CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 454	**Date: March 14, 2013**
	Change Request 8205

NOTE: Transmittal 451, dated March 1, 2013, is being rescinded and replaced by Transmittal 454, dated March 14, 2013, to delete a duplicate paragraph in section 1.3.9 of the Manual Instructions. All other information remains the same.

SUBJECT: Minor Changes to Chapter 1 of the Program Integrity Manual

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to add section 1893(b)(1) to the list of statutory authorities, and updates the OIG links for provider self-audits.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.3.7/The Affiliated Contractor (AC) and MAC Medical Review Program
R	1/1.3.9/Provider Self Audits

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

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 obliged 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: 454	Date: March 14, 2013	Change Request: 8205

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SUBJECT: Minor Changes to Chapter 1 of the Program Integrity Manual

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

I. GENERAL INFORMATION

A. Background: Section 1893(b)(1) is one of the statutory authorities for the Medical Review program. It states "Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section)."

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8205.1	Contractors shall be aware of the changes to Chapter 1 sections 1.3.7 and 1.3.9 of the Program Integrity Manual.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Della Johnson, 410-786-8820 or della.johnson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's 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 do 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.

1.3.7 - The Affiliated Contractor (AC) and MAC Medical Review Program

(Rev.454; Issued: 03-14-13; Effective Date: 04-01-13, Implementation Date: 04-01-13)

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;

- *Section 1893(b)(1) establishes the Medicare Integrity Program which allows contractors to review activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies. . .”*

- 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.

1.3.9 – Provider Self Audits

(Rev.454; Issued: 03-14-13; Effective Date: 04-01-13, Implementation Date: 04-01-13)

Providers may conduct self-audits to identify coverage and coding errors. The Office of Inspector General (OIG) Compliance Program Guidelines *can be found at https://oig.hhs.gov/compliance/compliance-guidance/index.asp and the statistical guidelines in https://oig.hhs.gov/authorities/docs/selfdisclosure.pdf (if statistical sampling is utilized during the audit).* 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 *3.2.1*. 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 *4.*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.