

CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 107

Department of Health &
Human Services

Center for Medicare and &
Medicaid Services

Date: APRIL 8, 2005

CHANGE REQUEST 3754

SUBJECT: Updated Chapter 1 to Reflect Changes in Program Requirements

I. SUMMARY OF CHANGES: Reorganized section 1.1 and updated to include a description of the contractor evaluation program, S.P.A.C.E.. Section 1.2 was reorganized and revised to update the information on the MR program and the requirements for the MR/LPET Strategy. Section 1.4 was updated and reorganized to be consistent with the activities of the LPET program.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : May 9, 2005

IMPLEMENTATION DATE : May 9, 2005

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:

R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / SubSection / Title
R	1/1.1/Introduction
R	1/1.1.2/Types of Claims for Which Contractors Are Responsible
N	1/1.1.3/Quality of Care Issues
R	1/1.2/ The Medicare MR Program
N	1/1.2.1/Goal of the MR Program
N	1/1.2.2/MR Manager
N	1/1.2.3/Annual MR/LPET Strategy
N	1/1.2.3.1/Data Analysis and Information Gathering

N	1/1.2.3.2/Problem Identification & Prioritization
N	1/1.2.3.3/Intervention Planning
N	1/1.2.3.4/Program Management
N	1/1.2.3.5/Budget and Workload Management
N	1/1.2.3.6/Staffing and Workforce Management
R	1/1.4/Local Provider Education and Training (LPET) Program
R	1/1.4.1/LPET Activities
N	1/1.4.1.1/One-on-One Provider Education
N	1/1.4.1.2/Education Delivered to a Group of Providers
N	1/1.4.1.3/Education Delivered via Electronic Media
N	1/1.4.2/Description of Methods of Education
N	1/1.4.2.1/Proactive Local Educational Meetings
N	1/1.4.2.2/Comprehensive Educational Interventions
N	1/1.4.2.3/Comparative Billing Report Education
N	1/1.4.2.4/Frequently Asked Question Regarding Local Education Issues
N	1/1.4.2.5/Bulletin Articles/Advisories Regarding Local Education Issues
N	1/1.4.2.6/Scripted Response Documents on Local Education Issues
N	1/1.4.3/LPET Staff

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 107	Date: April 8, 2005	Change Request 3754
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SUBJECT: Updated Chapter 1 to Reflect Changes in Program Requirements.

I. GENERAL INFORMATION

A. Background: Reorganized section 1.1 and updated to include a description of the contractor evaluation program, S.P.A.C.E. Section 1.2 was re-organized and revised to update the information on the MR program and the requirements for the MR/LPET Strategy. Section 1.4 was updated and reorganized to be consistent with the activities of the LPET program.

B. Policy: N/A

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3754.1	Contractors shall consider Customer Service and Provider Communication's Provider/Supplier Service Plan when developing their MR/LPET Strategy.	X	X	X	X					
3754.2	Contractors should refer quality of care issues to the appropriate quality improvement organization and/or State agency.	X	X	X	X					
3754.3	Contractors shall place emphasis on reducing the paid claims error rate by educating the billing entities (i.e, providers, suppliers, or other approved clinician) that pose the greatest vulnerability to the Medicare program based on their claims submission errors	X	X	X	X					

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3754.4	The contractor shall appoint a MR point of contact, referred to as the MR manager, who will have primary responsibility for the development, oversight and implementation of the contractor’s MR/LPET Strategy, quarterly strategy analysis (QSA) and quality assurance process. In addition, the MR manager shall have the primary responsibility for ensuring the timely submission of the MR/LPET strategy, and QSA.	X	X	X	X					PSC’s with MR responsibilities
3754.4.1	Each fiscal year, the contractors shall develop and document a unique annual MR/LPET strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.	X	X	X	X					“full” PSC’s
3754.4.2	The contractor shall detail identified medical review issues, educational activities, projected goals, and the evaluation of educational activities and goals in their strategy.	X	X	X	X					“full” PSC’s
3754.4.3	The contractor shall analyze data from a variety of sources in the initial step in updating the MR/LPET Strategy. Sources of data include: <ul style="list-style-type: none"> ◆ CERT findings ◆ Findings for the review of claims ◆ Data from other operational areas 	X	X	X	X					“full” PSC’s
3754.4.3.1	The contractor shall develop and prioritize a problem list from the analyzed data.	X	X	X	X					“full” PSC’s
3754.4.3.2	The contractor shall consider the available resources and other problems currently being worked when prioritizing.	X	X	X	X					“full” PSC’s
3754.4.3.3	The contractor shall include metrics used in their prioritization process in their strategy.	X	X	X	X					“full” PSC’s
3754.4.4	The contractor shall develop MR and LPET interventions using the PCA process (IOM Pub.	X	X	X	X					“full” PSC’s

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	100-8, chapter 3, section 14) to address each prioritized problem.									
3754.4.5	The contractor shall only account for workload as medical review those claims that are reviewed based on a problem identified in their MR/LPET strategy.	X	X	X	X					“full” PSC’s
3754.4.6	The contractor shall develop multiple tools to effectively address the local Medicare providers’ variety of educational needs.	X	X	X	X					“full” PSC’s
3754.4.6.1	The MR/LPET strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems.	X	X	X	X					“full” PSC’s
3754.4.6.2	The contractor shall utilize a provider tracking system that documents educational contacts, specific issue addressed, and type of intervention used.	X	X	X	X					“full” PSC’s
3754.4.6.3	The contractor shall incorporate processes for follow-up that ensure appropriate resolution of the issue.	X	X	X	X					“full” PSC’s
3754.4.6.4	The contractor shall use the information contained in the provider tracking system to determine a more progressive course of action for providers who continue to have billing errors.	X	X	X	X					“full” PSC’s
3754.4.7	As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.	X	X	X	X					“full” PSC’s
3754.4.8	The contractor shall include in their strategy a section that describes the process used to monitor spending in each CAFM II Activity Code.	X	X	X	X					
3754.4.9	The contractor shall describe in their strategy how workload for each CAFM II Activity Code is accurately and consistently reported.	X	X	X	X					

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3754.4.10	Program safeguard contractors (PSC) shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the PSC ART system.									PSC’s with mr responsibilities
3754.4.11	The contractor shall include in their strategy a mechanism to monitor and improve the accuracy and consistency of LPET staff’s responses to specific inquiries regarding MR related coverage and coding issues.	X	X	X	X					“full” PSC’s
3754.4.12	In each element of the MR/LPET strategy, the contractor shall incorporate quality assurance activities as described.	X	X	X	X					“full” PSC’s
3754.4.13	The contractor shall have in place procedures for continuous quality improvement.	X	X	X	X					“full” PSC’s
3754.4.14	The contractor shall include the following elements in the MR/LPET strategy: <ul style="list-style-type: none"> ◆ Data Analysis and Information Gathering ◆ Problem Identification & Prioritization ◆ Intervention Planning ◆ Program Management ◆ Budget and Workload Management 	X	X	X	X					“full” PSC’s
3754.5	The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code.	X	X	X	X					
3754.6	The contractor shall automate as much review as possible.	X	X	X	X					“full” PSC’s
3754.7	The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall MR/LPET program for the contractor. In addition, the PSC shall be involved with the development of the MR/LPET strategy.	X	X	X	X					PSC’s with MR responsibilities

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3754.8	The contractor shall identify the process for determining when the contractor will develop or revise LCDs.	X	X	X	X					“full” PSC’s
3754.9	The contractor shall submit a MR/LPET strategy with their budget request to the appropriate RO and to CO at MRStrategies@cms.hhs.gov each fiscal year.	X	X	X	X					
3754.9.1	The MR/LPET strategy shall be updated as changes are made to the MR and LPET programs.	X	X	X	X					“full” PSC’s
3754.9.2	When an updated MR/LPET strategy requires a SBR, the updated MR/LPET strategy shall be sent with the SBR to the RO and to CO at MRStrategies@cms.hhs.gov .	X	X	X	X					
3754.9.3	The PSC shall submit strategies with their draft project plan and final project plan, and update as required.									“full” PSC’s
3754.10	The contractor shall develop one-on-one provider education in response to medical review related coverage, coding, and billing problems, verified and prioritized through the review of claims and/or the analysis of information.	X	X	X	X					“full” PSC’s
3754.10.1	The contractor shall choose the type of one-on-one educational activity based on the level of medical review related coverage, coding, and billing errors identified.	X	X	X	X					“full” PSC’s
3754.10.2	The contractor shall record all one-on-one contacts in the provider tracking system.	X	X	X	X					“full” PSC’s
3754.10.3	The contractor shall NOT use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted to select or track providers of services or suppliers for the	X	X	X	X					“full” PSC’s

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
	purposes of conducting any type of audit or prepayment review.									
3754.11	The contractor shall maintain a Web site for the dissemination of medical review bulletin articles and at the contractor’s discretion dissemination of LCDs.	X	X	X	X					“full” PSC’s
3754.12	The contractor shall NOT charge a fee for attendance to contractor sponsored meetings.	X	X	X	X					“full” PSC’s

III. PROVIDER EDUCATION: None.

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: May 9, 2005 Implementation Date: May 9, 2005</p> <p>Pre-Implementation Contact(s): Stacy Holdsworth, sholdsworth@cms.hhs.gov Post-Implementation Contact(s): Stacy Holdsworth, sholdsworth@cms.hhs.gov</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.</p>
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Medicare Program Integrity Manual

Chapter 1 - Overview of Medical Review (MR) and Benefit Integrity (BI) and Local Provider Education and Training (LPET) Programs

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1.1 - Introduction

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The Program Integrity Manual (PIM) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to *protect the Medicare Trust Fund from fraud, waste and abuse*. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare & Medicaid Services (CMS) follows four parallel strategies in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and data analysis; 3) close coordination with partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

Fiscal intermediaries and carriers that have transitioned some or all of their MR work to a PSC (from this point forward, referred to as Affiliated Contractors or ACs) and fiscal intermediaries and carriers that have not transitioned their MR work to a PSC (from this point forward, referred to as contractors) shall follow the entire PIM for medical review functions as they relate to their respective roles and areas of responsibility to MR. PSCs shall follow the PIM to the extent outlined in their respective task orders. The PSC, in partnership with CMS, shall be proactive and innovative in finding ways to enhance the performance of PIM guidelines.

The PIM supports the Government Performance Results Act (GPRA) and OMB's Program Assessment Rating Tool (PART). The GPRA requires contractors to reduce the error rates as identified in the Chief Financial Officer's (CFO) audit and developed through the Comprehensive Error Rate Testing (CERT) program.

The CMS' national objectives and goals as they relate to medical review are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical review of claims; 3) Effectively educate and communicate with the provider and supplier community; and 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse. In order to ensure these objectives are being met, CMS has developed the S.P.A.C.E. Program to evaluate contractor performance. The S.P.A.C.E. acronym identifies the following key components of this evaluation strategy:

- ***Self- Assessment** (Certification Package for Internal Controls (CPIC): This is a self-certification process in which a contractor performs a risk assessment to identify and select particular business function areas to thoroughly evaluate and find areas for improvement.*
- ***Performance Oversight** (Statement of Auditing Standards (SAS 70) Audit): The SAS-70 is a process currently utilized by Medical Review (MR) and other CMS components for contractor performance oversight. This performance*

oversight program utilizes the skills and expertise of independent auditors to complete a performance audit. The audit takes approximately six months to complete and the contractor's performance during the most recent two quarters of the fiscal year are evaluated. There are two types of SAS-70 audits. Type I audits determine if essential internal controls are in place. Type II audits determine if the internal controls are effective. Medical review internal control objectives can be found in Chapter 7 of the Medicare Financial Manual. The internal control objectives reflect CMS' requirements for an effective medical review operation.

- ***And***
- ***Comprehensive Error Rate Testing (CERT):*** *CERT is a CMS program that measures a contractor's payment error rate. The S.P.A.C.E. program considers a contractor's CERT score in conjunction with SAS-70 audit findings and CPICs when making an overall determination of a contractor's educational need.*
- ***Educational Training Program:*** *CMS Regional Office (RO) or Central Office (CO) staff may recommend an educational intervention for a contractor based on findings from a SAS-70 audit, problems with a contractor's Medical Review/Local Provider Education and Training (MR/LPET) Strategy, or for other concerns the RO or CO staff may have. A problem-focused educational interaction between CMS staff (RO & CO) and a contractor is based on potential or current areas of contractor vulnerability.*

The PIM requirements form the basis of CMS' S.P.A.C.E. Program oversight. The PIM serves as the foundation upon which MR internal control objectives are developed. These internal control objectives are the criteria against which the contractor is evaluated when performing a self-assessment and/or during the SAS 70 Audit. The PIM also serves as written guidance for contractor evaluation under the Comprehensive Error Rate Testing Program, which serves to ensure that contractors are exercising accurate, and defensible decision making on medical reviews.

Both MR and the BIU use data analysis *as* the foundation for detection of *aberrant billing practices*. *Through data analysis, the MR unit determines the extent of the problem and the potential threat to the Medicare Trust Fund. The most egregious problems are selected for validation by probe review. The results of the probe review will determine whether the problem is an unintentional error by the billing entity that will be pursued by the MR unit; or potentially fraudulent, which is pursued by the BIU; or determined not to be a problem.*

The purpose of this chapter is to *describe the MR and LPET* purpose, functions, and requirements.

1.1.2 - Types of Claims for Which Contractors Are Responsible

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors may perform MR functions for the following types of claims:

- All claims appropriately submitted to a carrier, durable medical equipment regional carrier (DMERC), or regional home health intermediary (RHHI) and;
- All claims appropriately submitted to an intermediary including but not limited to:
 - Acute Care Inpatient Prospective Payment System (PPS) Hospital Swing Beds
 - Ambulatory surgical centers (hospital based)
 - Inpatient rehabilitation freestanding hospitals or excluded rehabilitation units of PPS hospitals
 - Inpatient critical access hospitals including swing beds
 - Inpatient psychiatric freestanding hospitals or excluded psychiatric units of PPS hospitals
 - All ESRD facilities (freestanding and hospital based).

Prior to implementing medical review, contractors shall notify providers *their claims will* be subject to review. Contractors shall apply Progressive Corrective Action in review of these claims.

Due to the *quality improvement organizations (QIOs)* performing reviews, contractors shall not perform MR functions for:

- acute care inpatient PPS hospital (DRG) claims; and
- Long term care hospital (LTCH) claims

Contractors shall include claims from the above settings in doing data analysis to plan their medical review strategy using the same criteria employed in other settings. Amendments to plans and strategies *shall* be made as needed if analysis indicates adjustment of priorities.

As part of your annual review of local medical review policy (LMRP) *or local coverage determinations (LCDs)* in conformance with IOM Pub.100-8, chapter 13, section 13.3, consider the need to modify your policies to apply to these settings. As in any setting, contractors shall provide educational opportunities to assure knowledge of applicable policies and appropriate billing procedures.

1.1.3 - Quality of Care Issues

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Potential quality of care issues are not the responsibility of the MR unit, but are the responsibility of the QIO, State licensing/survey and Certification agency, or other appropriate entity in the service area. Contractors should refer quality of care issues to them. See Chapter 3, §1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

1.2 - The Medicare MR Program

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The MR program is designed to promote a structured approach in the interpretation and implementation of Medicare policy. The CMS makes it a priority to automate this process; however it may require the evaluation of medical records to determine the medical necessity of Medicare claims. The goal of the contractor's MR program is to participate in reducing the contractor's claims payment error rate by identifying, through analysis of data and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and by taking the necessary action to prevent or address the identified vulnerabilities.

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 contractors 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;
- Sections 1812, 1861, and 1832 which describe the Medicare benefit categories; and
- Sections 1874, 1816, 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.

*The CMS contracts with carriers, fiscal intermediaries (FIs), program safeguard contractors (PSCs), and **Medicare Administrative Contractors (MAC)** to perform MR functions: analyze data, write local **coverage determinations (LCD)**, review claims, and **educate providers**. All of these entities are referred to as Medicare "contractors." Not all Medicare contractors perform all MR functions. The contractor requirements listed in this manual apply to contractors who have responsibility for those particular functions. For example, if a contractor has a contract with CMS only to perform data analysis for all durable medical equipment, that contractor would not be required to comply with the **LCD** requirements, or any requirements other than data analysis.*

1.2.1 - Goal of MR Program

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Under GPRA, CMS has a goal to reduce the Medicare fee-for-service paid claims error rate. Contractors are not required to establish a baseline error rate or calculate a contractor specific error. The CERT Program will provide the baseline measurements.

The goal of the MR program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR program, contractors:

- Proactively identify potential MR related billing errors concerning coverage & coding made by providers 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) (IOM Pub. 100-8, chapter 2, describes these activities in further detail.);*
- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent; (IOM Pub. 100-8, chapter 3, describes these actions in further detail.)*
- Place emphasis on reducing the paid claims error rate by educating the individual billing entities (i.e, providers, suppliers, or other approved clinician) that pose the greatest vulnerability to the Medicare program based on their claims submission errors; and*
- Publish LCDs to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute.*

Providers may conduct self-audits to identify coverage and coding errors using the Office of Inspector General (OIG) Compliance Program Guidelines at <http://www.os.dhhs.gov/oig/modcomp/index.htm>. Contractors must follow IOM Pub. 100-8, chapter 4, section 4.18.4.1, in 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 MR unit shall follow the procedures listed in IOM PUB.100-8, chapter 3, §3.1. 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. Contractors shall take action commensurate with the error made. Contractors shall evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction. See IOM Pub. 100-8, chapter 3, §3.1.

1.2.2 - MR Manager

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

An effective MR/LPET program begins with the strategies developed and implemented by senior management staff. Contractors must name a MR point of contact referred to as the MR manager that will act as the primary contact between the contractor and CMS concerning the contractor's MR/LPET program. The MR Manager will also have primary responsibility for the development, oversight and implementation of the contractor's MR/LPET Strategy, quarterly strategy analysis (QSA) and quality assurance process. In addition, the MR Manager shall have the primary responsibility for ensuring the timely submission of the MR/LPET strategy and QSA.

For the PSC, the MR manager shall be designated as key personnel in the PSC SOW.

1.2.3 - Annual MR/LPET Strategy

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Each fiscal year, the contractors shall develop and document a unique annual MR/LPET Strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The MR/LPET strategy shall detail identified MR issues, educational activities, projected goals, and the evaluation of educational activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the MR/LPET strategy. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and LPET.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR and LPET activities. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop MR and LPET interventions using the PCA process (IOM Pub 100-8, chapter 3, section 14) to address each problem. The methods and resources used for the MR and LPET interventions depend on the scope and severity of the problems identified and the level of education needed to successfully address the problems. For example, for the more aberrant provider, or the provider who continues to bill incorrectly, it may be more effective to provide more intensive education, such as a site visit, or a tele-conference, as opposed to simply sending a letter. In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR/LPET strategy and reflected in the QSA. If resources allow, a MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address the local Medicare providers' educational needs. The MR/LPET strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of educational activities designed to resolve targeted medical review problems. In doing such, the contractor shall utilize a provider tracking system that documents educational contacts, specific issues addressed, and type of intervention used. As problems are addressed, the contractor shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information contained in the provider tracking system to determine a more progressive course of action. As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The MR/LPET strategy shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the PSC ART system.

Finally, the MR/LPET strategy shall include a mechanism to monitor and improve the accuracy and consistency of LPET staff's responses to specific inquiries regarding MR

related coverage and coding issues. This is to ensure that providers receive accurate and consistent answers to their Medicare claim questions.

In each element of the MR/LPET strategy, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In addition, the contractor shall have in place procedures for continuous quality improvement. Quality Improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported.

Figure 1

<i>FY 2004 Medicare Medical Review & Local Provider Education Strategy</i>	
<i>Contractor Name:</i>	
<i>Contractor Number:</i>	
<i>Contractor MR & LPET site location(s):</i>	
<i>Data Analysis Plan:</i>	
<i>Prioritized Problems:</i>	(1)
	(2)
	(3)
<i>Intervention Plan:</i>	(1)
	(2)
	(3)
<i>Follow up Plan:</i>	(1)
	(2)
	(3)
<i>Program Management:</i>	
• <i>Workload management process</i>	
• <i>Cost allocation management process</i>	
• <i>Staffing & Resource management process</i>	
• <i>CMS Mandates</i>	
• <i>PSC support</i>	
<i>Budget and Workload Chart:</i>	
<i>Staffing Chart:</i>	

The contractor shall include the following elements in the MR/LPET strategy:

1.2.3.1 Data Analysis and Information Gathering (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The Data Analysis Plan shall list the data resources used in developing the strategy and the MR/LPET process. Examples of helpful resources include national database reporting systems, internal claims reports, provider feedback, team meetings with appeals and provider inquiry, SADMERC data, provider tracking tools to identify potential coverage and coding problems, CERT data, SAS 70 findings, Benefit Integrity (BI) information, and any additional data developed by the contractor. The plan shall explain the process used to analyze the data and other information, to develop the problem list.

Quality Assurance:

For quality assurance purposes, the contractor shall develop a process that includes frequent review of data and how the information is used. For example, establish a committee that routinely reviews data results. Document committee members' job titles, qualifications and contract operational areas they represent. Describe the log system or tracking system utilized for data analysis and how this information was developed via meetings and/or brainstorming. The contractor can use the CERT findings to demonstrate how well the contractor is performing their data analysis.

1.2.3.2 Problem Identification & Prioritization (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR/LPET strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR/LPET strategy is a fluid document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR and LPET are not focusing on problems that are being addressed by the Provider Outreach and Education (POE) unit or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE, to cohesively address issues and share in educational opportunities.

1.2.3.3 Intervention Planning

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

To address the problems identified in the MR/LPET strategy, the contractor shall design a comprehensive plan of interventions. **The contractor shall include education for every one of the identified problems.** Other interventions may involve projected medical review of claims, edit modifications and development or revisions of LCDs.

Quality Assurance:

The contractor shall include a quality assurance element in each intervention that checks for effectiveness and progress towards the specified goal. The QA component shall include a projected goal, a timeline to achieve the goal, and an element to assess effectiveness of the intervention and progress towards the stated goal. Examples of QA for interventions include, but are not limited to, tests for edit effectiveness, post-test of educational interventions, claims review after an educational intervention, systematic reviews of LCDs, etc. Finally, the QA component shall include a determination of whether the problem has been resolved or a more progressive course of action is required.

1.2.3.4 Program Management

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The MR Program Management encompasses managerial responsibilities inherent in managing the MR and LPET programs, including: development, modification, and periodic reporting of MR/LPET strategies and quality assurance activities; planning monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS MR instructions.

Quality Assurance:

The contractor shall describe in detail the Quality Improvement Process. Include the processes employed to assure accuracy and consistency in the reporting of spending, workload and staffing levels. The contractor shall address how to maintain accuracy in decision-making (inter-reviewer reliability) and response to provider inquiries. In addition, the contractor shall describe system for review and evaluation of the MR/LPET strategy.

1.2.3.5 Budget and Workload Management

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

In order to effectively determine appropriate budget levels and accurately predict workload, the contractor shall complete the following chart (omitting the shaded areas) for each strategy developed. Note that this chart is only for the purposes of developing a MR/LPET strategy. Contractors are expected to report workloads and costs associated

ACTIVITY CODE	ACTIVITY	BUDGET	PROJECTED WORKLOAD		
			Workload 1	Workload 2	Workload 3
MEDICAL REVIEW PROGRAM					
21001	Automated Review				
21002	Routine Reviews				
21007	Data Analysis				
21206	Policy Reconsideration/Revision				
21207	MR/LPET Program Management				
21208	New Policy Development				
21220	Complex Probe Sample Review				
21221	Prepay Complex Manual Review				
21221/01	Reporting for Advanced Determinations of Medicare Coverage (ADMC)				
21222	Postpay Complex Review				
21901	MIP CERT Support				
LOCAL PROVIDER EDUCATION AND TRAINING (LPET)					
24116	One-on-One Provider Education				
24117	Education Delivered to a Group of Providers				
24118	Education Delivered via Electronic or Paper Media				

with all CAFM II activity codes and assigned workloads. program safeguard contractors (PSC) shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the PSC ART system.

NOTE: When submitting the Interim Expenditure Report (IER), all defined workloads shall be entered.

In addition:

- *The contractor shall explain methods for determining the appropriate amount of review for each CAFM II Activity Code. Contractors may perform automated, routine, and complex prepayment review and post-payment reviews. Contractors shall determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration shall be given to the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate.*
- *The contractor shall automate as much review as possible. For those types of review that cannot be automated, the contractor shall be able to justify why they cannot be automated. Only in those instances where reviews cannot be automated and does not require clinical judgment shall the contractor conduct routine reviews.*
- *The contractor shall identify any support services that will be provided to a PSC. The strategy shall detail the role of the PSC in the overall MR/LPET program for the contractor. For the PSCs that perform some medical review functions, they shall be involved with the development of the MR/LPET Strategy.*
- *The contractor shall identify the process for determining when the contractor will develop or revise LCD.*

1.2.3.6 Staffing and Workforce Management

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors shall complete and include the following chart to project the number of full-time-equivalent (FTE) employees, their job titles and qualifications.

CAFM II Code	FTE	Description & Qualifications
<i>21001</i>		
<i>21002</i>		
<i>21007</i>		
<i>21010</i>		
<i>21206</i>		
<i>21207</i>		
<i>21208</i>		
<i>21220</i>		
<i>21221</i>		
<i>21221/01 (DMERCs only)</i>		
<i>21222</i>		
<i>24116</i>		
<i>24117</i>		
<i>24118</i>		
<i>Totals</i>		

The contractor shall submit a MR/LPET Strategy with their budget request to the appropriate RO and to CO at MRStrategies@cms.hhs.gov each fiscal year. The subject line of the e-mail shall begin with the contractor name followed by “Strategy” with the identifying fiscal year. The MR/LPET Strategy shall be updated as required. When an updated MR/LPET Strategy requires a SBR, the updated MR/LPET Strategy shall be sent with the SBR to the RO and to CO at MRStrategies@cms.hhs.gov. The PSC shall submit strategies with their draft project plan and final project plan, and update as required.

1.4 - Local Provider Education and Training (LPET) Program

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The local provider education and training (LPET) program is designed to support medical review by educating those providers who demonstrate erroneous claims-submission behaviors. All LPET activity supports the MR program. As such, all LPET activity is a response to program vulnerabilities identified through the analysis of the CERT findings, medical review findings, information from the various operational areas of the contractor, and other data from various sources. The ultimate goal of the LPET program is the continual reduction in the national claims payment error rate by proactively targeting individual provider aberrant billing patterns. The contractor shall evaluate the information, develop and prioritize the identified program vulnerabilities, and design educational interventions that effectively address the identified problems.

Like provider communications (PCOM), the LPET program is intended to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. Teaching providers how to submit claims accurately, assures correct payment for services rendered. Unlike PCOM activities that address Medicare’s national issues, the LPET education is always a response to the local provider’s claim submission patterns and information needs. To meet this goal, contractors shall use various methods, such as print, Internet, telephone, and face-to-face contacts. Simply sending a letter in response to the review of claims is not always the most effective mechanism with which to educate providers on coverage, coding, and billing errors identified by medical review. Contractors must use a wide range of tools, both reactively and proactively to address the educational needs of the provider community.

Clinical expertise is required to educate providers concerning coverage, coding, and billing issues related to medical review. Educational interventions shall be performed at the direction of the MR manager, clinicians, and by specially trained non-clinical staff working under the direction of the clinicians.

1.4.1 - LPET Activities

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

1.4.1.1 - One-on-One Provider Education

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors shall develop one-on-one provider education in response to medical review related coverage, coding, and billing problems, verified and prioritized through the review of claims and/or the analysis of information. As these contacts are directly with the provider, clinical expertise is required to conduct this activity. One-on-one provider education includes face-to-face meetings, telephone conferences, videoconferences, letters, and electronic communications (e-mail) directed to a single provider in response to specific medical review findings. Included in this activity code are the costs and workload included in responding to provider questions concerning their specific medical review activities, or new or revised local policies.

Contractors choose the type of one-on-one educational activity based on the level of medical review related coverage, coding, and billing errors identified. For a moderate problem, the contractor may choose to educate a provider via telephone conference. For more severe problems, or a problem that was not resolved through a telephone conference, a face-to-face meeting may be more appropriate. Follow-up written correspondence of the education delivered might be appropriate for more severe problems or upon provider request. All one-on-one contacts shall be recorded in the provider tracking system (PTS). The information to include in the PTS should be an explanation of the problem, the type of educational intervention performed, and the directions given to correct the errors. While one-on-one provider education is likely to correct most medical review related coverage, coding and billing errors, it may be necessary for contractors to provide additional remedial education if the provider's billing pattern continues to demonstrate aberrancies. Refer to IOM Pub. 100-8, ch. 11, § 3 for additional information on cost and workload reporting.

1.4.1.2 - Education Delivered to a Group of Providers

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors may determine that certain issues are best addressed by administering education to a group of providers. To remedy wide spread service-specific aberrancies, contractors may elect to educate a group of providers, rather than provide one-on-one contacts. Other subjects more appropriately addressed in a group setting include, but are not limited to, proactive seminars regarding medical review topics and local provider educational needs presented by new LCDs. This activity is not to be used to educate providers on issues of national scope. Education delivered to a group of providers is designed to educate groups of providers with specific education needs based on MR findings.

Education delivered to a group of providers may include seminars, workshops, and teleconferences. A differentiating factor between education delivered to a group of providers and educational delivered via electronic media is the necessity of live

interaction between educator and providers. A computer module with the capacity to educate many providers simultaneously, would not be captured here, but would be captured under education delivered via electronic media. The determining factor is that there are not spontaneous, live interactions between educator and providers, with the computer module. Refer to IOM Pub. 100-8, ch. 11, § 3 for additional information on cost and workload reporting.

Contractors shall NOT use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted to select or track providers of services or suppliers for the purposes of conducting any type of audit or prepayment review.

1.4.1.3 - Education Delivered via Electronic Media (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors may elect to provide education via electronic media. Education delivered solely by electronic media that does not involve the facilitation or interpretation of a live educator would be reported under this activity code. However, an electronic tool developed and utilized as an adjunct to education delivered one-on-one or education delivered to a group of providers shall not be allocated to this activity code.

Contractors are required to maintain a website for the dissemination of medical review bulletin articles, FAQs and at the contractor's discretion dissemination of LCDs. Contractors who choose to also publish hard copies of bulletin articles and FAQs shall also report that cost in this activity code. It is not the act of publishing, rather the act of developing the education that should be considered. In addition, contractors are required to submit to CMS those articles/advisories/bulletins that address medical review related coverage and coding billing issues. Contractors are required to update their FAQs to their website quarterly. Contractors are encouraged to develop FAQ systems that allow providers to search FAQ archives and subscribe to FAQ updates. Another example of education delivered via electronic media includes, but is not limited to, scripted response documents to be utilized by the customer service staff. Refer to IOM Pub. 100-8, ch. 11, § 3 for additional information on cost and workload reporting.

1.4.2 - Description of Methods of Education (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

The following is a sample of methods to be used in the above LPET activities. This is by no means an all-inclusive list and contractors are encouraged to be creative in developing educational interventions.

1.4.2.1 - Proactive Local Educational Meetings (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Proactive local educational meetings include seminars, workshops, classes, and other face-to-face meetings, as well as other live interactive meetings like Webinars that educate and train providers regarding local medical review policies and coverage/coding/medical review related claim and billing considerations. Contractors shall use clinical staff as a resource at proactive educational meetings. Additionally, contractors should address the local educational needs presented by new coverage policies, and bulletin articles/advisories concerning medical review considerations. Whenever feasible, contractors should collaborate in holding these events with interested groups and organizations as well as CMS partners in their service area. Whenever feasible, hold teleconferences to address and resolve inquiries from providers as a method to maximize the number of providers reached.

Contractors shall NOT charge a fee for attendance to contractor sponsored meetings. However, contractors may attend or sponsor provider-requested local education meetings at the contractors' discretion. Contractors may charge a fee for providing these discretionary services, however any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. Revenues collected from these discretionary activities shall only cover the cost of these activities, and may not be used to supplement other contractor activities.

1.4.2.2 - Comprehensive Educational Interventions

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors may provide comprehensive educational interventions for a specific-provider specialty (e.g., podiatry, cardiology or psychiatry) or specific benefit (e.g., partial hospitalization programs, ambulance services, durable medical equipment) in response to large-scale coverage/coding/medical review related billing and claim issues. These educational activities may be identified by the contractor or by CMS.

Comprehensive educational interventions should be made available only to individual or small provider groups for pervasive coverage/coding/medical review related claims and billing issues throughout the provider specialty or benefit. These special projects require clinical expertise to develop a thorough educational program of the coverage, coding, and documentation requirements needed to assure the appropriate claims submission. Contractors should consider using sanitized claim and documentation examples, as well as examples of best practices in supporting their educational program.

1.4.2.3 - Comparative Billing Report Education

(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors can develop and issue comparative billing reports in 3 situations: (1) provider-specific reports for high utilization individuals, (2) provider-specific reports for individuals who have requested a report, and (3) service-specific reports.

1) Provider-specific reports for high utilization individuals.

To address potential over-utilization, contractors may give provider-specific comparative billing reports to those providers that demonstrate the highest utilization for the services they bill. These reports must provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the provider's billing pattern more clearly. When provider-specific reports are distributed, contractors must develop and provide specific written educational information concerning the billing report and the highest utilized services. Contractors may not offer the report without this required educational documentation. Contractors may NOT charge a fee for providing these reports.

2) Provider-specific or specialty-specific comparative billing reports for requestors.

In order to provide good customer service, contractors may give provider-specific reports to providers or provider associations who request such a report. Contractors may charge a fee for providing these discretionary reports. However, any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. Revenues collected from these discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities. If contractors choose to make such reports available, contractors must describe on their website the mechanism by which a provider or provider association can request such a report and the fee for it.

3) Service-specific comparative billing reports.

When widespread problems are verified, contractors may post service-specific comparative billing reports to their Web sites. Contractors may NOT charge a fee for posting these reports.

***1.4.2.4 - Frequently Asked Questions Regarding Local Education Issues
(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)***

Contractors shall develop a web-based searchable response document in Q and A format of frequently asked questions regarding LMRPs/LCDs, medical review related coverage, coding and billing considerations. When providing the response to frequently asked questions, contractors must adhere to the requirements in the PIM concerning the publication of articles. At a minimum, the FAQ document must be updated quarterly.

***1.4.2.5 - Bulletin Articles/Advisories Regarding Local Education Issues
(Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)***

Contractors shall develop bulletin articles/advisories and alerts concerning LMRPs/LCDs and medical review related coverage, coding or billing considerations.

Clinical staff shall develop bulletin articles/advisories or alerts and adhere to the requirements in the PIM concerning the publication of articles.

Articles may include any newly developed educational materials, coding instructions, or clarification of existing policy or instruction. Contractors are encouraged to send bulletin articles/advisories to specialty societies for inclusion in their publications and Web sites. All newly created bulletins must be posted on the contractor's Web site where duplicate copies may be obtained by physician/suppliers. All bulletins must have either a header or footer that includes the following bolded language: " THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PHYSICIAN/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO COST FROM OUR WEBSITE AT (INSERT CONTRACTOR WEBSITE ADDRESS)".

Physicians/suppliers should be encouraged to obtain electronic copies of bulletins and other notices through the contractor website. If physicians/suppliers are interested in obtaining additional paper copies on a regular basis, contractors are permitted to charge a fee for this. The fee for this subscription should be 'fair and reasonable' and based on the cost of producing and mailing the publication. A charge may also be assessed to any physician/supplier who requests additional copies. However, any money collected must be reported as a credit in the applicable CAFM II Activity Code and accompanied with a rationale for charging the fee. Revenues collected must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities.

1.4.2.6 - Scripted Response Documents on Local Education Issues (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Contractors may develop scripted response documents that address LMRPs/LCDs, and medical review coverage, coding and billing questions to be utilized by the customer service staff. The customer service staff may use these documents to respond to coverage questions. MR/LPET staff and the CMD shall make themselves available to Provider Relations Research Specialists to assist them in answering providers questions concerning local policy.

1.4.3 - LPET Staff (Rev. 107, Issued: 04-08-05; Effective/Implementation Dates: 05-09-05)

Clinical expertise is needed to educate providers concerning LMRPs/LCDs, and medical review coverage, coding and billing issues. The delivery and design of the educational interventions are performed at the direction of the MR manager and can be supported by specially trained non-clinical staff working under the direction of the clinicians.