instructions Regarding Hospital Outlier Payments.
- In accordance with guidance provided in the CMS PM-A-01-141 (CR 1468), all intermediaries are to achieve currency in settlement of all provider cost reports. The time period to become current has been extended until September 2005.
- Concentrate on the largest teaching hospitals and multi-facility hospitals. Intermediaries should place special emphasis during field audits/reviews on the GME/IME intern and resident counts in teaching hospitals. In addition, special emphasis must be placed on the audit of TOPs payments and Medicaid days for the DSH adjustment. Intermediaries should consider reviewing the claimed observation bed days to insure that the provider counted those days in accordance with regulations and program instructions.
- Concentrate on Critical Access Hospitals to insure that all costs claimed are reasonable and necessary, are related to patient care, and that the statistics used to allocate and apportion cost are appropriate and accurate.
- Concentrate on those hospitals with hospital-based Home Health Agencies (HHAs), for cost reporting periods prior to the implementation of Home Health Prospective Payment System (PPS) if the cost report is still open. Intermediaries should give special attention to those hospitals that have management contracts for the administration of their HHAs. HHA PPS cost reports should not be an area of concentration unless they contain unusual pass-through costs
- Reviews of Skilled Nursing Facility (SNF) cost reports covered by the SNF Prospective Payment System (PPS) should focus on bad debts only. However, for any SNF cost reports that are still open for pre-PPS years, the intermediaries should give them priority. Focus those reviews on SNFs that have subproviders, respiratory therapy services, and the allocation of cost between Certified and Non-certified areas to ensure the provider has the proper documentation to properly

reflect the separation of costs. If the documentation does not exist, the areas are to be collapsed into one unit.

- Give priority to Chain Home Office cost statements for those chains that have significant cost reimbursement. Focus the reviews toward those chains with more cost based units and large Home Health Agency Chains that are not reimbursed based on PPS. The intermediaries are to insure that the chains are properly allocating costs to the providers in the chain in a manner approved by CMS. Determine that you are able to account for all related organizations. In addition, the intermediary is to review the due to and due from accounts on the home office trial balance to insure proper costing. Home Office cost report reviews are not needed if the providers in the chain are not reimbursed based on cost.
- Consider reviewing Community Mental Health Centers if they receive significant TOPS payments. Review the providers cost and charges related to outpatient services.
- End Stage Renal Disease (ESRD) Facilities are to be audited in accordance with BBA requirements. The intermediaries are to insure that one-third of freestanding and hospital based ESRD facilities with cost reports ending between 1/01/01 and 12/31/01, are reviewed in FY 2004. One-third of these facilities should have been reviewed in FY 2003, with the final one-third to be reviewed in FY 2005. The objective is to complete audits of all ESRDs by FY 2005.
- Concentrate on Rural Health Clinics that share offices with Physician Offices to insure that the proper costs are allocated to the Medicare cost report and that Medicare is not being charged for costs that are not program related.
- Concentrate on hospitals with organ procurement costs of \$500,000 or more.
- Any audit initiatives that the contractors believe should be included, that differ from the above priorities, should be discussed with the regional office.

As funds permit, an intermediary may perform a limited number of cyclical reviews on those providers whose cost reports are not normally subjected to a full desk review. However, providers who have no cost reimbursed payment should only be minimally selected, i.e., Hospice, SNF, HHAs. This cyclical effort is used to maintain the sentinel effect of the audit process.

The number of field audit/review hours required for PPS Hospitals, Tax Equity & Fiscal Responsibility Act (TEFRA) Hospitals, and other providers, should reflect the estimated time necessary to complete the review in accordance with CMS guidance regarding the implementation of Government Auditing Standards.

Intermediaries are no longer required to comply with the TEFRA and PPS audit review guidelines contained in Sections 4117 and 4118 of CMS PUB-13-4, Medicare

Intermediary Manual. These guidelines have been removed from the internet version of the manual and will not be reinstated. Field audits must include the review of a provider's documentation to support Form CMS-838, Medicare Credit Balance Report. The applicable hours to complete credit balance reviews are to be included in the total number of hours needed to perform an audit.

Appeals and Reopenings

Intermediaries are to process cost report reopenings within 180 days of receipt of all necessary information. Intermediaries should identify and settle all reopened cost reports for which additional information is not required: e.g., providers with home office adjustments; requests from providers; reopenings from appeals decisions, etc. Reopenings should be initiated where appropriate, in accordance with CMS instructions. Intermediaries must insure that all provider cost reports which still require Home Office Cost Statement finalization, have been reopened in accordance with program requirements.

Intermediaries should request funding for Intermediary and Provider Reimbursement Review Board (PRRB) appeal activities. Intermediaries should focus its activities to assist in the reduction of backlog cases at the PRRB. Intermediaries must process appeals in accordance with PRRB required time frames.

Supporting Documentation

Contractors are to submit the requested information in Attachment A.

Description of Activity Codes

Provider Desk Reviews (Activity Code 26001)

Include funding for activities related to the cost report acceptance, tentative settlement, desk review, and audit scoping.

Include in Workload 1, Activity Code 26001, the total number of cost report desk reviews completed. This count is the same as line 2a of the CASR IER (CIER). The CIER total number of units (line 2a) is the total of lines 3a (limited desk reviews) and 4a (full desk reviews). Workload 2 is line 3a (limited desk reviews). Workload 3 is line 4a (full desk reviews). This does not include any count for provider-based facilities.

Provider Audits (Activity Code 26002)

Include funding for all activities after the desk review, but prior to the settlement.

Report the total count for all audit types (focused audits and field audits) as Workload 1, in Activity Code 26002. An audit includes all work efforts subsequent to the completion of the desk review up to, but not including, the revising the cost report. Include the total

count for all audit types shown in line 6b of the CASR IER, (This is the total of line 7b - focused audit and line 8b - field audit).

Provider Settlements (Activity Code 26003)

Include funding for all work performed after the desk review/focus review and field audit through the Notice of Program Reimbursement (NPR) issuance. Settlements include work performed on a cost report, after the completion of the desk review, focus review, or audit, and after the final exit conference. Do not include any appeal or hearing work. Report the number of costs reports settled as Workload 1, in Activity Code 26003. This is the amount reported in line 10a of the CASR IER, the number of cost reports settled. A cost report is settled when the NPR is mailed or transmitted.

Cost Report Reopenings (Activity Code 26004)

Include funding for all work related to the reopening of a cost report.

Report the number of reopenings as Workload 1, in Activity Code 26004. This is the amount included in line 13b of the CASR IER, the number of reopenings completed. Do not include a count for denials.

Wage Index Review (Activity Code 26005)

Include funding for all activities related to wage index reviews.

Report the number of wage index reviews completed as Workload 1.

PRRB and Intermediary Hearings (Activity Code 26011)

Include funding for all work performed on cost reports related to a provider's appeal.

Report the number of cases closed as Workload 1. This count should include all cases that are closed through hearings, administrative resolutions, mediation, withdrawn, etc. Group cases should be counted as one case only.