MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 1 – MEDICAID INTEGRITY PROGRAM (MIP)

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(Rev. 10384, Issued: 10-09-20)

1.1 - Basis of Authority – Statutory/Regulatory Citation
(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Section 1936 of the Social Security Act (the Act), established by the Deficit Reduction Act of 2005, is the statutory authority under which the UPICs operate their Medicaid functions. Section 1936(a) of the Act provides that the Secretary must enter into contracts with eligible entities to conduct certain activities specified at section 1936(b) of the Act. Section 1936(b) of the Act provides that eligible entities under contract with the Centers for Medicare & Medicaid Services' (CMS) can audit claims for payment for items or services furnished under a state plan as well as identify overpayments made to individuals or entities receiving federal funds under Medicaid to determine whether fraud, waste, or abuse has occurred or is likely to occur.

Additionally, Section 6402 of the Patient Protection and Affordable Care Act (PPACA) provides guidance related to the Medicaid integrity program, health care fraud oversight and guidance, suspension of Medicaid payments pending investigation of credible allegations of fraud, and the increased funding associated with targeting and preventing Medicaid fraud, waste, and abuse. Lastly, Section 6506 of the PPACA provides guidance related to Medicaid overpayment recoupment and federal repayment.

1.2 - BACKGROUND
(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Unified Program Integrity Contractors (UPICs) are contracted entities with CMS that conduct investigations and audits related to activities in an effort to reduce fraud, waste, and abuse in both the Medicare and Medicaid programs. The UPICs operate in geographic areas or "jurisdictions" defined by individual Task Orders.

The UPICs perform numerous functions to detect, prevent, and deter specific risks and broader vulnerabilities to the integrity of the Medicare and Medicaid programs including, but not limited to:

- Proactively identify incidents of potential fraud, waste, and abuse that exist within its service area and take appropriate action on each case;
- Investigate allegations of fraud made by beneficiaries, providers/suppliers, CMS, Health & Human Services Office of Inspector General (OIG), and other sources;
- Explore all available sources of fraud leads, including the state Medicaid agency (SMA) and the Medicaid Fraud Control Unit (MFCU);
- Refer and/or recommend appropriate Medicaid administrative actions to state Medicaid agencies where there is reliable evidence of fraud, including, but not limited to, overpayments, payment suspensions and terminations;
- Refer cases to the OIG/Office of Investigations (OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions;
- Partner with state Medicaid Program Integrity Units to perform the above activities for the Medi-Medi program and Medicaid-only investigations; and

- Work closely with CMS on joint projects, investigations and other proactive, anti-fraud activities.

The UPICs utilize a variety of techniques to address any potentially fraudulent, wasteful, or abusive billing practices based on the various leads they receive. The UPICs integrate the program integrity functions for audits and investigations across Medicare and Medicaid, and assure that CMS's national priorities for both Medicare and Medicaid are executed and supported at the state level or within the UPIC jurisdiction.

1.3 - Definitions

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The following definitions provide additional context for the UPICs to reference while collaborating with SMAs. However, CMS recognizes that each SMA may use other terms and definitions than those noted below. The UPIC shall consult with each SMA to determine the appropriate terms and definitions to utilize during the collaboration.

Investigation - The review of Medicaid claims suspicious aberrancies, and/or to establish evidence that potential fraudulent activity and/or improper payments has occurred. Generally, the activities associated with an investigation may include, but are not limited to, the following actions: interviews of recipients or providers, documentation requests (i.e., questionnaires, attestations, etc.) to providers, post-payment review, auditing for third party liability as well as usual and customary charges, and overpayment determinations, as well as potential referrals to the State for potential payment suspension or termination actions. While some State Medicaid Agencies (SMA) may prefer an investigative approach, other SMAs may prefer an audit approach. State preference concerning the review of Medicaid claims shall be discussed at the onset of the collaboration and followed throughout the investigative and/or audit process. For consistency purposes, the term "investigation" will be primarily used in this chapter.

Medicaid - The Medicaid program was established under title XIX of the Social Security Act. The program is a joint federal-state funded health insurance program that is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans. The federal government establishes minimum requirements for the program and states design, implement, administer, and oversee their own Medicaid programs. In general, states pay for the health benefits provided, and the federal government, in turn, matches qualified state expenditures based on the Federal Medical Assistance Percentage (FMAP), which can be no lower than 50 percent.

All states participate in the Medicaid program, and as a requirement for receipt of federal matching, payments must cover individuals who meet certain minimum financial eligibility standards. Additionally, the states must cover certain medical services, such as physician, hospital, and nursing home care and are provided the flexibility to offer a large number of optional benefits to beneficiaries. States also have the option to expand their Medicaid programs to cover additional beneficiaries who have income above the minimum financial threshold, up to statutory limits on income levels. State governments

have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments.

Medicaid Initial Findings Report – Initial summary of Medicaid findings resulting from a UPIC investigation of a Medicaid provider. A Medicaid Initial Findings Report details the timeframe of the claims review period and a summary of the claims review findings. At the completion of a UPIC investigation, a Medicaid Initial Findings Report is submitted to the SMA and provider (if applicable) for review and comment. This report is only to be used when the UPIC identifies a Medicaid overpayment to be referred to the SMA. Upon approval by CMS and the SMA, the findings will be documented in a Medicaid Final Findings Report.

Medicaid Final Findings Report - Summary of Medicaid final findings resulting from a UPIC investigation of a Medicaid provider. A Medicaid Final Findings Report is provided to the SMA by CMS detailing timeframe of the claims review period, summary of the claims review findings, total computable overpayment, total federal financial participation overpayment, and the detail associated with the federal requirement for the state to remit the federal share of the overpayment to CMS within one year from the date of the letter. This report is only to be used when the UPIC identifies a Medicaid overpayment to be referred to the SMA.

Overpayment – Overpayments are categorized in different forms. However, no overpayment can be processed without confirmation from the SMA. For example, an actual overpayment is, for those claims reviewed, the sum of payments (based on the amount paid to the provider/supplier and Medicaid approved amounts) made to a provider/supplier for services which were determined to be medically unnecessary or incorrectly and/or improperly billed. This includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claim submission, unacceptable practices, fraud, abuse, or mistake. In addition, an estimated overpayment can be assumed by calculating potential claims in error either from billing issues that do not meet SMA policy requirements or through an actual medical review of claims. Finally, an extrapolated overpayment is an overpayment obtained by calculating claims denials and reductions typically from a medical records review based on a statistical sampling of a claims universe.

State Medicaid Agency (SMA) - The single state agency administering or supervising the administration of a state Medicaid plan. Each SMA establishes and administers their own Medicaid programs; they determine the type, amount, duration, and scope of benefits within broad federal guidelines. While all state Medicaid programs have financial responsibility for any improper payments identified through program integrity activities, the scope and execution of program integrity activities varies by state. State entities that may be involved in the program integrity oversight include the SMAs, Medicaid fiscal agents, MFCUs, State, State Attorney General offices, and other agencies with program integrity missions, such as Medicaid Inspector General and State Comptroller offices.

States are critical partners in stewardship of the public trust and are strongly committed to ensuring the accuracy of Medicaid payments and detection/prevention of fraud, waste, and abuse. States are required to establish and maintain program integrity activities which meet federal requirements and which coordinate with federal program integrity efforts.

For all other definitions, reference the Medicare Program Integrity Manual Exhibits at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83exhibits.pdf.

1.4 - State Collaboration Purpose

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The purpose of collaboration between the SMA and the UPIC is to identify state priorities, specialty areas of analytical and investigative interest, clarification of state policy, and to ensure there is no duplication of efforts.

Prior to the UPIC opening an investigative lead, the UPIC will vet the providers identified for investigation with the state. The UPIC shall provide the state a list of potential investigations generated by the data analysis, complaints, referrals, etc. If the state is conducting an audit or investigation of the same provider for similar Medicaid issues, CMS may cancel or postpone the UPIC investigation of the provider. Through this information exchange, CMS avoids duplicating the efforts of other Medicaid audits and investigations.

Collaboration between the SMA and the UPIC may differ from state to state. While some states may prefer an investigative approach, other states may prefer an audit approach. State preference in regards to the review of Medicaid claims shall be discussed at the onset of the collaboration, and continue throughout the investigative and/or audit process.

1.5 - Complaint and Lead Screening

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPIC may receive complaints alleging fraud, waste, or abuse in the Medicaid program from multiple sources (i.e., SMAs, the Internet, news media, industry groups, conferences, etc.). Upon receipt, the UPIC shall consult with the state to determine if the SMA or the UPIC will proceed with further review of the lead. If the SMA chooses to review the complaint, the UPIC shall refer all documentation received with the complaint to the SMA and close the lead. Otherwise, the UPIC shall screen the lead to determine if further investigation is warranted.

In accordance with the requirements at 42 CFR 455 Subpart A, the SMA may also refer these complaints to their respective MFCU. Entities that may commit fraud, waste, or abuse include, but are not limited to: Medicaid providers, Medicaid managed care organizations, their employees, and/or agents or subcontractors.

For further guidance related to Complaint and Lead Screening, the UPICs shall follow the Medicare PIM guidelines at 4.6.3 – Screening Leads.

1.6 - Vetting Process

(Rev. 10384; Issued: 10-09-20; Effective: 10-10-20; Implementation: 11-10-20)

All leads and any new subjects that the UPIC determines warrant further investigation shall be vetted through CMS for approval before transitioning to an investigation. The UPICs shall follow the Medicare PIM 4.6.4 - Vetting Leads with CMS. Following the vetting process, the UPICs are assigned the providers for further investigation.

All investigative leads shall be vetted through the SMA concurrently with CMS. The SMA's acceptance or declination of the proposed investigation shall be clearly documented *in the UCM* by the UPIC. If the SMA declines a potential investigation that the UPIC believes is a major risk to the applicable state Medicaid program, the UPIC will inform CMS.

1.7 - Investigation Review Process

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

An investigation is the review of Medicaid claims suspicious aberrancies, and/or to establish evidence that potential fraudulent activity and/or improper payments has occurred. The UPIC shall focus its investigation in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicaid dollars. However, the investigative process may differ by each SMA; therefore, the UPIC shall coordinate and confirm the use of its investigative approach with the SMA at the onset of the collaboration.

Activities that the UPIC may perform in relation to the investigative process include, but are not limited to:

- Screening of leads received and/or identified;
- Contact with the provider via telephone or on-site visit;
- Beneficiary/Recipient interviews;
- Medical record requests and reviews; and
- Recommendation of administrative actions.

For further guidance related to investigations, the UPICs shall follow the Medicare Program Integrity Manual (PIM), Chapter 4 – Program Integrity, § 4.7 – Investigations. If additional guidance is needed, the UPIC shall consult with its Business Function Lead (BFL) on potential investigative strategies. If the SMA determines it would like the UPIC to utilize an audit and/or a financial accounting approach, the UPIC shall follow the guidance established by the SMA (i.e., Generally Accepted Government Auditing Standards) during an investigation.

Throughout the course of any investigation, CMS may request the UPIC to cease all

activity associated with an open investigation and allow CMS to review the current status of the investigation. During this time, the UPIC shall take no action, including, but not limited to, investigative and administrative actions, unless otherwise directed by CMS. Upon receiving CMS's request to review the investigation, the UPIC shall document in the applicable case tracking system(s) the reason for ceasing investigative activities at that time. After CMS has conducted its review, CMS will provide the UPIC with a determination. If the UPIC is instructed by CMS to close the investigation without further action, the UPIC shall do so within two (2) business days. If the UPIC is instructed to continue its investigation, it shall proceed with the appropriate investigative and administrative actions. The UPIC shall discuss any questions regarding the decision with its COR and BFL.

1.7.1 - Initiation of an Investigation

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Through ongoing collaboration with each state, areas of interest and priority related to Medicaid fraud, waste, and abuse shall be discussed for purposes of potential investigations. Once an investigative area of interest is identified, the state will provide the applicable Medicaid claims data to CMS (See Section 1.7.2 – Release of Medicaid data to UPIC), to be reviewed and analyzed by the UPIC.

Concurrently, the UPIC shall conduct state policy research and communicate with the appropriate state policy experts. Once the data is received and is accessible to the UPIC, analysis and summarization of the data will take place. Upon review of the data, clarification of data and policy issues, and agreement by the state on the focus of the investigation and/or identified target(s), the UPIC shall vet the lead in accordance with Section 1.6.

Once the lead is cleared and approved by CMS, the UPIC shall begin investigative efforts, in accordance with the Medicare PIM 4.6.4 - Vetting Leads with CMS timeliness guidelines.

1.7.2 - Release of Medicaid Data to UPIC

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPICs shall collaborate with each participating SMA in an effort to obtain Medicaid claims data for analysis and investigative purposes. Because the UPICs are not contractually permitted within their statements of work to store the data themselves, each participating SMA will be required to release subsets of data to CMS for analysis purposes. That data will be stored in Analytical Data Marts (ADM) in the CMS Integrated Data Repository (IDR), and accessed by the UPICs for program integrity purposes, unless otherwise directed by CMS. For access to the ADMs in the IDR, the UPIC shall request such access from their COR.

1.7.3 - Extrapolation

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

UPICs have the ability to extrapolate. However, they must first determine if each state allows for the use of extrapolation. Even if state law allows for extrapolation, based on the focus of the investigation, extrapolation may not be appropriate. For investigations where extrapolation can be used, the UPIC shall seek agreement from the SMA on the use of extrapolation. Each UPIC and state will continuously coordinate to determine the most efficient way to sample the claims universe and apply it to the investigation.

In addition, the UPIC may need to consult with its BFL on the appropriate use of extrapolation. The use of extrapolation may be dependent on the provider's previous history with the SMA or other Medicaid contractors. When applicable, this information should be provided to the BFL in order to make a determination.

1.7.4 - Look Back Period

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPIC shall defer to the state's look-back period for purposes of conducting an audit or investigation. If the SMA's look-back period exceeds five years, the UPIC shall consult with the COR and BFL on the appropriate review timeframe.

1.7.5 – Medical Review for Program Integrity Purposes

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Medical Review (MR) for program integrity purposes is one of the parallel strategies of the UPIC to encourage the early detection of fraud, waste, and abuse. The primary task of the UPIC is to identify suspected fraud, develop cases thoroughly and in a timely manner, and take immediate action to ensure that improper payments of Medicaid monies are identified. For this reason, the UPIC and the state must collaborate early in the development of the investigative process to ensure the UPIC is following the necessary state policies/guidelines, the policy/guidelines are interpreted accurately, and that grounds for potential appeals are taken into consideration. If the SMA prefers that the UPIC utilizes an audit protocol (i.e., Generally Accepted Government Auditing Standards), the UPIC shall follow those established protocols. Additionally, the UPIC and SMA staff shall coordinate and communicate throughout the course of the investigation/audit to prevent inappropriate duplication of review activities.

Typically, the focus of program integrity MR includes, but is not limited to:

- Possible falsification or other evidence of alteration of medical record documentation including, but not limited to: obliterated sections, missing pages, inserted pages, white out, and excessive late entries (i.e., information documented numerous days after the actual service was performed);
- Evidence that the service billed for was actually provided and/or provided as billed; and
- Patterns and trends that may indicate potential fraud, waste, and abuse.

It is essential that the MR is integrated early in the investigative plan of action to facilitate the timeliness of the investigative process. Before deploying significant MR resources to examine claims identified as potentially fraudulent, the UPIC may perform a MR probe to validate the data analysis or allegation by selecting a small representative sample of claims. The general recommendation for a provider/supplier-specific probe sample is 20-40 claims, unless otherwise specified by the SMA or CMS. This sample size should be sufficient to determine the need for additional post-payment MR actions. MR resources shall be used efficiently and not cause a delay in the investigative process. In addition, development of an investigation shall continue while the contractor is awaiting the results of the MR.

The UPIC may follow Medicare PIM Chapter 3.3.1.1 - Complex Medical Review, all other applicable chapters of the PIM, and any applicable state specific medical review requirements, where applicable, unless otherwise instructed in this chapter and/or in its Umbrella Statement of Work (USOW).

1. The UPIC shall maintain current references to support MR determinations. The review staff shall be familiar with the below references and be able to track requirements in the internal review guidelines back to the statute or manual. References include, but are not limited to:

- State statutes, administrative code, and/or specific state Medicaid policies and guidance;
- Code of Federal Regulations ;
- CMS guidance; and
- Internal review guidelines (sometimes defined as desktop procedures).

2. The UPIC shall have specific review parameters and guidelines established for the identified claims. Each claim shall be evaluated using the same review guidelines. The claim and the medical record shall be linked by patient name, applicable Medicaid ID, diagnosis, Medicaid claim number, and procedure when providing feedback to the SMA regarding the review outcome.

3. The UPIC shall evaluate if the provider specialty is reasonable for the procedure(s) being reviewed. For example, chiropractors should not bill for cardiac care, podiatrists for dermatological procedures, and ophthalmologists for foot care.

4. The UPIC shall evaluate and determine if there is evidence in the medical record that the service submitted was actually provided, and if so, if the service was medically reasonable and necessary. The UPIC shall also verify diagnosis and match to age, gender, and procedure.

5. The UPIC shall determine if patterns and/or trends exist in the medical record that may indicate potential fraud, waste, abuse or demonstrate potential patient harm.

6. The UPIC shall evaluate the medical record for evidence of alterations including, but not limited to, obliterated sections, missing pages, inserted pages, white out, and excessive late entries. The UPIC shall not consider undated or unsigned entries handwritten in the margin of a document. These entries shall be excluded from consideration when performing medical review.

7. The UPIC shall document errors found and communicate these to the provider/supplier in writing when the UPIC's review does not find evidence of questionable billing or improper practices.

8. The UPIC shall adjust payment for the service, in part or in whole, depending upon the service under review, when medical records/documentation do not support services billed by the provider/supplier.

9. The UPIC shall thoroughly document the rationale utilized to make the MR decision.

10. The UPIC shall coordinate with the SMA to validate the review, in order to ensure the necessary state policies/guidelines were referenced and interpreted accurately.

1.7.6 - Request for Medical Records

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

At the beginning of any review, the UPIC sends the provider a record request letter, which includes a request for specific Medicaid medical records. Typically, the UPIC will allow the provider 30 days to produce the records, with a permissible 15-day extension if requested by the provider, unless otherwise specified by the SMA or CMS. If no records are received within the specified timeframe and the provider has made no reasonable attempt to provide the requested records, the UPIC shall coordinate with CMS and the state to determine if the full overpayment should be recouped due to non-response.

1.7.7 - Review of Medical Records

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPIC shall consult with the state to ensure the focus of the UPIC's medical review is consistent with the state's medical review process, procedures, and coverage policies. In addition, the UPIC shall follow the guidance provided in Section 1.9. If there is a discrepancy between the methodologies outlined between the state and Medicaid PIM, the UPIC shall consult with its COR and BFL for guidance.

1.7.8 - Completion of a Medical Records Review

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Upon completion of the review, the UPIC makes a determination if there is a potential overpayment. If a potential overpayment exists, the UPIC shall prepare an initial report, which is shared with CMS and the state for comment. When applicable, the UPIC shall adhere to any additional SMA requirements. Based on these comments, the report may be revised and resubmitted to CMS and the SMA for review. When the report with any associated overpayment is approved by CMS, the Medicaid Final Findings Report shall be submitted to the SMA by CMS. The state pursues collection of the overpayment from the provider in accordance with the state's laws, regulations, and procedures.

Sometimes a 100% overpayment is identified because the provider or supplier does not provide the contractor with the required medical record documentation to conduct post-payment medical review. A 100% overpayment means that all the claims in the contractor's selected sample universe are considered to be improperly billed and paid based on the documentation received. Therefore, they are fully denied through post payment review. In these instances, the UPIC shall consult with its BFL and SMA on any potential 100% overpayment determinations prior to initiation of state overpayment reporting actions or notice to the provider/supplier. If approved, the UPIC shall coordinate the overpayment reporting actions with the SMA. If denied, the UPIC shall follow the instructions provided by its COR and IAG BFL.

1.8 - Overpayment Assessment

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

When assessing potential Medicaid overpayments, the UPIC shall ensure the necessary state law and/or SMA overpayment methodologies and requirements are followed at all times.

In certain instances, in collaboration with the SMA, the UPIC may identify overpayments based solely on data analysis. In these instances, the UPIC shall collaborate with the state to validate the analysis and to ensure the policy interpretation is accurate. Additionally, the UPIC shall coordinate with each individual SMA and the COR/BFL team to determine a state specific dollar threshold for action on overpayments based solely on data analysis. Data driven overpayments that meet the dollar threshold, once reviewed and approved by CMS, shall be vetted in accordance with Section 1.6 prior to submitting the overpayment to the SMA by CMS through a Final Findings Report (FFR). All data analysis identified overpayments that fall below the state specified threshold will be sent to the SMA by the UPIC to take whatever action they deem necessary (i.e., collection of overpayment, identification of program vulnerabilities, necessary policy updates, automated edits, etc.).

1.9 - Documentation of Investigation and Medical Review Findings

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

All investigation and medical review findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the investigator during the course of the investigation or medical review and should be part of the investigation working file. The working paper file contains evidence accumulated throughout the investigation to support the work performed, the results of the investigation, including adjustments made, and all assumptions made by the reviewer.

Examples of documents are:
1. Copies of federal and/or state policies and regulations;
2. Copies of medical/financial records to support the finding;
3. Copies of state generated remittance advices which support the claim payment or credit adjustment;
4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists;
5. Investigator's notes regarding the investigation; and
6. Miscellaneous memoranda that pertain to the investigation.

1.10 - Overpayment Resolution Process

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Upon identification of an overpayment based on a Medicaid audit and/or an investigative medical review, Initial Findings Reports (IFR) are sent to the SMA for a 30-calendar day review and comment period. State comments are considered by the CMS CORs and BFLs and the UPIC, and, as necessary, the IFR is revised to account for these comments. The revised IFR, or original IFR if the state review did not necessitate a revision, may then be transmitted by the UPIC to the provider for a 30-day review and comment period, if required by the SMA. The CMS CORs, BFLs, and the UPIC review provider responses, if any, to determine if further revision is necessary to the IFR, after which the updated IFR is again sent to the state, this time with a 15-day review and comment window. CMS, the UPIC, and, if necessary, the state reconcile any issues with the updated IFR, after which the UPIC produces a FFR. CMS, upon approving the FFR, sends the FFR to the state.

The FFR identifies the total overpayment amount paid to the provider and specifies the amount of Federal Financial Participation (FFP) that the state must return to CMS. It is the state's responsibility to adjudicate the review findings with the provider. The state has one year from the date the overpayment is identified to recover or attempt to recover the overpayment from the provider before the federal share must be refunded to CMS. Under CMS's regulations, the date of discovery of overpayments begins on the date that CMS first notifies the SMA in writing of the overpayment and specifies a dollar amount subject to recovery. (See 42 C.F.R. § 433.316).

In certain instances, the SMA may require an update to the FFR, based on updated analysis by the state, issues identified within the referenced policy, etc. In these instances, the UPIC shall notify CMS of the discrepancies and discuss a proposed resolution. If it is determined that an update to the FFR is necessary, CMS and the UPIC

shall collaborate to draft a FFR Addendum which CMS shall submit to the SMA upon completion.

1.10.1 - Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPIC shall calculate the FFP amount for each discrepant claim line identified based on the FMAP in place at the time of the state Medicaid agency's date of expenditure (i.e., the date the state Medicaid agency paid the applicable claim). The total overpayment amount shall be entered into Appendix A of the FFR. The UPIC shall comply with the following directions when preparing FFRs for all assigned Medicaid investigations.

- The UPIC shall add columns to Appendix A identifying the "Federal Share Percentage" and "Federal Share Amount" for each Fiscal Year (FY) and FY Quarter identified per discrepant claim.
- The UPIC shall add a column to Appendix A identifying the date of expenditure, in addition to the date of service.
- The UPIC shall use the appropriate "Federal Share Percentage" for FY and Quarter.
- The UPIC shall add a column to Appendix A identifying the "Federal Share Total."
- The UPIC shall sum total the "Federal Share Total" column at the bottom of the Appendix A.

(Example)

Federal Share % (FY '15)	**Federal Share % (FY '16)**	**Federal Share Amount (FY '15)**	**Federal Share Amount (FY '16)**	**Federal Share Total**
%	%	$	$	$
			Total	**$**

In calculation of the FFP, the UPIC shall consult the following sources for guidance on calculating the FFP using the FMAP and shall monitor any changes to the FMAP as published in the Federal Register on an ongoing basis. The Federal Register displays adjustments to the FMAP for states and territories periodically based on legislation, (i.e., the American Recovery and Reinvestment Act (2009) increased the FMAP for certain claims for services on or after October 1, 2008. In addition, The Patient Protection and Affordable Care Act (2010) allowed states to file a State Plan Amendment (SPA) to expand Medicaid to cover additional populations. The federal government financed the costs of these newly eligible beneficiaries at a different rate than those who were previously eligible.).

- http://aspe.hhs.gov/health/fmap.htm -This chart is the basis for FMAP calculations absent modifying Federal Register notices.
- https://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR - Federal Register notices

The UPIC shall ensure that the calculations for each claim are accurate for each FY, as well as for the Quarter within the FY. If, as a result of an appeal, the overpayment needs to be recalculated, the UPIC shall follow the methodology used in the original overpayment calculation.

1.11 - State Appeal Process

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

CMS does not dictate the process by which UPIC Medicaid review findings are appealed. Rather, appeal processes are determined by each state and are subject to the state's Medicaid program requirements. SMAs must defend the review findings in administrative appeal or judicial proceedings, although the UPIC may provide testimonial support and other assistance to the state to defend review findings throughout administrative or judicial proceedings.

It's recommended that the UPIC review each SMA's appeal process during the onset of any proposed investigation, so they understand the level of support needed and can plan appropriately should the SMA require support during the appellate process.

The UPIC should alert the BFLs/COR to any situation where states indicate a reluctance to defend FFR findings in an appeal.

1.12 – Close-Out Letters

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

If a Medicaid audit/investigative medical review is being discontinued for reasons other than identification of an overpayment, a close out letter will be issued to the provider. The close out letter provides notification to the provider that the review has been stopped and that an overpayment has not been identified. The UPIC is responsible for obtaining CMS, COR, and BFL clearance prior to issuing a close out letter. Upon approval, the UPIC sends the close out letter to the provider in question, and sends copies to the state and CMS.

1.13 - Medicaid Settlement Negotiations

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Overpayment settlement negotiations are a function of the SMA. If the SMA and provider agree to a negotiated settlement, the SMA is still required to remit payment for the full FFP referred by CMS.

The UPIC shall not participate in any discussions or review of the negotiated overpayment since this is the responsibility of the SMA.

1.14 - Requests for Information

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

For further guidance related to Requests for Information, follow the Medicare PIM guidelines at 4.4.1 – Requests for Information from outside Organizations.

Additionally, if an outside organization is requesting only Medicaid claims data, the UPIC shall refer the requestor to the SMA to have the request fulfilled. However, if an outside organization is requesting Medicaid claims data, in addition to Medicare and Medi-Medi crossover claims data in a Medi-Medi state, the UPIC can fulfill the request. However, the UPIC shall notify and gain approval by the SMA prior to releasing the Medicaid claims data.

1.15 - Medicaid Payment Suspensions

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Implementation of Medicaid payment suspensions is an SMA function and should be in accordance with 42 C.F.R. § 455.23. Although UPICs may recommend the implementation of a Medicaid payment suspension based on a credible allegation of fraud, it is at the state's discretion to take the appropriate action.

1.16 - Prepayment Medical Review

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

When the UPIC investigative results identify the need for a Medicaid prepayment edit placement at the SMA, the UPIC may notify the state of this proposed administrative action. In the majority of instances when a Medicaid prepayment review is needed, the SMA shall take this action. However, on a case-by-case basis, the UPIC may assist the state with this action. Prior to assisting the state with this action, the following steps must take place:

- The UPIC shall obtain COR/BFL approval prior to assisting the state with a Medicaid prepayment medical review. The UPIC shall work with the state to get an estimate of the claims volume involved with the prepayment edit and the estimated time associated with the prepayment medical review. The UPIC shall notify the COR and BFL of this information when requesting approval.
- The UPIC shall have a system in place to evaluate the effectiveness of those edits on an ongoing basis as development continues.

- The SMA shall provide the UPIC access to the claims data necessary to evaluate edits submitted at the request of the UPIC.
- The UPIC shall use data analysis of the selected provider's claims history to verify possible changes in billing patterns and share this information with the state throughout the prepayment review.
- The UPIC shall notify the SMA, at least monthly of the results of the prepayment medical review.
- The UPIC shall follow Medicare PIM Chapter 3.3.1.1 - Complex Medical Review and any applicable state specific review process and timeliness requirements, unless otherwise instructed in this chapter and/or in its USOW.

1.17 – Revocations and Terminations

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

If the UPIC is made aware of an enrolled Medicaid provider who has been revoked from the Medicare program, the UPIC may notify the SMA immediately, so they can take the necessary action(s), as referenced in 42 C.F.R. § 455.416(c). For example, if the UPIC confirms and revokes a provider for being out of the country during the time they are supposedly rendering services, the UPIC may notify the SMA of the revocation so the SMA can take any appropriate Medicaid action(s).

If the UPIC identifies potential grounds for Medicaid termination, the UPIC shall notify the SMA so it can review the facts and consider the appropriate action.

1.18 - Immediate Advisements

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UPIC shall follow the Medicare PIM guidelines at 4.18.1.2 - Immediate Advisements to the OIG/OI and notify the SMA of such advisements when they are assisting the state with a Medicaid investigation and there are:

- Indications of UPIC or SMA employee fraud;
- Allegations of kickbacks or bribes, discounts, rebates, and other reductions in price;
- Allegations of a crime committed by a federal or state employee in the execution of their; duties; or
- Indications of fraud by a third-party insurer that is primary to Medicare

1.19 - Fraud Referrals

(Rev. 10185, Issued: 06-19-2020, Effective: 07-21-2020 Implementation: 07-21-2020)

In the course of conducting an investigation or audit of a provider, the UPIC may identify potential Medicare or Medicaid fraud. Should the UPIC identify potential Medicaid fraud throughout the course of a Medicaid investigation/audit, the UPIC shall discuss the matter with the COR/BFL. If CMS agrees that referral to LE is appropriate, the UPIC shall update the UCM within seven (7) calendar days as appropriate. All identified LE referrals should be submitted no later than thirty (30) calendar days prior to the next SMA/UPIC FWA Workgroup meeting. The UPIC shall notify CMS once these actions are complete. Once the UCM is updated appropriately and the UPIC notifies CMS, CMS will coordinate with LE. CMS will notify the UPIC of the outcome of that coordination. If LE indicates that they are interested in the case, the UPIC shall place the cases on the agenda for the next SMA/UPIC FWA Workgroup meeting.

The UPIC shall ensure all revisions and updates to the case are completed in the UCM three (3) days prior to the SMA/UPIC FWA Workgroup meeting. The UPIC shall prepare the meeting agenda and coordinate with CMS to ensure the proper attendees are included in the SMA/UPIC FWA Workgroup meeting invitation. The CMS, HHS-OIG OI, and applicable SMA Program Integrity Unit staff should be in attendance to this meeting in an effort to discuss the details of the referral, and identify any potential secondary actions.

The SMA/UPIC FWA Workgroup meetings is an opportunity for UPICs to discuss their proposed Medicaid fraud referrals with CMS, the SMA, and LE. The goal is to collaborate with all of the key decision makers, provide guidance on each proposed LE referral, and identify any proposed secondary actions.

Following the SMA FWA Workgroup meeting, when applicable, the UPIC shall submit a formal referral to the appropriate LE within seven (7) calendar days, unless otherwise advised by CMS. Referrals shall include all applicable information that the UPIC has obtained through its investigation/audit at the time of the referral. The UPIC shall utilize the “LE Referral Template” available in CMS IOM 100-08: Exhibit 16.1. Once the referral package is complete, the UPIC shall submit the referral to LE and copy CMS, and SMA Program Integrity Unit point-of-contact. Upon submission of the referral to OIG/OI and/or MFCU, the UPIC shall request written and/or email confirmation from OIG/OI and/or MFCU acknowledging receipt of the referral. The UPIC shall update UCM with the date the referral was sent, the name of the agent acknowledging receipt of the referral, and the date of receipt. In the event that written confirmation is not received, the UPIC shall notify the CMS. Additionally, the UPIC shall refrain from implementing any additional administrative actions against the provider/supplier without CMS approval. If the UPIC has any questions related to LE referrals, the UPIC shall coordinate with CMS. In regards to cases declined by LE, the UPIC shall update UCM with the declination and notify CMS within two (2) business days in order to move forward with any approved secondary administrative actions.

1.20 - Unified Case Management (UCM) System Entries

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

UPICs shall utilize the Unified Case Management (UCM) system as described in the UPIC USOW. The UCM will capture investigations and all related activities associated with that investigation, including referrals to law enforcement. Other activities that should be captured in UCM include, but are not limited to, screening leads, administrative actions, and requests for information/assistance. The UPIC shall complete all appropriate UCM training and reference the UCM user guide for specific instructions on how to utilize the UCM.

1.20.1 - Background

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

The UCM is a nationwide database that UPICs use to enter and update Medicare and Medicaid fraud, waste, and abuse leads, investigations, administrative actions, and referrals initiated by the UPICs.

All entries initiated by the UPIC shall be saved in the UCM and shall contain identifying information on the subject of the entry, as well as general information on activities performed by the UPIC to substantiate the allegation of potential fraud, waste, or abuse.

The UCM shall also capture the UPIC's work related to administrative actions like post-payment reviews, pre-payment reviews, overpayments, etc., as well as referrals to other entities (SMAs, Law Enforcement, etc.). The UCM also has monitoring and reporting capabilities which facilitate CMS oversight of the UPIC's workload.

1.20.2 - Entry Requirements for Leads

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Leads shall be entered into the UCM once the UPIC receives the lead, or within seven (7) business days of receipt of the lead. Information entered by the UPIC regarding the lead shall capture the ongoing work done by the UPIC. All leads are required to be screened within 21 days in accordance Section 1.5 of this chapter and with the Medicare PIM guidelines at Chapter 4, Section 4.6.3 – Screening Leads. Therefore, all activities related to the lead screening, including the appropriate documents obtained through the screening process, shall be completed within 21 days, unless otherwise directed by CMS.

Leads shall be closed in accordance with Section 1.5 of this chapter. The UPIC shall enter all appropriate actions or referrals taken as part of the disposition of the lead screening, prior to closing the lead in the UCM.

The UPIC shall be responsible for ensuring that all data entered into the UCM are entered correctly. This requirement includes the spelling of names and accuracy of addresses and identifiers entered.

1.20.3 - Entry Requirements for Investigations

(Rev. 10384; Issued: 10-09-20; Effective: 10-10-20; Implementation: 11-10-20)

There are no mandatory systematic update requirements for investigations entered in UCM; however, the UCM is the system of record for the UPICs. Therefore, CMS expects the UPICs to make regular updates to the UCM throughout the course of an investigation. At minimum, the UPIC shall enter all appropriate updates no later than every 15 calendar days to make the UCM entry complete, accurate, and current with the major activities. For the investigation entries, the UPIC shall document all major activities it has performed in order to substantiate any allegations of potential fraud, waste, or abuse. For example, on-site visits, medical review, audits, and data analysis shall be documented along with dates for each action.

The UPIC shall take all appropriate administrative actions in accordance with Sections 1.7, 1.8, 1.9, 1.10, and 1.16 of this chapter and in conjunction with the SMA. Each action shall be noted in UCM under the appropriate entry category and linked to the main investigation file. In addition, all applicable documents linked to these activities shall be uploaded to UCM. After such actions are taken, the UPIC may refer the investigation to law enforcement (the OIG, DOJ, FBI, or AUSA), if the referral meets the requirements identified in section 1.19 of this chapter. Once referred, the UPIC shall update UCM with the referral information within seven (7) calendar days of referral.

For investigations referred to law enforcement (the OIG, DOJ, FBI, AUSA, etc.), updates to the UCM shall be made within the following parameters:

- Upon notice from law enforcement on the status of the referral, UCM updates shall be made within 7 calendar days;
- If the investigation is accepted and the contractor has ongoing or pending administrative actions, the UPIC shall update the status when information is communicated to the UPIC by either law enforcement or CMS;
- If the investigation is accepted and the contractor has no ongoing or pending administrative actions, the UPIC shall close the case in UCM.

If problems that interfere with the UPIC's ability to get updated information are encountered, this matter shall be discussed with the appropriate COR and BFL.

The UPIC shall also be responsible for:

- Capturing and documenting subsequent law enforcement referrals (e.g., OIG declines investigation, UPIC refers case to FBI, FBI accepts investigation);
- Keeping apprised of MR/provider audit and reimbursement actions if they are taking actions on a case; and/or
- Entering and linking related UCM entry numbers.

If the UPIC does not receive a response from the OIG within the first 60 calendar days following a referral, the UPIC may pursue a subsequent referral to the FBI, when appropriate. In instances where the FBI declines a referral or does not respond within 45 calendar days, the UPIC shall request any outstanding overpayments and take any

additional administrative actions necessary. If the FBI declines the case, the UPIC may refer the investigation to any other law enforcement agency with interest in the case. Once all subsequent activities are complete, the UPIC may close the investigation in UCM or when the investigation is accepted and there are no subsequent administrative actions to pursue.

The UPIC shall be responsible for ensuring that all data entered into the UCM are entered correctly. This requirement includes the spelling of names and accuracy of addresses and identifiers entered.

After all actions are taken and all subsequent administrative activities are complete, the UPIC shall close the investigation in the UCM within seven (7) calendar days.

1.20.4 - Duplicate Entries

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

A duplicate entry exists when a UPIC inadvertently enters a provider, supplier, or beneficiary as the subject of a lead, investigation, etc.; absent different allegations or other differentiating criteria requiring a separate investigation, case, payment suspension or RFI entry.

Entries shall not be considered a duplicate if multiple UPICs enter the same provider/supplier as the subject of the lead, investigation, etc. These entries should be cross-referenced in UCM to indicate that more than one UPIC is involved in investigating the provider/supplier. UCM shall link the numbers of each entry.

If a new lead or investigation is initiated on a provider/supplier that was already the subject of a closed investigation or case, a new entry shall be opened. The closed entry, however, shall be mentioned and linked to the new entry in UCM.

The target, whether a business or individual, shall be entered as the subject of the UCM entry, when possible. The UPIC shall check for potential duplicate entries of leads, investigations, etc. when making their initial entry into UCM.

1.20.5 – Deleting Entries in UCM

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

Entries can be deleted from the UCM only by users with the system administrator designation. The UPIC shall contact its COR and BFLs to discuss the need for deleting an entry. If the COR and BFLs agree that the entry should be deleted, the UCM system administrator has the ability to delete any entries. To initiate any deletions, the UPIC shall send an e-mail to the UCM helpdesk at UCMHelpDesk@cms.hhs.gov or UCMHD@us.ibm.com, copying its CORs and BFLs, and requesting that the entry be deleted.

1.20.6 – UCM Helpdesk

(Rev. 3, Issued: 02- 02-18, Effective: 04-03-18, Implementation: 04-03-18)

For UCM issues, users can contact the UCM helpdesk at UCMHelpDesk@cms.hhs.gov

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10384MPI	10/09/2020	Updates to Chapter 1 of Publication (Pub.) 100-15	11/10/2020	12000
R10185MPI	06/19/2020	Update to Chapter 1 of Publication (Pub.) 100-15	07/21/2020	11813
R3MPI	02/02/2018	Update to the Medicaid Program Integrity Manual (PIM)	04/03/2018	10340
R1MPI	09/23/2011	Initial Publication of Manual	09/23/2011	NA

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