CMS Manual System

Pub. 100-15 Medicaid Program Integrity Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1 **Date: September 23, 2011**

SUBJECT: **Medicaid Program Integrity Manual – Initial Release**

I. SUMMARY OF CHANGES: The purpose of the Medicaid Program Integrity Manual is to promote continuity and consistency of the Medicaid Integrity Program (MIP) by providing a comprehensive guide to its overall operations. The manual will primarily serve as a reference tool to assist State Medicaid officials, providers, health care organizations, the Centers for Medicare & Medicaid Services (CMS) components, and other Federal agencies in the following:

1. Understanding the goals and objectives of the MIP;
2. Improving the communication and transparency of the MIP; and
3. Educating outside entities of the evolving functions of the MIP.

This is an initial release of Pub. 100-15, Medicaid Program Integrity Manual. In February 2006, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, was signed into law and created the MIP under section 1936 of the Social Security Act. The manual provides further information on the operating procedures for the MIP, the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. It is an Internet-only manual and may be accessed at the CMS Web site: http://www.cms.hhs.gov/manuals

NEW/REVISED MATERIAL - EFFECTIVE DATE*: September 23, 2011
IMPLEMENTATION DATE: September 23, 2011

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapters 1 to 16

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

MEDICAID PROGRAM INTEGRITY MANUAL
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(Rev. 1, Issued: 09-23-11)

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INTRODUCTION

1000 – PURPOSE OF MANUAL

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The purpose of the Medicaid Program Integrity Manual is to promote continuity and consistency of the Medicaid Integrity Program by providing a comprehensive guide to its overall operations. The Medicaid Program Integrity Manual will primarily serve as a reference tool to assist State Medicaid officials, providers, health care organizations, the Centers for Medicare & Medicaid Services (CMS) components, and other Federal agencies in the following:

1. Understanding the goals and objectives of the MIP;
2. Improving the communication and transparency of the MIP; and
3. Educating outside entities of the evolving functions of the MIP.

1005 – MEDICAID PROGRAM: BACKGROUND AND OVERVIEW

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government that provides health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State. Medicaid covers a broad range of services to meet the health needs of eligible beneficiaries. Federally mandated services include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and x-ray services, physician services, and nursing home care. Commonly offered optional services include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, home and community-based services and services in intermediate care facilities for individuals with a mental illness.

1010 – CENTER FOR PROGRAM INTEGRITY (CPI)/MEDICAID INTEGRITY GROUP (MIG) STRATEGY

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Within the CMS, the MIG serves as one of five operating divisions organizationally located in the CPI that advises the Agency on program integrity matters.

As part of the CPI, the MIG has worked to accomplish the following:

Provide Training on Program Integrity (PI)

The Medicaid Integrity Institute (MII) was created in 2007 through a partnership with the Department of Justice (DOJ) Office of Legal Education. The MII provides high

quality program integrity training to State Medicaid Agency employees at no cost to the States. By the end of FY 2010, the MII had convened 38 classes in a variety of disciplines such as data analysis, fraud investigation and Current Procedural Terminology (CPT) coding and trained approximately 1,900 students. The MII has 15 classes scheduled for FY 2011 with an anticipated 850 State program integrity staff participating in those courses.

Leverage the Information Technology Infrastructure

The Information Technology Infrastructure includes six years of State Medicaid claims data with an estimated 3 billion claims per year, and 60 million recipient records. The CMS and its Medicaid Integrity Contractors (MICs) use the Information Technology Infrastructure to review Medicaid claims to identify billing aberrancies and vulnerabilities for referral to the Audit MICs. Concurrently, the MIG is working to increase the number of data fields within the database to collect additional State provider and payment information to make analysis more precise in identifying actionable findings, which will result in better detection of improper payments.

Work with States to Identify Vulnerabilities and Share Best Practices

The CMS continues to provide States with technical assistance on PI activities, and to conduct systematic reviews of State program integrity operations. The CMS will identify and work to group States with similar Medicaid program integrity vulnerabilities. These grouped States will share information on fraud, waste, and abuse that penetrate across State lines. The CMS continues to work with the Medicaid Fraud and Abuse Technical Advisory Group (TAG) to learn more about emerging trends and to identify ways States need technical and other assistance. This feedback continuously updates and improves technical assistance and support to the States.

Expand Recovery Audit Contractors (RACs) to Medicaid

The Patient Protection and Affordable Care Act of 2010 (hereafter "Affordable Care Act"), requires CMS to expand the RAC program to Medicare Parts C and D, and Medicaid. In 2010, CMS worked with the States on the approach to Medicaid RACs. The expansion of the RAC program will aid the identification of overpayments in the Medicaid program and identify patterns to help prevent the program from making future improper payments.

Report Supplemental Measures of Medicaid Improper Payment Error Rates

In support of the implementation of Executive Order 13520 regarding improper payments, the CMS developed a plan to conduct supplemental measurements of payment errors. In 2010, the CMS identified four national focus areas that we encourage States to target for their supplemental error rates. This measurement must focus on higher risk areas within Medicaid and inform on root causes of error that a corrective action can fix. In addition, the supplemental measurement should leverage

available and accessible information (e.g., claims, payments, files) for the current year rather than previous years, to the extent possible. The initial four focus areas are long-term care, home health, inpatient hospital services, and pharmacy services. However, these areas can/will change from year to year based on the Payment Error Rate Measurement (PERM) results and other data analysis.

1015 – MEDICAID INTEGRITY PROGRAM (MIP) BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS is committed to combating Medicaid provider fraud, waste, and abuse, which diverts dollars that would otherwise be spent to safeguard the health and welfare of Medicaid beneficiaries. In February 2006, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, was signed into law and created the MIP under section 1936 of the Social Security Act. The MIP is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program.

1015.1 – MIP RESPONSIBILITIES

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS has two broad responsibilities under the MIP:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on MIP issues; and
- To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse.

The Medicaid Integrity Group (MIG) is charged with implementing the MIP.

1020 – AFFORDABLE CARE ACT

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Department of Health and Human Services was delegated the responsibility for implementing many major provisions of the historic health reform bill known as the Affordable Care Act. The CMS is responsible for implementing the provisions of the legislation that address Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the American Health Benefit Exchanges and related private insurance provisions.

1020.1 – AFFORDABLE CARE ACT PROVISIONS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The provisions of the Affordable Care Act that most affect the MIP are as follows:

1. Section 6401 – Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP

Section 6401 of the Affordable Care Act creates new provider screening requirements that apply to all Medicare, Medicaid, and CHIP providers, both individual and institutional. Section 6401(b), which creates a new section 1902(a)(77) of the Social Security Act (the Act) and amends Section 2107(e)(1) of the Act, sets forth specific provider and supplier screening, oversight and reporting requirements. These requirements include provider screening, provisional period of enhanced oversight, disclosure requirements, temporary moratorium on enrollment of new providers, compliance programs, reporting of adverse provider actions, enrollment and National Provider Identifier (NPI) for ordering or referring providers and other State oversight.

2. Section 6402 – Enhanced Medicare and Medicaid Program Integrity Provisions
Section 6402(a) provides that:

- An Integrated Data Repository be established which will include claims and payment data from Medicare, Medicaid, CHIP, health-related programs administered by the Secretary of Veterans Affairs and the Secretary of Defense, the program of old-age, survivors, and disability insurance benefits established under Title II of the Act, and the Indian Health Service and the Contract Health Service program. Data is to be shared and matched between various Federal agencies for the purpose of identifying potential fraud, waste and abuse under the Medicare and Medicaid programs.
- The Inspector General of the Department of Health and Human Services may obtain information from any individual (including a beneficiary) or entity that is a provider of medical or other items or services, supplier, grant recipient, contractor or subcontractor; or directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies or receives medical or other items or services payable by any Federal health care program regardless of how the item or service is paid for, or to whom such payment is made.
- The Secretary of Health and Human Services must impose an administrative penalty on individuals who knowingly participate in a health care fraud offense or a conspiracy to commit a Federal health care fraud offense.
- Providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations or PDP sponsors that have received an overpayment must report the reason for that overpayment and return that overpayment.
- All Medicare and Medicaid providers of medical or other items or services and suppliers that qualify for a national provider identifier (NPI) must include their NPI on all applications for enrollment and claims submitted for payment in such programs.

Section 6402(h)(2) provides for the following:

- Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when

there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State, unless the State determines that good cause exists not to suspend such payments.

Section 6402(j)(2) provides that:

- The contractor will provide the Secretary and Inspector General of the Department of Health and Human Services with performance statistics.
- The performance statistics reported must include:
    - number and amount of overpayments recovered;
    - number of fraud referrals; and
    - return on investment of these activities by the contractor.
- The Secretary will conduct evaluations of the Medicaid Integrity Program's contractors at least every 3 years.

NOTE: The Audit MICs have had the requirement to report on performance statistics added to their contracts, and at this time, they are the only type of MIG contractors providing this information.

3. Section 6411 – Expansion of the Recovery Audit Contractor (RAC) Program

   Section 6411(a) creates Section 1902(a)(42) of the Act, which requires States and territories to establish Medicaid RAC Programs consistent with State laws. States and territories are required to establish programs with one or more Medicaid RACs, by amending their State Plans, unless an exception is granted by CMS. Medicaid RACs must identify and recover overpayments and identify underpayments. States must pay Medicaid RACs on a contingency fee basis for identification and recovery of overpayments. States will determine the fee paid to Medicaid RACs to identify underpayments. Payments to Medicaid RACs must be made only from amounts recovered. Medicaid RACs must coordinate their efforts with other auditing entities, including State and Federal law enforcement agencies.

4. Section 6501 – Termination of Provider Participation under Medicaid if Terminated under Medicare or Other State Plan

   Section 6501 creates a new section 1902(a)(39) of the Act, which requires States to terminate or exclude from Medicaid participation any individual or other entity that has been terminated from participation in Medicare or from another State's Medicaid program.

5. Section 6503 – Billing Agents, Clearing Houses, or Other Alternate Payees Required to Register under Medicaid

Section 6503 creates a new section 1902(a)(79) of the Act, which requires any agent, clearinghouse, or alternate payee that submits claims on behalf of a health care provider to register with the State and HHS in a form and manner to be determined by HHS.

6. Section 6504 – Requirement to Report Expanded Set of Data Elements under MMIS to Detect Fraud and Abuse

   Section 6504 amends, in pertinent part, section 1903(r)(1)(F) of the Act and provides that in order for a State to receive federal payments for the use of automated data systems used in the administration of the State Plan, the State must provide enrollee encounter data (in a format consistent with the Medical Statistical Information System (MSIS)) that HHS determines necessary for program integrity, program oversight, and program administration at a frequency determined by HHS.

7. Section 6505 – Prohibition on Payments to Institutions or Entities Located Outside of the United States

   Section 6505 creates a new section 1902(a)(80) of the Act, which prohibits the State from paying for Medicaid items or services under the State Plan, or a waiver program to any financial institution or entity located outside the United States.

8. Section 6506 – Overpayments

   Section 6506 amends section 1903(d)(2) of the Act by extending the deadline for the State to return the Federal share of overpayments from 60 days to 1 year for most overpayments. For overpayments resulting from fraud where a final determination of the amount of the overpayment is not made under an administrative or judicial process, the deadline extends to 30 days after the date of the final judgment (including any appeal).

9. Section 6507 – Mandatory State Use of National Correct Coding Initiative (NCCI)

   Section 6507 of the Affordable Care Act amends section 1903(r) of the Social Security Act (the Act) and requires each State Medicaid program to implement compatible methodologies of the National Correct Coding Initiative (NCCI), to promote correct coding and to control improper coding leading to inappropriate payment.

NOTE: On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010, which repealed new section 1902(a)(78) of the Act, as originally added by Section 6502 of the Affordable Care Act. The MIG sent an Informational Bulletin on December 30, 2010 notifying States of the repeal.

1025 – EXECUTIVE ORDER 13520: REDUCING IMPROPER PAYMENTS AND ELIMINATING WASTE IN FEDERAL PROGRAMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Executive Order 13520, dated November 23, 2009, directed Executive Branch agencies to engage in a concerted effort to reduce improper payments. In Fiscal Year (FY) 2009, Federal agencies made $98 billion in improper payments, which represented an increase of 27% over the prior fiscal year. Among the measures outlined in this Order, the President directed the Secretary of the Treasury and the Director of the Office of Management and Budget (OMB), in consultation with the Council of Inspectors General on Integrity and Efficiency (CIGIE), the DOJ and program experts, to make recommendations for "actions designed to reduce improper payments by improving information sharing among agencies and programs, and where applicable, State and local governments and other stakeholders." The Order focuses on broad categories of action including boosting transparency and holding agencies accountable.

Under the Order, agencies with high-priority programs are required to establish annual or semi-annual measurements for reducing improper payments. The CMS was designated such an Agency due to the improper payment rate under Medicare and Medicaid. This measure must focus on higher risk areas within Medicaid and inform on root causes of error that can be fixed through corrective actions. Through the review and analysis of Payment Error Rate Measurement (PERM) findings the CMS identified several high vulnerability/high risk areas to work with States to target. The initial national focus areas include: nursing homes, inpatient hospital, home health and pharmacy. The CMS proposed Medicaid supplemental measures to demonstrate achievable improvements in improper payments while developing enhanced oversight and reporting mechanisms to evaluate the effectiveness of Federal and State program integrity efforts. The CMS is actively engaged with States in efforts to have successful Payment Accuracy Improvement Groups (PAIGs). The purpose of the PAIG is to facilitate information sharing among States addressing similar issues and to enable the CMS to target staff and contractor resources to provide States with in-depth technical assistance to address and correct the identified problems in a meaningful way. States are expected to develop efforts to reduce improper payments. These efforts require "supplemental metrics" to evaluate the success of the PAIG intervention. The CMS will assist with technical assistance, contractor support, and State metric reporting to evaluate the success of the PAIG intervention.

1030 – MEDICAID INTEGRITY PROGRAM (MIP) EFFORTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

1030.1 – MIG GOALS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has identified the following primary goals:

- Promote the proper expenditure of Medicaid program funds;
- Improve Medicaid program integrity performance nationally;
- Ensure the operational and administrative excellence of the MIP;
- Demonstrate effective use of MIP funds; and
- Foster collaboration with internal and external stakeholders of the MIP.

1030.2 – Core Business Processes Under 1936 of the Act (The Medicaid Integrity Program)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has identified four core business processes and two main business operations to successfully meet its goals and the requirements of section 1936 of the Act.

The Core Business Processes are:

- Planning and Program Management
- Ensuring Accountability
- Communication and Collaboration
- Information Management and Research

1030.3 – Main Business Operations

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Main Business Operations are:

- **Medicaid Integrity Contracting:** procuring and managing contracts for Medicaid Integrity Contractors (MICs) and other MIP projects; and
- **State Program Integrity Operations:** providing effective support and assistance to States to improve Medicaid program integrity activities and conducting reviews of State Medicaid integrity programs.

1030.4 MIG Efforts

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Medicaid Integrity Institute (MII): The first national Medicaid program integrity-training venue, the MII offers training at no cost to State Medicaid PI staff in various disciplines. MII is located at the U.S. Justice Department's National Advocacy Center, where participants learn techniques to safeguard program dollars. The MII hosts numerous classes each year, training hundreds of State PI employees.

Review and Audit of Providers: Pursuant to section 1936 of the Act, MICs have been procured to review and audit providers' claims and identify potential overpayments.

Education of Providers and Others: Education on payment integrity and quality of care issues is available for Medicaid providers and others.

Fraud, Waste and Abuse Research: Fraud, waste, and abuse detection algorithms have been developed to assist MIG, State program integrity units, and the MICs in the detection of fraud, waste, and abuse. Moreover, State Performance Integrity Assessments (SPIAs) provide a baseline of Medicaid program integrity accomplishments across the country. The SPIA is the MIG's effort to identify a State-by-State baseline of program integrity demographics. It includes information on a wide variety of program integrity functions, staffing, and accomplishments. In FY 2009, the MIG published the first-ever compilation of SPIA results

representing FY 2007 State demographics. The SPIA is now an annual process and will help identify strengths and opportunities for improvement in Medicaid's program integrity infrastructure.

Technical Assistance: Program integrity technical assistance is available to States and other stakeholders. The MIG provides guidance on selected provisions under section 1936 of the Act and other regulatory and legislative requirements.

The MIG's staff provides ongoing technical assistance to States on a variety of program integrity related topics including, but not limited to, provider fraud; billing concerns; provider enrollment; PERM; statistical analysis and program integrity regulations.

Upon request, the MIG staff provides resources to support State special projects to target suspect providers in high-fraud areas. Between October 2007 and March 2009, MIG employees took part in six special field projects. Five of these were investigations coordinated by the Florida Agency for Health Care Administration. One was an investigation coordinated by the California Department of Health Services. In each project, State and Federal staff interviewed Medicaid clients and providers and examined medical records, which allegedly supported the services billed. For three of these projects, the State Agency reviewed paid claims for similar time periods before and after the special projects. In each case, there was a significant decrease in paid claims after the project. The estimated savings from these three projects totaled approximately $10.1 million.

State Program Integrity (PI) Reviews:
The purpose of State PI reviews are to:

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and noteworthy practices;
3. Help the States improve their overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Through State comprehensive program integrity reviews, MIG staff identifies program integrity related issues in State operations and, in turn, help States improve program integrity efforts. Each State undergoes a comprehensive review every three years. In addition to evaluating State compliance and identifying issues in State operations, MIG staff use these reviews to identify and disseminate best practices.

In each of the State program integrity reviews, State staff answers questions in the review guide and provides supporting documentation in the areas of program integrity, provider enrollment, managed care, and information regarding the Medicaid Fraud Control Unit (MFCU). That information is then confirmed through review of documentation and interviews with program integrity, provider enrollment, managed care, and MFCU staff.

Best Practices Guidance: The MIG also provides technical assistance in the form of guidance documents. The MIG has issued State Medicaid Director Letters on topics such as enhanced Federal Financial Participation for false claims acts; false claims education requirements; tamper resistant prescription pad requirements; cooperation with the MIG; and provider

exclusions. The State Medicaid Director Letters are available on the CMS Website at **http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopofPage.** Also see Medicaid Program Integrity Manual Section 16005 – State Medicaid Director Letters Authored by MIG (in whole or in part).

In September 2008, the MIG issued CMS MIG Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a MFCU in order to determine the percentage of accepted referrals that were provided by State Medicaid Agencies to their MFCUs. At no time previously had program integrity units been issued performance standards that measured the number of referrals made to their MFCUs. Along with the Referral Performance Standards, the MIG issued a Best Practices document that elaborated on whether and when cases should be referred to the MFCU, the content of quality referrals, and how to maintain a good relationship between the State program integrity unit and the MFCU.

In May 2009, the MIG also issued its first annual summary of program integrity review results. It included information about effective practices, areas of vulnerability, and areas of non-compliance.

1035 – OVERPAYMENT AND ERRORS VERSUS FRAUD, WASTE, AND ABUSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

An **improper payment** is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts include overpayments and underpayments. An improper payment includes any payment that was made to an ineligible recipient, payment for non-covered services, duplicate payments, payments for services not received, and payments that are for the incorrect amount. In addition, when an Agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment must also be considered an improper payment. (42 CFR § 431.958; Improper Payments Elimination and Recovery Act (IPERA); and Appendix C to OMB Circular A-123 (M-10-13))

Data processing errors are errors resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System (MMIS), related systems, and our outside sources of provider verification. The difference in payment between what the State paid and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error. (42 CFR § 431.960(b)(1) and (b)(2))

Medical review errors are errors resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed. The difference in payment between what the State paid and what the State should have paid is the dollar measure of the payment error. (42 CFR § 431.960(c)(1) and (c)(2))

NOTE: Eligibility errors are not defined in this manual.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 433.304 and 455.2)

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR § 433.304 and 455.2)

In cases where there is suspected fraud, but the case has been refused by law enforcement, audit contractors deny the claim(s) and collect the overpayment after notifying law enforcement. An actual overpayment is the sum of payments (based on the amount paid to the provider and Medicaid approved amounts) made to a provider for services which were determined to be medically unnecessary or incorrectly billed.

Section 6402 of the Affordable Care Act, which creates section 1128J of the Act, defines "**overpayment**" to mean "any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title. (Sec. 1228J of the Social Security Act) Under section 6506 of the Affordable Care Act, States now have one year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud, the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the one-year period ends, regardless of whether the State recovers the overpayment.

Section 6506(a)(1)(B) of the Affordable Care Act further amended the Act by adding section 1903(d)(2)(D)(ii) pertaining to overpayments made due to fraud. Specifically, when a State has been unable to recover overpayments due to fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share.

Additionally, the discovery date for overpayments due to fraud begins on the date of the final written notice of the State's overpayment determination to the provider. (42 CFR § 433.316).

1040 – RETURN ON INVESTMENT

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

In addition to the MIP annual Report to Congress required under section 1936 of the Act, the MIG is required to report return on investment (ROI) for the Government Performance Results Act (GPRA). ROI is a performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments. To calculate ROI, the benefit

(return) of an investment is divided by the cost of the investment, and the result is expressed as a percentage or a ratio. The purpose of this measure is to evaluate the success of the MIP.

1045 – PARTNERSHIP WITH OTHER COMPONENTS AND STAKEHOLDERS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

One of the primary goals of the MIG is to foster collaboration with internal and external stakeholders of the MIP. To that end the MIG has developed:

- Comprehensive Medicaid Integrity Plan (CMIP) – developed in consultation with required stakeholders.

- Medicaid Integrity Program Advisory Committee – In FY 2006, the MIG established the Medicaid Integrity Program Advisory Committee to provide input and consultation on the development of its oversight approaches to State program integrity operations and Medicaid Integrity contracting. The committee members included program integrity representatives from 16 States, the Federal Bureau of Investigation (FBI), HHS Office of Inspector General (OIG), and CMS' Regional Offices. The advisory committee last met in October 2008.

- Medicaid Fraud and Abuse Technical Advisory Group (TAG). Sponsored by CMS, the technical advisory group (TAG) consists of one State program integrity director per CMS region and a State program integrity director also serves as the chair of the TAG. The TAG meets by conference call on a monthly basis and face to face as needed. The TAG provides an important venue for CMS to obtain advice and counsel on program integrity issues.

- Internal Collaboration with CMS Program Integrity Partners. The MIG is engaged in the following activities:
    - Continues ongoing collaboration and communication with other components of CMS and other agencies within HHS.
    - Conducts regular standing meetings with other CMS and HHS components on program integrity issues, emphasizing the integration of program integrity into policy and programmatic decision-making.
    - Continues collaboration on joint initiatives with other CMS and HHS components and other program integrity partners.

- Other External Communication with Program Integrity Partners and Stakeholders. The MIG is engaged in the following activities:
    - Attend regular meetings with law enforcement at the management and staff levels to promote collaboration and communication.
    - Forward suspected cases of Medicaid provider fraud to HHS OIG.
    - Outreach via participation in CMS Open Door Forums/audio conferences and presentations to the Medicaid Integrity Program.

- Conduct presentations on the Medicaid Integrity Program at conferences, industry meetings, and other venues.
- Communication and coordination with State program integrity partners.
- Conduct outreach calls on the MICs.

The following list provides examples of MIG's partners and the activities that convey the main communication messages the MIG uses to assist its various stakeholders:

State Medicaid Partners (e.g., Program Integrity Unit staff, MFCU) The MIG can assist these partners with resources and is not meant to duplicate these partners' current auditing efforts. Current efforts include: Introductory Calls; TAG Calls; National Association for Medicaid Program Integrity (NAMPI) presentations; and special projects with States.

Provider Community (e.g., Providers, Provider/Medical/Hospital Associations, Attorneys for Providers, Pharmacy Associations, Other Advocacy Groups)
Current efforts include: Provider association forums and MIP Open Door Forums/audio conferences.

Federal law enforcement partners (e.g., DOJ, OIG)
The MIP is a complement to these partners' efforts and the MIP audits are not meant to duplicate these partners' current auditing efforts. Current efforts include: Vetting of targets to avoid duplication and regular meetings to collaborate/coordinate efforts.

Congress; Other Public Officials
Current efforts include: Report to Congress; and responding to inquiries and requests for technical assistance on a wide variety of Medicaid integrity issues from Congress and other public officials.

General Public
The MIP is in place to protect and improve the Medicaid program. Current efforts to share information with the public about goals and accomplishments include posting information to the CMS website at www.cms.hhs.gov.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 2 – MEDICAID INTEGRITY GROUP (MIG)

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2000 – RESPONSIBILITIES OF MIG DIVISIONS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Office of the Group Director – serves as the primary point of contact on Medicaid provider fraud, waste, and abuse issues within CMS and with other partners, including law enforcement and the States; and directs the activities of MIG staff, including its four divisions.

Division of Medicaid Integrity Contracting (DMIC) – serves as the primary MIG focal point for procurement, functional administration and oversight of all MICs; develops statements of work and task orders for contractors; and develops performance measurements for MICs and monitors their contractual performance.

Division of Fraud Research & Detection (DFRD) – provides statistical and data support to the MIG; identifies emerging aberrant trends through data mining and other advanced analytical techniques; conducts special program integrity studies as appropriate; assists in the development of program integrity training curricula and conducting training; identifies appropriate performance measurements for State program integrity units; provides technical assistance to the DMIC and the MICs in the execution of provider oversight activities; and provides support and assistance to States through oversight, training, best practices and other forms of technical assistance.

Division of Field Operations (DFO) – serves as CMS' primary point of contact with State program integrity units; acts as CMS' primary liaison with the Medicaid Fraud and Abuse TAG; conducts Medicaid program integrity reviews; acts as primary Agency focal point for State provider audit issues; identifies and disseminates best practices in Medicaid & CHIP program integrity efforts to States and other program integrity partners; establishes and maintains a National Medicaid Fraud alert system; conducts environmental scanning on program integrity issues; identifies and executes technical assistance opportunities for States; coordinates the MIG's interactions with RO CMS Medicaid Financial Management staff and State representatives; collaborates with internal and external partners in the development and execution of anti-fraud strategies and activities; and develops program integrity training curricula and conducts training. The DFO has field offices in New York, Atlanta, Dallas, Chicago, and San Francisco.

Division of Audits & Accountability (DAA) – serves as the primary point of contact for the national Medicaid Audit Program under the MIP; provides leadership to the Medicaid Audit Resolution Team, as well as other components within the MIG regarding the Medicaid audit process; develops the MIP Report to Congress and CMIP; collaborates with internal and external partners to provide input and/or resolve issues related to critical functions that include the Health Information Technology for Economic and Clinical Health (HITECH) Act, PERM, legislation, Executive Order 13520 implementation (e.g., coordinates with internal and external partners to participate in, and respond to, conferences and issues related to OIG and GAO reports that affect the MIP; develops the ROI methodology for the MIP and oversees the monitoring of that measure; and works as liaison with other Medicaid components (e.g. CMCS) on issues related to Medicaid program integrity).

2005 – DATA ANALYSIS AND INFORMATION GATHERING

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Data utilized to identify potential improper payments are from the Medicaid Statistical Information System (MSIS). MSIS consists of eligibility and claims program data submitted from States to CMS. The five files, submitted quarterly, include one file which contains eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter, and four separate files of claims adjudicated for payment during the quarter for long term care services, drugs, inpatient hospital stays and all other types of services. The State-submitted data include over 40 million eligibility records and over 2 billion claims records per year.

To date, the MIG, working with its Review of Provider MICs, has developed 105 algorithms covering the following service areas: Dental, Durable Medical Equipment, Inpatient Hospitals, Lab and X-Ray, Nursing Facilities, Outpatient Hospitals, Pharmacy, Inpatient, Professional, Long term Care, Physicians, Prescribed Drugs, and Psychiatric.

Algorithms developed generally fall into three different categories: overpayment, metric, and model. Overpayment algorithms are developed to identify claims with possible overpayments and are used to identify providers suspected of high overpayment. Metric algorithms derive metric values for comparison of utilizations among providers. No overpayment amount is calculated by metric algorithms; however, suspicious activity may be identified. Algorithm models look at a number of indicators and data elements and produce a composite ranking based on the combination of those elements. Rather than a direct overpayment amount, an algorithm model identifies potential fraud, waste, and abuse activities, which may then be subject to further review.

2010 – AUDIT FOCUS AND PRIORITIZATION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG uses a data driven approach to determine areas of audit focus and prioritization. While the MIG reviews all types of Medicaid providers, we have identified several areas of national focus. Using PERM findings, State corrective action plans from MIP audit contractor reviews, and Medicaid claims data CMS has identified several highly vulnerable/ high-risk areas that are the primary focus of our audit activities. The initial areas of national focus include:

- Long Term Care
- Home Health
- Inpatient Hospital
- Pharmacy

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CHAPTER 3 – PROVIDER RELATIONS/OUTREACH

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CHAPTER 3 – PROVIDER RELATIONS/OUTREACH
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3000 – RELATIONS & OUTREACH

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG is committed to an effective program of provider outreach. To that end, it conducts numerous provider-oriented presentations on the MIP, including CMS Open Door Forum teleconference calls. The MIG is particularly interested in interacting with providers in the four key areas of interest under the MIP: Long Term Care, Home Health Inpatient Hospital and Pharmacy.

If an organization is interested in hosting a provider-oriented presentation on the MIP, it may submit a speaking request. All speaking requests should be sent to the MIG Corporate e-mail at **medicaid_integrity_program@cms.hhs.gov.** Please use the Speaker Request form located in this manual under Exhibits. Please allow at least eight (8) weeks notice for events in which an in person presentation is expected and at least four (4) weeks notice for teleconferences and Webinars.

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4000 – MIP REPORTS TO CONGRESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

CMS is required under section 1936 of the Act to report to Congress annually on the use and effectiveness of the funds appropriated for the MIP. (To view this document and its updates, see the links in Chapter 15 – Useful Websites).

4005 – COMPREHENSIVE MEDICAID INTEGRITY PLAN (CMIP)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Section 1936 of the Act requires a five-year CMIP be written to ensure the integrity of the program. The MIG uses the CMIP to guide MIP development and operations. (To view this document and its updates, see the links in Chapter 15 – Useful Websites).

The CMIP details the two major operational requirements of the MIP:

- to use the contractors to review provider activities, audit claims, identify overpayments, and conduct provider education; and
- to provide effective support and assistance to States in their efforts to combat provider fraud and abuse.

Section 1936 of the Act also requires that the CMIP be revised in five-year cycles. The first CMIP was published in July 2006. The most recent CMIP can be accessed at **http://www.cms.gov/DeficitReductionAct/Downloads/CMIP2009-2013.pdf**; however, CMS may update the CMIP on a more frequent basis.

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5000 – SETTLEMENT AGREEMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG Director frequently coordinates program content perspectives with the appropriate, relevant CMS components regarding specifics in proposed settlement agreements between DOJ and other private entities. Additionally, when States have concerns regarding OIG/DOJ provider exclusion and/or overpayment settlements, the MIG Law Enforcement Coordinator may act as a facilitator between States and Federal law enforcement.

5005 – MEMORANDA OF UNDERSTANDING (MOU)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG currently has MOUs with OIG laying out a protocol for referrals of suspected fraud discovered by MICs, and also has signed MOUs with both OIG and numerous MFCUs regarding notice to these entities by MIG of planned MIC audits. MOUs have provisions requiring that they be reevaluated periodically for possible amendment.

5010 – FALSE CLAIMS ACT

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Under section 1909 of the Act, a State that enacts a false claims act (FCA) determined by the HHS-OIG to meet specific requirements set forth in this statute is entitled to an enhanced Federal medical assistance percentage (FMAP). States will receive a 10 percent increase on any amounts recovered pursuant to a State FCA action. In September 2006, CMS released a State Medicaid Director Letter regarding this provision and the availability of the FMAP adjustment for those States that enacted approved laws **(http://www.cms.gov/smdl/downloads/SMD091906.pdf).**

Since enactment of the DRA, 36 States and the District of Columbia have enacted their own State FCAs. Many of these State FCAs mirror the essential terms of the Federal FCA, although many State FCAs contain various elements that distinguish them from the Federal FCA. Prior to March 2011, the HHS-OIG approved 14 State FCAs as qualifying for the financial incentives described above. Since enactment of the DRA in early 2006, several pieces of legislation have amended the Federal FCA, and on March 24, 2011 the OIG announced that, prospectively, it will analyze a State's eligibility for the DRA's financial incentives in light of the Federal FCA as amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), the ACA, and the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Dodd-Frank Act) **(see http://oig.hhs.gov/fraud/state-false-claims-act-reviews/index.asp).** As of July 2011, the OIG has not approved any State FCAs as DRA-compliant under its new assessment standards, and it has granted the 14 previously approved States a grace period until March 31, 2013 to amend their State FCAs to come into compliance with the new standards.

5015 – RESPONDING TO REQUESTS FOR ASSISTANCE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

A "request for assistance or information" is a communication from law enforcement or health care fraud investigative personnel to the MIG asking for help regarding the investigation and/or prosecution of suspected fraud or abuse of funds by providers. The request could be in connection with a particular matter, or be concerned with general procedures, systems, rules or processes for such investigations.

The MIG may receive requests for assistance or information from a variety of law enforcement or health care fraud investigative personnel. These sources include:

- Special agents from OIG;
- Investigators or attorneys from State MFCUs;
- Local law enforcement staff (such as county or city police);
- Assistant United States Attorneys or other U.S. Department of Justice attorneys or staff;
- Special agents or staff from other Federal law enforcement agencies, such as the FBI, Internal Revenue Service, or United States Postal Inspection Service;
- State Medicaid program integrity staff; or
- Medicare program integrity or Medicare contractor staff.

When appropriate, MIG staff should make reasonable attempts to follow up with the person making the request to determine the resolution of the matter at issue.

5020 – REFERRALS OF SUSPECTED FRAUD

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

All allegations of fraud, abuse or other misconduct related to Medicaid (e.g., patient abuse) must be reported to the appropriate oversight entity. This includes, but is not necessarily limited to the State Medicaid Agency, the State MFCU, the State provider licensing board, or the OIG. Such allegations typically involve suspected fraud or abuse by a Medicaid enrolled provider, Medicaid managed care organization, Medicaid waiver program contractor, or their employees, agents or subcontractors, or Medicaid State Agency employees.

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6000 – Overview of State Program Integrity Reviews

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The DFO within the MIG conducts a comprehensive review of each State's Medicaid program integrity procedures and processes every three years. The MIG assesses the effectiveness of the State Agency's program integrity efforts and identifies its best practices, vulnerabilities and non-compliance with Federal Medicaid program integrity statutes and regulations. The review examines areas including provider enrollment, disclosures, program integrity, and managed care. The review also includes an interview with the State's MFCU director and staff to better understand how the MFCU interacts with the State Medicaid Agency in coordinating fraud and abuse efforts.

Approximately four months prior to the planned review, the State Medicaid director and the MFCU director receive a formal notice of the review. The notice includes a letter that provides information about the conduct of the review and requests for documentation to be provided to the MIG team prior to the onsite review.

The MIG team is onsite in State offices for approximately one week. The date of the onsite visit is selected through a first come, first served process in which the States under review identify which quarter of the fiscal year they would prefer for the visit. The MIG accommodates States to the greatest degree possible in scheduling the onsite visit An entrance conference is conducted on the first day of the onsite visit. The MIG staff interview the State Medicaid director, State staff, contractors (e.g., MCO staff, fiscal agent) and the MFCU director during the review. An exit conference is held via conference call within 30 days from the last day of the onsite review. During the exit conference, the team discusses concerns identified during the review. The State then has the opportunity to review and provide informal comments on the team's draft review report. The review report includes effective practices, areas of vulnerability and regulatory findings. The final report and the State's official response along with its corrective action plan are posted on the CMS website.

6005 – Identifying Potential Program Integrity Issues/Selection of States for Review

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

A. State PI Review Guide

The Review Guide is the primary tool used to gather information about the State Agency's program integrity program. The Review Guide consists of:

1. **State Documents**
    - Program Integrity Module;
    - Provider Enrollment & Disclosures Module;
    - Managed Care Module;
    - Charts for Review Guide – All Modules;
    - Summary of Document Requests – State Agency (optional); and
    - Summary of Sample Requests – State Agency (optional)

2. Managed Care Entity Documents

- Managed Care Entity Questionnaire;
- Managed Care Entity Module; and
- Summary of MCE Document Requests and Sample Requests (optional)

3. MFCU Documents

- MFCU Module and
- Summary of MFCU Document Requests and Sample Requests

B. Notification to State of the Review and Selection

1. Selection of States for Review

States are reviewed on a triennial basis. The MIG maintains a master schedule identifying the States to be reviewed each Federal fiscal year (FFY). The original schedule was designed to prevent comprehensive program integrity reviews from being conducted in the first year of a State's PERM cycle.

2. Notification to State of the Review

In the third quarter of each FFY, the MIG notifies scheduled State Medicaid Agencies that they have been selected for a comprehensive program integrity review in the next FFY. The communication includes information about the purpose of the review and potential dates for the reviews.

The selected States receive a formal notice of the planned review 16 weeks prior to the onsite review. The formal notice is sent to the State Medicaid director and the State Program Integrity director. The notice includes an introductory letter, which describes the conduct of the review, the Review Guide Modules, and a copy of the report from the State's last program integrity review.

A notice is also sent to the State MFCU 16 weeks prior to the onsite review. The notice includes an introductory letter, MFCU Review Guide documents, and a copy of the report from the State's last program integrity review. The State and MFCU provide the completed Review Guide Modules to the MIG six weeks prior to the onsite review.

C. Documentation Specifications for Areas Selected for State PI Review

1. Requests

The Review Guide contains requests for documents in each of the modules. The documents vary from internet links or electronic copies of statutes or regulations or policies or procedures to copies of contracts or other documents like notices or

explanations of medical benefits. In the PI module, we request 62 documents; in the Provider enrollment and Disclosures (PED) module, 54 documents; in the MC module, 38 documents. We request similar documents from the MFCU and from the MCE. In those modules, respectively, we request seven and 12 documents.

2. Sample Requests

In the course of the program integrity reviews, we select samples of files from lists of records we have requested in the Review Guide. We determine from the sample files whether the State's responses in the Review Guide accurately portray its procedures. Each module contains sample requests, including the MFCU and MCE modules.

6010 – INTERNAL STATE PI REVIEW GUIDELINES

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

A. Gathering Information Prior to Onsite Review

The MIG Review Team Leader (RTL) is available to the State throughout the review process. Frequent communication with the State prior to the onsite review allows the State to ask questions and allows for development of an agenda for the onsite review.

In an effort to reduce the burden on the State, the MIG Review Team collects as much information as possible from other sources. Sources include, but are not limited to, the CMS ROs, State websites, the CMS website, the OIG and GAO websites, and internal CMS information.

B. The Onsite Review

The MIG Review Team is onsite in State offices for approximately one week. An entrance conference is conducted on the first day of the review.

Using the State and MFCU responses to the Review Guide Modules, the MIG Review Team interviews various State and MFCU staff, including contractors. The team reviews additional documents provided by the State or its contractors and conducts sampling of provider enrollment applications, case files, and other primary data to validate the State's program integrity practices. The MIG Review Team also conducts walkthroughs of business processes, such as the State's provider enrollment process.

C. The Exit Conference

An exit conference is held via conference call within 30 days from the last day of the onsite review.

6015 – NOTIFICATION TO STATE OF THE DRAFT REVIEW

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG Review Team prepares a written review report, which includes areas of non-compliance, vulnerabilities in the State's practices and processes, and effective practices utilized by the State. The CMS RO has the opportunity to offer comments on the draft review report before the report goes to the State. The MIG provides a draft review report to the State and to the MFCU. The State and MFCU then have the opportunity to provide informal comments on the draft report within 30 days of receipt of the report.

6020 – NOTIFICATION TO STATE OF THE PI REVIEW RESULTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

After reviewing the State's comments on the draft report, the report is finalized and sent to the State. A letter, summarizing the review findings and requesting a corrective action plan (CAP) and formal comments on the final review report, accompanies the final comprehensive review report. The State has 30 days in which to provide the CAP and formal comments on the final report.

6025 – CORRECTIVE ACTION PLAN (CAP)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

States are required to submit a CAP, which addresses each area of regulatory non-compliance discovered during State Medicaid program integrity reviews. States are also asked to address the vulnerabilities identified. States have 30 days from the date of the final report to submit a CAP, ideally achieving compliance within 90 days. The MIG asks for explanations on any corrective actions that require more than 90 days to implement. The DFO State liaisons will provide technical assistance as requested and will provide oversight to monitor implementation of the CAP.

6030 – ANNUAL PI REVIEW SUMMARIES (NOTEWORTHY PRACTICES, FINDINGS & VULNERABILITIES)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Program Integrity Review Annual Summary reports include a compendium of data collected from comprehensive integrity reviews for which final reports have been issued during the calendar year. The report includes information about effective practices, areas of vulnerability and areas of regulatory non-compliance. The MIG publishes this report annually as part its statutory obligation to provide effective support and assistance to the States.

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7000 – BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has developed the SPIA to annually collect standardized, national data on State Medicaid program integrity activities for the purposes of program evaluation and technical assistance support.

7005 – PURPOSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS will use the data from the SPIA to develop descriptive reports for each State, identify areas to provide States with technical support and assistance, and assess State performance over time. Further, States can use the data from SPIA to assist with process improvement activities and explore what other States are doing within their program integrity activities.

7010 – DATA COLLECTION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The SPIA data are collected via an online data collection instrument, which includes questions on State Medicaid integrity program characteristics, planning, prevention, detection, investigation and recovery activities, and technical assistance needs.

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8000 – TYPES OF CONTRACTORS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Section 1936 of the Act requires CMS to enter into contracts to perform four key program integrity activities:

1. Review provider actions;
2. Audit claims;
3. Identify overpayments; and
4. Educate providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

CMS has awarded umbrella contracts to several contractors to perform the functions outlined above. These contractors are known as the Medicaid Integrity Contractors (MICs). There are three types of MICs: Review MICs, Audit MICs, and Education MICs.

8005 – REVIEW MICS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Review MICs are responsible for performing the following functions:

- Conducting data mining analysis and performing risk assessment of Medicaid data including, but not limited to, claims for payment under a State plan under Title XIX or any approved waiver of such plan; and
- Developing data mining tools to analyze the Medicaid data including, but not limited to, paid claims.

8010 – AUDIT MICS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Audit MICs take the results of the Review MIC's data mining efforts in order to perform the following functions:

- Identifying overpayments to individuals or entities receiving Federal funds by conducting both comprehensive and focused audits of individuals and entities, including but not limited to, Fee for Service (FFS) providers and MCOs, by reviewing the medical documentation and other supporting information for paid Medicaid claims of items or services furnished under a State plan in accordance with Title XIX of the Act; and
- Identifying whether possible fraud, waste or abuse has occurred.

8015 – EDUCATION MICS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Education MICs educate providers of services, MCEs, Medicaid beneficiaries and others about Medicaid payment integrity and quality of care issues. Another goal of the Education MICs is to highlight the value of education in preventing fraud, waste, and abuse in the Medicaid program.

8020 – COORDINATION AMONG CONTRACTORS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MICs will work cooperatively with other entities, including, but not limited to other MIC Contractors, Medicare Integrity Program contractors and any other specialty contractors.

8025 – CONFLICTS OF INTEREST

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

8025.1 – PURPOSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

This subpart describes general policies related to personal, organizational and consultant conflicts of interest in the context of MIG contracting. This policy provides information and guidelines to help avoid a conflict of interest or the appearance of a conflict of interest during the acquisition and contracting processes and serves to remind contractors, contracting officers and other personnel (Project Officers, Government Task Leaders) of certain restrictions on conduct when interacting with vendors, contractors and potential contractors.

The CMS contracting officers and government contractors are expected to adhere to Federal Acquisition Regulations (FAR) (48 CFR §1 *et seq*. (2010)), related Federal laws and regulations, as well as policies established by the CMS and articulated in the Statements of Work and other contract related documents. (See https://www.acquisition.gov/far/ and http://www.gpoaccess.gov/cfr/.)

8025.2 – REQUIREMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The contractor should make every effort to conduct a self-review of possible conflicts of interest pre-award, and conduct ongoing post award reviews. The following examples of potential conflicts of interest related to the MIP must be identified during the contracting process and mitigated accordingly (this list is not all-inclusive):

- The contractor's key personnel include a stakeholder with conflicting financial or personal interests (e.g., the medical director has a financial interest in the audit target);
- The contractor's personnel and/or performance on concurrent contracts may suggest that decisions on the collection, analysis and interpretation of data may be compromised;
- The contractor or the MIG identifies an apparent organizational COI that, because of other activities or relationships with other persons or entities, the contractor is unable to render impartial and objective assistance or advice to the government;
- The contractor performed advisory, consulting, analytical, evaluation, study, or similar work in the project planning that may preclude participation in any capacity in government contractual efforts which stem directly from the planning efforts; and/or
- The contractor receives any fee, compensation, gift, payment of expenses, or any other thing of value from any entity that is reviewed, evaluated, or audited under the contract.

8025.3 – ACTION REQUIRED WHERE CONFLICT OF INTEREST IS IDENTIFIED

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

MIG personnel will work with the contracting officer to avoid, neutralize, and/or mitigate significant potential conflicts before the contract is awarded. (*See* FAR 9.504) Throughout the contracting process, and post-award, all parties should be cognizant of potential or actual conflicts of interest, as renewals and follow-ons can be affected. The contracting officer may direct the contractor to mitigate the adverse effects in accordance with Federal law and regulations, and the terms of the contract. Additionally, where mitigation is not appropriate or applicable, MICs will work with the contracting officer to support other action prior to award selection, as well as post-award. This may include non-selection of a contractor; modification or termination of the contract; recusal of parties subject to the conflict, the continuation of a contract based on cost benefit analysis, and other appropriate resolution responses.

Contractors are required to notify the CMS if a potential or actual conflict of interest exists at any time while performing the requirements of the contracts. If a conflict of interest exists, the contractor must identify the actual or potential conflict and submit a mitigation plan, if the issue can in fact be mitigated. The contractor and/or the CMS will analyze the issue, and determine the appropriate course of action. Each individual contracting situation should be examined based on its particular facts and the nature of the proposed contract.

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9000 – IDENTIFYING POTENTIAL AUDIT SUBJECTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The DFRD identifies potential payment errors and trends related to fraud, waste, and abuse. This is accomplished by analyzing Medicaid claims data for potential overpayments, reviewing and identifying fraud, waste, and abuse trends, and conducting studies to support MIG activities and State Medicaid integrity programs. Identifying potential fraud, waste, and abuse related overpayments is accomplished in two phases (concept and algorithm development) and includes four steps:

1. A MIG staff person or the Review MIC proposes new algorithm concepts to DFRD for approval.
2. Subject Matter Experts (SMEs) within the DFRD review the concepts and either accept or reject the new algorithm concept.
3. Accepted algorithm concepts are then prioritized.
4. The DFRD authorizes the development and/or analysis of the algorithms by the Review MIC.

New algorithm concepts to identify potential fraud, waste, and abuse overpayments are initiated based on factors including, but not limited to: referrals from authoritative sources (Review MICs, Audit MICs, OIG, DOJ, States, etc.), specific State collaborations (high visibility collaborations or analysis based on known or perceived hot zones), CMS Medicare-Medicaid dual eligible crossover issues, previous experiences, and other environmental and mass media news sources.

Approval of new algorithm concepts are prioritized based on criteria including: return on investment potential, complexity, individual State policies, legal defensibility, data availability, and data analysis limitations.

Once an algorithm concept is identified and approved it is developed by the Review MIC. Once the algorithm is developed and it is accepted by the DFRD, it is available for assignment to the Audit MIC. The Audit MIC then reviews State policy and audits claims data to identify potential overpayments.

9005 – ALGORITHM DEVELOPMENT, ACCEPTANCE, & DATA ANALYSIS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

New algorithm development is dependent on the availability of quality data specific to the approved concepts process described above. During the validation process of the proposed algorithm, the DFRD determines whether each concept overlaps or complements any existing analysis, the level of effort needed and potential return on investment for the development of the algorithm, and the relevance to the Medicaid program on a national level.

Once a concept is finalized, the Review MIC develops the algorithm for the approved concept that will identify potential fraud, waste, and abuse payments. During development of the algorithm, the Review MIC runs it against the MSIS data in the Information Technology

Infrastructure and the findings from the algorithm are reviewed by policy, clinical and technical subject matter experts from the DAA, the DFRD and the Review MIC. Claims information and other related data are analyzed to identify potential errors or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or in the aggregate. The algorithm development and refinement process is an integrated, ongoing component of fraud, waste, and abuse detection and research and can be modified and rerun in a timely manner. Results are used to identify potential targets for audit.

Analysis of the data includes:

- Reviewing the data and conducting data investigation to run frequency distributions on certain variables and run validity checks on clinical codes;
- Looking at trends by quarter and annual intervals for each claim type to establish baseline and identifying areas of potential errors;
- Looking for adjustment indicators and missing values to ensure the variables needed for the algorithm are well populated;
- Conducting a data quality evaluation and making recommendations based on experience with the MSIS data;
- Having technical and clinical reviews of both algorithm specifications and output. Assisting in defining appropriate leads, removing false positives, and providing short, effective lead lists; and
- Establishing by claim and by provider minimum thresholds and recommend leads that are pursuable under relevant State Medicaid laws.

The Review MICs get assignments on algorithms from the DFRD on a monthly basis. They are tasked with developing new algorithms and data models that can be used to identify abnormalities and individual or group indicators that describe statistically significant outliers or aberrant trends. Examples of indicators or variables are:

- Standard deviation from the mean;
- Percent above the mean or median; and/or
- Percent increase in billing activity, payment charges and number of visits/services from one period to another.

9005.1 – PERSONNEL

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The DFRD and the Review MICs include staff with clinical expertise (e.g., registered nurses, clinical pharmacists) and a mix of technical and statistical skills in programming (SAS, SQL, and Oracle), data mining, statistics and Medicaid subject matter experts. The DFRD and the Review MICs are responsible for the development of algorithms/models and are responsible for identifying potential audit targets for Audit MIC through their analytical work. They make use of available data and apply innovative analytical methodologies critical to the success of Medicaid Integrity Programs.

The DFRD and the Review MICs have staff with appropriate training, expertise and skills to conduct systematic analyses and clinical evaluation of claims data for the development of algorithms for the new concepts. The DFRD and the Review MIC analysts use research and

experience in the field to develop approaches and techniques useful in the data analysis of the algorithm. In addition, staff continually maintains communication with State Medicaid agencies concerning policies and data issues relevant to their data analysis activities.

The DFRD and the Review MICs are expected to provide State specific knowledge and apply State policy to algorithm and model development.

To date, the DFRD and the Review MICs have developed 105 algorithms covering service areas that include dental, durable medical equipment, inpatient hospital, lab and X-ray, nursing facilities, outpatient hospital, physician, prescribed drugs, and psychiatric services.

9010 – SAMPLING AND EXTRAPOLATION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG examined the feasibility of implementing a Sampling and Extrapolation strategy for the Medicaid provider audit program managed by the MIG. The MIG contracts with Audit MICs to perform audits of paid claims that have been identified by algorithms as potential fraud, waste, and abuse overpayments. The main goal is to establish a gold standard MIG sampling plan that can be used by all the Audit MICs so that there is no ambiguity in contractors' understanding their role and responsibility in conducting the sampling, extrapolation and audits. The MIG used sampling and extrapolation during test audits; however it is not currently being used in audits conducted as part of the National Audit Program. The MIG plans to systematically pursue greater use of extrapolation in the future as the data is refined.

9015 – SOURCES OF DATA – THE INFORMATION TECHNOLOGY INFRASTRUCTURE, MMIS, MSIS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

9015.1 – THE INFORMATION TECHNOLOGY INFRASTRUCTURE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has developed a scalable suite of data hosting, mining, and analysis services called the Information Technology Infrastructure. This infrastructure provides a high performance, clustered database system with terabyte-scale capacity and data mining software, hosted at the University of California San Diego (UCSD) campus. The database and support software operates on a scalable cluster of high memory servers that connect to an open architecture storage area network environment providing high bandwidth connectivity to expandable storage capacity. The system is configured to support data analysis and mining algorithms that allow the MIG to perform Medicaid fraud, waste, and abuse overpayment prevention and detection.

The Information Technology Infrastructure consists of a variety of Commercial Off-the-Shelf (COTS) software and hardware. From a user's standpoint, there are three major software tools:

1. **Statistical Analysis Software (SAS)**

SAS is a statistical analysis application. SAS provides a user interface through which MIG users and Review MICs can analyze the Medicaid data using established CMS algorithms, generate end user statistical reports, and conduct basic data mining.

SAS is used for routine analysis and reporting. SAS Analytics provides a wide range of statistical analysis tools from traditional analysis of variance to exact methods and dynamic visualization.

SAS provides users with the ability to select the range of data on which they would like to perform analysis. Additionally, users may choose the type of analysis they would like to perform. Users can customize the information and format that is returned to them and designate if they would like to save the information as a report.

2. **Oracle Data Miner (ODM)**
   ODM is an advanced data mining application for identifying data anomalies and trends. MIG users and Review MICs will use ODM to generate end user reports to help identify suspected fraud, waste, and abuse. Through ODM's user interface, users can select the range of data on which they would like to perform analysis and choose the type of analysis they would like to perform. ODM allows users to manipulate the data analysis and searches, and compile and save reports on the Information Technology Infrastructure.

   ODM is used for mining larger data sets, increasing the performance of complex analysis tasks, or running data mining algorithms outside the scope of SAS.

   ODM algorithms that support solutions for classification problems include Decision Trees, Naïve Bayes, Generalized Linear Models (GLM) and Support Vector Machines (SVM). Regression problems can be solved using GLM or SVM. Text mining, feature extraction and anomaly detection utilize SVM and attribute importance uses Minimum Description Length (MDL). Associations employ Apriori and feature extraction uses non-negative Matrix Factorization (NMF), while clustering has several methods available, including hierarchical K and O-means.

3. **Oracle Business Intelligence Enterprise Edition (OBIEE)**
   The Oracle Business Intelligence (BI) suite of applications provides a comprehensive collection of BI products, delivering the full range of BI capabilities including interactive dashboards, full ad hoc querying and reporting, proactive intelligence and alerts, precise reporting, real time predictive intelligence, disconnected analytics, and more. The Oracle Business Intelligence Suite is based on a proven, modern Web Services Oriented Architecture that delivers true next generation BI capabilities. As resources are available, Information Technology Infrastructure Team members will scope, develop, and utilize the Oracle BI suite to allow for enhanced web based access to BI tools and reporting capabilities.

9020 – Sources of Data

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The following is a list of data sources available on the Information Technology Infrastructure.

9020.1 – Medicaid Statistical Information System (MSIS)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MSIS was developed in 1999 to provide the CMS with a detailed national database of program information capable of supporting a broad range of analytic and user needs. Using MSIS requirements, States supply the CMS with eligibility and paid claims information extracted from their Medicaid Management Information Systems (MMIS). The MIG Information Technology Infrastructure relies heavily on Medicaid data to conduct program integrity activities required by section 1936 of the Act. The CMS requires that States extract certain sets of raw Medicaid eligibility and claims data from their MMIS and submit them in a standardized format to the MSIS. The States submit five types of data to CMS on a quarterly basis:

- Eligibility actions;
- Inpatient hospital claims;
- Long term care claims;
- Prescription drug claims; and
- All other outpatient claims.

9020.2 – Social Security Administration (SSA) Death Master File

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Death Master File provided by SSA contains the death records for all individuals who registered with the SSA.

9020.3 – National Plan and Provider Enumeration System (NPPES)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

National Provider Identifier (NPI)

HIPAA mandates the adoption of national, standard unique identifiers for health care providers and health plans. As a result, the CMS developed NPPES to assign unique NPIs for all registered providers and health plans.

9020.4 – Third Party Files

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

A. Drugs Files

The National Drug Data files provide prices, descriptions, and collateral clinical information on drugs approved by the US Food and Drug Administration (FDA), plus commonly used over the counter drugs.

B. National Correct Coding Initiative (NCCI)

The NCCI was developed by the CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for reasons explained in the Coding Policy Manual.

C. The Current Procedural Terminology (CPT)

The CPT code set includes the codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers and are maintained by the American Medical Association.

D. Healthcare Common Procedure Coding System (HCPCS)

The HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies.

E. Diagnosis Related Group (DRG)

The DRG is a system used to classify hospital cases into one of approximately 500 groups expected to have similar hospital resource use. Developed for Medicare as part of the prospective payment system, DRGs are assigned based on ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.

F. International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)

The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.

The CMS is working with the States to implement the conversion from ICD-9 to ICD-10 codes to ensure all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013 utilizes ICD-10 codes. Information and guidance regarding the conversion is available on the CMS website. In addition, informational bulletins, as well as other communication resources are being shared with the States to help facilitate and support the ICD-10 implementation.

9025 – SECURITY

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

9025.1 – SYSTEM SECURITY

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG works with a variety of information using a variety of system tools. The security level required for each operational task is determined by the type of information to be protected as categorized in Federal Information Processing Standard (FIPS) Publication 199. Security is integrated into business processes using an integrated Life Cycle approach based on the National Institute of Standards and Technology (NIST) 800 series government publications which contain government recommended procedures and criteria for assessing and mitigating threats. The CMS has created their own CMS integrated IT Investment and System Life Cycle Framework for Security (CMS ILC) adapting the NIST 800 series of publications to the unique CMS environment. The CMS ILC includes specific roles and responsibilities for personnel, reviews (4 Governance Reviews and 12 Projects Reviews), and documents (e.g., System Security Plan, Information Security Risk Assessment, Test Plan, Contingency Plan). For each identified security risk, a mitigating control must be implemented or in special cases, low risks may be accepted.

The MIG handles information about persons (in the form of claims data), financial, budgetary, commercial proprietary information (provider information), internal administration (MIG operations), and other Federal Agency information (e.g., Social Security, law enforcement), all of which is categorized at the moderate security level in FIPS-99. Using the CMS ILC, the MIG has implemented a variety of mitigating controls to protect the data used in MIG operations and we are continuously reassessing security threats including mandated tri-annual security reviews. Examples of some of the mitigating security controls the MIG uses to protect data include 2-factor login authentication, cryptography, isolated network connectivity, firewalls, virus and intrusion detection, system software patching, and staff training.

9025.2 – PHYSICAL & OPERATIONAL SECURITY REQUIREMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

To ensure a high level of security for the MICs, the MICs must develop, implement, operate, and maintain security policies and procedures that meet and conform to the requirements of the Business Partners Security Manual (BPSSM) and the Core Security Requirements (CSR) and its operational appendices (A, B, C, and D). The BPSSM is located at: **http://www.cms.hhs.gov/manuals/downloads/117_systems_security.pdf and the CSR is at http://www.cms.hhs.gov/it/security.** Further, the MICs must adequately inform and train all their employees to follow all security policies and procedures so the information the MICs obtain is confidential.

The MICs collect and use individually identifiable information on behalf of the MIG to routinely perform the business functions necessary for the administration of MIP activities. Any data the collected by the MICs, including sensitive information obtained as a part of the administration of their contracts is the property of the MIG. Consequently, any disclosure of individually identifiable information by the MIC without prior consent from the individual to whom the information pertains, or without statutory or contract authority, requires prior approval from the MIG.

9030 – POLICY, CLINICAL, AND TECHNICAL QUALITY ASSURANCE PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Quality assurance is an integrated, ongoing component of MIG and Review MIC activities. With the DFRD as the lead, quality assurance is performed by the DFRD and the DAA for general surveillance and review of reports submitted by Review MICs and is a tool for identifying potential abnormalities or anticipating potential problems in audits. The quality assurance process analyzes claim information and other related data to verify potential errors in an algorithm or with its results.

During the development of the algorithm, a sample is sent to the State for validation. If the State finds issues in the sample, the Review MIC contacts the DFRD for guidance. The DFRD reviews the concerns and makes recommendations so a valid algorithm and an accurate Algorithm Findings Report (AFR) will be produced. The quality assurance process includes in-depth policy, clinical, and technical analysis used to confirm the findings contained in the AFR. The policy review looks at all Federal and State factors that may affect algorithm findings, while the clinical review analyzes the logic utilized to identify the medical diagnosis, treatment, services contained in the AFR. The technical review validates the programs in the header section, reviews the logic in the SAS code, and validates the Review MIC programming requirements.

Policy review of the AFR considers:

- State specific payment and coverage policies;
- State waivers, where applicable;
- State laws;
- Federal laws;
- Medical Coding or Classification policies; and
- State sample report validation or invalidation.

Clinical review of the AFR considers:

- Language;
- Medical coding and classification guidelines relating to the diagnoses and procedures within algorithms and or models under review;
- State specific payment policies and guidelines;
- Federal policies;
- Clarity;
- References;
- Citations;

- Congruency of the concept with State policy and regulations;
- Limitations and exceptions;
- Data anomalies; and
- Those recommendations are correlated with findings.

Technical review of the AFR consists of:

- Confirmation of the appropriate use of data based on concept description;
- Confirmation that the data is clinically based on concept description;
- Confirmation the output is consistent with defined policy in the concept description;
- Confirmation that the validity of the result findings coincides with what is written in the limitations, exclusions, and recommendation descriptions; and
- Confirmation of the accuracy of key fields in relation to the concept description such as:
    - National Drug Codes (NDC);
    - Current Procedural Terminology (CPT) codes;
    - Health Care Common Procedural Coding Systems (HCPCS) Codes;
    - Current Dental Procedures (CDT) Codes;
    - ICD-9-CM diagnoses and procedure codes;
    - Adjudication dates;
    - Medicaid Paid Amounts;
    - Adjustment codes; and
    - Algorithm review under review dates

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 10 – MEDICAID INTEGRITY AUDITS

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10000 – BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Audit Medicaid Integrity Contractors (Audit MICs) are private companies that conduct audit-related activities under contract with the CMS MIG. Audit MICs conduct post- payment audits of all types of Medicaid providers and, where appropriate, identify overpayments.

10005 – BASIS OF AUTHORITY - STATUTORY/REGULATORY CITATION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Section 1936 of the Act, established by the Deficit Reduction Act of 2005, is the statutory authority under which the Audit MICs operate. Section 1936(a) provides that the Secretary must enter into contracts to conduct certain activities specified at section 1936(b). Sections 1936(b)(2) and (3) provide that the CMS' contractors can audit claims for payment for items or services furnished under a State plan and can identify overpayments made to individuals or entities receiving federal funds under Medicaid. The CMS' Audit MICs perform these functions.

In addition, section 1936(b)(1) provides that the CMS' contractors can review the actions of individuals or entities furnishing items or services for which payment may be made under a State plan to determine whether fraud, waste, or abuse has occurred or is likely to occur. Although this function is, in large measure, the responsibility of the Review MIC, the Audit MICs share the ongoing responsibility to assess during the course of an audit whether audit findings suggest the possibility of fraud, waste, or abuse and, if so, to make an appropriate referral to law enforcement. The Review MIC conducts data mining analysis and algorithm development to identify potential provider overpayments in various program areas. The identified providers are vetted extensively with Federal and State law enforcement entities, the State Medicaid Agency, and Medicare to determine if they are already under review or investigation. Following the vetting process the Audit MICs are assigned the providers and provided the claims information from which to audit.

10010 – PURPOSE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The objectives of the MIC audits are to audit provider claims and identify overpayments by ensuring that claims are paid for items and services provided and properly documented; that items and services are billed using appropriate procedure codes; and the covered items and services are paid in accordance with Federal and State laws, regulations and policies.

10015 – AUDIT DEFINITIONS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Focused Desk Reviews –Focused desk reviews are conducted at the auditor's desk and are based primarily on the findings from rules-based algorithms and a review of medical records that the provider faxes, scans, or mails to the auditor. These rules- based algorithms generate

lists of like-problem claims, sorted by provider, with relevant transaction details. The focused desk review will center on the specific claims in dispute identified by the algorithm.

Focused Field Audits – Focused Field Audits are audits that are also based primarily from the findings from rules-based algorithms. These are similar to the focused desk reviews in that a single question may be at issue although there may be several questions at issue if the provider has been identified under several algorithms. Because of questions that arise with respect to the number or type of issues and the volume of claims, a field visit to a provider's premises is deemed by the MIG to be appropriate. This visit is made for a specific reason such as on-site documentation collection is required, or the actual service provision or business processes must be observed, or there is reason to believe that an accurate appraisal of the facts will only be gathered with a site visit.

Comprehensive Audits – Comprehensive audits are detailed investigations of all areas relevant to the proper payment of Medicaid funds to the provider being audited. In the conduct of these audits, the MIC receives initial direction from the MIG, but is also allowed to take the audit in any direction that suspect data leads them. Comprehensive audits will, under most circumstances, take place on a provider's premises where on-site documentation is required or actual services or business processes (e.g., hours of operation, site exists, products or services are available) or must be observed by the Audit MIC. These audits may also involve auditing a variety of complex suspect activities (e.g., medical necessity, review of all therapy-related services in an outpatient clinic). Comprehensive audits will also include auditing for Third Party Liability (TPL) and usual and customary charges.

10020 – FRAUD REFERRALS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Through the course of conducting an audit of a provider or institution, the Audit MIC may identify potential Medicare or Medicaid fraud. The Audit MIC is required to simultaneously and immediately make a fraud referral to the MIG and the OIG. The OIG is to notify and provide information to the appropriate MFCU within 14 days of receiving the referral. The OIG has 60 days to determine whether to accept the referral. The OIG will notify the MIG of any declination at that time or report quarterly thereafter on cases that it accepts. The Audit MICs are required to cooperate with all reasonable requests for assistance from the OIG and MFCU. Section 1936(c)(1)(B) of the Act and 42 CFR 455.230(b) requires cooperation with law enforcement. The Audit MIC Statement of Work requires all suspected fraud to be referred to the OIG.

The Audit MIC will continue with the audit and will not disclose to the provider at any time during the course of the audit that there is a suspicion of fraud or abuse or that a referral has been made. The Audit MIC will not report any audit results to anyone other than the MIG (i.e., will not report the draft findings to the provider or the State) without MIG and OIG approval.

10025 – AUDIT REVIEW PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

At the beginning of an audit, the Audit MIC sends the provider a notification letter. Most of the audits are desk audits, where the Audit MIC requests provider documentation and reviews the records at the Audit MIC's office. On some occasions, Audit MICs conduct field audits, in which the auditors actually conduct the audits at the provider's location. If concerns arise, a provider may send specific questions or concerns regarding an Audit MIC to **Medicaid_Integrity_Program@cms.hhs.gov.** All audits are being conducted according to Generally Accepted Government Auditing Standards (Yellow Book). If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report, which is shared with the State and the provider for comment. A State agency may send specific questions or concerns regarding an Audit MIC to their assigned CMS MIG Audit Liaison. Based on these comments, the audit report may be revised. The MIG makes the final decision on any revisions or changes. When the audit report with any associated overpayment is finalized, the MIG sends the final audit report to the State. The State pursues collection of the overpayment from the provider in accordance with the State's laws, regulations, and procedures.

10030 – LOOK BACK PERIOD

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Audit MIC is to comply with the following directions when preparing to engage the provider to be audited. The Audit MIC is to send the provider an engagement letter and a request for records. Effective October 1, 2010 the look back period when requesting records must be for 5 years from the start of the audit (date the engagement letter is sent to the provider). For example, if an audit begins in October 2010, the look back period for reviewing claims and request for records would go back to October 2005.

10035 – REQUEST FOR RECORDS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

When making the request for records, the Audit MIC must allow the provider 30 days to produce the records, with a permissible 15-day extension if requested by the provider.

10040 – DOCUMENTATION OF FINDINGS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

All audit findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the auditor during the course of the audit and should be part of the audit working paper file. The working paper file contains evidence accumulated throughout the audit to support the work performed, the results of the audit, including adjustments made and the judgment of the auditor.

Examples of documents are:

1. Copies of Federal and/or State policies and regulations;

2. Copies of medical/financial records to support the finding;
3. Copies of State generated Remittance Advices which support the claim payment or credit adjustment;
4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists;
5. Auditor's notes regarding the audit; and
6. Miscellaneous memoranda that pertain to the audit.

10045 – AUDIT RESOLUTION PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Draft audit reports (DARs) are sent to the State Medicaid Agency for a 30-day review and comment period. State comments are considered by the MIG and the Audit MIC and, as necessary, the DAR is revised to account for these comments. The revised DAR, or original DAR if the State review did not necessitate a revision, is then transmitted by the Audit MIC to the provider for a 30-day review and comment period. The MIG and the Audit MIC review provider responses, if any, to determine if further revision is necessary to the DAR, after which the Revised Draft Audit Report (RDAR) is again sent to the State, this time with a 15-day review and comment window. The MIG, the Audit MIC, and, if necessary, the State reconcile any issues with the RDAR, after which the Audit MIC produces a Final Audit Report (FAR). The MIG, upon approving the FAR, sends the FAR to the State. The FAR identifies the total overpayment amount paid to the provider and specifies the amount of FFP that the State must return. It is the State's responsibility to adjudicate the audit findings with the provider. The State has 1 year from the date the overpayment is identified to recover or attempt to recover the overpayment from the provider before the Federal share must be refunded to CMS. Under CMS' regulations, the discovery date for overpayments begins on the date of the final written notice of the State's overpayment determination to the provider. (42 CFR § 433.316).

10050 – STATE COORDINATION & JOINT OPERATING AGREEMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Before providing an Audit MIC with an audit assignment, the MIG vets the providers identified for audit with partners and stakeholders in the State. This includes State Medicaid agencies, State and Federal law enforcement agencies and Medicare contractors. These entities are provided a list of potential audits generated by the data analysis mentioned above. If any of the audit partners and/or stakeholders within the State is conducting an audit or investigation of the same provider for similar Medicaid issues, the MIG may cancel or postpone the Audit MIC audit of the provider. In this way, the MIG avoids duplicating the efforts of other Medicaid audits.

Further, each Audit MIC is to establish a Joint Operating Agreement (JOA) with each State Medicaid Agency within their Task Order. The JOA is to help States understand how the Audit MIC will carry out its responsibilities as auditors of Medicaid providers as well as what the State's role is in assisting the Audit MIC. The JOA covers such areas as communication, dispute resolution, audit planning, audit report process, avoiding conflict of interest, fraud referrals and data issues.

10055 – STATE APPEAL PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS does not dictate the process by which MIP audit findings are appealed. Rather, appeal processes are determined by each State and are subject to the State's Medicaid program requirements. State Medicaid Agencies must defend MIP audit findings in administrative appeal or judicial proceedings as if they are their own, although the Audit MIC may provide testimonial support and other assistance to the State to defend audit findings throughout administrative or judicial proceedings. States that wish to challenge the findings of a FAR can do so by filing an appeal through the HHS Departmental Appeals Board Appellate Division.

10060 – CLOSE OUT LETTERS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Upon completion of an audit, the Audit MIC will issue either an audit report or a close out letter. The close out letter provides notification to the provider that the audit has been stopped for reasons other than identification of overpayments. The Audit MIC is responsible for obtaining MIG clearance prior to issuing a close out letter. Upon approval, the Audit MIC sends the close out letter to the provider in question, and sends copies to the State and the MIG.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 11 – STATE REPORTING OF OVERPAYMENTS – FORM CMS 64

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CHAPTER 11 – STATE REPORTING OF OVERPAYMENTS - FORM CMS 64

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11000 – INTRODUCTION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The **Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program** (Form CMS 64) is a quarterly statement of actual program costs and administrative expenditures for which States are entitled to Federal reimbursement under the authority of Title XIX of the Act. Administrative expenses associated with the State's program integrity activities are reported specifically on Line 20, From CMS 64.10 (Expenditures for State and Local Administration for the Medical Assistance Program). Form CMS 64 is also the vehicle for adjustments made to correct overpayments and underpayments.

Spending reported on Form CMS 64 is a tabulation of actual, documented Medicaid expenditures, drawn from source documents such as invoices, cost reports and eligibility records. If a State is unable to document a claim for expenditures made in the current quarter, the claim must be withheld until it can be supported. The State then reports the amount on a future Form CMS 64 as a prior period adjustment. Spending therefore reflects all expenditures made during the quarter, not all services used.

The sections of the Form CMS 64 applicable to the MIP are described in more detail, below.

11005 – GENERAL

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Fraud, Waste and Abuse Improper Payments

This is the amount paid by a Medicaid Agency to a provider which is in excess of the amount allowed for benefit services described under the approved State plan for medical assistance and is due to fraud, waste or abuse.

Note: Overpayments arising from the Federal matching for **administration** are not considered under section 9. In addition, overpayments and collections resulting from probate and third party liabilities are not considered under Section 9.

Reporting the Identification and Collection of Fraud, Waste and Abuse Improper Payments

Both the identification and the collection of fraud, waste and abuse improper payments must be reported on the **Summary Sheet (Form CMS 64 Summary)** and the Line 9.C.1 feeder form (Form CMS 64.9C1) and Form CMS 64.9O that feeds into Line 10c. In addition, an overpayment can be reported as identified but not yet collected. Line 9.C.1 is for collections and line 10.C is for amounts identified but not yet collected.

Under section 1903(d)(2) of the Act (as amended by section 6506 of the Affordable Care Act), States have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud the adjustment to refund the Federal share must be made no later than the deadline for filing the Form CMS 64 for the quarter in which the one-year period ends, regardless of whether the State

recovers the overpayment. Previously, States were allowed up to 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share.

In addition, Section 6506(a)(1)(B) of the Affordable Care Act added new language to section 1903(d)(2) the Act pertaining to overpayments made resulting from fraud. Specifically, when a State has been unable to recover overpayments resulting from fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share. Previously, the Act did not distinguish between overpayments due to fraud and other overpayments, although Federal regulations at 42 CFR section 433.316 provide that the date of discovery of an overpayment resulting from fraud or abuse is determined differently than for other types of overpayments. The terms "fraud" and "overpayment" are defined at 42 CFR sections 433.304 and 455.2. (See also – Chapter 1, Section 1035 – Overpayment and Errors Versus Fraud, Waste and Abuse)

Reporting and Returning Medicaid Overpayments Not Due to Fraud and Abuse

The State Medicaid Agency must refund the Federal share of overpayments at the end of the one-year period following discovery of the overpayment, whether or not the State has recovered the overpayment from the provider. Federal regulations at 42 CFR section 433.316(c) describe when an overpayment not due to fraud or abuse is discovered. The Federal share of the overpayment collection is to be reported on the Form CMS 64 in the first quarter following the providers report and return of the overpayment. The State has one year to continue collection efforts following the report before the balance of the reported overpayment must be reported as an identified but not collected overpayment on Line 10.C of the Form CMS 64.

11010 – SOURCES OF OVERPAYMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Detection of improper payments resulting from fraud, waste and abuse is done through various Medicaid program integrity efforts. Examples include:

- Analysis and data mining;
- Referrals from a State Agency;
- RACs;
- Provider self-reporting of overpayments;
- MICs;
- Provider audits; and
- Other.

11015 – OVERPAYMENT TRANSACTION CODES (RESERVED FOR FUTURE USE)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Codes are used to identify the characteristics of the overpayments. The CMS uses the information for monitoring, policy development and reporting on program integrity activities.

Transaction Codes to identify types of Providers

01 – hospital;
02 – hha;
03 – pharmacy; and
04 – ambulance

Transaction Codes to Identify Causes of Overpayments

01 – duplicate claim payment error by fiscal agent;
02 – duplicate claim payment error by provider;
03 – rate adjustment; and
04 – coding/billing error by provider

Note: For overpayments identified by the MIC and recovered by the State the CMS will add additional transaction codes to capture the NPI and the MIC report number.

11020 – Interest Received on Medicaid Fraud, Waste and Abuse Recoveries

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Interest collected on an overpayment should be reported on line 3A of the Form CMS 64 summary sheet.

11025 – State Reporting of Underpayments Identified by RACs

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Underpayments identified by State program integrity RACs are to be identified and reported separately.

11030 – Overpayments Identified by the State but Not Collected in One Year from Identification

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

This form is used to provide detail about overpayments that have been identified but which have not yet been collected and the time period for collection has passed.

11035 – Feeder Form CMS 64.9C1 (Collected) that Flows to CMS 64 Line 9C and Feeder Form CMS 64.9O that Flows to the CMS 64 Line 10C (Not Yet Collected)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Form CMS 64.9C1 feeder form is used to provide detail about the fraud, waste and abuse collection efforts and flows into line 9c of the Form CMS 64. The Form CMS 64.9O feeder form that flows into line 10c of the Form CMS 64 is used to provide detail about overpayments that have been identified **but not yet collected**. The data reported on the feeder forms flow

directly to the Form CMS 64 Summary sheet. States should enter the data following the guidance outlined below.

CMS-Feeder Form 64.9c1

Line 1- Amounts identified and collected from State PI activities

Identifies the total overpayments collected from both line 1A and 1B whose source was a State Program Integrity initiative, protocol, program, or audit.

Line 1A-Data mining activities

Used to report overpayment amounts collected as a result of activities that used automated processes/technologies to sift through databases. Data mining uncovers trends, patterns, predictors, and correlations that identified overpayments that resulted in a notice of overpayment or caused formal recoupment action to begin. The data mining may/may not have included a provider audit but did result in an identified overpayment and a reportable collection. This also includes data mining activities conducted by the State's Surveillance Utilization Review Subsystem (SURS) unit or other staff.

Line 1B- Program Integrity (PI) Provider Audits

Used to report overpayments collected from State onsite or desk audit investigations (not Federal MIC audits) for both institutional and non-institutional providers involving potential fraud, waste or abuse (e.g., services not rendered, services not medically necessary, potential duplicates, services paid from wrong fee schedule, and upcoding, etc.) Generally, the review involves looking at source documentation and is not solely reliant on data mining detection. As noted above data mining overpayments and collections are reported on line 1A.

Example 1: Joe Collect's Ambulance was investigated by the State and a notice of a $10,000 overpayment was sent to the provider on April 1, 2010. The provider requested and received an approval to repay the overpayment in installments over a 12 month repayment schedule. The provider continues to make monthly payments and those payments collected (not the full amount of the overpayment) during that quarter are to be reported on line 1B of the 9c1 feeder form for that quarter. However, on April 1, 2011 a $1000 unpaid balance remains. That balance needs to be reported on line 1 (overpayments not collected) of the Form CMS 64.9O which flows into line 10c (Overpayment Adjustments) on the Form CMS 64 Summary.

Example 2: Joe Collect's Ambulance appeals the $10,000 overpayment in Example 1 on May 1, 2010. On July 1, the appeal finds that the overpayment is reduced to $7,000. Assuming that Federal share amounts were properly returned previously, the State enters a $3,000 decreasing adjustment on line 2 of the Form CMS 64.9O which flows into line 10c on the Form CMS 64 Summary.

Line 1C- Other

Line 1C captures overpayments that cannot be entered on any other line 1 activity or any other line on the 64.9c1 feeder form. Line 1C should be used only when the other lines do not apply and the work effort is derived from State PI activities.

Line 2-MFCU Investigations

Used to report overpayment amounts collected from investigations conducted by the State's MFCU.

Line 3- Overpayments Collected from Settlements or Judgments

Used to report overpayments collected from settlements and/or judgments against a Medicaid provider for violations of Medicaid laws, rules, regulations or policies.
A settlement occurs when there is a negotiated agreement of the overpayment amount between the State and the provider. Either full or partial collections may be made here. However, the balance of the overpayment that is not collected one year from the date of the discovery must be reported on line 1 (overpayments not collected) of the Form CMS 64.9O which flows into line 10c (Overpayment Adjustments) on the Form CMS 64 Summary in the quarter in which the one year ends (per SMD letter #10-014 issued July 2010).

Example: On August 1, 2010, the State and a provider agree on the amount of an overpayment after a protracted discussion and negotiation. The provider begins repayment of the overpayment on August 15, 2010 and every month thereafter on the 15th of the month. For the 3rd quarter Form CMS 64 reporting, the State would report collections for two months, August and September, and for every quarter thereafter that collections are received on line 3 of the 9c feeder form. However, at the end of one year a balance of $5,000 remains. The State must report the $5,000 balance on line 1 (overpayments not collected) of the Form CMS 64.9O which flows into line 10c (Overpayment Adjustments) on the Form CMS 64 Summary for the quarter in which the one year ends.

Line 4- Civil Monetary Penalties

Used to report overpayment amounts identified from penalties, fines, or other sanctions against a Medicaid provider for conduct that violates Federal and/or State statutes and regulations governing the Medicaid program.

Collections may be made by the Federal government as part of Civil Monetary Penalty (CMP) actions. Where a CMP action is taken, and the provider returns an overpayment to the Federal government, the State share is returned by a U.S. Treasury check. In these instances, return of the overpayment is recognized by reporting a Line 9.C adjustment. Since the Federal government obtains the Federal share of the overpayment, the CMS does not recognize the decreasing adjustment for Federal funding purposes.

Collections may be made by the State or local entity as part of CMP actions. Where a CMP action is taken and the State collects the Federal and State share, the return of the overpayment is recognized by reporting a Line 9.C adjustment. Also include is a footnote identifying the CMP collection, the total computable amount and the Federal share. Since the Federal government has not obtained the Federal share of the overpayment, the CMS includes the adjustment in the grant award computation.

Line 5 – CMS Medicaid Integrity Contractors

Used to report overpayment amounts identified from the Federal contractors (e.g., MIC audits) procured to review Medicaid providers, conduct audits of claims, and identify overpayments per section 1936 of Act.

Line 6 – Other PI Activities

Overpayment amounts identified from other PI activities not specified in lines 1-5.

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12000 – MEDICAID INTEGRITY INSTITUTE (MII)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

12000.1 – BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

In September 2007, the MIG established the MII, the first national Medicaid program integrity training program. The MII was created through a partnership with the DOJ Office of Legal Education. The MII provides a unique opportunity for the CMS to offer substantive training, technical assistance, and support to the States in a structured learning environment.

12000.2 – MISSION

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The mission of the MII is to provide effective training tailored to meet the ongoing needs of State Medicaid program integrity employees, with the goal of raising national program integrity performance standards and professionalism. By embracing and utilizing sound learning methodology and instructional design, coupled with progressive technology, the MII training staff endeavors to provide outstanding professional education.

12000.3 – OPERATING STATEMENT

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MII focuses on developing a comprehensive program of study addressing aspects of Medicaid program integrity including fraud investigation, data mining and analysis, and case development. Instructors at the MII include State Medicaid program administrators and subject matter experts, Federal and State law enforcement officers, private consultants and academia. Training at the MII is provided at no cost to the States. The training needs of State employees from the Medicaid program integrity units will be primarily addressed; however, employees from other Medicaid components may also be able to participate depending on the course objectives. At this time, only State employees are eligible to attend MII training programs. The MII intends to obtain certifications and accreditation for its programs.

12000.4 – MII WEBSITE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

www.justice.gov/usao/eousa/ole/mii

12005 – Technical Assistance to States

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

12005.1 – TECHNICAL ASSISTANCE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Since the inception of the MIG, staff has received requests for technical assistance from CMS ROs, the States, and from other internal and external stakeholders. The MIG tracks the requests and ensure that the requests are directed to the proper entity for response. A "request for technical assistance" (TA) is any communication requesting an opinion or official response, regardless of the format (e.g., telephone, letter, facsimile, or email), regarding the detection and prevention of Medicaid fraud, waste, or abuse. The MIG may receive requests for TA from sources within and outside of the CMS. These sources include, but are not limited to:

12005.2 – REQUEST FOR CMS TECHNICAL ASSISTANCE

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

- MIG Staff;
- CMS Administration;
- Other CMS Staff;
- MIG contractors; and
- CMS contractors.
- Federal Agency staff;
- Federal Elected Officials;
- State or local Elected Officials;
- State Medicaid Agency staff;
- State Program Integrity directors;
- Other State Agency staff, for example, from agencies that administer public; health or professional licensing programs;
- Law enforcement;
- Media;
- Recipients of Medicaid services; and
- General Public.

12010 – FRAUD REFERRALS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG staff sometimes receives complaints of alleged provider and recipient fraud, waste and abuse. Because the MIG is not a law enforcement entity, the MIG must have a procedure for referral of complaints to the proper law enforcement entity at the State or Federal level. A "complaint" is a communication, regardless of the format (e.g., telephone, letter, facsimile, email, or electronically via *RightNow*), regarding suspected Medicaid fraud, waste, or abuse.

Matters within MIG authority include suspected fraud, waste, or abuse alleged to have been committed by a Medicaid enrolled provider, Medicaid managed care organization, or waiver program contractor, or their employees, agents or subcontractors. Matters outside MIG authority include suspected fraud, waste, or abuse alleged to have been committed by a Medicaid recipient and patient abuse and neglect. Other communications to CMS regarding provider or recipient behavior may appear to be complaints as defined here, but do not allege

fraud, waste, or abuse, and so are not within the MIG's authority. These types of complaints will be forwarded to the appropriate State Agency.

12010.1 – Fraud Referrals Sources

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

- MIG staff;
- CMS Administration;
- Other CMS staff;
- MIG contractors; and
- CMS contractors.
- Federal Agency staff;
- Federal Elected Officials;
- State or local Elected Officials;
- State Medicaid Agency staff;
- Other State Agency staff, for example, from agencies that administer public; health or professional licensing programs;
- Law enforcement;
- Media;
- Beneficiaries of Medicaid services;
- General Public; and
- OIG Hotline.

12015 – State Training outside of the MII

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

In an effort to support the MIG goal to provide support and assistance to States in order to enhance program integrity efforts, the MIG has established conferences that increase best practices, knowledge, and understanding of medical coding issues as practiced by the American Academy of Professional Coders (AAPC). Specifically, these conferences address the areas as it relates to Certified Professional Coder (CPC)/Current Procedure Terminology (CPT), medical record auditing, evaluation and management, outpatient, inpatient and DRG services, and interviewing techniques.

12020 – Education MICs

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The MIG has contracted with an education contractor which is working with a wide variety of stakeholders to enhance awareness of Medicaid fraud, waste and abuse among providers, clients, managed care organizations and others. The contractor has undertaken a gap analysis to identify areas where increased information about fraud, waste, abuse and payment integrity issues is lacking. Working with the MIG, it has identified 14 priority areas to be addressed with new outreach and training materials. In developing materials on the priority areas, the contractor will draw on the expertise of stakeholders from State Medicaid agencies, law enforcement agencies, provider and advocacy organizations and other relevant groups.

Questions about the work of the Education contractor may be directed to:
medicaidprovidereducation@cms.hhs.gov.

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CHAPTER 14 – RECOVERY AUDIT CONTRACTORS (RACS) IN MEDICAID

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CHAPTER 15 – POINTS OF CONTACTS

Medicaid Integrity Group
7500 Security Blvd./Mailstop AR-18-50
Baltimore, MD 21244

Medicaid Integrity Group Director's Office

Division of Medicaid Integrity Contracting

Division of Fraud Research & Detection

Division of Audits & Accountability

Division of Field Operations
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601

For additional information visit:
www.cms.hhs.gov/medicaidintegrityprogram
E-mail: **Medicaid_Integrity_Program@cms.hhs.gov**

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CHAPTER 16 – USEFUL WEBSITES & SOCIAL MEDIA

The following list of websites is offered as useful to our stakeholders.

Affordable Care Act
http://www.healthcare.gov/law/introduction/index.html

APHSA – American Public Human Services Association
www.aphsa.org

ARRA
http://www.recovery.gov/Pages/default.aspx

CMIP
http://www.cms.gov/DeficitReductionAct/02_CMIP.asp#TopOfPage

CMS
http://www.cms.gov/

CMS Manuals
http://www.cms.gov/Manuals/

Executive Order 13250
http://www.whitehouse.gov/the-press-office/executive-order-reducing-improper-payments

False Claims Act 31 USC §3729-3733
http://uscode.house.gov

FOIA
http://www.cms.gov/FOIA/

Form CMS 64
http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp

HCCA – Health Care Compliance Association
www.hcca-info.org

How to report fraud, waste and abuse
http://oig.hhs.gov/report_fraud/OIGFraudForm.asp
http://www.cms.gov/FraudAbuseforConsumers/02_How_to_Report_Suspected_Fraud.asp#TopOfPage
www.stopmedicarefraud.gov

MII
http://www.cms.gov/FraudAbuseforProfs/07_MedicaidIntegrityInstitute.asp#TopOfPage

MIP
http://www.cms.gov/MedicaidIntegrityProgram/

NAMFCU – National Association of Medicaid Fraud Control Units
www.namfcu.net

NAMD – National Association of Medicaid Directors
www.namd-us.org

NAMPI – National Association for Medicaid Program Integrity
www.nampi.org

NASMD – National Association of State Medicaid Directors
www.nasmd.org

NHCAA – National Health Care Anti-Fraud Association
www.nhcaa.org

Referral Performance Standards & Best Practices
http://www.cms.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage

Report to Congress
http://www.cms.gov/DeficitReductionAct/021_repcongress.asp#TopOfPage

Section 1936 of the Act
http://www.cms.gov/DeficitReductionAct/

SPIA
http://www.cms.gov/FraudAbuseforProfs/11_SPIA.asp#TopOfPage

State Medicaid Director Letters
http://www.cms.gov/SMDL/SMD/list.asp

State Medicaid Fraud Contacts
http://www.cms.gov/FraudAbuseforConsumers/Downloads/smafraudcontacts.pdf

State Program Integrity Reviews
http://www.cms.gov/FraudAbuseforProfs/05_StateProgramIntegrityReviews.asp#TopOfPage

Taxpayers Against Fraud
www.taf.org

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 17 – EXHIBITS

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17020 – SAMPLE LETTER FOR PI REVIEW
17025 – SAMPLE CLOSE OUT LETTER
17030 – SAMPLE MEMORANDUM OF UNDERSTANDING (MOU)
17035 – SAMPLE JOINT OPERATING AGREEMENT (JOA)
17040 – SPEAKER REQUEST FORM

THIS GLOSSARY IS A LIST OF GENERAL DEFINITIONS AS THEY ARE COMMONLY USED IN THE MEDICAID INTEGRITY PROGRAM.

17000 – GLOSSARY OF TERMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

ABUSE: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. 42 CFR § 455.2.

ACCEPTED REFERRAL: Referral of a potentially fraudulent Medicaid provider to the State's Medicaid Fraud Control Unit (MFCU) that is accepted by the MFCU.

ADMINISTRATIVE ACTION: Provider sanction, payment suspension or other action taken by the State against a Medicaid provider before a determination of Medicaid fraud, waste or abuse or overpayment has been made.

ALGORITHM: A set of well-defined rules or procedures for solving a problem in a finite number of steps.

ARTIFICIAL INTEGELLIGENCE: An algorithm or set of algorithms that can make decisions in a logical way.

AUDIT: An assessment, evaluation, inspection, or investigation of services rendered or items furnished by a Medicaid provider.

AUDIT, COMPREHENSIVE: Examinations of the adequacy, legality, and efficiency of the application of public funds. Such examinations involve not only individual fiscal transactions but also the financial management, internal controls, policies, and operating environments governing such transactions.

AUDIT, COST REPORT: An examination of financial transactions, accounts, and reports as they relate to the cost report submitted by a provider in order to evaluate the provider's compliance with applicable Medicaid laws, regulations, manual instructions, and directives and to verify the accuracy and applicability of the costs.

AUDIT, DESK: An audit that is wholly or principally carried out in the office(s) of the auditor.

AUDIT, FIELD: An audit that is carried out at the office(s) of the organization being audited or includes a substantial "on-site" component.

AUDIT, FOCUSED: A review of services rendered or items furnished by a Medicaid provider that is limited in scope to a specific set of services or items or particular inappropriate billing practices.

AUDIT, PROVIDER SELF: An audit that is carried out wholly or principally by the provider being audited.

CASE: An investigation by a Medicaid Program Integrity office, a Medicaid Fraud Control Unit, or other Agency, to determine whether there has been a violation by a Medicaid provider of Medicaid laws, rules, or regulations or accepted standards.

CIVIL MONEY PENALTIES: Any monetary penalty, imposed by either CMS or OIG against individuals/entities for conduct that violates Federal and/or State statutes and regulations governing the Medicaid program. 42 CFR Part 402.

CLAIM: A request for payment for services and benefits rendered by a Medicaid provider, also known as bills or invoices.

COLLECTIONS: Cash recovered in reimbursement of overpayments or other cash received as a result of Medicaid program integrity activities.

COMPREHENSIVE MANAGED CARE: Managed care plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations) that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract. 42 CFR Part 438.

COST AVOIDANCE: An action or intervention that reduces or eliminates a cost or outlay that would have occurred if not for that action or intervention.

COST REPORT: Report required from providers on an annual basis in order to make a proper determination of reimbursement rate under the Medicaid program based on the expenses incurred by the provider in the course of supplying services.

CREDENTIALING: Review procedures conducted for the purpose of determining whether a potential or existing provider meets certain standards that are a prerequisite for them to begin or continue participation in a given health care plan.

DATA MINING: The analysis of large volumes of data maintained in databases or data warehouses using query tools, algorithms, and models to identify patterns, trends, and relationships or correlations among the data and to develop useful information for investigative and management purposes.

DATA REPOSITORY PLATFORM: A logical partitioning of data where multiple databases that apply to specific applications or sets of applications reside. A central place where data is stored and maintained.

DATA WAREHOUSE: A relational database designed for query and analysis, rather than for transaction processing. It usually contains historical data derived from transaction data, but can include data from other sources. It separates analysis workload from transaction workload and enables an organization to consolidate data from several sources.

DECISION SUPPORT SYSTEMS (DSS): A systematic collection of data, techniques, and supporting software and hardware by which an organization gathers and interprets relevant information from business and the environment and turns it into a basis for making management decisions.

DETECTION: Activities such as data mining, auditing, surveillance utilization and reviews or other methods, aimed at identifying possible fraud, waste, and abuse in the Medicaid program.

DISTINCT PROGRAM INTEGRITY MODEL: Organizational structure in which a distinct Medicaid program integrity unit exists within the State. Medicaid Integrity activities such as prevention, detection, audit and investigation lie wholly within the State Medicaid Agency but are not necessarily centralized in a Medicaid "Program Integrity Unit."

DOLLARS IDENTIFIED FOR RECOVERY: Represents the dollar amount of claims inappropriately paid as identified by data mining, audit, surveillance utilization review or other methods.

DOLLARS RECOVERED: Represents total dollar amount of overpayments actually recovered by the State (as opposed to dollars identified or an agreement by the provider to refund the program).

EDITS: "Front end" reviews or controls in the Medicaid Management Information Systems (MMIS) that examine the information in each claim in relation to certain Medicaid policies and to other claims, and cause the claim to be paid, pended, or denied.

ENCOUNTER DATA: Data related to the services and items received by a Medicaid recipient in an encounter with or visit to a Medicaid provider through managed care. Also referred to as "shadow claims".

ENROLLMENT: The process of admitting (or not admitting) a prospective provider or recipient into the Medicaid program or a component of the program, such as managed care.

EXCLUDED INDIVIDUALS OR ENTITIES: Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid and other Federal or State health care programs. Exclusions may occur due to OIG sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the State Medicaid Agency.

EXCLUDED PARTIES LIST SYSTEM (EPLS): An electronic, web-based system maintained by the General Services Administration (GSA) that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. Can be found at http://www.epls.gov.

EXPENDITURE: Refers to funds spent as reported by the State.

EXTRAPOLATION: The process of predicting a future cost (or other measure) using current data or results from the past.

FEE-FOR-SERVICE (FFS): Traditional method of payment for medical services where payment is made to providers for each service rendered.

FRAUD: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Includes any act that constitutes fraud under applicable Federal or State law. 42 CFR 455.2.

INVOLUNTARY DISENROLLMENT: Administrative action by a State to terminate a provider's participation in the Medicaid program due to noncompliance with Medicaid rules, regulations, payment policy and/or quality of care standards.

JUDGMENT: A court's final determination on an appeal of the rights and obligations of the parties in a case.

LIST OF EXCLUDED INDIVIDUALS AND ENTITIES (LEIE): List maintained by OIG of individuals and business excluded from participating in Federally funded health care programs available at http://www.oig.hhs.gov/fraud/exclusions.html.

MANAGED CARE: A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider. 42 CFR Part 438.

MANAGED CARE ORGANIZATION (MCO): An organization or entity that has a comprehensive risk contract under Medicaid to provide benefits to Medicaid clients. 42 CFR Part 438

MANAGED CARE OVERSIGHT: Management and/or supervision of managed care organizations to ensure compliance with Medicaid rules, regulations, and policies.

MEDICAID FRAUD CONTROL UNITS (MFCUs): A functional entity, usually located in the offices of the State Attorney General, or other Department designated by the State that investigates and prosecutes Medicaid fraud cases and reviews complaints alleging abuse or neglect of patients in health care facilities receiving Medicaid payments. MFCUs operate under a Memorandum of Understanding with the State Medicaid Agency and are subject to oversight by the DHHS' OIG. MFCUs must meet the requirements of 42 CFR Part 1007.

MEDICAID INTEGRITY: Planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse.

MEDICAID INTEGRITY PROGRAM (MIP): A program established by the Deficit Reduction Act (DRA) of 2005 at section 1936 of the Social Security Act (Act). MIP provides

the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, identify, and recover inappropriate Medicaid payments. The two main operational responsibilities under the program are: 1) reviewing the actions of those furnishing items or providing services under Medicaid and 2) providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS): An automated claims processing and information retrieval system required under the Medicaid program that produces service utilization and management information.

MEDICAID RAC PROGRAM: Recovery audit contractor administered by a State to identify overpayments and underpayments and recoup overpayments. They are typically paid through contingency fee arrangements.

MEDICARE RAC PROGRAM: Recovery audit contractor program administered by CMS to identify overpayments and underpayments and recoup overpayments under the Medicare program.

NATIONAL PRACTITIONER DATABANK : A computerized data bank maintained by the federal government that contains information on physicians who have paid malpractice claims or against whom certain disciplinary actions have been taken.

OFFSET: Withholding of funds from future provider payments to recover overpayments identified through Medicaid program integrity activities.

OVERPAYMENT: Any payment made to a Medicaid provider in excess of the payment to which the provider was entitled under State or federal laws and regulations.

PARTICIPATING PROVIDER: Provider that actively bills the Medicaid program.

PREDICTIVE MODEL: A mathematical or statistical method for analyzing a body of data and predicting or forecasting future results or behavior.

PREVENTION: Activities to minimize the risk of fraud, waste, or abuse entering the payment system and activities used to educate Medicaid program staff and providers.

PRIMARY CARE CASE MANAGEMENT (PCCM): The health care management activities of a provider that contracts with the State to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services reimbursed on a FFS basis. 42 CFR Part 438.

PRIOR AUTHORIZATION: A formal process by which, as a precondition for provider reimbursement, providers or clients must obtain approval for certain medical services, equipment, or supplies (based on medical necessity) before the services are provided to clients.

PROPRIETARY DATABASE: A copyrighted database accessible by subscription.

PROVIDER: Any person or entity enrolled in the Medicaid program that provides services and/or furnishes items that are billable under Medicaid.

PROVIDER EDUCATION/COMMUNICATIONS: Activities designed to educate and communicate with providers about Medicaid rules, regulations, and policies to ensure quality of care and payment integrity.

PROVIDER PAYMENT SUSPENSION: The withholding of payment by a State Medicaid Agency to a provider or supplier before a determination of the amount of the overpayment exists.

RAMS II: An advanced version of the mainframe Surveillance and Utilization Review Subsystem (SURS) system developed by a MMIS contractor.

RECIPIENT: An individual who receives benefits under the Medicaid program.

RECOVERY: Collections and offsets received from providers as a result of overpayments or other State program integrity activities. Does not include third party liability (TPL) or prior authorizations.

REFERRAL: Information on potential provider fraud that is forwarded from the State Medicaid Agency to the Medicaid Fraud Control Unit (MFCU) or other State or federal investigative Agency.

RETURN ON INVESTMENT (ROI): Savings/collections attributable to Medicaid program integrity efforts per dollar invested.

SAMPLING: Random selection of a subset of a population.

SANCTION: A penalty assessed on a Medicaid provider for a violation or violations of Medicaid laws, rules, regulations, or policies. May be in the form of a fine, suspension, termination, exclusion, civil monetary penalty, requirement for correction action, or other remedy/action.

SETTLEMENT: A negotiated agreement to collect identified overpayments from a Medicaid provider.

SINGLE STATE AGENCY (SSA): The single Agency within the State responsible for the administration of the State Medicaid plan on behalf of the State.

STANDARD OPERATING PROCEDURE: An established procedure to be followed in a given situation.

STATISTICAL ANALYSIS: Process of examining data to draw conclusions or make inferences about a population based on a sample or subset of the population.

STRATEGIC PLAN: A document used by an organization to align its policies and budget structure with organizational priorities, missions, and objectives. Should include a mission Statement, a description of the Agency's long-term goals and objectives, and strategies or means the Agency plans to use to achieve these goals and objectives. May also identify external factors that could affect achievement of long-term goals.

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS): A component of the Medicaid Management Information System designed to process information on medical and health care services to assist Medicaid program managers in identifying possible fraud and abuse by providers and Medicaid clients. State SURS staffs perform data mining and other research for post-pay utilization review of providers and clients in order to identify questionable patterns of service delivery and utilization.

SURS I: The early version of the mainframe-based SURS system developed in the late 1970's/early 1980's.

SURS II: An updated version of the mainframe-based SURS-I system.

SURS, ADVANCED: Advanced versions of the mainframe-based SURS-I and SURS-II systems.

SURS, PC-BASED: A client-server, PC-based system that can be operated through a dedicated network and that provides a place to store extensive SURS data, process SURS runs, and store reports. More user-friendly than traditional mainframe SURS (i.e., uses "point-and-click" technology and is capable of performing several functions at the same time) and allows users to perform analyses from desktops and receive relatively quick results.

SURS, CS-BASED: An advanced version of the PC-based SURS system.

TERMINATED PROVIDER: A provider who has been terminated from Medicaid program participation by the State Medicaid Agency due to program integrity concerns.

THIRD PARTY LIABILITY (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.

TIP: Complaint of suspected Medicaid provider fraud, waste or abuse.

TOTAL RECOVERIES: Dollars recovered by the State from overpayments, settlements/judgments, and other collections (excluding TPL and prior authorization).

WITHDRAWN PROVIDER: A provider who has withdrawn from participation in the Medicaid program.

17005 – MEDICAID PROGRAM INTEGRITY MANUAL ACRONYMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Algorithm Findings Report (AFR)
American Academy of Professional Coders (AAPC)
Audit Medicaid Integrity Contractors (Audit MICs)
Business Partners Security Manual (BPSSM)
Center for Program Integrity (CPI)
Centers for Medicare & Medicaid Services (CMS)
Certified Professional Coder (CPC)
Children's Health Insurance Program (CHIP)
Civil Monetary Penalties (CMPs)
Civil Monetary Penalty (CMP)
CMS integrated IT Investment and System Life Cycle Framework for Security (CMS ILC)
Commercial Off-the-Shelf (COTS)
Comprehensive Medicaid Integrity Plan (CMIP)
Conflicts of interest (COI)
Core Security Requirements (CSR)
Corrective action plan (CAP)
Current Dental Procedures (CDT) Codes
Current Procedural Terminology (CPT)
Deficit Reduction Act (DRA)
Department of Justice (DOJ)
Diagnosis Related Group (DRG)
Division of Audits & Accountability (DAA)
Division of Field Operations (DFO)
Division of Fraud Research & Detection (DFRD)
Division of Medicaid Integrity Contracting (DMIC)
Draft audit reports (DARs)
Education Medicaid Integrity Contractors (Education MICs)
Federal Acquisition Regulations (FAR)
Federal financial participation (FFP)
Federal fiscal year (FFY)
Federal Information Processing Standard (FIPS)
Fee for Service (FFS)
Final audit report (FAR)
Fiscal Year (FY)
Food and Drug Administration (FDA)
Fraud, waste, and abuse (FWA)
Generalized Linear Models (GLM)
Generally Accepted Government Auditing Standards (GAGAS or Yellow Book)

Healthcare Common Procedure Coding System (HCPCS)
Joint Operating Agreement (JOA)
Managed Care (MC)
Managed Care Entity (MCE)
Medicaid Fraud Control Unit (MFCU)
Medicaid Integrity Contractor (MIC)
Medicaid Integrity Contractors (MICs)
Medicaid Integrity Group (MIG)
Medicaid Integrity Institute (MII)
Medicaid Integrity Program (MIP)
Medicaid Statistical Information System (MSIS)
Memoranda of Understanding (MOUs)
Minimum Description Length (MDL)
National Advocacy Center (NAC)
National Association for Medicaid Program Integrity (NAMPI)
National Correct Coding Initiative (NCCI)
National Drug Codes (NDC)
National Institute of Standards and Technology (NIST)
National Plan and Provider Enumeration System (NPPES)
National Provider Identifier (NPI)
Non-negative Matrix Factorization (NMF)
Nursing facility (NF)
Office of Inspector General (OIG)
Office of Management and Budget (OMB)
Oracle Business Intelligence (BI)
Oracle Business Intelligence Enterprise Edition (OBIEE)
Oracle Data Miner (ODM)
Patient Protection and Affordable Care Act (Affordable Care Act)
Payment Accuracy Improvement Groups (PAIG)
Payment Error Rate Measurement (PERM)
Program Integrity (PI)
Provider Compliance Group (PCG)
Provider enrollment and Disclosures (PED)
Quarterly Medicaid Statement of Expenditures For the Medical Assistance Program (Form CMS 64)
Recovery Audit Contractors (RACs)
Return on investment (ROI)
Review Team Leader (RTL)
Revised DAR (RDAR)
Social Security Act (the Act)
State Liaisons (SL)

State Performance Integrity Assessments (SPIAs)
Statistical Analysis Software (SAS)
Subject Matter Experts (SME)
Support Vector Machines (SVM).
Surveillance Utilization Review Subsystem (SURS)
Technical Advisory Group (TAG)
Technical assistance (TA)
Third Party Liability (TPL)
Title XIX of the Social Security Act (Medicaid)

17010 – STATE MEDICAID DIRECTOR LETTERS AUTHORED BY MIG (IN WHOLE OR IN PART)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SMDL 06-021, State False Claims Acts.
This State Medicaid Director Letter (SMDL) was issued September 19, 2006, to encourage States to implement a State False Claims Act. Section 6031 under section 1936 of the Act encourages and provides incentive for adoption of State False Claims Acts by decreasing the Federal medical assistance percentage by 10 percentage points for recoveries from legal actions brought pursuant to such laws. Section 6031, became effective January 1, 2007, also equally rewards those State False Claims Acts already in place that meet specified requirements.
http://www.cms.gov/smdl/downloads/SMD091906.pdf

SMDL 06-025, Employee Education About False Claims Recovery.
This SMDL was issued December 13, 2006, to offer guidance to State Medicaid agencies on the implementation of Section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery." The SMDL included a State plan preprint, and the SMDL clarified definitions incorporated in the State plan preprint.
http://www.cms.gov/smdl/downloads/SMD121306.pdf

SMDL 07-003, Final Guidance Regarding Employee Education For False Claims Recovery.
This SMDL was issued March 22, 2007, to offer additional guidance to State Medicaid agencies on the implementation of section 6032 under section 1936 of the Act. The SMDL included frequently asked questions (FAQs) to supplement the guidance that CMS provided in SMDL 06-024. States had also requested an official description of the Federal False Claims Act for purposes of uniformity. The Department of Justice had provided that description, which was also included in this SMDL.
http://www.cms.gov/smdl/downloads/SMD032207.pdf
http://www.cms.gov/smdl/downloads/SMD032207Att1.pdf
http://www.cms.gov/smdl/downloads/SMD032207Att2.pdf

SMDL 07-012, Tamper Resistant Prescription Pads.
This SMDL was issued August 17, 2007, to offer guidance to State Medicaid agencies on section 7002(b) of the US Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 regarding the use of tamper resistant prescription pads, required for all Medicaid prescriptions as of October 1, 2008. The SMDL also sets forth the three characteristics for a Medicaid prescription to be considered compliant with the requirement.
http://www.cms.gov/SMDL/downloads/SMD081707.pdf

SMDL 08-002, Cooperation with the Medicaid Integrity Program (MIP).
This SMDL was issued April 28, 2008, to provide a Medicaid State Plan amendment (SPA) preprint that States may use to comply with the requirements of sections 1936 and 1902(a)(69) of the Social Security Act (the Act) (section 6034 of the Deficit Reduction Act of 2005 (DRA)).

Section 6034 under section 1936 of the Act requires that States amend their States plans assuring compliance with any requirements determined by the Secretary to be necessary to carry out the MIP established under section 1936 of the Act. The SMDL included a State plan preprint that States could have used to implement this provision.
http://www.cms.gov/SMDL/downloads/SMD042808.pdf

SMDL 08-003, Excluded Providers.
This SMDL was issued June 12, 2008, to provide guidance to State Medicaid agencies clarifying CMS policy on States' obligations to screen for excluded individuals and entities prior to and during provider enrollment; reminding States of the obligation to report to the Health and Human Service Office of Inspector General (OIG) both convictions related to the Medicaid program and sanctions imposed by the State Medicaid Agency on Medicaid providers; and reminding States of the consequences set forth in Federal laws and regulations for failure to prevent Medicaid participation by excluded individuals and entities.
http://www.cms.gov/smdl/downloads/SMD061208.pdf

SMDL 09-001, Provider Exclusions.
This SMDL was issued January 16, 2009, to advise State Medicaid agencies of their obligation to direct providers to screen the providers' employees and contractors for excluded persons. The SMDL also clarifies Federal laws and regulations prohibiting Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs; and reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities.
http://www.cms.gov/SMDL/downloads/SMD011609.pdf

SMDL 10-014, Extended Period for Collection of Provider Overpayments.
This SMDL was issued July 13, 2010, to provide initial guidance on Section 6506 of the Patient Protection and Affordable Care Act, which is entitled, "Overpayments." This section was effective March 23, 2010, the date of enactment, and provides an extension of the period for collection of overpayments. For overpayments identified prior to the effective date, the previous rules on discovery of overpayments will be in effect. Section 6506 also extends the period pertaining to overpayments made due to fraud, which is defined in Federal regulations at 42 CFR sections 433.304 and 455.2. Specifically, when a State has been unable to recover overpayments due to fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share. Previously, there had been no specific exception for fraud recoveries in the statute.
http://www.cms.gov/smdl/downloads/SMD10014.pdf

SMDL 10-021, Recovery Audit Contractors (RACs) for Medicaid.

This SMDL was issued October 1, 2010, to provide preliminary guidance to States on the implementation of the Affordable Care Act (P. L. 111-148). Specifically, it provided initial guidance on section 6411 of the Affordable Care Act, *Expansion of the Recovery Audit Contractor (RAC) Program*, which amends section 1902(a)(42) of the Act. States were advised that they should attest

that they would establish a Medicaid RAC program by submitting a State Plan Amendment (SPA) to CMS no later than December 31, 2010, or indicate that they would be seeking to be excepted from one or more of the proposed provisions, or indicate that they would be seeking a complete exception from establishing a Medicaid RAC program. CMS initially expected States to fully implement their RAC programs by April 1, 2011. However, on February 1, 2011, CMS issued an Informational Bulletin stating that the proposed April 1, 2011 implementation date would be delayed, in part, to ensure that State would be able to comply with the provisions of the final regulations.

http://www.cms.gov/smdl/downloads/SMD10021.pdf

SAMPLE AUDIT NOTIFICATION LETTER

AUDIT MIC LETTERHEAD

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

< Date >

Provider Number:
License Number:

< Provider Name >
< Provider Street Address >
< Provider City, State, Zip >

Dear < >:

This is to inform you that you or your facility has been selected for an audit of claims billed to Medicaid with dates of services from < > through < >. The objective of our audit is to determine whether the <type of services> claims were billed and paid in accordance with applicable Federal and <State> Medicaid laws, regulations, policies, and rules.

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program, through which the Centers for Medicare & Medicaid Services (CMS) shall conduct reviews and audits of claims submitted by Medicaid providers. As a Medicaid provider and a recipient of funds under the <State name> Medicaid program, you are subject to these reviews and audits. The DRA authorizes CMS to utilize contractors, including <Audit MIC name>, to conduct such reviews and audits.

In accordance with the DRA and other applicable Federal laws, you are required to provide CMS and its contractor, <Audit MIC name>, with timely, unrestricted access to all documents and records that relate in any way to Medicaid claims and payments.

To facilitate the audit, we are requesting that certain information/records, as shown in the enclosed document, be assembled and provided to <Audit MIC name>. The documents must be legible and arranged in an orderly manner. Be aware that this list is not all-inclusive and that <Audit MIC name> may request additional documentation necessary to conduct and complete its audit. The requested information should be forwarded to the <Audit MIC name> office at the following address within <# of days> business days from the date of this letter.

<Audit MIC Name >
< MIC Street Address >
< MIC City, State, Zip >

Any applicable State sanctions may be imposed against you if you fail to provide the information that is requested. Depending on the laws in your State, sanctions may include, but not be limited to, vendor hold and/or exclusion from participation as a provider in the <State> Medicaid program, until the matter is resolved. Additionally, payments for services for which you fail to produce records to <Audit MIC name> will be recovered from you.

<Auditor name> from <Audit MIC name> will be contacting you in the near future to schedule a telephone entrance conference. We ask that at least the <insert persons you need at entrance> and

17020 – SAMPLE LETTER FOR PI REVIEW

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SMD SAMPLE NOTICE LETTER

CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICAID INTEGRITY GROUP

Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244

[date]

[name]
[title]
[agency]
[address]
[address]

Dear Mr. /Ms. *[name]*:

This letter is to inform you that we plan to conduct a review of *[state name]*'s Medicaid program integrity procedures and processes during the week of *[date]* at your offices in *[city]*. A team from the Medicaid Integrity Group (MIG), led by *[name of Review Team Leader]* from our *[city]* Field Office, will conduct the review. You are welcome to attend the review entrance conference which has been scheduled for 9:00 AM on Monday, *[date]*.

We will make an assessment of the effectiveness of *[state name]*'s program integrity efforts. In addition, we will determine whether *[state name]*'s program integrity policies and procedures comply with Federal statutory and regulatory requirements. We are also interested in learning about effective State program integrity practices.

We have enclosed a copy of our review guide modules and a questionnaire. The information and materials requested on these documents will assist us in completing the review as efficiently as possible. Please note that your responses to the questions should be entered directly into the documents.

The FY*[year]* MCE Questionnaire should be sent to all managed care entities (MCEs) providing Medicaid services under contract or other agreement with the State Medicaid agency. Please forward all MCE responses to the FY*[year]* MCE Questionnaire to Mr./Ms. *[name of Review Team Leader]* by *[date]*. This information will be used to select MCEs to interview during the onsite review. We will ask the selected MCEs for additional information prior to the review.

Please provide responses to the following items by *[date]*:

- FY*[year]* Review Guide PI Module
- FY*[year]* Review Guide PED Module
- FY*[year]* Review Guide MC Module
- FY*[year]* Charts for All Modules

17025 – SAMPLE CLOSE OUT LETTER

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE MIC CLOSE OUT LETTER

AUDIT MIC LETTERHEAD

Provider No:

<Provider Name>
<Provider Address>

Dear Provider:

(Contractor Name) has conducted an audit on behalf of the Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Program. This audit examined claims for <audit issue> for the time period <date 1> through <date 2>.

Based upon this audit, CMS has determined no further action is necessary at this time.. You should retain the records pertaining to the items and services that were the subject of this audit in accordance with applicable [State] and federal law. <Cite>. You are advised that all the claims that were the subject of this audit may be re-audited or reinvestigated at a future date by [name of applicable State], the CMS, or other state or federal agencies or authorities.

Thank you for your cooperation during this audit.

Sincerely,

<Name>
Audit MIC

cc: <State POC>

Bcc: DMIC POC
DFO POC
DFRD POC

17030 – SAMPLE MEMORANDUM OF UNDERSTANDING (MOU)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE

MEMORANDUM OF UNDERSTANDING BETWEEN

<STATE> MEDICAID FRAUD CONTROL UNIT

AND

CENTERS FOR MEDICARE AND MEDICAID SERVICES,
MEDICAID INTEGRITY GROUP

I. PURPOSE

This Memorandum of Understanding (MOU) is entered into by the <State> Medicaid Fraud Control Unit (MFCU), and the Centers For Medicare & Medicaid Services, Medicaid Integrity Group (CMS-MIG) in order to efficiently and effectively further their intention to combat Medicaid fraud, waste and abuse, and protect the integrity of the Medicaid Program.

II. DEFINITION

"Audit MIC" refers to a contractor of CMS-MIG that, pursuant to sections 6034(b)(2) and (3) of the Deficit Reduction Act of 2005 (42 U.S.C. § 1396u-6(c)(2)(B)), will conduct post-payment Medicaid provider audits and, as appropriate, identify Medicaid overpayments.

III. SCOPE

The scope of this MOU is limited to those referrals received by MFCU from the Department of Health and Human Services, Office of the Inspector (OIG) that OIG itself received from an Audit MIC, and the interactions that relate to those referrals. This MOU does not address the Audit MIC or CMS-MIG's responsibilities to respond to MFCU requests that are not related to referrals that originated with an Audit MIC. In addition, MFCU and CMS-MIG recognize that Audit MICs are neither required nor expected to perform case development activities.

IV. TERMS

CMS-MIG agrees:

1) To create and follow processes providing that OIG will share with MFCU all referrals it receives from the Audit MICs concerning allegations of fraud against MFCU's State Medicaid program within 14 days of OIG's receipt of such referrals, subject to certain possible law enforcement exceptions (e.g., a Federal grand jury investigation).

SAMPLE

Framework for Joint Operating Agreements (JOAs)
Between Audit Medicaid Integrity Contractors (MICs)
and State Medicaid Agencies (SMAs)

PURPOSE OF JOA *(required)*
In accordance with the Deficit Reduction Act (DRA) of 2005, the Centers for Medicaid & Medicare Services, Medicaid Integrity Group (CMS-MIG) is obligated to engage MICs to audit claims for payment for items or services under a State plan, and identify overpayments to individuals or entities receiving Federal funds. The JOA is an agreement between <Audit MIC name> and <State Medicaid Agency> designed to promote cooperation and collaboration between the parties, and to establish guidelines, duties, and shared expectations of how each will conduct business with each other. The JOA provides the framework for sharing information in order to complete CMS-MIG-mandated audits successfully and in a timely way, to decrease unnecessary duplication of effort by clarifying roles and responsibilities between the parties, and to improve the integrity of the Medicaid program as a whole.
(Note that because of its unique role in the process, CMS-MIG, while not a party to the agreement must approve the agreement before the MIC may sign it.)

ROLE OF AUDIT MEDICAID INTEGRITY CONTRACTORS *(required)*
The obligation of the <Audit MIC name> pursuant to its contract with CMS-MIG is to conduct audits that examine payments made to individuals or organizations providing services or items under Title XIX of the Social Security Act, as amended. As appropriate, the audits may result in the identification of potential overpayments. The types of audits to be conducted include audits of Medicaid providers, including individual practitioners, institutions, and other providers, cost report audits, and audits of managed care organizations as directed by CMS-MIG. In the course of these audits, medical documentation and other supporting information will be reviewed for paid Medicaid claims of services or items furnished under the state plan in accordance with Title XIX of the Social Security Act, as amended. <Audit MIC name> is free to set forth a detailed listing of <Audit MIC name>'s responsibilities in the JOA.

ROLE OF STATE MEDICAID AGENCY (SMA) *(required)*
The State Medicaid Agency will review and vet audit subjects; and review draft audit reports provided to it by CMS-MIG and/or the MIC. The State will participate in various communications efforts with <Audit MIC name>. The State will also assist <Audit MIC name> by providing <Audit MIC name> with information regarding the State's Medicaid laws, regulations, and policies; and provider contact information for audit subjects. In accordance with its Medicaid State Plan Amendment regarding the Medicaid Integrity Program, the State must comply with any requirements determined by CMS-MIG to be necessary for carrying out MIC audits, pursuant to Section 1902(a)(69) of the Social Security Act.

ROLE OF CMS-MIG *(required)*
CMS-MIG will exercise oversight and approval authority over the entirety of the <Audit MIC name>'s auditing processes. <Audit MIC name> will not proceed with any audit unless the proposed audit has first been approved by CMS-MIG. All audit protocols utilized by <Audit MIC name> including State protocols which <Audit MIC name> proposes to adopt, must be approved by CMS-MIG. All draft and final audit findings completed by <Audit MIC name> will be presented to CMS-MIG, which will review them, receive input from both the State and the provider who is the subject of the audit, and direct <Audit MIC name> to make changes as appropriate. Upon transmittal of a final audit report to the State, the State will be responsible for repaying the Federal share of any identified overpayment amount to CMS-MIG pursuant to 42 CFR § 433.316(a) and (e). As described below, CMS-MIG will be the point of contact for resolution of disputes between the <Audit MIC name> and the State.

17040 – SPEAKER REQUEST FORM

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

CMS SPEAKING REQUEST FORM

Save this document to your local drive. Fill it out as completely as possible, noting required fields, and save again to your local system. Please then return the completed document to the individual that sent it to you via email. Please note that ALL fields are important to complete, but those with asterisks (*) are required to process your request. ***Email this document to:*** *OASpeechRequest@cms.hhs.gov – you may also call 202-205-6306.*

* *Name of event:*
* *Specific Date/Time of Request:*
* *Sponsoring organization:*
* Sponsor's Mailing Address
* *Street:*
* *City, State Zip:*
* *Sponsor's main phone #:*
* *Brief description of sponsoring organization (please include website address):*

Location of event site:
Building or Hotel:
* *Street Address:*
* *City, State:*
* *Zip Code:*
(we cannot process your request without the location's zip code)

Point of contact:
* *Name:*
* *Phone:*
Email:

Event Information
* *Event description (e.g. annual meeting, conference, seminar, board meeting):*

* *Speech format (e.g. keynote address, seminar, panel participant):*

Length of speech:

Length of Q&A session:

* *Proposed theme or topic for speech:*

Audience
* *Number of attendees expected for this speech:*
* *Attending Audience (who will hear the speech):*
* *Target Audience (if different):*
(The attending audience may be cardiologists but the content is "heart disease" therefore the Target audience is "People with Heart Disease")
Event open to public or is Invitation only: ☐ Public ☐ Invitation only *Event open to press:* ☐ Yes ☐ No

Speakers
Are you requesting a specific CMS speaker? ☐ Yes ☐ No
If yes, Who?

Are there Other CMS officials speaking at the event? ☐ Yes ☐ No