CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 313	Date: November 20, 2009
	Change Request 6546

SUBJECT: Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7

I. SUMMARY OF CHANGES: The CMS is reorganizing the PIM. This process will delete duplications, relocate sections within the PIM for better flow of information and ease of use. The sections on medical review strategy that were originally in chapter 1, have been moved in their entirety to chapter 7, all changes and updates to these sections will be made in a future change request.

NEW / REVISED MATERIAL
EFFECTIVE DATE: December 21, 2009
IMPLEMENTATION DATE: December 21, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/1.1/Overview of Program Integrity and Provider Compliance
D	1/1.1.1/Definitions
D	1/1.1.2/Types of Claims for Which contractors Are Responsible
D	1/1.1.3/Quality of Care Issues
R	1/1.2/Definitions
D	1/1.2.1/Goal of the MR Program
D	1/1.2.2/MR Manager
D	1/1.2.3/Annual MR Strategy
D	1/1.2.3.1/Data Analysis and Information Gathering
D	1/1.2.3.2/Problem Identification and Prioritization
D	1/1.2.3.3/Intervention Planning
D	1/1.2.3.4/Program Management
D	1/1.2.3.5/Budget and Workload Management

D	1/1.2.3.6/Staffing and Workforce Management
R	1/1.3/Medicare Improper Payment Reduction Efforts - Provider Compliance
N	1/1.3.1/Types of Contractors
N	1/1.3.2/Improper Payment Prevention Goals
N	1/1.3.3/Applicable Program Integrity Manual Sections
N	1/1.3.4/Performance Metrics
N	1/1.3.5/Types of Claims for Which Contractors Are Responsible
N	1/1.3.6/Quality of Care Issues and Potential Fraud Issues
N	1/1.3.7/The Affiliated Contractors (AC) and MAC Medical Review Program
N	1/1.3.8/Goal of AC and MAC MR Program
N	1/1.3.9/Provider Self Audits
N	1/1.3.10/Coordination Among Contractors
R	1/1.5/Medical Review Manager
N	1/1.6/Maintaining the Confidentiality of MR Medical Records and Documents
N	1/1.7/Benefit Integrity
N	1/1.8/Medical Review for Benefit Integrity (MR for BI)
R	2/Table of Contents
R	2/2.1/Identifying Potential Errors - Introduction
R	2/2.2/Data Analysis
D	2/2.2.1/Data Analysis to Detect Potential Errors or Potential Fraud
D	2/2.2.1.1/Resources Needed for Data Analysis
D	2/2.2.2/Frequency of Analysis
D	2/2.2.3/Sources of Data
D	2/2.2.4/Steps in the Analysis Process
D	2/2.2.4.1/Determine Indicators to Identify Norms and Deviations
D	2/2.2.4.2/Document Data Strategy
R	2/2.3/Sources of Data for PSCs and ZPICs
N	2/2.4/Sources of Data for ACs, MACs, PSCs and ZPICs
R	7/Table of Contents
N	7/7.1/Annual MR Strategy
N	7/7.1.1/Data Analysis and Information Gathering

N	7/7.1.2/Problem Identification and Prioritization
N	7/7.1.3/Intervention Planning
N	7/7.1.4/Program Management
N	7/7.1.5/Budget and Workload Management
N	7/7.1.6/Staffing and Workforce Management

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 313	Date: November 20, 2009	Change Request: 6546

SUBJECT: Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7

Effective Date: December 21, 2009
Implementation Date: December 21, 2009

I. GENERAL INFORMATION

A. Background: This change request deletes duplications, relocates sections for a better flow of information and ease of use. The medical review strategy section in chapter 1, has been moved to chapter 7, in its entirety with no changes made.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6546.1	Contractors shall follow the entire PIM for functions as they relate to their respective roles and areas of responsibility relating to medical review and benefit integrity and supporting the PSCs, ZPICs, CERT, and RACs.	X	X	X	X	X					PSC ZPIC CERT RAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, Debbie.skinner@cms.hhs.gov, 410-786-7480
Post-Implementation Contact(s): Melanie Combs-Dyer, Melanie.combs-dyer@cms.hhs.gov, 410-786-7683

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

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

Table of Contents
(Rev. 313, 11-20-09)

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

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

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

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

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

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

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

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

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

A. The CERT Contractors

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

B. ACs and MACs

For the purpose of this manual, the term affiliated contractors or AC will be used to refer to carriers and fiscal intermediaries. ACs and MACs primarily use error rates produced by the CERT program and vulnerabilities identified through the RAC program to identify where to target their improper payment prevention efforts. The ACs and MACs analyze their internal data to determine which corrective actions would be best to prevent the

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

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

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

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

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

C. RACs

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

1.3.2 - Improper Payment Prevention Goals

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

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

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

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

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

CERT contractors

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

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

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

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

A. AC MR Units Performance

The AC MR Units Performance is measured by:

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

- **Performance Oversight** (Statement of Auditing Standards (SAS 70) Audit): The SAS-70 is a process currently utilized by medical review (MR) and other CMS components for *AC* performance oversight. This performance oversight program utilizes the skills and expertise of independent auditors to complete a performance audit. The audit takes approximately four months to complete and the *AC*'s performance during the most recent two quarters of the fiscal year are evaluated. There are two types of SAS-70 audits. Type I audits determine if essential internal controls are in place. Type II audits determine if the internal controls are effective. *MR* internal control objectives can be found in *Pub.100-06* , Medicare Financial Management Manual, chapter 7. The internal control objectives reflect CMS' requirements for an effective *MR* operation. *The PIM serves as the foundation criteria against which the AC is evaluated during the SAS 70 audit.*

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

The AC MR Units' performance is corrected by:

- **Educational Training Program**: Regional office (RO) or central office (CO) staff *should* recommend an educational intervention for *an AC* based on findings from a SAS-70 audit, problems with an *AC*'s medical review (MR) strategy, or for other concerns the RO or CO staff may have. A problem-focused educational interaction between CMS staff (RO *and* CO) and *an AC* is based on potential or current areas of contractor vulnerability.

B. MAC MR Units Performance

The MAC MR Unit performance is measured by:

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

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

C. RAC Performance:

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

D. CERT Performance

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

1.3.5 - Types of Claims for Which Contractors Are Responsible
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. ACs and MACs

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

Although they will continue to perform a number of quality functions, quality improvement organizations (QIOs) will no longer be performing the majority of utilization reviews for acute inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) *claims. The review of acute IPPS hospital and LTCH claims* (which, for the purposes of this section, also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) is now *the responsibility of the ACs and MACs. An exception occurs when a provider requests a higher-weighted diagnosis related group (DRG) review from the QIO. The QIO will continue to perform those reviews. QIOs will also continue to perform reviews related to quality of care and expedited determinations.*

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

B. CERT

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

C. RACs

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

1.3.6 - Quality of Care Issues and Potential Fraud Issues
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

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

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

1.3.7 - The Affiliated Contractor (AC) and MAC Medical Review Program
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

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

The statutory authority for the MR program includes the following sections of the Social Security Act (the Act):

- Section 1833(e) which states, in part "...no payment shall be made to any provider... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ...;"

- Section 1842(a)(2)(B) which requires *ACs and MACs* to "assist in the application of safeguards against unnecessary utilization of services furnished by providers ...; "

- Section 1862(a)(1) which states no Medicare payment shall be made for expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;"

- The remainder of Section 1862(a) which describes all statutory exclusions from coverage;

- Sections 1812, 1861, and 1832 which describe the Medicare benefit categories; and

- Sections 1874, 1816, *and* 1842 which provide further authority.

The regulatory authority for the MR program rests in:

- 42 CFR 421.100 for intermediaries.
- 42 CFR 421.200 for carriers.
- *42 CFR 421.400 for MACs.*

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

1.3.8 - Goal of AC and MAC MR Program

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

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

- Identify provider noncompliance with *coverage, coding, billing, and payment policies* through analysis of data. (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data). (*c*hapter 2, describes these activities in further detail.);

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

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

1.3.9 – Provider Self Audits

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

Providers may conduct self-audits to identify coverage and coding errors using the Office of Inspector General (OIG) Compliance Program Guidelines at

http://www.os.dhhs.gov/oig/modcomp/index.htm. *ACs and MACs shall* follow chapter 4, section 4.16, handling any voluntary refunds that may result from these provider self-audits.

Most *errors* do not represent fraud. Most *errors* are not acts that were committed knowingly, willfully, and intentionally. However, in situations where a provider has repeatedly submitted claims in error, the *ACs and MACs* shall follow the procedures listed in *chapter 3, section 3.1.* For example, some *errors* will be the result of provider misunderstanding or failure to pay adequate attention to Medicare policy. Other *errors* will represent calculated plans to knowingly acquire unwarranted payment. *Per chapter 4, section 2.1, ACs and MACs* shall take action commensurate with *errors* made. *ACs and MACs* shall evaluate the circumstances surrounding the *errors* and proceed with the appropriate plan of correction.

1.3.10 – Coordination *Among Contractors*

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

A. Coordination among ACs, MACs, PSCs and ZPICs

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

B. Coordination among ACs, MACs and the RACs

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

1.5 – *Medical Review Manager*

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

A. Contractors To Which This Section Applies

This section applies to ACs and MACs only.

B. General

An effective MR program begins with the strategies developed and implemented by senior management staff. Contractors *shall* name an MR point of contact referred to as the MR Manager who will act as the primary contact between the contractor and CMS concerning the contractor's MR program. The MR Manager will also have primary responsibility for the development, oversight and implementation of the contractor's MR

Strategy, SAR, and quality assurance process. In addition, the MR Manager shall have the primary responsibility for ensuring the timely submission of *required reports.*

1.6 – Maintaining the Confidentiality of MR Medical Records and Documents

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

A. Contractors to Which This Section Applies

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

B. General

Contractors *shall* maintain the confidentiality of all MR *medical records and documents* before, during, and after the MR process. Similarly, contractors that use a subcontractor(s) to perform MR, to store MR *documents*, and/or to transport MR *documents*, are responsible for ensuring that the subcontractor(s) maintains the confidentiality of the MR *documents* that it handles. This responsibility applies to all contact with these *documents* by all parties and entities, however derived from the contractor. The responsibility is not limited or ended if the subcontractor allows an additional party or entity to have contact with these *documents*. Thus, just as the contractor *shall* assure that the subcontractor maintain confidentiality itself, so too *shall* the contractor assure that the subcontractor similarly assures that any third party or other entity, such as a sub to the subcontractor, which has contact with the *documents*, maintain confidentiality.

1.7 - Benefit Integrity

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

A. Contractors to Which This Section Applies

This section applies to PSCs and ZPICs only.

B. General

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

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

1.8 - Medical Review for Benefit Integrity (MR for BI)
(Rev. 313; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. Contractors to Which This Section Applies

This section applies to PSCs and ZPICs.

B. General

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

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

Medicare Program Integrity Manual

Chapter 2 – Data Analysis

Table of Contents

(Rev. 313, 11-20-09)

2.1 – Identifying Potential Errors - Introduction

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

A. Contractors To Which This Section Applies

This section applies to ACs and MACs.

B. General

This chapter specifies resources and procedures *ACs and MACs shall* use to identify and verify potential errors to produce the greatest protection to the Medicare program. *ACs and MACs* should objectively evaluate potential errors and not take administrative action unless they have verified the error and determined that the error is a high enough priority to justify the action. *ACs and MACs should also archive the error including supporting rationale for selection.* (See Reliable *Information* in Pub. 100-08, Exhibits, Exhibit 4.)

C. Review of Data

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis *should* include simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

Data analysis itself *shall* be undertaken as part of general surveillance and review of submitted claims, or *shall* be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, *f*raud *a*lerts, reports from CMS, other *ACs, MACs*, or independent government and nongovernmental agencies.

2.2 – Data Analysis

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

A. Contractors To Which This Section Applies

This section applies to ACs, MACs, PSCs, and ZPICs. This section does not apply to the RACs. RACs should follow the data analysis instructions listed in their Statement of Work.

B. General

Data analysis is a tool for identifying *actual or* potential claim payment errors. Data analysis compares claim information and other related data to identify potential errors and/ or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers, or beneficiaries) individually or in the aggregate. Data analysis is an integrated, on-going component of MR and *benefit integrity (BI)* activity.

The *ACs', MACs', PSCs', and ZPICs'* ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. *They* should use research and experience in the field to develop new approaches and techniques of data analysis. *ACs, MACs, PSCs, and ZPICs* should have ongoing communication with other government organizations (e.g., QIOs and the State Medicaid agencies) concerning new methods and techniques.

Analysis of data should:

- Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;

- Establish baseline data to enable the *recognition of* unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;

- Identify where there is a need for *an LCD*;

- *Identify where there is a need for targeted education efforts;*

- Identify claim review strategies that efficiently prevent or address potential errors (e.g., prepayment edit specifications or parameters);

- Produce innovative views of utilization or billing patterns that illuminate potential errors;

- Identify high volume or high cost services that are being widely overutilized. This is important because these services do not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk;

- Identify program areas and/or specific providers for possible fraud investigations; and

- *Determine if major findings identified by RACs, CERT, and CMS represent significant problem areas in the AC's or MAC's jurisdiction.*

This data analysis program *shall* involve an analysis of national data furnished by CMS as well as review of internal billing utilization and payment data to identify potential errors.

The goals of the data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

The ACs, MACs, PSCs, and ZPICs shall document the processes used to implement their data analysis program and provide the documentation upon request.

In order to implement a data analysis program, the *ACs, MACs, PSCs, and ZPICs* shall:

- Collect data from sources such as:

  - Historical data, e.g., review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement (PS&R) data, billing data, Common Working File (CWF), data from other Federal sources, i.e., QIO, other *ACs and MACs*, Medicaid; and

- Referrals from internal or external sources (e.g., provider audit, PSC, beneficiary, or other complaints);

- Conduct data analysis to identify potential errors;

- Institute ongoing monitoring and modification of data analysis program components through the QIP.

The shared system maintainer shall allow the ACs and MACs the ability to select claims using the NPI or the legacy number (OSCAR or UPIN) as a criterion for medical review.

C. Resources Needed for Data Analysis

The ACs, MACs, PSCs, and ZPICs shall have available sufficient hardware, software, and personnel with analytical skills to meet requirements for identifying problems efficiently and developing and implementing corrective actions. If *ACs and MACs* are unable to employ staff with the qualifications/expertise to aid in an effective analysis, they *shall* use other entities (e.g., universities, consultants, other contractors) who can provide the technical expertise needed. The following are minimum resource requirements for conducting data analysis, *evaluation, and reporting*.

1. Data Processing Hardware

Adequate equipment for data analysis includes facilities to process data (i.e., mainframes and personal computers) and to store data (i.e., tape drive, disk drives, etc.). Upgrading current resources (i.e., mainframe computers, shared systems, etc.) or the purchase of new capabilities (i.e., microcomputer workstations or subcontracts for computer services) may provide additional processing capabilities. In addition, *ACs, MACs, PSCs, and ZPICs shall* have telecommunication capabilities to interact with the CMS Data Center.

2. Data Processing Software

The CMS provides *ACs, MACs, PSCs, and ZPICs* with software to allow communication with the CMS Data Center. At their discretion, *ACs, MACs, PSCs, and ZPICs that* wish to develop or acquire additional software that allows for analysis of internal data or other data obtained from the CMS Data Center *may do so*. *ACs, MACs, PSCs, and ZPICs* should have internal software to support the analyses of data to meet program goals.

3. Personnel

The ACs, MACs, PSCs, and ZPICs shall have staff with appropriate training, expertise and skills to support the application of software and conduct systematic analyses and clinical evaluation of claims data. CMS strongly encourages *ACs, MACs, PSCs, and ZPICs* to have staff with clinical expertise (e.g., registered nurses) and a mix of skills in programming, statistics, and data *mining* analysis (e.g., trending and profiling of providers/codes).

The ACs, MACs, PSCs, and ZPICs shall also employ *a* staff that has training in developing analytical and sampling strategies for overpayment projections.

D. Frequency of Analysis

The ACs and MACs shall have a minimum of 18 months of data but are encouraged to have 36 months. The *ACs, and MACs shall*, at a minimum, compare the current 6-month period to the previous 6-month period to detect changes in providers' current billing patterns and to identify trends in new services. Summary data or valid samples can be used when dealing with very large volumes of data.

E. Determine Indicators to Identify Norms and Deviations

The ACs, MACs, PSCs, and ZPICs shall develop indicators that will be used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends and the most significant abnormalities or trends. Examples of indicators or variables are:

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

F. Document Data Strategy

While CMS is deliberately not prescriptive in terms of the technical details of how *to* reach data analysis goals, *ACs, MACs, PSCs,and ZPICs* are expected to develop the most sophisticated and effective methods and procedures to meet these goals and will be held accountable for *accurate,* effective reports, procedures, and *quality* outcomes.

2.3 – Sources of Data for PSCs and ZPICs

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

A. Contractors To Which This Section Applies

This section applies to PSCs and ZPICs.

B. General

The PSC*s' and the ZPICs*' approach for combining claims data (*AC data, MAC data, RAC data from the RAC data warehouse)* and other data to create a platform for conducting complex data analysis shall be documented in their Information Technology Systems Plan. By combining data from various sources, the PSC *or the ZPIC* will present an entire picture of a beneficiary's claim history regardless of where the claim was processed. The primary source of this data will be the CMS National Claims History (NCH). The PSC *or the ZPIC* shall be responsible for obtaining data for all beneficiaries for whom the AC(s) or MAC(s) paid the claims.

The PSCs *and ZPICs* are required to store at a minimum the most recent 36 months worth of data (including Part A, Part B, *DME, home health & hospice*) for the jurisdiction *or zone* defined in their task order.

If the jurisdiction of the AC(s) or MAC(s) is not defined geographically, the PSC *or the ZPIC* shall obtain a complete beneficiary claims history for each unique beneficiary for whom the AC(s) or MAC(s) paid a claim.

EXAMPLE 1: The AC(s) or MAC(s) jurisdiction being competed covers Maryland but includes a hospital chain with facilities in Montana. The PSC *or the ZPIC* would request claims history from NCH for all claims paid by the AC(s) or MAC(s).

EXAMPLE 2: The AC(s) or MAC(s) jurisdiction being competed covers Maryland, a beneficiary lives in Pennsylvania, and the beneficiary saw a doctor in Maryland. The PSC *or the ZPIC* would request claims history from NCH for all claims paid by the AC(s) or MAC(s).

The PSCs *and the ZPICs* will not be able to tap data from the Common Working File (CWF).

The PSCs *and the ZPICs should, at their discretion*, if agreement and cooperation of the AC(s) or MAC(s) are obtained, use data directly from the claims processing system of the AC(s) or MAC(s), and then supplement the other data using NCH.

In developing this plan the PSCs *and the ZPICs* shall address the above requirements and, at a minimum, establish read-only access to the AC's or MAC's shared claims processing system(s) and access to the Part A, B, and D data available through the NCH for the jurisdictional area defined in the Task Order. The PSC *and the ZPIC* shall obtain denial data *either through PIMR or the ACs and MACs and document the process for obtaining this data from the AC(s) or MAC(s) in the Joint Operating Agreement*. At a minimum, the denial data shall include data for edits that were requested and/or recommended by the PSC *or the ZPIC*.

The PSC *and the ZPIC shall* have the ability to receive, load, and manipulate CMS data. The data *shall* also be maintained in accordance with CMS and Federal privacy laws and regulations as described in the CMS Data Use Agreement. For planning purposes, the PSCs *and ZPICs* should assume that there are 30 claims per HIC per year, on average. A claim record is about 1000 bytes. To calculate the storage space necessary, use the following formula:

#HICs X 30 claims X #years X 1000 = #bytes

The CMS *contract officer's technical representative (COTR*) and PSC *and ZPIC* will need to complete:

- Data use agreement to give permission to receive privacy protected data.
- Data request form to specify all data required by the PSC *and the ZPIC.*
- HDC application for HDC access and/or CMS systems' access to get access to the data center and/or to specify which CMS systems the PSC *and the ZPIC* will access.
- DESY system application form. (This is provided to the PSC *and the ZPIC* post-award.)

Information on data files, including file layouts and data dictionaries, is available at http://cms.hhs.gov/data/purchase/default.asp.

2.4– Sources of Data for ACs, MACs, PSCs and ZPICs

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

A. Contractors To Which This Section Applies

This section applies to ACs, MACs, ZPICs and PSCs. The sources of data for CERT and RACs are specified in their SOWs.

B. General

The data sources that *ACs, MACs, PSCs and ZPICs* use will depend upon the issue(s) being addressed and the availability of existing data. Some of the provider information that *should* be used includes:

- Types of providers;
- Volume of business;
- Volume (or percentage) of Medicare/Medicaid patients;

- Prevalent types of services;
- Location;
- Relationships to other organizations;
- Types of ownership;
- Previous investigations by the *PSC or ZPIC*;
- Size and composition of staff;
- Administrative costs;
- Claims history; and
- Other information needed to explain and/or clarify the issue(s) in question.

Systematic data analysis requires *ACs, MACs, PSCs and ZPICs* to have in place the hardware and software capability to profile providers in aggregate, by provider type, by common specialties among providers, or individually.

Where possible, the selection of providers should show a representative grouping, in order to accurately reflect the extent of program losses.

C. Primary Source of Data

Claims data is the primary source of information to target abuse activities. Sources of claims data are:

- National Claims Data – *ACs, MACs, PSCs and ZPICs* should utilize the reports accessible from Health Care Customer Information System (HCIS). *ACs, MACs, PSCs and ZPICs* utilize the CMS Data Center's *Part B Analytics System*, which show comparative utilization ratios by code, *AC or MAC*, and specialty. *ACs, MACs, PSCs and ZPICs shall* use national data where available. National data for services billed by skilled nursing facilities (SNFs) and home health agencies (HHAs) is available at the CMS Data Center; and

- Contractor Local Claims Data – Local data should be compiled in a way to identify which providers in the contractor's area may be driving any unusual utilization patterns.

D. Secondary Sources of Data

The ACs, MACs, PSCs and ZPICs should consider other sources of data in determining areas for further analysis. These include:

- OIG and General Accounting Office (GAO) reports;
- Fraud *A*lerts;
- Beneficiary, *physician* and provider complaints;
- Referrals from the QIO, other contractors, CMS components, Medicaid fraud control units, Office of the U.S. Attorney; or other federal programs;
- Suggestions provided directly or implicit in various reports and other materials produced in the course of evaluation and audit activities, e.g., contractor evaluations, State assessment, CMS-directed surveys, contractor or State audits of providers;
- Referrals from medical licensing boards;
- Referrals from the CAC;
- Information on new technologies and new or clarified benefits;
- Provider cost reports (Intermediaries);
- Provider Statistical and Reimbursement (PS&R) System data (intermediaries) *and MACs*;
- Enrollment data;
- *Overpayment data;*
- Common Working File (CWF);

- Referrals from other internal and/or external sources (e.g., *PDAC, AC or MAC* audit staff, audit staff or, *AC or MAC* quality assurance (QA) staff);
  - *Pricing, data analysis, and coding (PDAC) data*; and
  - Any other referrals.

  While the *AC, MAC, RAC, PSC, and ZPIC* should investigate reports from the GAO, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not be used as a main source for leads on fraud cases.

Medicare Program Integrity Manual

Chapter 7 - MR Reports

Table of Contents

(Rev. 313, 11-20-09)

7.1 - Annual MR Strategy

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

Each fiscal year, the contractors shall develop and document a unique annual MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The MR strategy shall detail identified MR issues, activities, projected goals, and the evaluation of activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the MR strategy. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. CERT is only a pointer and cannot be relied upon as a single source of information. Contractors should use their internal data to verify that the CERT findings are (or are not) currently problems of sufficient magnitude to be included in their MR strategy in the appropriate priority. Other problems identified from other sources may be of higher priority, but contractors must review the CERT findings in terms of their own data and MR activities. Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and provider outreach and education POE.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR activities. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop MR interventions using the PCA process (IOM Pub 100-8, chapter 3, section 14) to address each problem.

The methods and resources used for MR interventions depend on the scope and severity of the problems identified and the action needed to successfully address the problems. For example, if initial MR actions such as an MR notification letter to the provider and placement on prepayment review are insufficient to improve the provider's billing accuracy, a priority referral to POE for potential intervention may be necessary. Alternately, if on initial probe, a medium or high priority problem is identified, MR may determine that the initial issuance of probe result letter is insufficient, and a priority referral to POE, and/or more intensive medical review corrective actions may be required. A priority referral is an indication to the POE department that this is a problem which MR has determined will likely require further educational intervention. If, through communication with POE, it is determined that MR intervention and POE educational

efforts have not effectively resolved the problem, a referral to the PSC BI unit may be indicated.

In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR strategy and reflected in the SAR. If resources allow, an MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address identified problems for the local Medicare providers. The MR strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of activities designed to resolve targeted medical review problems. These evaluation methods will be dependent upon effective communication between the MR and POE departments. MR shall work with POE to develop an effective system of communication regarding the disposition of problems referred to POE. Within MR, a system shall be used to track referrals to POE, follow-up communication with POE, and MR interventions used to address identified problems. The PSC shall include what information is required in the referrals to POE within the AC or MAC JOA.

As problems are addressed within MR or referred to POE, the MR department shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information gathered through communication with POE to determine a more progressive course of action, such as increase in prepay MR, priority referral to POE, or referral to BI in cases of suspected fraud. Effective tracking of MR and POE efforts to resolve identified problems is integral to development of any case referred for potential investigation by the PSC (see PIM, chapter 4, section 4.3). As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The MR strategy shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) and Medicare administrative contractors (MACs) shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the CMS analysis, reporting, and tracking (ART) system.

In each element of the MR strategy, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In

addition, the contractor shall have in place procedures for continuous quality improvement. Quality improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported. Examples of actions which might be listed in the intervention list include, but are not limited to service-specific probes, notification letters, POE priority referrals, and automated denials based on LCDs.

Figure 1

FY 200_ Medicare Medical Review Strategy

Contractor Name:
Contractor Number:
Contractor MR site location(s):

Data Analysis Plan:
Prioritized Problems: **(1)**
(2)
(3)
Intervention Plan: **(1)**
(2)
(3)
Follow up Plan: **(1)**
(2)
(3)
Program Management:

- **Workload management process**
- **Cost allocation management process**
- **Staffing & Resource management process**
- **CMS Mandates**
- **PSC support**

Budget and Workload Chart:

Staffing Chart:

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR consults with POE to ensure that duplicate efforts are not being undertaken or consistently being

overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

7.1.1 - Data Analysis and Information Gathering

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

The data analysis plan shall list the data resources used in developing the strategy and the MR process. Examples of helpful resources include national database reporting systems, internal claims reports, provider feedback, team meetings with appeals and provider inquiry, SADMERC data, provider tracking tools to identify potential coverage and coding problems, CERT data, SAS 70 findings, benefit integrity (BI) information, and any additional data developed by the contractor. The data analysis plan shall list the data resources and processes used in development of the MR strategy.

Quality Assurance:

For quality assurances purposes, the contractor shall develop a process that includes frequent review of data and how the information is used. For example, establish a committee that routinely reviews data results. Document committee members' job titles, qualifications and contract operational areas they represent. Describe the log system or tracking system utilized for data analysis and how this information was developed via meetings and/or brainstorming. The contractor can use the CERT findings to demonstrate how well the contractor is performing their data analysis.

7.1.2 - Problem Identification & Prioritization

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

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR is not focusing on problems that are being addressed by the POE unit or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

7.1.3 - Intervention Planning

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

To address the problems identified in the MR strategy, the contractor shall design a comprehensive plan of interventions. Interventions may involve projected medical review of claims, referral of providers to POE or the PSC BI unit, edit modifications and development or revisions of LCDs.

Quality Assurance:

The contractor shall include a quality assurance element in each intervention that checks for effectiveness and progress towards the specified goal. The QA component shall include a projected goal, a timeline to achieve the goal, and an element to assess effectiveness of the intervention and progress towards the stated goal. Examples of QA for interventions include, but are not limited to, tests for edit effectiveness, post-test of educational interventions, claims review after an educational intervention, systematic reviews of LCDs, etc. Finally, the QA component shall include a determination of whether the problem has been resolved or a more progressive course of action is required.

7.1.4 - Program Management

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

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

Quality Assurance:

The contractor shall describe in detail the quality improvement process. Include the processes employed to assure accuracy and consistency in the reporting of spending, workload and staffing levels. The contractor shall address how to maintain accuracy in decision-making (inter-reviewer reliability) and response to provider inquiries. In addition, the contractor shall describe the system for the review and evaluation of the MR strategy.

7.1.5 - Budget and Workload Management

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

In order to effectively determine appropriate budget levels and accurately predict workload, the contractor shall complete the following chart (omitting the shaded areas) for each strategy developed. Note that this chart is only for the purposes of developing an MR strategy. Contractors are expected to report workloads and costs associated with all CAFM II activity codes and assigned workloads. PSCs and MACs shall not report

cost and workload using the CAFM II system. Instead, the PSC shall report cost and workload in the CMS ART system.

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	MR Program Management				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				

NOTE: When submitting the Interim Expenditure Report (IER), all defined workloads shall be entered.

In addition:

- The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code. Contractors may perform automated, routine, and complex prepayment review and post-payment reviews. Contractors shall determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration shall be given to the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate.

– The contractor shall automate as much review as possible. For those types of review that cannot be automated, the contractor shall be able to justify why they cannot be automated. Only in those instances where reviews cannot be automated and does not require clinical judgment shall the contractor conduct routine reviews.

– The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall MR program for the contractor. For the PSCs that perform some medical review functions, they shall be involved with the development of the MR strategy.

- The contractor shall identify the process for determining when the contractor will develop or revise LCD.

7.1.6 - Staffing and Workforce Management

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

Contractors shall complete and include the following chart to project the number of full-time-equivalent (FTE) employees, their job titles and qualifications.

CAFM II Code	FTE	Description & Qualifications
21001		
21002		
21007		
21010		
21206		
21207		
21208		
21220		
21221		
21221/01 (DMERCs only)		
21222		

The contractor shall submit a MR strategy each fiscal year via the MR system located at CMS's Local Coverage Systems Portal Web site. The MR strategy shall be updated as required. MAC contractors shall submit a MR strategy within 30 days after contract award and thereafter 30 calendar days prior to option year award.