

**MEDICAID PROGRAM INTEGRITY MANUAL**  
**CHAPTER 2 – *Exhibits***

**Table of Contents**  
***(Rev. 3, Issued: 02-02-18)***

**Transmittals for *Exhibits***

- 1 - Medicaid Program Integrity Manual Acronyms*
- 2 - Sample Desk or Field Audit Notification Letter*
- 3 - Sample Final Findings Report*
- 4 - Sample Final Findings Report Addendum*
- 5 - Sample Close-Out Letter*

***Exhibit 1 – Medicaid Program Integrity Manual Acronyms  
(Rev. 3, Issued: 02-02-18, Effective: 04-03-18, Implementation: 04-03-18)***

*American Academy of Professional Coders (AAPC)*  
*Business Function Lead (BFL)*  
*Center for Program Integrity (CPI)*  
*Centers for Medicare & Medicaid Services (CMS)*  
*Certified Professional Coder (CPC)*  
*Children’s Health Insurance Program (CHIP)*  
*Civil Monetary Penalty (CMP)*  
*Contracting Officer’s Representative (COR)*  
*Current Procedural Terminology (CPT)*  
*Deficit Reduction Act (DRA)*  
*Department of Justice (DOJ)*  
*Federal Medical Assistance Percentage (FMAP)*  
*Federal Financial Participation (FFP)*  
*Final Findings Report (FFR)*  
*Initial Findings Report (IFR)*  
*Internet Only Manual (IOM)*  
*Local Coverage Determination (LCD)*  
*Medicaid Fiscal Agent (MFA)*  
*Medicaid Fraud Control Unit (MFCU)*  
*Medical Review (MR)*  
*National Coverage Determination (NCD)*  
*Office of Inspector General Office of Investigations (OIG OI)*  
*Program Integrity (PI)*  
*State Medicaid Agency (SMA)*  
*Surveillance Utilization Review Subsystem (SURS)*  
*Umbrella Statement of Work (USOW)*  
*Unified Program Integrity Contractor (UPIC)*

***Exhibit 2 – Sample Desk or Field Audit Notification Letter***

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

*Date*

*Provider Name*

*Attn:*

*Provider Address*

*Provider Number:*

*NPI Number:*

*Dear PROVIDER NAME:*

*This is to inform you that you or your facility has been selected for an audit of claims billed to Medicaid with dates of services from DATE through DATE. The objective of our audit is to determine whether the claims for services were billed and paid in accordance with applicable federal and state Medicaid laws, regulations, and policies.*

*Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program, through which the Centers for Medicare & Medicaid Services (CMS) shall conduct reviews and audits of claims submitted by Medicaid providers. As a Medicaid provider and a recipient of funds under the state Medicaid program, you are subject to these reviews and audits. The DRA authorizes CMS to utilize contractors, including UPIC NAME, to conduct such reviews and audits.*

*In accordance with the DRA and other applicable federal laws, you are required to provide CMS and its contractor, UPIC NAME, with timely, unrestricted access to all documents and records that relate in any way to Medicaid claims and payments.*

***THE FOLLOWING LANGUAGE IS RELATED TO A DESK AUDIT:***

*To facilitate the audit, we are requesting that all documentation related to the listed claim lines on the enclosed claims listing be assembled and provided to UPIC NAME. We have included a list of types of documentation that may be required to support the claims billed. The documents must be legible and arranged in an orderly manner. Be aware that this list is not all inclusive and that UPIC NAME may request additional documentation necessary to conduct and complete its audit. The requested information should be forwarded to UPIC NAME at the following address within 30 business days from receipt of this letter.*

***UPIC NAME  
ATTN  
ADDRESS***

***THE FOLLOWING LANGUAGE IS RELATED TO A FIELD AUDIT:***

*An auditor from UPIC NAME, will be contacting you in the near future to schedule an entrance conference and discuss the audit process, which will include an on-site visit. Upon arrival at the on-site visit, UPIC NAME, will conduct an entrance conference, and will need adequate workspace to conduct the audit. During the entrance conference, UPIC NAME, will request an overview of your organization, including your Medicaid claims submission process, any policies and procedures related to this process, and an organizational chart.*

*To facilitate the audit, we are requesting that certain information shown in the enclosed document be assembled and provided to UPIC NAME, at the entrance conference.*

*The documents must be legible and arranged in an orderly manner. This list is not all inclusive, and UPIC NAME may request additional documentation necessary to conduct and complete the audit.*

*Any applicable state sanctions may be imposed against you if you fail to provide the information that is requested. Depending on the laws in your state, sanctions may include, but not be limited to, vendor hold and/or exclusion from participation as a provider in the state Medicaid program, until the matter is resolved. Additionally, payments for services for which you fail to produce records to UPIC NAME will be recovered from you.*

***Exhibit 3 – Sample Final Findings Report***

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

*<Date>*

*<Name of State Medicaid Director>, <Title>*

*<Address>*

*<City, State, Zip Code>*

*Dear < Mr. /Ms. State Medicaid Director Last Name>:*

*Enclosed is the final findings report for <provider name>, State Medicaid provider #<number>. The investigation was conducted by <name of UPIC> on behalf of the Centers for Medicare & Medicaid Services (CMS), and concerned Medicaid claims paid to <provider name>. The investigation encompassed the Medicaid claims for services provided during the period of <date audit period started > through <date audit period ended >.*

*<Name of State> is responsible for initiating the state recovery process and furnishing the final findings report to the provider. CMS will not send a copy of the final findings report to the provider. The final findings report identifies <\$0,000.00> total computable, (<\$0,000.00> FFP) in unallowable claims paid to <provider name>. In accordance with §1903(d)(2)(C) of the Social Security Act, <name of state> has one (1) year from the date of this letter to recover or attempt to recover the overpayment from the provider before the Federal share must be refunded to CMS. Any amounts actually collected prior to the expiration of the one year time limit, however, remain due on the CMS-64 form for the quarter in which collection is actually made (see <http://www.cms.gov/smdl/downloads/SMD10014.pdf>).*

*Please report on Line 9C1, Recoveries: Fraud, Waste and Abuse Efforts, in the amount of <\$0,000.00> total computable (<\$0,000.00> FFP) on the next regular quarterly submission of Form CMS-64 which occurs after the last day of the one (1) year period mentioned above. This amount should first be entered on feeder Form CMS-64.9C1, Line 5, CMS Medicaid Integrity Contractors (MICs).*

Page 2 – <Mr. /Ms. First and Last Name of State Medicaid Director>

If you have any questions regarding this final findings report, please contact  
ENTER CMS CONTACT HERE by telephone at (###) ###-#### or by e-mail at  
XXXXX.XXXXX@cms.hhs.gov.

Sincerely,

ENTER CMS CONTACT & TITLE HERE  
ENTER CMS CONTACT'S DIVISION

HERE

cc: <Name of State PI Director>, <State> PI Director  
<UPIC contact>  
<Name of CMS Region Contact>, CMS Region <XX>, ARA,  
DMCHO

***Exhibit 4 – Sample Final Findings Report Addendum***  
***(Rev. 3, Issued: 02-02-18, Effective: 04-03-18, Implementation: 04-03-18)***  
***<Date>***

***<Name of State Medicaid Director>, <Title>***  
***<State Medicaid PI Dept. Name***  
***<Address>***  
***<City, State, Zip Code>***

***Dear < Mr. /Ms. State Medicaid Director Last Name>:***

***On <date FFR issued>, the Centers for Medicare & Medicaid Services (CMS) issued a final findings report for <provider name>, State Medicaid provider #<number>. The investigation was conducted by <name of UPIC> on behalf of CMS, and encompassed the Medicaid claims for services provided during the period of <date audit period started > through <date audit period ended >.***

***Subsequent to the issuance of the final findings report, issues relating <brief description of discrepancies identified> were discovered. Consequently, the overpayment amount on Appendix A has been revised, resulting in the identify overpayment changed from <\$0,000.00> to <\$0,000.00>. The Federal share has changed from <\$0,000.00> to <\$0,000.00>.***

***The remainder of the above referenced final findings report shall remain unchanged and shall continue in full force and effect.***

***Sincerely,***

***ENTER CMS CONTACT & TITLE HERE***  
***ENTER CMS CONTACT'S DIVISION***

***HERE***

***cc: <Name of State PI Director>, <State> PI Director***  
***<UPIC contact>***  
***<Name of CMS Region Contact>, CMS Region <XX>, ARA,***  
***DMCHO***

***Exhibit 5 – Sample Close-Out Letter***

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

*Provider Name*  
*Attn:*  
*Provider Address*

*Provider Number:*  
*NPI Number:*

*Dear PROVIDER NAME:*

*UPIC NAME has conducted an audit on behalf of the Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Program. This audit examined claims for AUDIT ISSUE for the time period DATE through DATE.*

**Transmittals Issued for this Chapter**

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<a href="#"><u>R3MP</u></a> <a href="#"><u>I</u></a>	02/02/2018	Update to the Medicaid Program Integrity Manual (PIM)	04/03/2018	10340



R1MP 09/23/2011 Initial Publication of Manual  
I

09/23/2011 NA

[Back to top of Chapter](#)