CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 279	Date: December 19, 2008
	Change Request 6171

SUBJECT: Zone Program Integrity Contractor (ZPIC) Updates

I. SUMMARY OF CHANGES: Benefit integrity work will transition form PSCs to ZPICs and the ZPICs will be locted in 7 zones. Therefore, the instructions have been updated to include ZPICs.

NEW / REVISED MATERIAL
EFFECTIVE DATE: January 26, 2009
IMPLEMENTATION DATE: January 26, 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	2/Table of Contents
R	2/2.2/Data Analysis
R	2/2.2.3/Sources of Data
R	2/2.3/Sources of Data for PSCs and ZPICs

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: 279	Date: December 19, 2008	Change Request: 6171

SUBJECT: Zone Program Integrity Contractor (ZPIC) Updates

Effective Date: January 26, 2009
Implementation Date: January 26, 2009

I. GENERAL INFORMATION

A. Background: Benefit Integrity work will transition from PSCs to ZPICs and the ZPICs will be located in 7 zones. Therefore, the instructions in chapter 2 of the PIM have been updated to include ZPICs.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
6171.1	ZPICs shall follow the requirements in PIM chapter 2.										ZPICs

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:
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:

V. CONTACTS

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Post-Implementation Contact(s): Kimberly Downin, Kimberly.Downin@cms.hhs.gov, 410-786-0188

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* 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)*, use 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 2 – Data Analysis

Table of Contents
(Rev.279, 12-19-08)

2.2 – Data Analysis

(Rev.279, Issued: 12-19-08, Effective: 01-26-09, Implementation: 01-26-09)

Data analysis is a tool for identifying potential claim payment errors. Data analysis compares claim information and other related data (e.g., the provider registry) 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 BI activity.

The contractor's ability to make use of available data and apply innovative analytical methodologies is critical to the success of the MR and BI programs. Contractors should use research and experience in the field to develop new approaches and techniques of data analysis. Ongoing communication with other government organizations (e.g., QIOs, the State Medicaid agencies, fiscal intermediaries, carriers, *A/B MACs* and the *DME MACs*) concerning new methods and techniques should occur.

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 contractor to recognize unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;

- Identify where there is a need for LCD;

- 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; and

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

This data analysis program must 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 contractors' data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

Contractors 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 contractor shall:

- Collect data from sources such as:

  o 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 carriers and fiscal intermediaries (FIs), Medicaid; and

  o Referrals from internal or external sources (e.g., provider audit, BI unit, beneficiary, or other complaints);

- Conduct data analysis to identify potential errors;

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

2.2.3 – Sources of Data

(Rev.279, Issued: 12-19-08, Effective: 01-26-09, Implementation: 01-26-09)

A. Primary Source of Data

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

- National Claims Data – Contractors should utilize the reports accessible from Health Care Customer Information System (HCIS). Carriers utilize the CMS Data Center's Part B Extract Summary System (BESS), especially the focused medical review (FMR) reports, which show comparative utilization ratios by code, carrier, and specialty. Intermediaries must 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.

B. Secondary Sources of Data

Contractors 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 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);

- Enrollment data;

- Common Working File (CWF);

- Referrals from other internal and/or external sources (e.g., statistical analysis *DME MAC*, MR, intermediary audit staff or, carrier quality assurance (QA) staff); and

- Any other referrals.

While the contractor should investigate reports from the GAO, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, PSC *and Zone Program Integrity Contractor (ZPIC)* network, 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.

2.3 – Sources of Data for PSCs *and ZPICs*

(Rev.279, Issued: 12-19-08, Effective: 01-26-09, Implementation: 01-26-09)

The PSCs' *and the ZPICs'* approach for combining claims data (fiscal intermediary, regional home health intermediary, carrier, and durable medical equipment regional carrier data) 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 the ZPICs* are required to store at a minimum the most recent 36 months worth of data (including Part A, Part B, and *DME*) for the jurisdiction 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 CMS Office of Information Services (OIS) has advised that this methodology for obtaining data will not be allowed.

The PSCs *and the ZPICs* may, 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 also work with the AC(s) or MAC(s) to obtain denial data 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* must have the ability to receive, load, and manipulate CMS data. The data must 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 the 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 Government Task Leaders (GTL) 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 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.