

Medicare Program Integrity Manual

Chapter 1 - *Overview of Medical Review (MR) and Program Integrity (PI) Programs*

Table of Contents
(Rev. 12772; Issued: 08-09-24)

Transmittals for Chapter 1

- 1.1- Overview of Program Integrity and Provider Compliance
- 1.2 - Definitions
- 1.3 - Medicare Improper Payment Reduction Efforts – Provider Compliance
 - 1.3.1 – Types of Contractors
 - 1.3.2 – Improper Payment Prevention Goals
 - 1.3.3 – Applicable of Problem Integrity Manual Sections
 - 1.3.4 – Performance Metrics
 - 1.3.5 – Types of Claims for Which Contractors Are Responsible
 - 1.3.6 – Quality of Care Issues and Potential Fraud Issues
 - 1.3.7 – The MAC and SMRC Medical Review Program
 - 1.3.8 – Goal of MAC and SMRC MR Program
 - 1.3.9 – Provider Self Audits
 - 1.3.10 – Coordination Among Contractors
- 1.4 - Contractor Medical Director (CMD)
- 1.5 - Medical Review Manager
- 1.6 – Maintaining the Confidentiality of MR Medical Records and Documents
- 1.7 – *Program* Integrity
- 1.8 – Medical Review for *Program* Integrity (MR for *PI*)

1.1- Overview of Program Integrity and Provider Compliance (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The term “Review Contractor” throughout the Program Integrity Manual refers to:

- Medicare Administrative Contractors (MACs)
- Comprehensive Error Rate Testing (CERT) contractors
- Recovery Auditors
- Unified Program Integrity Contractors (UPICs)
- Supplemental Medical Review Contractor (SMRC)

Review Contractors shall follow all sections of the PIM unless otherwise indicated as required by their applicable Statements 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. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

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 and promoting compliance with Medicare coverage and coding rules 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. The CMS contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the Medicare FFS program:

- CERT contractors;
- MACs;
- Recovery auditors; and
- SMRC.

1.3.1 - Types of Contractors (Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

A. CERT Contractors

The CMS implemented the CERT program which establishes error rates and estimates of improper payments that is compliant with the Improper Payments Elimination and Recovery Improvement Act (IPERIA).

B. MACs

The MACs primarily use error rates produced by the CERT program and vulnerabilities identified through the Recovery Audit program to identify where to target their improper payment prevention efforts. The MACs analyze their internal data to determine which corrective actions would be best to prevent the CERT-identified and Recovery Auditor-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 MACs' efforts to prevent improper payments is each contractor's 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, 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. Recovery Auditors

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

D. Supplemental MR Contractor (SMRC)

The Supplemental Medical Review Contractor's (SMRC) main tasks are to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs. Having a centralized medical review (MR) resource that can perform large volume MR nationally allows for a timely and consistent execution of MR review, activities and decisions. The focus of the reviews may include but are not limited to issues identified by CMS internal data analysis, the CERT program, professional organizations and other Federal agencies, such as the OIG/GAO and comparative billing reports.

1.3.2 - Improper Payment Prevention Goals

(Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

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 improving provider compliance and lowering the error rate, CMS follows three parallel strategies:

- Preventing improper payments through MACs and SMRC evaluation of 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 Recovery Auditors
- 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. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

- The MACs, CERT, Recovery Auditors, UPICs, and SMRC shall follow all sections of the PIM unless otherwise indicated
- The MACs, CERT, Recovery Auditors, UPICs and SMRC shall follow the PIM to the extent outlined in their SOWs.

1.3.4 - Performance Metrics

(Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

A. 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.

B. Recovery Auditor Performance:

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

C. 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.

D. SMRC

A performance measure of the SMRC contractor is the accuracy rate. This will be coordinated by CMS annually. Additional performance measures are listed in their SOW.

1.3.5 - Types of Claims for Which Contractors Are Responsible (Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

A. MACs

The 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 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. Recovery Auditors

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

D. SMRC

Medical review will be performed on Part A, Part B, and DME providers and suppliers as directed by CMS.

1.3.6 - Quality of Care Issues and Potential Fraud Issues

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

Potential quality of care issues are not the responsibility of the MAC, CERT or Recovery Auditor, *UPIC*, and SMRC but they are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. MACs, CERT, Recovery Auditor, *UPICs* and SMRC 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 shall 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 *UPICs* for development. See chapter 4, section 4.9.4.2 for a discussion on *program* integrity interaction with QIOs.

1.3.7 - The MAC and SMRC Medical Review Program

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The MR program is designed to prevent improper payments in the Medicare FFS program. Whenever possible, 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 UPICs shall refer to chapter 4 for MR for BI purposes.

1.3.8 - Goal of MAC and SMRC MR Program

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

The goal of the MAC and SMRC 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,

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). (Chapter 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 UPICs.

SMRC:

- Identify provider noncompliance with coverage, coding, billing, and payment policies through the research and analysis of data related to assigned task. (e.g., profiling of providers, services, or beneficiary utilization)
- As directed by CMS, perform medical review
- As directed by CMS, perform extrapolation
- Notify the individual billing entities (i.e., providers, suppliers, or other approved clinician) of review findings identified and make appropriate recommendations for POE and UPIC referrals

1.3.9 – Provider Self Audits

(Rev. 11032; Issued: 09-30-21; Effective: 10-12-21; Implementation: 11-10-21)

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). The MACs shall follow chapter 4, section 4.2.2.8.1.3, 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 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, MACs shall take action commensurate with errors made. The MACs shall evaluate the circumstances surrounding the errors and proceed with the appropriate plan of correction.

1.3.10 – Coordination Among Contractors

(Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

A. Coordination among MACs and UPICs

The MAC MR staff shall coordinate and communicate with their associated UPIC 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 UPIC for development.

B. Coordination among MACs and the Recovery Auditors

See Pub. 100-06, Financial Management Manual, chapter 4, section 100.1-100.15, for a description of the coordination efforts between MACs and Recovery Auditors. In addition, the MACs shall coordinate and communicate with the Recovery Auditors to

get the specifics on Recovery Auditor identified vulnerabilities for use in the MAC's data analysis and possible corrective actions.

C. SMRC

The SMRC shall make all recommendations for referrals through their CMS Contract Officer Representative (COR).

1.4 - Contractor Medical Director (CMD)

(Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

MACs:

The MACs shall employ a minimum of two FTEs contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. The CMD FTEs shall be composed of either a Doctor of Medicine or a Doctor of Osteopathy. All clinicians employed or retained as consultants shall be currently licensed to practice medicine in the United States, and the contractor shall periodically verify that the license is current. When recruiting CMDs, contractors shall give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties are listed below.

Primary duties include:

- Leadership in the provider community, including:
 - Interacting with medical societies and peer groups;
 - Educating providers, individually or as a group, regarding identified problems or LCDs; and
 - Acting as co-chair of the Contractor Advisory Committee (CAC) (see chapter 13 §13.8.1.4 of this manual for co-chair responsibilities).
- Providing the clinical expertise and judgment to develop LCDs and internal MR guidelines:
 - Serving as a readily available source of medical information to provide guidance in questionable claims review situations;
 - Determining when LCDs are needed or must be revised to address program abuse;
 - Assuring that LCDs and associated internal guidelines are appropriate;
 - Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;

- Selecting consultants licensed in the pertinent fields of medicine for expert input into the development of LCDs and internal guidelines;
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
- Providing the clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse; and
- Serving as a readily available source of medical information to provide guidance in questionable situations.

Other duties include:

- Interacting with the CMDs at other contractors to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and

Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.

SMRC:

Primary duties include:

- Serving as a readily available source of medical information to provide guidance in questionable claims review situations
- Providing the clinical expertise and judgment to develop LCDs and internal MR guidelines
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse
- Providing clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse
- Serving as a readily available source of medical information to provide guidance in questionable situations

1.5 - Medical Review Manager

(Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

MACs:

An effective MR program begins with the strategies developed and implemented by senior management staff. The MACs 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.

SMRC:

An effective Medical Review program begins with the senior management staff. The Contractor shall name a Medical Review point of contact referred to as the Medical Review Manager who will act as the primary contact between the Contractor and CMS concerning the SMRC medical review program. The MR Manager will also have primary responsibility for development, oversight and implementation of the Contractor's quality assurance process. In addition, the MR Manager shall have the primary responsibility for ensuring the timely submission of required reports. The MR Manager shall be a registered nurse. The MR Manager shall work collaboratively with their Project Manager and Contract Medical Director to plan, implement and evaluate all MR projects/tasks directed by CMS.

1.6 – Maintaining the Confidentiality of MR Medical Records and Documents

(Rev. 508; Issued: 03-07-14, Effective: 04-08-14, Implementation: 04-08-14)

A. Contractors to Which This Section Applies

This section applies to MACs, CERT, Recovery Auditors, and SMRC.

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 - *Program Integrity*

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

A. Contractors to Which This Section Applies

This section applies to UPICs only.

B. General

In addition to reducing improper payments, CMS strives to protect the program from potential fraud. CMS contracts with Unified Program Integrity Contractors (UPICs) to identify and stop potential fraud.

The primary task of UPICs 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. UPICs 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 *Program Integrity* (MR for *PI*) ***(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)***

A. Contractors to Which This Section Applies

This section applies to UPICs.

B. General

The goal of the MR for *PI* 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.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R12772PI</u>	08/09/2024	Updates of Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Chapter 9 in Publication (Pub.) 100-08, Including Complaint Referral Coordination Between Contractors	09/20/2024	13719
<u>R11032PI</u>	09/30/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08	11/10/2021	12375
<u>R10984PI</u>	09/09/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08 - Rescinded and replaced by Transmittal 11032	11/10/2021	12375
<u>R10365PI</u>	10/02/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08-	08/27/2020	11884
<u>R10228PI</u>	07/27/2020	Updates to Chapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, and Exhibits of Publication (Pub.) 100-08 Rescinded and Replaced by Transmittal 10365	08/27/2020	11884
<u>R508PI</u>	03/07/2014	Supplemental Medical Review Contractor	04/08/2014	8578
<u>R454PI</u>	03/14/2013	Minor Changes to Chapter 1 of the Program Integrity Manual	04/01/2013	8205
<u>R451PI</u>	03/01/2013	Minor Changes to Chapter 1 of the Program Integrity Manual – Rescinded and replaced by Transmittal 454	04/01/2013	8205
<u>R448PI</u>	01/31/2013	Deletion of MR Operations Mailbox	03/04/2013	8187
<u>R425PI</u>	06/15/2012	Provider Self Audits	07/16/2012	7851
<u>R313PI</u>	11/20/2009	Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7	12/21/2009	6546
<u>R264PI</u>	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
<u>R229PI</u>	11/23/2007	Medical Review Strategy and Strategy Analysis Report	04/07/2008	5760
<u>R220PI</u>	08/24/2007	Various Medical Review Clarifications	09/03/2007	5550
<u>R203PI</u>	05/25/2007	Strategy Analysis Report	07/02/2007	5519
<u>R174PI</u>	11/17/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
<u>R170PI</u>	11/03/2006	Transition of Medical Review Educational Activities	10/06/2006	5275
<u>R163PI</u>	09/29/2006	Transition of Medical Review Educational Activities	10/06/2006	5275

<u>R136PI</u>	02/01/2006	Contractor Medical Director Requirements	03/01/2006	4105
<u>R118PI</u>	08/12/2005	Various Benefit Integrity (BI) Clarifications	09/12/2005	3896
<u>R107PI</u>	04/08/2005	Updated Chapter 1 to Reflect Changes in Program Requirements	05/09/2005	3754
<u>R099PI</u>	01/21/2005	Waivers Approved by the Regional Office (RO) by Replacing Regional Office with Central Office (CO)	02/22/2005	3646
<u>R071PI</u>	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
<u>R065PI</u>	01/30/2004	Requirement Removal of Fiscal Intermediary Medical Review on Long Term Care Hospitals	03/02/2004	2905
<u>R040PIM</u>	05/16/2003	Local Provider Education and Training Program	05/16/2003	2466
<u>R033PI</u>	11/01/2002	FY 2003 Budget Performance Requirement Revisions	11/01/2002	2407
<u>R025PIM</u>	04/25/2002	Types of claims for which Contractors are Responsible	07/01/2002	2122
<u>R024PIM</u>	04/05/2002	Removes the LMRP and related sections from Chap 1 and moves to Chap 13	10/01/2002	2061
<u>R021PIM</u>	02/28/2002	Inpatient Hospital Claims for Which Contractors are Responsible for Performing MR	04/01/2002	1969
<u>R019PIM</u>	02/08/2002	Benefit Integrity Unit Security Requirements	02/08/2002	1907
<u>R017PIM</u>	12/12/2001	Reorganizes chapter 3, sections 4, 5, and 6 and Removes reference to outdated MCM and MIM overpayment collection instructions and lists the more current CFR citations instead.	04/01/2002	1891
<u>R016PIM</u>	11/28/2001	Adds Various Program Memoranda for BI Requests for Information, Organizational Requirements, Unsolicited Voluntary Refund Checks, Anti-Kickback Statute Implications	11/28/2001	1732
<u>R014PIM</u>	09/26/2001	Local Medical Review Policy (LMRP) Format and Submission/Requirements	10/01/2001	1859
<u>R010PIM</u>	09/17/2001	Timeframe for Contractor Advisory Committees (CAC) Meetings	10/17/2001	1744
<u>R009PIM</u>	07/30/2001	LMRP Process	NA	1021
<u>R008PIM</u>	07/11/2001	Replaces PIM Chapter 1, Sections 2, 2.1, and sections 2.3 up through and including 2.3.4.	07/11/2001	1485
<u>R006PIM</u>	05/24/2001	Maintaining the Confidentiality of MR Records	05/24/2001	1581
<u>R003PIM</u>	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292

<u>R001PIM</u>	06/2000	Initial Release of Manual	NA	931
----------------	---------	---------------------------	----	-----

[Back to top of chapter](#)