CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-15 Medicaid Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13385	**Date: August 28, 2025**
	Change Request 14174

SUBJECT: Updates of Chapter 3 and the Appendices Chapter in Publication (Pub.) 100-15, Including Updates to the Medicaid Proactive Project Development Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise various sections within Chapter 3 and the Appendices Chapter in Pub. 100-15. The revisions include updates to the Medicaid Proactive Project Development process, in addition to the Medicaid Medical Review for Program Integrity Purposes processes. Additionally, the Analytic Findings Report Sample has been added to the Appendices Chapter.

These updates do not affect the provider and/or beneficiary populations. Rather, these updates are solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

EFFECTIVE DATE: September 29, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 29, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2/Proactive Project Development
R	3/3.9/Medical Review for Program Integrity Purposes
R	3/3.10/Request for Medical Records
R	Appendices/Table of Contents
N	Appendices/Appendix O/Analytic Findings Report Sample

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-15	Transmittal: 13385	Date: August 28, 2025	Change Request: 14174

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update sections in Chapter 3 and add a template in Appendices of Pub. 100-15. Specifically, guidance in Chapter 3 is being updated to clarify steps within the proactive project development process. The addition in the Appendices chapter reflects a sample Analytic Findings Report.

B. Policy: This CR does not involve any legislative or regulatory policies.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14174.1	The Unified Program Integrity Contractor (UPIC) shall submit potential provider targets, on an Analytic Findings Report, to Medicaid Business Function Lead with the total dollars at risk for the scheme.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14174.1.1	The UPIC shall be advised that the Analytic Findings Report shall summarize the data analysis performed, identify potential leads that justify further action (also referred to as "actionable"), and provide recommendations for activities that may include further investigation, audit, referral to law enforcement, or administrative action.									UPICs
14174.2	The UPIC shall complete the medical review process within 60 calendar days, unless otherwise directed by the Centers for Medicare & Medicaid Services, to promote investigation timeliness.									UPICs
14174.3	The UPIC shall document "no receipt of records" with CMS and the state and move forward with the investigation/audit if no records are received within the specified timeframe and the provider has made no reasonable attempt to provide the requested records.									UPICs
14174.4	The UPIC shall utilize the Analytic Findings Report Sample, as referenced in Appendix O of the Appendices chapter.									UPICs

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 3 – Medicaid Investigations & Audits
(Rev. 13385; Issued: 8-28-25)

3.2 - Proactive Project Development
(Rev. 13385; Issued: 08-28-25; Effective: 09-29-25; Implementation: 09-29-25)

Through ongoing collaboration with each state, the UPIC shall discuss areas of interest and convey CMS' priorities related to Medicaid fraud, waste, and abuse for purposes of potential investigations. As outlined in the UPIC statement of work, the UPIC shall be flexible and shall have the capability to adapt to the changing landscape of fraud, waste, and abuse in their jurisdiction. The UPIC shall keep CMS and the state informed as to the highest investigative priorities in such a way as to assure that CMS and the state always has a full understanding of the UPIC's highest priorities and supports State PI efforts.

Once an investigative area of interest is identified, the UPIC shall access the applicable Medicaid claims data for analysis through the CMS/CPI Integrated Data Repository (IDR).

Concurrently, the UPIC shall conduct state policy research and communicate with the appropriate state policy experts. Once the policies have been researched and clarified, the UPIC will conduct an analysis of the applicable data. The UPICs shall develop proactive, innovative and robust analytic tools for investigations that commence with an exposure (i.e. Medicaid dollars-at-risk associated with the specific scheme/allegation) greater than $50,000 total computable. If a state is interested in pursuing an audit where exposure does not reach the $50,000 threshold, UPICs shall ensure that the exposure is greater than the total cost of the audit. In these instances, the UPICs should consult with their Medicaid BFLs/CORs prior to lead screening to discuss the value of proceeding and document the reason for proceeding in the UCM case record. The threshold would not apply to cases where fraud is suspected.

Upon review of the data, clarification of policy interpretation, and agreement by the state on the focus of the investigation, the UPIC will identify those "targets" or "potential leads" that meet the criteria of the project and submit those potential leads to the Medicaid BFL for review/approval. When submitting a potential lead to CMS, the UPIC will submit the total dollars at risk for the allegation to be investigated. The dollars at risk do not include the total amount billed by the provider for all services. The dollars at risk will only include the dollars for the service code(s) that are outliers on any specific data algorithm or analysis, and which will be the focus of the investigation/audit. Once approved, those leads will then be screened in accordance with Section 3.3 of this manual. In lieu of a workflow diagram, please see the step-by-step process below to demonstrate this workflow.

Step 1: UPIC conducts proactive data study as a PDP/Data Project Record (DPR) in UCM.
Step 2: UPIC identifies potential targets it would like to pursue that are outliers on the data study and which meet or exceed the $50,000 threshold. It is understood that there may be numerous outliers in a large state, and the UPIC may choose to pursue only a portion of them at any one time. The DPR may remain open as it continues to generate leads, with the data being refreshed as needed, or at least every 30 days per the Medicare PIM. 4.12.1. [The $50,000 threshold may not be applicable to certain projects such as opioid prescribing.]
Step 3: UPIC submits the potential provider targets*, on an Analytic Findings Report (Appendix O),* to Medicaid BFL with the total dollars at risk for the scheme. *The Analytic Findings Report shall summarize the data analysis performed, identify potential leads that justify further action (also*

referred to as "actionable"), and provide recommendations for activities that may include further investigation, audit, referral to law enforcement, or administrative action.

Step 4: BFL approves or declines potential targets.

Step 5: For those targets which were approved, the UPIC will open a CSE in UCM within seven (7) calendar days of approval by the BFL and begin the screening process.

3.9 - Medical Review for Program Integrity Purposes

(Rev. 13385; Issued: 08-28-25; Effective: 09-29-25; Implementation: 09-29-25)

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

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

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

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

The UPIC shall follow Medicare PIM Chapter 3.3.1.1 - Medical Record Review, all other applicable chapters of the PIM, and any applicable state specific medical review requirements, where applicable, unless otherwise instructed in this chapter and/or in its Task Order Statement of Work (TO SOW). If there is a discrepancy between the methodologies outlined between the state and Medicaid PIM, the UPIC shall consult with its COR and BFL for guidance. *To promote investigation timeliness, the UPIC shall complete the MR process within 60 calendar days, unless otherwise directed by CMS, as stated in Medicare PIM Chapter 3.3.1.1.*

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

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

2. The UPIC shall have specific review parameters and guidelines established for the identified

claims/claim lines. Each claim/claim line shall be evaluated using the same review guidelines. The claim/claim line and the medical record shall be linked by patient name, applicable Medicaid ID, diagnosis, Medicaid claim number, and procedure when providing feedback to the SMA regarding the review outcome.

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

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

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

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

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

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

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

10. The UPIC shall follow the guidance provided in Chapter 4 of this manual on documenting medical review findings.

3.10 - Request for Medical Records

(Rev. 13385; Issued: 08-28-25; Effective: 09-29-25; Implementation: 09-29-25)

At the beginning of any review, the UPIC sends the provider a record request letter, which includes a request for specific Medicaid medical records (Appendix C). The UPIC shall collaborate with the SMA to determine if additional steps are required and/or if state approval is required prior to sending record requests to the provider. *The* UPIC will allow the provider 30 days to produce the records, with a permissible 15-day extension if requested by the provider, unless otherwise specified by the SMA or CMS. If no records are received within the specified timeframe and the provider has made no reasonable attempt to provide the requested records, the UPIC shall *document this with* CMS and the state*, and move forward with the investigation/audit.*

Medicaid Program Integrity Manual

Appendices

Table of Contents
(Rev. 13385; Issued: 8-28-25)

Transmittals for Appendices

O Analytic Findings Report Sample

Appendix O

Analytic Findings Report Sample
(Rev. 13385; Issued: 8-28-25)

UPIC Name
Proactive Data Analysis

Proactive Title:	
UCM PDP ID:	*PDP-xxxxxx-xxxxx*
Prepared by:	
Date Prepared:	*xx/xx/xxxx*

Introduction and Background

Allegation:
Services not rendered, services not medically necessary, upcoding, patient harm, etc.

Methodology:

Medicaid-Only / Non-Crossover Criteria:
- *Claim Type (T-MSIS):*
- *DOS:*
- *Paid Dates:*
- *Final, paid claims*
- *Procedure Codes:*

Metrics for target selection:

Summary of Findings:

Target Selection:
The below targets were selected.

Provider 1:

Provider Name:	
NPI:	
Selection Rationale:	

Universe dollar amount:	
Allegation specific dollar amount:	

Provider 2:

Provider Name:	
NPI:	
Selection Rationale:	
Universe dollar amount:	
Allegation specific dollar amount:	