Medicare Program Integrity Manual

Chapter 11 - Fiscal Administration

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(Rev. 10365, 10-02-20)

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11.1 - Medical Review (MR)

(Rev. 174, Issued: 11-17-06; Effective: 10-01-2006; Implementation: 10-02-06)

Contractors are required to incorporate Activity Based Costing (ABC) in the budget process. ABC is a management reporting system that allows contractors to focus on the costs of the work activities instead of the standard cost centers associated with the traditional cost accounting structure. ABC identifies an all inclusive business process for each activity so that the total costs of the activity are fully visible to the MR business manager. Refer to Medicare Financial Management Manual, www.cms.gov/manuals/106_financial/fin106index.asp chapters 1, 2, 5, and 6 for more detailed explanation of ABC.

11.1.1 – MR Overview

(Rev. 174, Issued: 11-17-06; Effective: 10-01-2006; Implementation: 10-02-06)

This chapter of the PIM lists the requirements contractors must follow when allocating MR Costs, Savings and Workload to the MR activities in CAFM and CROWD. These requirements formerly appeared in MCM, Part 1, 4213; MIM, Part 1, 1213 and the MR Budget and Performance Requirements (BPRs). Contractors must allocate to the MR activity code in CAFM II only the workload and costs associated with MR tasks. Contractors must allocate to the MR line in CROWD only these savings that are generated by MR tasks. For example:

- If a nurse reviewer spends 90% of her time performing prepay complex medical review and 10% of her time performing appeals review at the request of the appeals unit, the contractor must allocate 90% of this nurse's salary/fringes to 21221 and the 10% to the appropriate appeals activity code.

- If a non-clinician medical reviewer spends 80% of his time performing Routine review and 20% of his time performing suspect duplicate reviews, the contractor must allocate 80% of this reviewer's salary/fringes to 21002 and the 20% to the appropriate claims processing activity code.

- If a nurse reviewer spends 70% of her time performing postpay complex review for the purpose of making a coverage determination on a provider who has been selected for targeted PCA review and 30% of her time performing reviews to support the claims processing unit, the contractor should report 70% to Postpay Complex Review 21222 and 30% to the appropriate claims processing activity code.

Refer to chapter 1, section 2 www.cms.gov/manuals/108_pim/pim83c01.asp#Sect2 of this manual for detailed overview of the MR Program. This chapter lists the requirements contractors must follow when allocating MR costs and workload to the MR activities in CAFM II. Contractors will be given a specified maximum budget for MR. Based on this budget the contractor is asked to develop a unique MR strategy within their jurisdiction that is consistent with the goal of reducing the error rate. The contractor shall utilize their

targeted budget in its entirety on MR activities toward the prevention of waste and abuse to the Medicare program.

11.1.2 –Reporting MR Workload and Cost Information and Documentation in CAFM II

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Workload information and associated workload cost information shall be maintained and documented on-site by all MR contractors. Each site shall maintain records of its own workload information and associated workload cost information. Contractors shall be able to provide this information upon request from RO and/or CO. Site-specific workload and cost information shall be reported in the remarks section of CAFM II. With RO consent, this information may be submitted by other means with an indication made in the remarks section of the CAFM II IER report.

The MR strategy shall include a section that describes the process used to monitor spending in each activity code. The process shall ensure that spending is consistent with the allocated budget and includes a process to revise the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each activity code is accurately and consistently reported. The workload reporting process shall also assure proper allocation of employee hours required for each activity.

Contractor's MR workload records shall include workload information captured by the Interim Expenditure Report (IER). Only costs (direct, indirect, overhead) incurred to support MR activities are reported on the MR line. Contractors are responsible for ensuring the accuracy of the information contained in CAFM II. The contractor shall alert the RO (for *UPICs*, the GTL, Associate GTL, and SME) to any software or hardware problems that hinder the contractor's ability to report accurate data in CAFM II. The contractor should cc MROperations@CMS.HHS.gov.

11.1.3 – CAFM II Reporting for MR Activities

(Rev. 174, Issued: 11-17-06; Effective: 10-01-2006; Implementation: 10-02-06)

Contractors shall report all costs associated with the medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions. All costs associated with collecting the overpayment shall be allocated to the appropriate overpayment collection CAFM II activity code.

To be counted as medical review workload, all claims reviewed by medical review shall be identified in the MR strategy and be the result of a MR edit. If resources allow, a MR clinician may be shared with another functional area, such as provider outreach and education, claims processing or appeals, as long as only the percentage of the clinician's time spent on MR activities is identified in the strategy and accounted for in the appropriate functional budget area.

The review of a claim for MR purposes is only counted as medically reviewed once no matter how many times the same claim is reviewed during claims processing. MCS users will be exempt from this requirement until July 5, 2005. Effective July 5, 2005 the MCS system shall be revised to automatically deny duplicates of denied lines. Duplicates of denied lines are defined as newly submitted lines that duplicate a line that a contractor has (a) already denied, (b) medically reviewed, or (c) for which the contractor requested but did not received documentation. Denial of duplicate lines shall not be appealable unless the provider documents that the service was not a duplicate because it was performed more often than indicated in the original line. Use a "Duplicate non-paid" denial message whenever this denial is made.

11.1.3.1 - Automated Review Workload and Cost (Activity Code 21001)

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Contractors shall report the costs associated with automated review including personnel to install and activate supplemental edit software in Activity Code 21001. In the workload section of the CAFM II, Activity Code 21001, contractors shall report the number of claims denied in whole or in part in Workload 1. To the extent the contractor can report claims subjected to automated medical review, this number should be reported in Workload 2. (IOM Pub 100-08, ch.3, §3.4.5.)

11.1.3.2 - Routine Review Workload and Cost (Activity Code 21002)

(Rev. 130, Issued: 11-10-05, Effective: 10-01-05, Implementation: 12-12-05)

Contractors shall report all costs associated with routine reviews in Activity Code 21002. Costs associated with collecting an overpayment shall not be reported to this activity code. In the workload section of CAFMII, Activity Code 21002, report the number of claims reviewed in Workload 1. Contractors shall report number of claims denied in whole or in part in Workload 2. Include those post payment claims where no documentation was received in workload 2. Report the number of providers subject to routine review in Workload 3. (IOM Pub 100-08, ch.3 §3.4.5.)

11.1.3.3 - Data Analysis Cost (Activity Code 21007)

(Rev. 174, Issued: 11-17-06; Effective: 10-01-2006; Implementation: 10-02-06)

Contractors shall report costs associated with data analysis activities associated with discovering program vulnerabilities and developing a MR prioritized problem list (IOM Pub 100-8, ch. 1) in CAFM II Activity Code 21007. However, analysis of the data to develop and deliver educational interventions shall not be reported in an MR activity code. In addition, data analysis associated with benefit integrity and law enforcement support shall not be reported here. There is no claims workload to be reported for this activity.

11.1.3.4 - Third Party Liability or Demand Bills Workload and Cost (Activity Code 21010)

(Rev. 185, Issued: 01-26-07, Effective: 02-26-07, Implementation: 02-26-07)

Intermediaries shall report only the workload and costs associated with the medical review of third party liability claims and the workload and costs associated with the medical review of demand bills. Funding for claims processing and the appeals for third party liability and demand bills must be funded through program management.

Intermediaries shall report the costs associated with the medical review of third party liability claims and the medical review of demand bills in Activity Code 21010. Intermediaries shall report the total number of claims reviewed, i.e., third party liability claims plus claims for demand bills, in Workload 1 in CAFM II Activity Code 21010. Intermediaries shall report the number of claims denied in whole or in part in Workload 2. Intermediaries shall report demand bills (claims) reviewed in Workload 3.

An exception to the preceding instruction may occur when the provider submits a home health demand bill (condition code 20) type 32X, 33X, or 34X, and the beneficiary has not selected the checkbox indicating that he or she wants Medicare to be billed on the Home Health Advance Beneficiary Notice (HHABN). In most cases, the contractor shall return to the provider (RTP) such claims submitted in error, except in the case of dual-eligible beneficiaries where there is a state-specific policy regarding billing Medicare. Contractors and HHAs who serve dual-eligibles shall comply with a state-specific policy on billing for dual-eligible beneficiaries (see CMS Pub. IOM 100-04, chapter 60, §60.5 A. for further instruction on that situation).

11.1.3.5 - Policy Reconsideration/Revision Activities (Activity Code 21206)

(Rev. 130, Issued: 11-10-05, Effective: 10-01-05, Implementation: 12-12-05)

In an attempt to achieve jurisdictional consistency, multi-state contractors shall develop and revise local policies that apply to all their states. When reporting workload to CAFM II, the contractor shall report just one LCD, even if that policy varies slightly from state to state.

Report all costs associated with reconsiderations and revisions to LCD in CAFM II Activity Code 21206. Include reconsideration requests made as a result of IOM Pub.100-08 ch.13 §13.10. The cost of inputting the LCD into the Fu database shall also be reported here and not in activity code 24118 – Education delivered through electronic or paper media. Report the total number of policies revised or retired in the month it became effective in Workload 1. Report the number of policies revised that required notice or comment as Workload 2. Report the number of policies revised due to an outside request (e.g., beneficiary or provider request) in Workload 3.

11.1.3.6 – MR Program Management Costs (Activity Code 21207)

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

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

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

- Develop and periodically modify MR strategy;
- Develop and modify quality assurance activities, including special studies, inter- reviewer reliability testing, committee meetings, and periodic reports;
- Evaluate edit effectiveness;
- Plan, monitor and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff;
- Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shifts in workload focus when indicated;
- Implement MR instructions from regional and/or central office;
- Educate staff on MR program, new CMS instructions, and quality assurance findings (this is different from the internal training of MR staff to perform MR activities); and,
- Support service for *UPIC* performing MR activities other than for the CERT contractor.

11.1.3.7 - New Policy Development Activities (Activity Code 21208)

(Rev. 130, Issued: 11-10-05, Effective: 10-01-05, Implementation: 12-12-05)

In an attempt to achieve jurisdictional consistency, multi-state contractors shall develop and revise local policies that apply to all their states. When reporting workload to CAFM II, the contractor shall report just one LCD, even if that policy varies slightly from state to state.

Report all costs associated with new LCD development activity in CAFM II Activity Code 21208. Include in this cost inputting the LCD into the Fu database, do not report this cost in activity code 24118 – Education delivered through paper or electronic media.

Report the number of new policies that were presented for comment as Workload 1. Report the number of new policies that were released for notice in the month that it became effective in Workload 2. Report the number of Investigational Device Exemption (IDE) requests reviewed in Workload 3.

11.1.3.8 - Complex Probe Review Workload and Costs (Activity Code 21220)

(Rev. 130, Issued: 11-10-05, Effective: 10-01-05, Implementation: 12-12-05)

Report all costs associated with complex probe review in Activity Code 21220. In the workload section of CAFM II, Activity Code 21220, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. Report the number of providers subject to complex probe review in Workload 3.

11.1.3.9 - Prepay Complex Review Workload and Cost (Activity Code 21221)

(Rev. 171; Issued: 11-09-06; Effective: 01-01-07; Implementation: 12-09-06)

Report all costs associated with prepay complex review in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. Report the number of providers subject to prepay complex review in Workload 3.

The DMERCs shall report the number of Advanced Determinations of Medicare Coverage accepted (CMS IOM Pub.100-8, chapter.5, section 5.7) to miscellaneous code 21221/01.

The carriers and fiscal intermediaries shall report the therapy cap workload in activity code *27021*.

11.1.3.10 - Postpay Complex Review Workload and Cost (Activity Code 21222)

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Contractors shall report all costs associated with Postpay Complex Review in Activity Code 21222. In the workload section of Activity Code 21222, contractors shall report the total number of claims reviewed on a postpayment basis as Workload 1 and report the total number of claims denied in whole or in part as Workload 2. Report the number of providers subject to postpay complex review in Workload 3. (IOM Pub 100-08, ch. 3. §4.5.)

11.1.3.11 – Postpay Complex Review Workload and Cost (Activity Code 21222)

(Rev.)

11.1.4 - MIP Comprehensive Error Rate Testing (CERT) Support

(Rev. 174, Issued: 11-17-06; Effective: 10-01-2006; Implementation: 10-02-06)

Beginning in FY 2005, CMS will provide funding earmarked for the AC to support the CERT contractor. This funding will be a "reverse auction" funding system as is found in the MR program. The CERT Support funding is over-and-above the level of funding provided to perform the MR activities listed above. Contractors are not required to develop a MIP CERT Support strategy. Contractors shall not include MIP CERT Support work in their MR strategies. Contractors shall not shift additional funds from MR activities to this line.

In addition to satisfying all requirements contained here, contractors shall carry out all CERT Support activities identified in IOM Pub.100-8, chapter 12, and all relevant MIP CERT Support One Time Notifications.

11.1.4.1 - MIP CERT Support (Activity Code 21901)

(Rev. 220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Report the costs associated with time spent on MIP CERT Support Activities. These activities include but are not limited to the following:

- Providing review information to the CERT contractor as described in IOM Pub. 100-08, ch.12 § 3.3.2.

- Providing feedback information to the CERT contractor as described in IOM Pub. 100-08, ch.12, § 3.3.3 including but not limited to:

    + CMD discussions about CERT findings;

    + Participation in biweekly CERT conference calls;

    + Responding to inquiries from the CERT contractor; and

    + Preparing dispute cases.

- Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub..100-08, ch. 12, §3.9 (Do not include costs of developing MR Strategy or the Quarterly Strategy Analysis (QSA). The cost of developing the MR Strategy and QSA shall be captured in MR CAFM code 21207).

- Educating the provider community about CERT as described in IOM Pub. 100-08, ch.12, § 3.8.

- Contacting non-responders and referring recalcitrant non-responders to the OIG as described in IOM Pub. 100-08, ch.12, § 3.10.

Contractors shall NOT report costs associated with the following activities in this activity code:

- Providing sample information to the CERT Contractor as described in IOM Pub. 100-08, ch. 12, §3.3.1A&B (these costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR);

- Ensuring that the correct provider address is supplied to the CERT Contractor as described in IOM Pub. 100-08, ch. 12, §3.3.1.C (these costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR);

Researching 'no resolution' cases as described in IOM Pub. 100-08, ch. 12, §3.3.1.B (these costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR).

11.1.5 – Reporting Internal Staff Training

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

For all internal staff training, charge the portion of the salaries for individuals attending the training to the activity(s) that the individual performs.

For training related to a particular MR activity(s) allocate the cost for the training and any associated travel cost to the activity(s) that the training benefits in other direct costs.

For training that benefits the overall MR program – if an individual attends the training - charge the costs of the training and any associated travel costs to the activity(s) that the individual performs in other direct costs. If a group attends the training, distribute the costs of the training and any associated travel costs among all MR activity codes in other direct costs.

For training that is required by CMS or benefits the Medicare program, allocate training and travel costs to overhead.

11.1.6 - Reporting MR Savings in CROWD

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Contractors shall report in CROWD only those actual savings that are generated from MR claims review.

Include as MR savings the following:

- Actual savings that result from all coverage and coding reviews done for MR purposes. Include all benefit category, statutory exclusion and, reasonable and necessary reviews done for MR purposes.

Contractors shall not include as MR savings:

- Avoided costs (e.g. a reduction in the number of claims submitted, compared to historical patterns, attributed to a new or revised LCD) shall not be considered "savings."

- Savings that result from coverage or coding reviews performed at the request of the fraud unit.

- Savings that result from any review other than coverage or coding.

11.2 - LPET Overview

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Contractors shall consider various elements when planning their LPET budget. For example, contractors shall explain how they plan to allocate provider educational activities between LPET and PCOM. The LPET subjects include medical review findings, and education on LCDs as identified through the PCA process. PCOM subjects include issues of national scope or impact. While there are fundamental differences between the LPET and PCOM programs, there may be circumstances when it would be feasible to provide educational events that encompass the scope of both of these programs. For any function such as seminars, conventions, or conferences that address LPET as well as PCOM subjects, the proportional share of the cost of that function to be allocated to LPET, is equal to the percentage of time related to addressing LPET subject matter, multiplied by the cost of the function. For example, the proportional share of the cost of a seminar to be allocated to LPET, is equal to the percentage of the seminar related to addressing LPET subjects, multiplied by the cost of the seminar (e.g., if it costs $4,000 to arrange and conduct a seminar containing 75 percent MR and 25 percent national coverage information, then the LPET cost would be $4,000 multiplied by 0.75 or $3,000 and the remaining $1,000 would be charged to PCOM). However, if the intent of the educational intervention is purely LPET, but PCOM issues arise; address the issues to the extent possible, but charge the cost of the intervention to LPET. This methodology for allocating costs also applies to other general, all-purpose provider education tools or materials, such as regularly scheduled bulletins/newsletters. The costs for developing, producing, and distributing bulletins, should be allocated proportionally according to the percentage of the time spent on each subject in the bulletin between LPET and PCOM.

Each contractor will be given a specified maximum budget for LPET activities. Contractors shall identify the appropriate budget and workload for each activity code within the constraints of their budgets. Contractors are not permitted to charge providers/suppliers for planned educational activities and training materials. However, contractors may assess fees of no more than the cost for educational activities delivered at a non-Medicare contractor sponsored event, or when specifically requested by specialty societies or associations. In addition, although contractors are mandated to supply providers with a paper copy of their bulletin at no cost, contractors may assess a fee to cover costs if the provider requests additional copies. All monies collected must be reported as a credit in the applicable activity code and accompanied with a rationale for charging the fee. The fees must be fair and reasonable. Revenues collected from

discretionary activities must be used only to cover the cost of these activities and may not be used to supplement other contractor activities.

11.2.1 - Reporting LPET Workload and Cost Information and Documentation in CAFM II

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

Workload information and associated workload cost information shall be maintained and documented on site by all contractors. Each site shall maintain records of its own workload information and associated workload cost information. Contractors shall be able to provide this information upon request from RO and/or CO. Site-specific workload and cost information should be reported in the remarks section of CAFM II. With RO consent, this information may be submitted by other means with an indication made in the remarks section of the CAFM II IER report.

The contractors' LPET workload records shall include workload information captured by the Interim Expenditure Report (IER). Only costs (direct, indirect, overhead) incurred in LPET activities are reported in CAFM II activity codes. Analysis of the data to develop and deliver LPET interventions shall be reported in an associated LPET activity code.

Contractors are responsible for ensuring the accuracy of the information contained in CAFM II. The contractor shall alert the RO (for *UPICs*, the GTL, Co-GTL, and SME) to any software or hardware problems that hinder the contractor's ability to report accurate data on CAFM II.

Since LPET is related to medical review activities, Joint Operating Agreements between *Unified Program Integrity Contractors (UPIC)* and Affiliated Contractors (AC) should reflect proportionate allocation of tasks delineated to MR and LPET. When negotiating Joint Operating Agreements, the *UPICs* should be cognizant of their task order.

11.2.2.1 – One-on-One Provider Education Workload and Cost (Activity Code 24116)

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Report the costs associated with One-on-One Provider Education in Activity Code 24116. Written materials, or electronic communications to providers during a One-on-One Provider Education, shall not be reported in Education Delivered via Electronic or Paper Media, Activity Code 24118, but included in the cost for One-on-One education. Activity Code 24116 - One-on-One Provider Education shall capture the one-on-one contact between the contractor and provider, and the written materials or electronic communication used to facilitate the one-on-one education. Included in this activity code would be letters sent to a provider that specifically addresses the medical review findings and instructions to correct the errors. Any provider contact made solely by paper or computer, without specifically addressing an individual provider, should not be reported here. (IOM Pub. 100-08, chapter 1.)

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

11.2.2.2 – Education Delivered to a Group of Providers Workload and Cost (Activity Code 24117)

(Rev. 130, Issued: 11-10-05, Effective: 10-01-05, Implementation: 12-12-05)

Report the costs associated with Education Delivered to a Group of Providers in Activity Code 24117. Report the number of group educational activities in Workload 1. Report the number of providers educated in Workload 2. If a provider sends a representative(s) on his behalf to a group education activity, count the number of provider(s), not representative(s), to whom the educational activity was directed. (IOM Pub. 100-08, ch.1.)

11.2.2.3 – Education Delivered via Electronic or Paper Media Workload and Cost (Activity Code 24118)

(Rev. 89, Issued: 11-26-04, Effective: 12-27-04, Implementation: 12-27-04)

Report the costs associated with Education Delivered via Electronic or Paper Media in Activity Code 24118. Report the total number of educational documents developed for use in non-interactive educational interventions in Workload 1. Report the number of CBRs developed in Workload 2 (do not include CBRs developed for Activities in 24116 and 24117). Report the number of articles/advisories/bulletins developed in Workload 3.Workloads 2 and 3 are subsets to workload 1. If an educational bulletin is published in a number of different venues, count that bulletin only once, even if publication occurs in different months.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10365PI	10/02/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08	08/27/2020	11884
R10228PI	07/27/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08 Replaced by Transmittal 10365	08/27/2020	11884
R220PI	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
R185PI	01/26/2007	Updating Financial Reporting Requirements for Workload and Cost Associated With the Return of Demand Bills	02/26/2007	4378
R174PI	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
R171PI	11/09/2006	Outpatient Therapy Cap Clarifications	12/09/2006	5271
R170PI	11/03/2006	Transition of Medical Review Educational Activities - Replaced by Transmittal 174	10/06/2006	5275
R163PI	09/29/2006	Transition of Medical Review Educational Activities - Replaced by Transmittal 170	10/06/2006	5275
R146PI	04/28/2006	Provider Enrollment Update	05/30/2006	4340
R140PI	02/15/2006	Therapy Caps Exception Process	03/13/2006	4364
R139PI	02/13/2006	Therapy Caps Exception Process - Replaced by Transmittal 140	03/13/2006	4364
R130PI	11/10/2005	Correction/Clarification of Several Sections	12/12/2005	4020
R104PI	02/11/2005	Requirement that Medicare Carrier System (MCS) Not Allow the Re-review of Previously Denied Claims	07/05/2005	3622
R089PI	11/26/2004	Updating Financial Reporting Requirements for Medical Review and Local Provider Education and Training	12/27/2004	3446
R071PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R36PI	12/27/2002	New sections added to Chapter	12/27/2002	2419
R033PI	11/01/2002	Fiscal Administration	11/01/2002	2407
R022PIM	05/05/2002	Clarification & Manualization of Chapter	04/01/2002	1962

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