CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-15 Medicaid Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13494	**Date: December 23, 2025**
	Change Request 14275

SUBJECT: Updates of Chapters 1-5 in Publication (Pub.) 100-15, Including Updates to the Guidance Terminology, Existing Definitions, and Details to Standing Guidance

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise various sections within Chapters 1-5 in Pub. 100-15. The revisions include updates to terminology, definitions, and details to existing guidance. Additionally, this update includes detailed updates to the Medicaid overpayment creation process.

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: January 26, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 26, 2026

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	1/Table of Contents
R	1/1.1 Basis of Authority – Statutory/Regulatory Citation
R	1/1.3 Definitions
R	2/2.0 State Collaboration Purpose
R	2/2.1/2.1.4 Joint Operating Agreement (JOA)
R	2/2.2/2.2.1 Program Management Meetings or Monthly Collaboration Meetings
R	3/Table of Contents
R	3/3.0 Overview
R	3/3.2 Data Project Record
R	3/3.3 Lead Screening
R	3/3.5 Investigations/Audits
R	3/3.9 Medical Review for Program Integrity Purposes
R	3/3.10 Request for Medical Records
R	4/4.2/4.2.2 Overpayment Assessed Solely by Data Analysis
R	4/4.3 Overpayment Resolution Process
R	4/4.3/4.3.1 Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure
R	4/4.4 State Appeal Process
R	4/4.5 Close-Out Letters
R	5/5.3 Creating Overpayment (OPT) Records

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: 13494	Date: December 23, 2025	Change Request: 14275

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update sections in Chapters 1-5 of Pub. 100-15. Specifically, guidance is updated to provide terminology, definition, and existing guidance clarification. The added guidance provides updates to the Medicaid overpayment creation procedures.

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	
14275.1	Unified Program Integrity Contractors (UPIC) shall be advised that Section 1902(a)(69) of the Act entitled, “State Requirement to Cooperate with Medicaid Integrity Program Efforts” requires that the Medicaid State plan “provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Program established under section 1936."									
14275.2	UPICs shall be advised that the Investigative Plan (or Audit Test Plan, ATP) outlines the plan of action for conducting the investigation/audit of a provider.									UPICs
14275.2.1	UPICs shall include the Investigative Plan elements as referenced in Section 1.3 – Definitions.									UPICs
14275.3	UPICs shall be advised that the Medicaid Initial Findings Report (IFR), is a summary of findings resulting from a UPIC investigation/audit of a Medicaid provider or a Managed Care Plan (MCP).									UPICs
14275.3.1	UPICs shall be advised that the IFR will detail the timeframe and summary of the initial findings from the claims/claim lines or financial review, along with any other findings discovered during the investigation.									UPICs
14275.4	UPICs shall be advised that the Medicaid Final Findings Report (FFR) is a final summary of the findings resulting from a UPIC investigation/audit of a Medicaid provider or MCP when an overpayment has been identified and is being referred to the State Medicaid Agency (SMA) for recovery.									UPICs
14275.4.1	UPICs shall be advised that the FFR provides details on the time period of the									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	review, findings discovered during the investigation, summary of the claims/claim lines or financial review findings, total computable overpayment, and the total federal financial participation overpayment.									
14275.5	UPICs shall perform activities in relation to the screening process as listed in Section 1.3 Definitions.									UPICs
14275.6	UPICs shall be advised that the purpose of collaboration between the SMA and the UPIC is to identify state priorities, share the Center for Medicare & Medicaid Services' (CMS) priorities and expectations, specialty areas of analytical and investigative interest, clarification of state policy, and to ensure there is no duplication of efforts.									UPICs
14275.7	UPICs shall be advised that their activities are governed by CMS' Task Order Statement of Work, the Medicaid Program Integrity Manual (PIM), and the Medicare PIM.									UPICs
14275.8	The UPIC Program Management Meetings with CMS and the SMA shall include Development of New Data Project Records on the agenda for discussion.									UPICs
14275.9	The UPICs shall be responsible for collaborating with SMAs in their respective jurisdiction to share CMS Center for Program Integrity (CPI)									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	priorities and processes and to develop processes for investigating Medicaid fraud, waste, and abuse issues.									
14275.10	UPICs shall submit the potential provider targets, on an Analytic Findings Report (Appendix O), to Medicaid Business Function Lead (BFL) with the total dollars at risk for the scheme.									UPICs
14275.10.1	UPICs 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
14275.11	UPICs shall be advised that creating an Investigative Plan (or ATP) is an activity that the UPIC may perform in relation to the screening process.									UPICs
14275.12	The UPIC shall upload the Investigative Plan in Unified Case Management (UCM) System for BFL approval.									UPICs
14275.13	UPICs shall be advised that an investigation/audit is the formal review of suspicious aberrancies in a provider's submitted Medicaid claims or financial payments to establish evidence that potentially fraudulent activities or other improper payments have occurred.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14275.14	The UPIC shall complete the medical review process within 60 calendar days, unless otherwise directed by CMS, as stated in Medicare PIM Chapter 3.3.1.1., to promote investigation timeliness.									UPICs
14275.15	The UPIC shall 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.									UPICs
14275.15.1	The UPIC shall document this 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
14275.16	UPICs shall be advised that, in certain instances, in collaboration with the SMA, the UPIC may identify overpayments based solely on data analysis from claims or financial payments.									UPICs
14275.17	The UPIC shall revise the IFR and incorporate any other grammatical or narrative corrections identified by the state and document the changes in the UCM.									UPICs
14275.17.1	UPICs shall be advised that the document shall remain an IFR.									UPICs
14275.17.2	The UPIC shall inform the BFL to determine the next									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	step if there are monetary changes.									
14275.18	The UPIC shall produce an FFR if no adjustments are made to the findings, resulting in no monetary changes to the Appendix A.									UPICs
14275.18.1	The UPIC shall make the revisions in a revised IFR (RIFR) and the RIFR shall be sent to CMS and the state, this time with a 15-day review and comment period, if adjustments to the findings, which result in monetary changes to the Appendix A, are necessary.									UPICs
14275.18.2	UPICs shall be advised that CMS, the UPIC, and, if necessary, the state will reconcile any issues with the RIFR, after which the UPIC produces an FFR and completes the FFR – State Transmittal Letter and submits both to CMS for approval within 13 months of the Medicaid Investigation Start Date.									UPICs
14275.19	UPICs shall be advised that, in certain instances, the SMA may require an update to the FFR, based on updated analysis by the state, resulting in a downward adjustment in the amount of an overpayment due to an appeal decision from an administrative law judge, informal hearing decision, issues identified within the referenced policy, etc.									UPICs
14275.19.1	The UPIC shall notify CMS of the discrepancies and discuss a proposed									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	resolution. If it is determined that an update to the FFR is necessary, CMS and the UPIC shall collaborate to draft a Revised FFR (RFFR), along with the FFR Addendum – State Transmittal Letter (Appendix H), which CMS shall submit to the SMA upon completion in these instances.									
14275.19.2	The UPIC shall edit the overpayment (OPT) financial information in UCM on the original OPT record, upload the RFFR and FFR Addendum - State Transmittal Letter, and notify the BFL via email.									UPICs
14275.20	UPICs shall be advised that the UPIC may also contact the SMA for the applicable Federal Medical Assistance Percentage rate.									UPICs
14275.21	The UPIC shall ensure that the calculations for each claim/claim line and financial payments are accurate for each fiscal year.									UPICs
14275.22	The UPIC shall notify CMS of any changes to the overpayment amounts resulting from hearing decisions.									UPICs
14275.23	UPICs shall issue the provider a close out letter if a provider has been notified of the initiation of an investigation/audit and the Medicaid investigation/audit is later discontinued, or if the findings are insufficient to pursue.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14275.24	UPICs shall be advised that for investigations/audits of managed care network providers, where the provider is enrolled in multiple managed care organizations (MCO), one OPT record will be opened.									UPICs
14275.24.1	The UPIC shall break down the overpayments of each MCO payor within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each payor.									UPICs
14275.25	UPICs shall be advised that in circumstances where the provider is being investigated/audited for both fee-for-service (FFS) claims and is enrolled in managed care, one OPT record will be opened.									UPICs
14275.25.1	The UPIC shall break down the overpayments for the FFS portion and the MCO within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each.									UPICs
14275.26	UPICs shall update the financial section of the OPT record with the revised amounts in the 'Original Overpayment Amount' column and include the date of the revision in the 'Determination Date' column whenever the overpayment is revised, either due to the state's review or the provider's review.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14275.26.1	UPICs shall be advised that the 'Original Overpayment Amount' column should reflect the overpayment amount identified in the FFR submitted to CMS.									UPICs
14275.27	UPICs shall be advised that the 'Federal Share Amount' of the "Overpayment Financials" will be the calculated federal share of the overpayment amount identified in the FFR.									UPICs
14275.27.1	UPICs shall be advised that if the FFR is revised after it has been issued to the SMA, and the overpayment changes, the 'Revised Overpayment Amount' will be revised to reflect the new overpayment amount, and the federal share will be recalculated, and the amount will be entered in the 'Revised Federal Share' column.									UPICs
14275.28	The UPIC shall update the financial amount by editing the original OPT record for a RFFR, that has occurred after the FFR is issued to the SMA.									UPICs
14275.29	The UPIC shall create a folder in the UCM and upload all RFFR documents and notify the BFL of the RFFR via email.									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 1 – **Authority, Background, and Definitions**

Table of Contents
(Rev.13494; Issued:12-23-25)

1.1 - Basis of Authority – Statutory/Regulatory Citation

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

A. Provisions for the Work of the Unified Program Integrity Contractors

Section 1936 of the Social Security Act (the Act), established by the Deficit Reduction Act of 2005, is the statutory authority under which the Unified Program Integrity Contractors (UPICs) operate their Medicaid functions.

Section 1936(a) of the Act provides that the Secretary must enter into contracts with eligible entities to conduct certain activities specified at section 1936(b) of the Act.

Section 1936(b) of the Act provides that eligible entities under contract with the Centers for Medicare & Medicaid Services (CMS) will provide the following activities:

(1) Review the actions of individuals or entities furnishing items or services (whether fee-for-service, risk, or other basis) under a State plan or any waiver to determine whether fraud, waste, or abuse has occurred; is likely to occur; or whether such actions have any potential for resulting in an expenditure of funds which is not intended.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan, including (A) cost reports; (B) consulting contracts; and (C) risk contracts under section 1903(m).

(3) Identification of overpayments to individuals or entities receiving federal funds under this title.

(4) Education or training, as the Secretary may establish, of certain individuals and entities with respect to payment integrity and quality of care.

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

Lastly, Section 6506 of the Affordable Care Act provides guidance related to Medicaid overpayment recoupment and federal repayment.

B. Provisions for State Collaboration with the Unified Program Integrity Contractors

Section 1902(a)(69) of the Act entitled, "State Requirement to Cooperate with *Medicaid* Integrity Program Efforts" requires that the Medicaid State plan "provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936."

C. Provisions for the Medicare-Medicaid Data Match Program (Medi-Medi Program)

Section 1893(g) of the Act established the Medicare-Medicaid Data Match Program, which stipulated that:

(1) Expansion of program.—

(A) In general.—The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the "Medi-Medi Program") is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of—

(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture—

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements.—The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority. The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for states. The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

1.3 - Definitions

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

The following definitions provide additional context for the UPICs to reference while collaborating with SMAs. However, CMS recognizes that each SMA may use other terms and definitions than those noted below. The UPIC shall consult with each SMA to determine the appropriate terms and definitions to utilize during the collaboration. In addition, the UPICs may refer to Exhibit 1 of the Medicare PIM for further definitions.

Abuse - Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Case - A case is a work product that the UPIC opens as an investigation/audit after screening and vetting of a potential lead.

Closing Summary – The Closing Summary is completed when an investigation/audit reveals that there are low/no findings (LNF) to pursue or the investigation/audit is being closed for other reasons, e.g., discontinued by the SMA and no overpayment was identified that would normally trigger an Initial Findings Report (IFR). The UPICs shall use the "Closing Summary" template found at Appendix B to summarize the investigation/audit.

Dollars at Risk – For Medicaid leads and investigations, dollars at risk will be identified at two levels:

1. **Total dollars at risk** include only the dollars for the service code/scheme that are outliers on any specific data algorithm, and which will be the focus of the investigation/audit. This amount is required when submitting a potential lead to CMS for review/approval and for pre-vetting with CMS and vetting with the SMA.
2. **Sample dollars at risk** are those dollars associated with the sample to be selected for review. When extrapolation is not being used, and the focus of the investigation/audit is identifying an overpayment (unlike an opioid project, which may focus more on quality of care or prescribing behavior), the sample dollars at risk must meet the $50,000 threshold for a Medicaid investigation/audit. This amount is required in the Investigative Plan for review/approval by CMS and the SMA.

Fraud – Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Investigation/Audit – An investigation/audit is the formal review of suspicious aberrancies in a provider's submitted Medicaid claims to establish evidence that potential fraudulent activities or other improper payments have occurred. The UPIC shall focus its investigation/audit in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicaid dollars.

Generally, the activities associated with an investigation/audit may include, but are not limited to:

- Interviews of recipients or providers,
- Documentation requests to providers in the form of questionnaires, attestations, request for medical records, Managed Care Plan (MCP) contracts and contract deliverables, etc.
- Post-payment reviews of claims/claim lines,
- Auditing for third party liability as well as usual and customary charges,
- Identifying overpayment determinations,
- Making referrals to the SMA for potential administrative actions, such as payment suspension or termination actions, and
- Making referrals to law enforcement agencies for possible fraudulent activity.

Investigative Plan (IP) – The *Investigative* Plan (or Audit Test Plan*, ATP*) outlines the plan of action for conducting the investigation/audit of a provider. The plan shall include the steps and timeframes necessary to meet investigative objectives. Please refer to the TO SOW at 4.4.1.

The Investigative Plan should include, at a minimum, the following elements:

- *Date*
- Provider Name
- Provider NPI
- Provider Medicaid Number, if different from NPI
- *UCM Case Number*
- Provider Address
- Provider Type
- *State*
- *Data Classification – FFS or MCO*
- *Data Analysis*
- Service codes and/or scheme being investigated
- Dollars-at-risk for the scheme or service codes in question (not total dollars paid for all services during the time period):
    - Total dollars at risk for the scheme or code and
    - Sample dollars at risk for the actual claims/claim lines to be reviewed

- Time period being reviewed
- Proposed action steps and estimated time to complete each step. (NOTE: Action steps need to include frequency of communication with the SMA.)
- Size of sample (i.e., number of claims/claim lines) to be reviewed and whether extrapolation will be used
- *Recommended plan of action: audit/investigation steps*
- *Criteria/Methodology to be Reviewed*
    - *Potential Findings (Criteria)*
    - *Methodology*
    - *State and Federal Citations*

Lead ("Initiation of an Issue") - A lead is some indication that points toward a suspected instance of fraud, waste, or abuse. A lead can come in the form of either proactive or reactive efforts, typically through complaints, data analysis, SMAs, newspaper articles, anonymous tips, or some other channel.

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

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

Medicaid Initial Findings Report – The Medicaid Initial Findings Report (IFR), is a summary of findings resulting from a UPIC investigation/audit of a Medicaid provider *or a Managed Care Plan (MCP)*. The IFR will detail the timeframe and summary of the initial findings from the claims/claim lines *or financial* review, along with any other findings discovered during the investigation.

Medicaid Final Findings Report – The Medicaid Final Findings Report (FFR) is a final summary of the findings resulting from a UPIC investigation/audit of a Medicaid provider *or MCP* when an overpayment has been identified and is being referred to the SMA for recovery. In addition, the FFR may include areas where provider education is recommended. The FFR is developed after CMS, the SMA, and the provider have fully reviewed the IFR, and the provider has had an opportunity to provide any rebuttal records to the initial findings, when applicable to the type of investigation/audit being conducted. Although the FFR is created by the UPIC, CMS is responsible for sending the FFR to the SMA. The FFR provides details on the time period of the review, findings discovered during the investigation, summary of the claims/claim lines *or financial* review findings, total computable overpayment, and the total federal financial participation overpayment. As part of the FFR, there is a transmittal letter attached to the report which contains details associated with the federal requirement for the state to remit the federal share of the overpayment to CMS within one year from the date of the letter.

Medicaid Major Case Coordination – The Medicaid Major Case Coordination (Medicaid MCC) is a collaborative meeting held with SMA staff, law enforcement (LE), the respective UPIC, and CMS whenever the UPIC has identified a potential case warranting a fraud referral to LE. It provides the opportunity for all entities to jointly discuss details of the investigation, determine whether LE will accept the referral, discuss any necessary administrative actions to be taken, and determine next steps following the MCC.

Medical Review - A medical review is a formal review of medical records by qualified UPIC personnel to determine if the documentation in the medical record supports what was billed by the provider and paid for by the Medicaid and/or Medicare programs. The process is used as part of an investigation/audit to determine potential fraud, waste, or abuse.

Overpayment – Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

Referral - A referral is the formal presentation of an issue to the SMA or law enforcement, or the receipt of a potential fraud lead from an SMA or another source.

Reliable Information - Reliable information includes credible allegations, oral or written, and/or other material facts that would likely cause a non-interested third party to think that there is a reasonable basis for believing that a certain set of facts exists, for example, that claims are or were false or were submitted for non-covered or miscoded services.

Reliable information of fraud exists if the following elements are found:

- **The allegation is made by a credible person or source.** The source is knowledgeable and, in a position, to know. The source experienced or learned of the alleged act firsthand, i.e., saw it, heard it, read it. The source is more credible if the source has nothing to gain by not being truthful. The source is competent, e.g., a beneficiary may not always be a credible source in stating that services received were not medically necessary. An employee of a provider who holds a key management position and who continues to work for the provider is often a highly credible source. The friend of a beneficiary who heard that the provider is defrauding Medicare may not be a particularly credible source.

- **The information is material.** The information supports the allegation that fraud has been committed by making it more plausible, reasonable, and probable (e.g., instructions handwritten by the provider delineating how to falsify claim forms).

- **The act alleged is not likely the result of an accident or honest mistake**. For example, the provider was already educated on the proper way to complete the form, or the provider should know that billing for a service not performed is inappropriate, or claims are submitted the same way over a period of time by different employees.

Reliable evidence includes, but is not limited to, the following:

- Documented allegations from credible sources that items or services were not furnished or received as billed.
- Billing patterns so aberrant from the norm that they bring into question the correctness of the payments made or about to be made.
- Data analysis that shows the provider's utilization to be well above that of its peers without any apparent legitimate rationale for this.
- Statements by beneficiaries and/or their families attesting to the provider's fraudulent behavior.
- Corroboration from provider employees (official and unofficial whistle blowers).
- Other sources, such as prepayment and postpayment review of medical records.
- Recommendations for suspension by HHS-OIG/OI, FBI, Assistant U.S. Attorneys (AUSAs), or CMS, based on their finding that the provider has already received overpayments and continued payments should be made only after a determination that continued payment is appropriate.

Screening - Screening is the initial step in the review of a lead to determine whether further investigation/audit is warranted based on the potential for fraud, waste, or abuse. Screening shall be completed within 45 calendar days after receipt of the lead.

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

- Verification of provider's enrollment status
- Data analysis
- Contact with the complainant, when the lead source is a complaint
- Beneficiary interviews
- Site verification to validate the provider's/supplier's practice location
- Review of state policy and regulations
- *Create IP (or ATP)*

State Medicaid Agency (SMA) — This is the single state agency administering or supervising the administration of a state Medicaid plan. Each SMA establishes and administers their own Medicaid programs; they determine the type, amount, duration, and scope of benefits within broad federal guidelines.

Vetting - Vetting is the process of determining whether a provider, who has been selected for an investigation/audit, is clear to pursue. All leads and any new subjects that the UPIC determines warrants further investigation/audit are vetted through CMS and the SMA for approval before transitioning to an investigation/audit. Determinations are based on any ongoing law enforcement activity and/or current SMA activity with the provider.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 2 – Collaboration with States

(Rev.13494: Issued:12-23-25)

2.0 - State Collaboration Purpose

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

The purpose of collaboration between the state Medicaid agency (SMA) and the UPIC is to identify state priorities, *share CMS priorities and expectations,* specialty areas of analytical and investigative interest, clarification of state policy, and to ensure there is no duplication of efforts.

All leads and any new providers that the UPIC determines warrant further investigation shall be vetted concurrently through the SMA and CMS for approval before transitioning to an investigation. The UPIC shall provide the state a list of potential investigations generated by the data analysis, complaints, referrals, etc. If the state is conducting an audit or investigation of the same provider for similar Medicaid issues, CMS may cancel or postpone the UPIC investigation of the provider. Through this information exchange, CMS avoids duplicating the efforts of other Medicaid audits and investigations.

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

The scope and execution of program integrity activities varies by state. CMS recognizes that states have different structures and that the program lead from each state may be located in different areas of the state organizational structure. If the program integrity function exists outside of a single state agency, CMS will encourage both the single state agency and the program integrity staff to collaborate on program activities. State entities that may be involved in the program integrity oversight includes the SMAs, Medicaid fiscal agents, Medicaid Fraud Control Units (MFCUs), State Attorneys General offices, and other agencies with program integrity missions, such as Medicaid Inspector General and State Comptroller offices.

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

2.1.4 - Joint Operating Agreement (JOA)

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

a. Purpose of the JOA

The UPICs' activities are governed by CMS' Task Order Statement of Work (TO SOW), the Medicaid PIM, and the Medicare PIM. However, the SMA is not governed by the PIM. The JOA is an agreement between the SMA and the UPIC that establishes guidelines, duties, and shared expectations of how each will conduct business with the other. The JOA will include any agreement between the SMA and the UPIC on program implementation and operation that is not specified in this manual or the TO SOW. CMS also has a role in mediating any disputes that may arise between the SMA and the UPIC during the creation of the JOA, and it will provide technical guidance regarding the JOA.

The template for the JOA can be found at Appendix J..

b. JOA Template and Instructions for Customizing the JOA

The UPIC shall customize the JOA template with input from the SMA. The template is a guide and includes suggested language, which may be changed pending the agreement of the

UPIC and the SMA. SMAs are encouraged to participate in other implementation activities while awaiting the review and execution of the JOA. However, it is at the discretion of the SMA whether to participate in other implementation activities while awaiting the JOA. It is a best practice for the SMA to sign the JOA as soon as possible as the JOA clarifies the working relationship between the SMA and the UPIC.

The following provides a summary for each section of the JOA:

Section 1. Introduction

This section describes the purpose of the coordination and the JOA. It also describes how the JOA should be maintained and updated.

Section 2. Implementation

This section describes the overall implementation process and each party's responsibilities.

Section 3. Dispute Resolution

This section describes how disagreements between the UPIC and the SMA will be resolved. It is recommended that disagreements be brought to the attention of the COR/BFL team for assistance.

Section 4. Communications Plan

This section outlines the requirements for establishing points of contact at the UPIC and SMA, regular meetings, and work groups. The UPIC and the SMA should establish points of contact to clarify communications between organizations. The JOA template suggests the creation of "leads" in the areas of the overall project, IT, data analysis, and investigations. The UPIC and SMA, as applicable, should revise and add to these roles as appropriate.

Section 5. Training and Information Sharing

In this section, the UPIC and the SMA acknowledge that each party will provide training to the other party and share information with each other as needed. The way in which training shall be provided should also be described in this section.

Section 6. Connectivity and Data Sharing, if applicable

This section outlines how the UPIC and the SMA will work together to share the necessary data. Due to the nature of this content, section 6.5 Security shall not be edited and/or revised by either the SMA or the UPIC.

Section 7. Data Analysis

This section describes the development of a Data Analysis Project Management Strategy and the process for prioritizing projects and sharing results.

Section 8. Investigations and Referrals

This section describes the investigation and referral processes for joint investigations. The JOA clarifies the rules outside of the PIM to which the UPIC and the SMA must adhere. It provides a forum through which the partners can agree on how to work together on joint investigations.

c. Process for Executing the Initial JOA

The UPIC and the SMA shall discuss the timeline and contents of the JOA during the Initial State Collaboration Meeting. Based on the results of this meeting, the UPIC shall customize the JOA template (Appendix J) collaboratively with the SMA and submit to CMS for approval. CMS will provide technical assistance on the customization as needed. If, after reasonable efforts by the UPIC, there are issues that the SMA and the UPIC cannot agree upon, either of the parties may notify CMS. CMS will coordinate resolutions of the disputes so that the implementation process is not delayed.

The UPIC and the SMA should agree to the content of the JOA, as it details how the partners will work together. The JOA is not a contract. Therefore, the SMA is not required to provide signatures for the JOA. In place of signing the JOA, the SMA can inform the UPIC through an e-mail or formal letter that the JOA accurately reflects how the parties will work together to implement and operate the coordinated efforts.

The UPIC shall distribute a copy of the final JOA to the SMA. The SMA lead should disseminate the final JOA within the agency.

d. Annual Review of the JOA

The UPIC and the SMA should review and revise the JOA at least annually. The revised JOA should be approved by the UPIC and the SMA and be submitted to CMS by the UPIC.

e. Other Revisions to the JOA

The UPIC and the SMA may revise the JOA on an as-needed basis, as long as the changes are agreed upon by both parties in accordance with a process that both parties establish during implementation.

2.2.1 - Program Management Meetings or Monthly Collaboration Meetings

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

UPICs shall facilitate additional program management meetings with CMS and the SMAs. The purpose of these meetings is to discuss the program's progress, identify issues and resolutions, and discuss the planned activities for the following month.

In the implementation phase, these meetings have various names including case coordination meetings or executive meetings. During the Initial State Collaboration Meeting, the partners will discuss the timing and purpose of the project management meetings, which shall be facilitated by the UPIC.

a. Timing

The UPIC shall convene the project management meetings on an agreed upon recurring basis, based on the availability of the COR/BFL and SMA program lead. CMS recommends these meetings be held on a monthly basis.

The CMS, the UPIC, and the SMA must have regularly scheduled standing meetings to discuss ongoing issues and to make sure that all members of the team are fully informed on all issues.

b. Agenda

The UPIC shall provide a draft agenda to the attendees prior to each meeting. The agenda should contain, at a minimum, the following areas for discussion:

- Status of current workload,
- Development of new *Data Project Records*,
- Data analytic findings,
- Administrative actions,
- State Issues/recommendations, and
- CPI Feedback/Input.

The CMS COR/BFL and the SMA program lead may provide comments on the agenda. The UPIC shall incorporate requested changes to the agenda and provide a final agenda prior to the meeting.

c. Meeting Location

The meetings will be held virtually via conference call or video conference. The UPIC is encouraged to use web-based technology that allows participants to share and view common applications, such as PowerPoint, live during the meeting.

d. Attendees

The UPIC shall invite the following individuals to the project management meetings or monthly collaboration meetings:

- SMA Program Integrity Director or Inspector General, or designee
- UPIC Medicaid Operations Lead or designee
- UPIC Data Analyst or Manager
- CMS COR/BFL.

The attendees may bring additional individuals to the meeting. The attendees should inform the UPIC in advance who will be joining the meeting.

e. Meeting Minutes

The UPIC shall be responsible for drafting the meeting minutes and be willing to make appropriate changes as requested by either CMS or the SMA.

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 3 – **Medicaid Investigations & Audits**

Table of Contents
(Rev.13494; Issued:12-23-25)

3.0 - Overview

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

The UPICs shall be responsible for collaborating with State Medicaid Agencies (SMAs) in their respective jurisdiction to *share CMS CPI priorities and processes and to* develop processes for investigating Medicaid fraud, waste, and abuse issues. The UPIC may be requested to provide the complete spectrum of investigative and audit services for a state or selected activity that augments programmatic reviews conducted by states regarding Medicaid including, but not limited to, identifying leads, conducting investigations, and referring cases to law enforcement.

The SMAs have established processes for investigating potentially fraudulent activities. The UPIC shall work with SMA to develop a state preferred, and CMS approved, process to perform Medicaid investigations and/or audits. Therefore, it is essential that the state and the UPIC work cooperatively to understand both parties' requirements. The UPIC shall establish ongoing meetings with SMAs (as referenced in Chapter 2 of this manual) to discuss vulnerabilities, update the status of existing investigations and referrals, and resolve any issues that may arise during ongoing investigations.

3.2 - *Data Project Record*

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

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.

3.3 - Lead Screening

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

Screening is the initial step in the review of a lead to determine whether further investigation/audit is warranted based on the potential for fraud, waste, or abuse. In addition to the guidance listed below, please refer to the Medicare PIM at Section 4.5 – Screening Leads if further guidance is needed.

The UPIC may identify leads through any number of sources:

a. Data Analysis: Discussions should take place between all stakeholders about data project analyses to facilitate the detection and prevention of fraud, waste, and abuse. In addition, the progress of data projects and/or investigations shall be communicated to partners on an ongoing basis through informal communications between the UPIC and the stakeholders. Prioritization is critical to ensure that resources are devoted to projects that are high priority to all the stakeholders including CMS, state Medicaid officials, and local law enforcement.

b. State Identified Leads: The SMA may provide leads to the UPIC that result from data analytics, tips, or any other source.

c. Medicare-related Leads: The UPIC may identify a lead resulting from work conducted in Medicare fraud, waste, and abuse.

d. Law Enforcement: The UPIC may receive Medicaid-related leads from law enforcement entities and/or through the HHS-OIG hotline.

e. CMS Identified Leads: These may include special projects (Moratorium, etc.), complaints from beneficiaries or their families via CMS regional offices, or inquiries from the CMS Administrator through SWIFT.

f. General Leads: The UPIC may receive or identify Medicaid-related leads from any source not identified above. These could include tips, newspaper, or internet articles.

g. Suspected Beneficiary Harm: CMS has a zero tolerance for beneficiary harm issues. When there is any indication that beneficiary harm may exists when investigating a lead, complaint, project, etc., the UPIC shall immediately contact the SMA and BFL with its preliminary findings. These allegations will be handled on a case-by-case basis dependent upon the severity of the potential patient harm.

Screening shall be completed within 45 calendar days after receipt of the lead.

If the lead resulted from data analysis conducted by the UPIC, the receipt of the lead shall be the date the lead was referred from the UPIC data analysis department to its investigation or screening unit.

For a new lead that is identified from an active or current UPIC investigation, the receipt of the lead shall be the date the new lead was identified by the UPIC investigator.

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

- Verification of provider's enrollment status, which would include verifying provider's eligibility through the Adverse Action Report generated by the Data Exchange System (DEX) to the TIBCO MFT Server. This report contains information related to:
    - Whether the provider has been terminated for cause from Medicare or a state Medicaid program and is ineligible for enrollment in Medicaid per 42 CFR 455.416(c).
    - Whether the provider has been excluded and is listed on the HHS-OIG's List of Excluded Individuals and Entities.
- Data analysis.
- Contact with the complainant when the lead source is a complaint.
- Beneficiary interviews.
- Site verification to validate the provider's/supplier's practice location, and
- Review of state policy and regulations.
- *Create IP (or ATP)*

Any screening activities shall not involve contact with the subject provider/supplier during this stage. If the lead involves potential patient harm, the UPIC shall immediately notify CMS within two (2) business days.

After completing its screening, the UPIC shall close the lead if it does not appear to be related to fraud, waste, or abuse. If the screening determines that further investigation is warranted, the UPIC will move forward with submitting the lead to vetting with CMS and the SMA. (See Section 3.4) *The UPIC shall upload the IP in UCM for BFL approval.*

At a minimum, the UPIC shall document the following information in its case file regarding the lead screening:

- The date the lead was received and closed.
- Lead source (e.g., PDP/DPR, SMA, beneficiary, LE, etc.).
- Record the name and telephone number of the individual (or organization), if applicable, that provided the information concerning the alleged fraud or abuse.
- Indicate the provider's/supplier's name, address, and ID number.
- Start and end date of the screening.
- Description of the actions/activities performed.
- Start and end date of each action/activity.
- A brief description of the action taken to close the lead (e.g., reviewed records and substantiated amounts billed). Ensure that sufficient information is provided to understand the reason for the closeout.
- The number of leads received to date regarding this provider/supplier, including the present lead. This information is useful in identifying providers/suppliers that are involved in an undue number of complaints.
- Any documentation associated with the UPIC's activities (i.e., referrals to other entities).

Additionally, if the screening process exceeds 45 calendar days, the UPIC shall document the reasons, circumstances, dates, and actions associated with the delay in UCM and to its COR and BFL within its monthly reporting in CMS ARTS.

3.5 - Investigations/Audits

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

An investigation/audit is the formal review of suspicious aberrancies in a provider's submitted Medicaid claims *or financial payments* to establish evidence that potentially fraudulent activities or other improper payments have occurred. The UPIC shall focus its investigation/audit in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicaid dollars.

The investigative/audit process may differ by each SMA; therefore, the UPIC shall coordinate and confirm the use of its investigative approach with the SMA at the onset of the collaboration. This may include determining how joint investigations will be conducted. It is important that the two parties discuss the process early.

The UPIC shall document the final investigative plan of action and share with the CMS Medicaid BFL for review and approval prior to sharing with the SMA for final approval.

The UPIC, SMA, and CMS shall determine the level of effort required by the UPIC in support of an investigation. CMS shall make the final approval or disapproval of any investigative strategy.

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

- Contact with the provider via telephone or on-site visit;
- Beneficiary/Recipient interviews;
- Interviews of employees or associates of the provider;
- Medical record requests and reviews; and
- Recommendation of administrative actions.

If additional guidance is needed, the UPIC shall consult with the Medicaid BFL on potential investigative strategies. If the SMA determines it would like the UPIC to utilize an audit and/or a financial accounting approach, the UPIC shall follow the guidance established by the SMA (i.e., Generally Accepted Government Auditing Standards) during an investigation.

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

In order to process investigations/audits in a timely manner, UPICs are expected to reach a decision on the ongoing status of a case within 180 days from the Medicaid Investigation Start Date. This would mean:

a) Determining whether there are low/no findings to pursue and submitting a request to close the investigation/audit to CMS; or
b) Determining there is sufficient evidence that warrants a law enforcement referral and initiating the referral process by completing the Major Case Coordination (MCC) Pre/Post Meeting Report - Work Details (hereon referred to as the Executive Summary) and submitting to CMS; or,
c) Identifying potential Medicaid overpayments and submitting an Initial Findings Report (IFR) to the SMA.

The UPIC shall not wait 180 days to request a discontinuance and closure of an investigation/audit due to low/no findings, begin making an LE referral, or begin developing the IFR. Action shall be taken once the investigation/audit has revealed what decision is needed. Please refer to Chapter 4 "Reporting Investigational Findings and Making Referrals" for more details on Close-Out Letters, LE referrals, and developing the IFR.

In addition, for any of these scenarios, vulnerabilities may be identified in the SMA's policies or processes that may warrant submitting the Vulnerability Template. Please refer to Chapter 4.11 of the Medicaid PIM on "Reporting State Vulnerabilities."

It is understood that investigations/audits may also be closed after an IFR has been issued to the SMA and/or the provider, and the findings have been changed due to the SMA's or the provider's feedback. Similarly, referrals to law enforcement may result in cases being returned to the UPIC with nothing to pursue. In these circumstances, closures following an IFR to the SMA/Provider or LE Referral would not be subject to the 180-day time frame.

3.9 - Medical Review for Program Integrity Purposes

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

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. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

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

Chapter 4 - Reporting Investigational Findings and Making Referrals

(Rev.13494; Issued:12-23-25)

4.2.2 - Overpayment Assessed Solely by Data Analysis

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

In certain instances, in collaboration with the SMA, the UPIC may identify overpayments based solely on data analysis *from claims or financial payments*. In these instances, the UPIC shall collaborate with the state to validate the analysis and to ensure the policy interpretation is accurate. Additionally, the UPIC shall coordinate with each individual SMA and the COR/BFL team to determine a state specific dollar threshold for action on overpayments based solely on data analysis. Data driven overpayments that meet the dollar threshold, once reviewed and approved by CMS, shall be vetted in accordance with Chapter 3.3 of this manual prior to submitting the overpayment to the SMA by CMS through a Final Findings Report (FFR). All data analysis identified overpayments that fall below the state specified threshold will be sent to the SMA by the UPIC to take whatever action they deem necessary (i.e., collection of overpayments, identification of program vulnerabilities, necessary policy updates, automated edits, etc.).

4.3 - Overpayment Resolution Process

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

Upon identification of an overpayment based on a Medicaid investigation/audit, an Initial Findings Reports (IFR) is sent to the Medicaid BFL for review and approval. Once the BFL has approved the IFR, the UPIC will send the IFR to the SMA within 180 days of the Medicaid Investigation Start Date for review and comments for 30 calendar days. The 180-day time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the Unified Case Management (UCM) system. If the state disagrees with the findings of the UPIC, which results in monetary changes to the Appendix A, the UPIC will revise the IFR and incorporate any other grammatical or narrative corrections identified by the state *and document the changes in the UCM, the document will remain an IFR. If there are monetary changes, the UPIC shall inform the BFL to determine the next step*. If the state's comments speak to the body of the report and are primarily grammatical or corrections to cited regulations, terminology, etc., the document will remain an IFR, and the UPIC will make any necessary corrections.

The IFR may then be transmitted by the UPIC to the provider for review and comments for 30 calendar days, if required by the SMA. The Medicaid BFL and the UPIC will review the provider's responses, if any, to determine if adjustments to the findings are necessary. *If no adjustments are made to the findings, resulting in no monetary changes to the Appendix A, the UPIC will produce an FFR.* If *adjustments to the findings, which result in monetary changes to the Appendix A, are necessary,* the UPIC will make the revisions *in a revised IFR (RIFR)* and the RIFR is sent to *CMS and* the state, this time with a 15-day review and comment period. CMS, the UPIC, and, if necessary, the state *will* reconcile any issues with the RIFR, after which the UPIC produces an FFR and completes the FFR – State Transmittal Letter and submits both to CMS for approval within 13 months of the Medicaid Investigation Start Date. The 13-month time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the Unified Case Management (UCM) system. CMS, upon approving the FFR, sends the FFR and State Transmittal Letter to the state. The FFR – State Transmittal Letter (Appendix E) can be found in the Appendices. Versions of the State Transmittal Letter are available for FFS and/or managed care investigations/audits, where the managed care overpayments can be recouped (Appendix E); FFS and managed care investigations/ audits when the managed care overpayments are not recoupable, but the FFS are (Appendix F); and managed care-only investigations/audits when there are only managed care overpayments that are not recoupable (Appendix G).

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

C.F.R. § 433.316).

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

In certain instances, the SMA may require an update to the FFR, based on updated analysis by the state, *resulting in a downward adjustment in the amount of an overpayment due to an appeal decision from an administrative law judge, informal hearing decision,* issues identified within the referenced policy, etc. In these instances, the UPIC shall notify CMS of the discrepancies and discuss a proposed resolution. If it is determined that an update to the FFR is necessary, CMS and the UPIC shall collaborate to draft a *Revised FFR (RFFR)*, along with the FFR Addendum – State Transmittal Letter (Appendix H), which CMS shall submit to the SMA upon completion. The UPIC will edit the OPT financial information in UCM on the original OPT record, upload the *RFFR and FFR* Addendum *– State Transmittal Letter, and notify the BFL via email*.

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

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

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

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

(Example)

Federal Share % (FY15)	Federal Share % (FY16)	Federal Share Amount (FY15)	Federal Share Amount (FY16)	Federal Share Total
%	%	$	$	$
			Total	$

In calculation of the FFP, the UPIC shall consult the Federal Register for the applicable FMAP rate and shall monitor any changes to the FMAP as published in the Federal Register on an ongoing basis. The relevant FMAP table can be found quickly and directly by searching the internet for "Federal Register FMAP rates

for FY [year]." The Federal Register displays adjustments to the FMAP for states and territories periodically based on legislation, (i.e., the American Recovery and Reinvestment Act (2009) increased the FMAP for certain claims for services on or after October 1, 2008. *The UPIC may also contact the SMA for the applicable FMAP rate.* In addition, The Patient Protection and Affordable Care Act (2010) allowed states to file a State Plan Amendment (SPA) to expand Medicaid to cover additional populations. The federal government financed the costs of these newly eligible beneficiaries at a different rate than those who were previously eligible.).

The UPIC shall ensure that the calculations for each claim/claim line *and financial payments* are accurate for each FY. If, as a result of an appeal, the overpayment needs to be recalculated, the UPIC shall follow the methodology used in the original overpayment calculation.

4.4 - State Appeal Process

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

The CMS does not dictate the process by which UPIC Medicaid review findings are appealed. Rather, appeal processes are determined by each state and are subject to the state's Medicaid program requirements.

It is the responsibility of the SMAs to defend review findings in an administrative appeal or judicial proceeding, although the UPIC may provide testimonial support and other assistance to the state to defend the review findings throughout administrative or judicial proceedings.

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

The UPIC should alert the Medicaid BFL/COR to any situation where a state indicates a reluctance to defend FFR findings in an appeal.

The UPIC will notify CMS of any changes to the overpayment amounts resulting from hearing decisions.

4.5 - Close-Out Letters

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

If the provider has been notified *of the initiation of* an investigation/audit and the Medicaid investigation/audit is later discontinued, or if the findings are insufficient to pursue, a close out letter will be issued to the provider. The close-out letter provides notification to the provider that the review has concluded and no further action on the part of the provider is necessary. The UPIC is responsible for obtaining approval from CMS prior to issuing a close-out letter. Upon approval, the UPIC sends the close-out letter to the provider in question, sends a copy to the state, and uploads a copy to UCM. A sample of the "Close-Out Letter" can be found at Appendix A.

In addition, the UPIC will complete a summary of the investigation that is submitted to the SMA along with the letter to the provider, and a copy is uploaded to UCM. This summary is not sent to the provider. The "Closing Summary" template can be found at Appendix B.

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5.3 - Creating Overpayment (OPT) Records

(Rev. 13494; Issued: 12-23-25; Effective: 01-26-26; Implementation:01-26-26)

When a Medicaid investigation/audit results in low/no findings or the identification of an overpayment, the UPIC shall spawn an overpayment (OPT) record in UCM from the CSE associated with the investigation/audit. The UPIC shall refer to the UCM User Manual for opening OPT records. The purpose of the OPT record for low/no findings is to track all investigations and their outcomes. [NOTE: As UCM evolves, these procedures may change.]

For investigations/audits of managed care network providers, where the provider is enrolled in multiple managed care organizations (MCOs), *one OPT record will be opened. The UPIC will break down the overpayments of each MCO payor within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each payor.*

In circumstances where the provider is being investigated/audited for both fee-for-service (FFS) claims and is enrolled in managed care, *one OPT record will be opened. The UPIC will break down the overpayments for the FFS portion and the MCO within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each.*

For the "Overpayment Financials" section of the OPT record, the 'Original Overpayment Amount' will be the amount in the IFR that goes to the SMA and may include any revisions in the overpayment amount based on the CMS review. Whenever the overpayment is revised—either due to the state's review or the provider's review—the UPIC shall update the financial section of the OPT record with the revised amounts in the '*Original* Overpayment Amount' column and include the date of the revision in the 'Determination Date' column. *The 'Original Overpayment Amount' column should reflect the overpayment amount identified in the FFR submitted to CMS.*

For the 'Federal Share Amount' of the "Overpayment Financials" section, the federal share will only be calculated for the FFR and will be entered prior to submitting the FFR to CMS. The amount will be the calculated federal share of the *overpayment amount identified in the FFR.* If the FFR is revised *after it has been issued to the SMA,* and the overpayment changes, the 'Revised Overpayment Amount' will be revised *to reflect the new overpayment amount*, and the federal share will be recalculated, and the amount will be entered in the 'Revised Federal Share' column.

For a *Revised FFR (RFFR),* that has occurred after the FFR is issued to the SMA, the UPIC will update the financial amount by editing the original OPT record. *The UPIC shall create a folder in the UCM and upload all RFFR documents and notify the BFL of the RFFR via email*