

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 264	Date: AUGUST 7, 2008
	Change Request 5849

Note to Contractors: This corrects Transmittal 264, Change Request 5849, and dated August 7, 2008. The changes are in the manual text, the effective and implementation dates were transposed, and all other material remains the same. The attached instructions may be communicated to the public and posted on your Web site as early as today, August 12, 2008.

SUBJECT: Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)

I. SUMMARY OF CHANGES: Instructions relative to transition of responsibility for medical review from QIOs to Medicare fiscal intermediaries and Medicare administrative contractors. Quality related activities remaining in the QIO SOW remain unchanged by this instruction.

NEW / REVISED MATERIAL

EFFECTIVE DATE: AUGUST 1, 2008

IMPLEMENTATION DATE: AS SOON AS POSSIBLE, BUT NO LATER THAN AUGUST 15, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.1.2/Types of Claims for Which Contractors Are Responsible
R	1/1.1.3/Quality of Care Issues
R	3/3.9.1.1/Fraud or Willful Misrepresentation Exists - Fraud Suspensions
R	4/Table of Contents
R	4/4.18.3/Coordination With Quality Improvement Organizations
R	4/4.19.2.2/Identification for Potential Exclusion Cases
R	6/Table of Contents
N	6/6.5/Medical Review of Hospital Claims
N	6/6.5.1/Screening Instruments
N	6/6.5.2/Medical Review of Inpatient Prospective Payment System (IPPS) Hospital or Long-Term Care Hospital (LTCH) Claims

N	6/6.5.3/DRG Validation Review
N	6/6.5.4/Review of Procedures Affecting the DRG
N	6/6.5.5/Special Review Considerations
N	6/6.5.6/Length-of-Stay Review
N	6/6.5.7/Readmission Reviews
N	6/6.5.8/Transfer Reviews
N	6/6.5.9/Circumvention of PPS
R	Exhibits/1/Definitions

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

Funding for implementation activities will be provided to contractors through the regular budget process.

SECTION B: 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.

This will be an additional workload to what was awarded to the MAC in their current SOW. A contract modification will be issued to fund this activity. You should coordinate with your contract officer and project officer to address any concerns.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 264	Date: August 7, 2008	Change Request: 5849
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Note to Contractors: This corrects Transmittal 264, Change Request 5849, and dated August 7, 2008. The changes are in the manual text, the effective and implementation dates were transposed, and all other material remains the same. The attached instructions may be communicated to the public and posted on your Web site as early as today, August 12, 2008.

SUBJECT: Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)

Effective Date: August 1, 2008

Implementation Date: As soon as possible, but not later than August 15, 2008.

I. GENERAL INFORMATION

A. Background: Under their 9th Statement of Work (SOW), QIOs will no longer be performing the majority of utilization reviews for acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims. They ceased selecting claims for review after December 31st, 2007. The Office of Financial Management is assuming responsibility for oversight of certain non quality-related medical review (MR) of claims, transitioning responsibility for this work to Medicare fiscal intermediaries (FIs) and Part A and B Medicare administrative contractors (A/B MACs). The QIOs will retain their responsibility for performing expedited determinations, HINN reviews, quality reviews, provider-requested higher-weighted DRG reviews, and other functions outside the scope of FI and MAC MR.

B. Policy: FIs and MACs will now perform medical review for Acute IPPS hospital and LTCH claims (which, for the purposes of this instruction, also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver), to ensure CMS only pays for covered, correctly coded, and medically necessary services. Like all other claim types, MR of these inpatient hospital claims will be based on data-analysis and conducted according to contractors' prioritized MR strategy. During the first year of the review, however, additional funding will be provided by CMS to contractors in order to ensure adequate review of these claims and reporting of findings and lessons learned. Contractors shall apply applicable coding and coverage policy, along with clinical judgment to make payment determinations and adjust claims as appropriate, as they do with all other Medicare benefits. FIs and MACs will have the authority to conduct prepayment review of these claims received beginning on the implementation of this CR and the authority to conduct postpayment review of claims submitted January 1, 2008 forward.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A	D	F	C	R	Shared-System Maintainers	OTHER PSCs/
		/	M	I	A	H		

										F I S S	M C S	V M S	C W F	
5849.1	The contractor shall include acute inpatient PPS (IPPS) hospital claims data in their data analysis for development of prioritized medical review strategies.	X	X											X
5849.2	The contractor shall include long term care hospital (LTCH) claims data in their data analysis for development of prioritized medical review strategies.	X	X											X
5849.3	The contractor shall include medical review interventions, including prepayment review, postpayment review, and provider notification and feedback, for acute IPPS hospital and LTCH, as part of their prioritized strategy and strategy analysis report (SAR) after March 31, 2009, as indicated in their data analysis.	X	X											X
5849.4	From implementation date of this instruction until March 31 st , 2009 only, contractors shall, at their discretion, perform random postpay review of acute IPPS and LTCH claims.	X	X											X
5849.5	From implementation date of this instruction until March 31 st , 2009 only, FIs shall report costs and workload in new CAFM II activity code #17609 in CAFM II for this first phase of acute IPPS hospital and LTCH claims review.	X	X											X
5849.6	A/B MACs shall report in CMS ARTS in the line to be specified in their respective contracts.	X												
5849.7	Contractors shall submit a report containing findings from the first phase of acute IPPS hospital and LTCH review, through March 31 st , 2009, no later than May 1, 2009.	X	X											X
5849.8	After March 31, 2009, contractors will report as they would report medical review for any other bill type.	X	X											X
5849.9	From implementation date of this instruction until March 31 st , 2009 only, contractors may only use funds distributed in association with this instruction to perform random and non-random review of acute IPPS hospital and LTCH claims.	X	X											X
5849.10	From information gained from review from the implementation date of this instruction until March 31 st , 2009, contractors shall submit a final report on acute IPPS hospital and LTCH claims workload and findings for these reviews by May 1, 2009.	X	X											X
5949.11	The FIs shall submit this report to Kim Spalding at the address below, and MACs shall submit this report to their project officer.	X	X											X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER PSCs/ ZPICs perform ing Pt A medic al review
							F I S S	M C S	V M S	C W F	
5849.12	The contractor shall consider performing postpayment review of acute IPPS hospital and LTCH claims submitted on January 1, 2008 or later.	X		X							X
5849.13	The contractor shall utilize screening instruments, as applicable, as part of the complex review of each acute IPPS hospital and LTCH claim.	X		X							X
5849.14	The contractor shall consult with physicians and/or other experts, as necessary, during the course of complex review.	X		X							X
5849.15	The contractor shall perform medical necessity/utilization review as part of their medical review of acute IPPS hospital and LTCH claims.	X		X							X
5849.16	The contractor shall determine whether inpatient hospital admission was medically necessary, according to IOM 100-02, chapter 1, §10.	X		X							X
5849.16.1	The contractor shall pay the claim according to the appropriate DRG, in accordance with IOM 100-08, chapter 6, §6.5.4, when an inpatient level of care is determined to have been appropriate from the date of admission.	X		X							X
5849.16.2.	The contractor shall utilize the first day on which an inpatient level of care is determined to be medically necessary as the deemed date of admission when it is determined that an inpatient level of care was not medically necessary on admission, but became medically necessary at some point during the stay.	X		X							X
5849.16.2.1	The contractor shall not include services provided prior to the deemed date of admission for the purposes of calculating outlier payments.	X		X							X
5849.16.2.2	The contractor shall pay the claim using the diagnosis determined to be chiefly responsible for the patient's need for covered services on the deemed date of admission as the principal diagnosis.	X		X							X
5849.16.3	The contractor shall deny the claim in full when they determine that care at an inpatient level was not	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER PSCs/ ZPICs perform ing Pt A medic al review
							F I S S	M C S	V M S	C W F	
	necessary at any time during the stay.										
5849.17	The contractor shall perform DRG validation review as part of their medical review of acute IPPS and LTCHs.	X		X						X	
5849.18	The contractor shall utilize individuals trained and experienced in ICD-9 CM coding to perform DRG validation review.	X		X						X	
5849.19	The contractor shall ensure consistency with ICD-9 CM coding guidelines for review of coding during DRG validation review.	X		X						X	
5849.19.1	The contractor shall use the ICD-9 CM coding guidelines in place at the time that services were rendered for review of coding during DRG validation review.	X		X						X	
5849.20	The contractor shall ensure consistency with Uniform Hospital Discharge Data element definitions during DRG validation review.	X		X						X	
5849.21	The contractor shall ensure that the proper principal and relevant secondary diagnoses were reported on the claim as part of DRG validation review.	X		X						X	
5849.22	The contractor shall insert any relevant secondary diagnoses identified through medical record review that were not recorded on the claim form, for DRG calculation purposes.	X		X						X	
5849.23	The contractor shall use the diagnosis which, after study, is determined to have occasioned the patient's admission to the hospital as the principal diagnosis for DRG calculation purposes.	X		X						X	
5849.24	The contractor shall exclude any diagnoses relating to an earlier episode, that have no bearing on the current hospital stay, for DRG calculation purposes.	X		X						X	
5849.25	The contractor shall verify that all procedures affecting DRG assignment were appropriately reported, for DRG calculation purposes.	X		X						X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER PSCs/ ZPICs perfor ming Pt A medic al review
							F I S S	M C S	V M S	C W F	
5849.26	The contractor shall deny a claim for which the sole purpose of admission was for a procedure determined not to have been medically necessary AND the patient never developed a need for a covered level of care.	X		X							X
5849.27	The contractor shall pay a claim for which the sole purpose of admission was NOT for a procedure subsequently determined not to have been medically necessary, according to the DRG calculated upon removal of the non-medically necessary procedure.	X		X							X
5849.28	The contractor shall exclude any days for which the patient was receiving care solely related to the performance of a procedure determined not to have been medically necessary, for the purposes of cost outlier calculation.	X		X							X
5849.29	The contractor shall make a referral to the QIO for any case in which a beneficiary received procedures which were not medically necessary.	X		X							X
5849.30	The contractor should consider including DRG 468 claims, claims with primary diagnoses representing questionable admissions, and claims with primary diagnoses that are only acceptable when billed with a secondary diagnosis in their data analysis for development of a prioritized MR strategy.	X		X							X
5849.31	The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers.	X		X							X
5849.32	The contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments	X		X							X
5849.33	The contractor shall make a referral to the PSC/ZPIC when it is determined that a beneficiary's stay was unnecessarily long, and potentially represents fraud or abuse.	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER PSCs/ ZPICs perform ing Pt A medic al review
							F I S S	M C S	V M S	C W F	
5849.34	The contractor shall review only Medicare-covered portions of inpatient hospital stays and as much of the stay preceding Medicare coverage as is necessary to make a payment determination.	X		X							X
5849.35	The contractor shall perform length-of-stay review for all inpatient hospital claims in PPS waived areas that are selected for medical review.	X		X							X
5849.36	The contractor shall perform medical review, as outlined in IOM 100-08, §6.5 and its subsections, then make a referral to the QIO for any claim selected for medical review that is associated with a readmission to an acute, short-term PPS hospital occurring within 31 days of discharge from the same or another acute, short-term hospital.	X		X							X
5849.37	The contractor shall perform medical review, as outlined in IOM 100-08, §6.5 and its subsections, then make a referral to the QIO for any claim selected for medical review that is associated with a transfer, as described in §6.5.6.	X		X							X
5849.38	The contractor shall make a referral to the QIO and the PSC/ZPIC for any case which it suspects represents an attempt at circumvention of PPS, as described in the Social Security Act, §1886(f)(2).	X		X							X
5849.39	Contractors shall utilize appropriate claim adjustment reason codes and remittance advice remark codes, as they do for all other claim types.	X		X							X
5849.40	Contractors shall advise beneficiaries and providers of their appeal rights on issuance of an inpatient hospital claim denial, as they do for all other claim types.	X		X							X
5849.41	PSCs and ZPICs shall coordinate with QIOs on only those acute IPPS hospital and LTCH claims with which the QIO has been involved.										X
5849.41.1	The PSC and ZPICs shall communicate with FIs and MACs on all other acute IPPS hospital and LTCH claims, as they do with all other Part A Medicare claims.										X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							F I S S	M C S	V M S	C W F	
5849.42	FIs/MACs shall consider a review decision made by the QIO final and binding on CMS. Therefore, the issue(s) under review shall not be reviewed by the FI, MAC, PSC or ZPIC.	X		X							X
5849.43	Contractors shall recommend suspensions of Inpatient Hospital claims to the central office Fraud And Abuse Suspensions And Sanctions (FASS) Team in the Division of Benefit Integrity Management Operations (DBIMO).	X		X							X
5849.44	Contractors shall follow instructions issued in a separate Joint Signature Memorandum regarding screening tools.	X		X							X
5849.45	Contractors shall use grouper software when adjudicating a claim.	X		X							X
5849.46	Contractors shall establish processes and procedures through joint operating agreements to ensure that the FI/MAC/PSC shall make appropriate referrals to the QIO for quality, coding, and utilization activities other than those performed by the FI/MAC/PSC/ZPIC or RAC.	X		X							X

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5849.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5849.5	The CMS will provide more detailed instructions to contractors who report in CAFM II in the near future
5849.10	The CMS intends to issue further guidance on the content and format of this report in the near future

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): For medical review issues: Dan Schwartz (daniel.schwartz@cms.hhs.gov), Kim Spalding (kimberly.spalding@cms.hhs.gov), Nancy Moore (nancy.moore@cms.hhs.gov). For claims processing issues: Joseph Bryson (joseph.bryson@cms.hhs.gov).

Post-Implementation Contact(s): Regional offices (FIs) and project officers (MACs).

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC): Additional funding will be provided by CMS through new NOBAs.

B. For Medicare Administrative Contractors (MAC):

The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

1.1.2 - Types of Claims for Which Contractors Are Responsible

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Contractors may perform MR functions for all claims appropriately submitted to a Medicare fiscal intermediary (FI), Medicare carrier, Part A and B Medicare administrative contractor (A/B MAC), and durable medical equipment Medicare administrative contractor (DME MAC).

Quality improvement organizations (QIOs) will no longer be performing the majority of utilization reviews for Acute Inpatient Prospective Payment System (IPPS) hospital and long-term care hospital (LTCH) claims. The review of acute IPPS hospital and LTCH claims (which, for the purposes of this section, also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) is now the responsibility of the A/B MACs or the FIs. An exception occurs when a provider requests a higher-weighted DRG review from the QIO. The QIO will continue to perform those reviews. QIOs will also continue to perform reviews related to quality of care and expedited determinations.

Contractors shall include claims for which they are responsible in doing data analysis to plan their medical review strategy. Amendments to plans and strategies shall be made as needed if analysis indicates adjustment of priorities.

1.1.3 - Quality of Care Issues

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Potential quality of care issues are not the responsibility of the contractor MR unit, but are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. Contractors should refer quality of care issues to the *QIO*. See chapter 3.1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

3.9.1.1 – Fraud or Willful Misrepresentation Exists - Fraud Suspensions *(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)*

Suspension of payment may be used when the contractor or CMS possesses reliable information that fraud or willful misrepresentation exists. For the purposes of this section, these types of suspensions will be called “fraud suspensions.”

Fraud suspensions may also be imposed for reasons not typically viewed within the context of false claims. *For example, a carrier or MAC* may find that suspected violation of the physician self referral ban is cause for suspension since claims submitted in violation of this statutory provision must be denied and any payment made would constitute an overpayment. Forged signatures on Certificates of Medical Necessity (CMN), treatment plans, and other misrepresentations on Medicare claims and claim forms to obtain payment result in overpayments. Credible allegations of such practices are cause for suspension pending further development. *This would also include, for example, fraud in the institutional setting, such as falsifying admissions orders, etc.*

Whether or not the contractor, PSC recommends suspension action to CMS is a case-by-case decision requiring review and analysis of the allegation and/or facts. The following information is provided to assist the contractor, PSC in deciding when to recommend suspension action.

A. Complaints

There is considerable latitude with regard to complaints alleging fraud and abuse. The history, or newness of the provider, the volume and frequency of complaints concerning the provider, and the nature of the complaints all contribute to whether suspension of payment should be recommended. If there is a credible allegation(s) that a provider is submitting or may have submitted false claims, the contractor shall recommend suspension of payment to *CMS Fraud and Abuse Suspensions and Sanctions (FSS) team*.

B. Provider Identified in CMS Fraud Alert

Contractors shall recommend suspension to *CMS FASS team* if a provider in their jurisdiction is the subject of a CMS National Fraud Alert and the provider is billing the identical items/services cited in the Alert or if payment for other claims must be suspended to protect the interests of the government.

C. Requests from Outside Agencies

Contractors, PSCs shall follow the suspension of payment actions for each agency request indicated below.

- CMS -- Initiate suspension as requested.

• *OIG/FBI – Contractors shall forward the written request to their respective PSCs or ZPICs who shall forward the request to the CMS FASS team for review and determination.*

• AUSA/DOJ – Contractors shall forward the written request to the *PSCs or ZPICs*, who shall forward the request to the CMS FASS team for review and determination.

• Other – Other situations the contractor, PSC may consider recommending suspension of payment to *the CMS FASS team* are:

○ Provider has pled guilty to, or been convicted of, Medicare, Medicaid, CHAMPUS, or private health care fraud and is still billing Medicare for services;

○ Federal/State law enforcement has subpoenaed the records of, or executed a search warrant at, a health care provider billing Medicare;

○ Provider has been indicted by a Federal Grand Jury for fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct related to a health care program;

○ Provider presents a pattern of evidence of known false documentation or statements sent to the contractor; e.g., false treatment plans, false statements on provider application forms.

Medicare Program Integrity Manual

Chapter 4 - Benefit Integrity

Table of Contents (Rev. 264, 08-07-08)

4.18.3 – *Coordination With* Quality Improvement Organizations

4.18.3 - Coordination With Quality Improvement Organizations *(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)*

Communication with the QIO is essential to discuss the potential impact of efforts to prevent abuse as well as efforts to ensure quality and access. More specifically, CMS expects dialogue between PSCs, or ZPICs, and the QIO to:

- Ensure that an LCD does not set up obstacles to appropriate care
- Articulate the program safeguard concerns or issues related to QIO activities; and
- Be aware of QIO initiatives (e.g., a QIO project to encourage Medicare beneficiaries to get eye exams), so they do not observe an increase in utilization and label it overutilization

The PSCs and the ZPICs should continue exchanging additional information such as data analysis methods, data presentation methods, and successful ways to interact with providers to change behavior. This includes special projects that PSCs or ZPICs and the QIO have determined to be mutually beneficial.

It is essential that the PSC and the ZPIC manager maintain an ongoing dialogue with his/her counterpart(s) at other PSCs and other ZPICs, particularly in contiguous States. This ensures that a comprehensive investigation is initiated in a timely manner and prevents possible duplication of investigation efforts.

The PSCs and the ZPICs should maintain an ongoing dialogue with the QIOs. If the PSC or the ZPIC refers a provider to the State licensing agency or medical society, i.e., those referrals that need immediate response from the State licensing agency, it should also send a copy of the referral to the QIO. Also, PSCs and ZPICs shall notify the QIO on utilization and quality issues for Part A providers and physicians that are suspected of fraud and of referrals to OIG/OI.

For the most part, QIOs will not be performing utilization review of Acute Inpatient Prospective Payment System (IPPS) hospital and long-term care hospital (LTCH) (which, for the purposes of this section, also includes any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) claims, as that responsibility has transitioned to the FIs and MACs. In limited circumstances, however, a PSC or the ZPIC may encounter a claim on which a QIO has made a determination at the provider's request for payment at a higher-weighted DRG, or a claim on which a decision related to a quality review was rendered by a QIO. In those instances, the PSC and the ZPIC shall coordinate the review of acute IPPS hospital and LTCH (which, for the purposes of this section, also includes any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) claims for benefit integrity purposes with the QIO to determine whether the QIO was involved with the claim. Otherwise, the PSC and the

ZPIC shall coordinate with the FI or MAC on acute IPPS hospital and LTCH claims, as it does with claims for all other Part A Medicare claims. The *PSC* and the ZPIC shall follow the definition of acute care inpatient prospective payment system (PPS) hospital found in PIM, chapter 1, §1.1.2 (http://www.cms.gov/manuals/108_pim/pim83c01.pdf). If the *PSC* or the ZPIC investigation indicates a need to review medical records, the *PSC* or the ZPIC shall request the medical records directly from the provider and have them sent directly to the *PSC* or the ZPIC. Upon receipt of the records, the *PSC* or the ZPIC shall perform a billing and document review of the medical record. The *PSC* or the ZPIC shall also review the medical records for medical necessity, as well as, any indications of potential fraud and abuse.

If a claim has been reviewed by the QIO, the decision made is final and binding on CMS and the specific decision rendered by the QIO shall not be overturned by the PSC or ZPIC.

4.19.2.2 - Identification of Potential Exclusion Cases

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The PSC and the ZPIC BI unit shall review and evaluate abuse cases to determine if they warrant exclusion action. Examples of abuse cases suitable for exclusion include, but are not limited to:

- Providers who have a pattern of adverse QIO,AC, or MAC findings.
- Providers whose claims must be reviewed continually and are subsequently denied because of repeated instances of overutilization.
- Providers who have been the subject of previous cases that were not accepted for prosecution because of the low dollar value
- Providers who furnish or cause to be furnished items or services that are substantially in excess of the *beneficiary's* needs or are of a quality that does not meet professionally recognized standards of health care (whether or not eligible for benefits under Medicare, Medicaid, title V or title XX).
- Providers who are the subject of prepayment review for an extended period of time (longer than 6 months) who have not corrected their pattern of practice after receiving educational/warning letters.
- Providers who have been convicted of a program related offense (§1128(a) of the Social Security Act).
- Providers who have been convicted of a non-program related offense (e.g., a conviction related to neglect or abuse of a *beneficiary*, or related to a controlled substance) (§1128(a) of the Social Security Act).

Also, §1833(a)(1)(D) of the Act provides that payment for clinical diagnostic laboratory tests is made on the basis of the lower of the fee schedule or the amount of charges billed for such tests. Laboratories are subject to exclusion from the Medicare program under §1128(b)(6)(A) of the Act where the charges made to Medicare are substantially in excess of their customary charges to other clients. This is true regardless of the fact that the fee schedule exceeds such customary charges.

Generally, to be considered for exclusion due to abuse, the practices have to consist of a clear pattern that the provider/supplier refuses or fails to remedy in spite of efforts on the part of the PSC, ZPIC, AC, MAC, or QIO groups. An exclusion recommendation is implemented only where efforts to get the provider/supplier to change the pattern of practice are unsuccessful. The educational or persuasive efforts are not necessary or desirable when the issues involve life-threatening or harmful care or practice.

If a case involves the furnishing of items or services in excess of the needs of the individual or of a quality that does not meet professionally recognized standards of health care, PSC and ZPIC BI units shall make every effort to obtain reports confirming the medical determination of their medical review from one or more of the following:

- The QIO for the area served by the provider/supplier
- State or local licensing or certification authorities
- QIO committees
- State or local professional societies
- Other sources deemed appropriate

Medicare Program Integrity Manual

Chapter 6 - Intermediary MR Guidelines for Specific Services

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6.5 - Medical Review of Inpatient Hospital Claims

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

During the first phase in which FIs and MACs assume responsibility for the review of acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims(which, for the purposes of this section, also includes any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver) CMS will provide additional funding to facilitate adequate oversight of inpatient hospital claims and reporting of findings from the implementation date of this change request through March 31st, 2009. With this additional funding, contractors will be required to perform data analysis, medical review, and reporting of findings on these IPPS and LTCH PPS hospital claims.

As a part of this specially-funded first-phase initiative, contractors will be permitted to perform random postpayment review of IPPS hospital LTCH claims in order to develop baseline data on utilization. The data compiled through this first-year initiative will serve to help FIs and MACs effectively target future medical review interventions. The contractor shall submit the one-time final report to the appropriate CMS contact at the end of the first phase.

Instructions in the subsequent sections are not limited to the first phase of IPPS hospital and LTCH claim review. They apply to the review of all IPPS hospital and LTCH claims.

6.5.1 Screening Instruments

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The reviewer shall use a screening tool as part of their medical review of acute IPPS and LTCH claims. CMS does not require that you use a specific criteria set. In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

The following shall be utilized as applicable, for each case:

- Admission criteria;*
- Invasive procedure criteria;*
- CMS coverage guidelines;*
- Published CMS criteria*
- DRG validation guidelines;*

➤ Coding guidelines; and

➤ Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community)

Contractors shall consult with physician or other specialists if necessary to make an informed medical review determination.

6.5.2 – Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) claims
(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The FIs and MACs shall conduct review of medical records for inpatient acute IPPS hospital and LTCH claims, as appropriate, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

A. Determining Medical Necessity and Appropriateness of Admission

The reviewer shall consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate.

Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay. See Pub. 100-02, chapter 1, §10 for further detail on what constitutes an appropriate inpatient admission.

B. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

When the contractor determines that the beneficiary did require an inpatient level of care on admission, utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM coding

guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review.

When you determine that the beneficiary did not require an inpatient level of care on admission, but that the beneficiary's condition changed during the stay and inpatient care became medically necessary, you shall review the case in accordance with the following procedures:

➤ *The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;*

➤ *The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and*

➤ *The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.*

➤ *Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.*

When you determine that the beneficiary did not require an inpatient level of care at any time during the admission, deny the claim in full.

6.5.3 - DRG Validation Review

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

NOTE: *For PPS waived/excluded areas, review shall be performed appropriate to your area.*

A. Coding

The contractor shall use individuals trained and experienced in ICD-9-CM coding to perform the DRG validation functions. The validation is to verify the accuracy of the hospital's ICD-9-CM coding of all diagnoses and procedures that affect the DRG.

The contractor shall base DRG validation upon accepted principles of coding practice, consistent with guidelines established for ICD-9-CM coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS. The contractor shall not change these guidelines or institute new coding requirements that do not conform to established coding rules.

The contractor shall verify a hospital's coding in accordance with the coding principles reflected in the ICD-9-CM Coding Manual. Contractors shall use the ICD-9 CM version in place at the time the services were rendered, and the official National Center for Health Statistics and CMS addenda, which update the ICD-9-CM Manual annually. The annual addenda are effective on October 1 of each year and apply to discharges occurring on or after October 1. The contractor shall use only ICD-9-CM Manual volumes based on official ICD-9-CM Addendum and updates when performing DRG validation.

Hospitals are not required to code minor diagnostic and therapeutic procedures (e.g., imaging studies, physical, occupational, respiratory therapy), but may do so at their discretion.

B. Diagnoses

Contractors shall ensure that the hospital reports the principal diagnosis and all relevant secondary diagnoses on the claim. The relevant diagnoses are those that affect DRG assignment. The hospital must identify the principal diagnosis when secondary diagnoses are also reported. When a comorbid condition, complication, or secondary diagnosis affecting the DRG assignment is not listed on the hospital's claim but is indicated in the medical record, insert the appropriate code on the claim form. If the hospital already reported the maximum number of diagnoses allowed on the claim form, delete a code that does not affect DRG assignment, and insert the new code.

The contractor is not required to additional diagnoses on the claim as long as all conditions that affect the DRG are reflected in the diagnoses already listed, and the principal diagnosis is correct and properly identified. The hospital can list the secondary diagnoses in any sequence on the claim form because the GROUPER program will search the entire list to identify the appropriate DRG assignment.

➤ *Principal Diagnosis – The contractor shall determine whether the principal diagnosis listed on the claim is the diagnosis which, after study, is determined to have occasioned the beneficiary's admission to the hospital. The principal diagnosis (as evidenced by the physician's entries in the beneficiary's medical record) (see 42 CFR 412.46) must match the principal diagnosis reported on the claim form. The principal diagnosis must be coded to the highest level of specificity. For example, a diagnosis from chapter 16 of the ICD-9-CM Coding Manual, "Symptoms, Signs, and Ill-defined Conditions," may not be used as the principal diagnosis when the underlying cause of the beneficiary's condition is known.*

➤ *Inappropriate Diagnoses – The contractor shall exclude diagnoses relating to an earlier episode that have no bearing on the current hospital stay. Delete any incorrect diagnoses and revise the DRG assignment as necessary.*

C. Procedures

The contractor shall ensure that the hospital has reported all procedures affecting the DRG assignment on the claim. If there are more procedures performed than can be listed on the claim, verify that those reported include all procedures that affect DRG assignment, and that they are coded accurately. See section 6.5.4 below for further detail on reviewing procedures.

6.5.4 – Review of Procedures Affecting the DRG

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The contractor shall determine whether the performance of any procedure that affects, or has the potential to affect, the DRG was reasonable and medically necessary. If the admission and the procedure were medically necessary, but the procedure could have been performed on an outpatient basis if the beneficiary had not already been in the hospital, do not deny the procedure or the admission.

When a procedure was not medically necessary, the contractor shall follow these guidelines:

➤ *If the admission was for the sole purpose of the performance of the non-covered procedure, and the beneficiary never developed the need for a covered level of service, deny the admission;*

➤ *If the admission was appropriate, and not for the sole purpose of performing the procedure, deny the procedure (i.e., remove from the DRG calculation), but approve the admission;*

➤ *If performing a cost outlier review, in accordance with Pub. 100-10, chapter 4, §4210 B., and the beneficiary was in the hospital for any day(s) solely for the performance of the procedure or care related to the procedure, deny the costs for the day(s) and for the performance of the procedure; and*

➤ *If performing a cost outlier review, and the beneficiary was receiving the appropriate level of covered care for all hospital days, deny the procedure or service.*

See Pub. 100-02, chapter 1, §10 for further detail on payment of inpatient claims containing non-covered services.

All medically unnecessary procedures represent quality of care problems as well as utilization problems and shall be referred to the QIO for quality review after claim adjustment is made.

6.5.5 – Special Review Considerations

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Refer to Pub. 100-04, chapter 3, §20 C. for information regarding handling of claims with DRG 468. This DRG represents a discharge with valid data but where the surgical procedure is unrelated to the principal diagnosis.

Refer to 100-04, chapter 3, §20.2.1, subsection D.9. for a description of questionable admission ICD-9-CM codes. FIs and MACS may wish to consider including these diagnoses in their data analysis.

For a listing of ICD-9-CM diagnosis codes identified as “questionable admission” codes see the Medicare Code Editor (MCE) Web site at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10>

Refer to 100-04, chapter 3, §20.2.1, subsection D.10 for a description of diagnoses which are acceptable only when coded with a secondary diagnosis. FIs and MACs may wish to include these diagnoses in their data analysis as the MCE will not reject them when they are billed with a secondary diagnosis.

For a listing of ICD-9-CM diagnosis codes that are acceptable only when coded with a secondary diagnosis see the MCE Web site at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10>

6.5.6 - Length-of-Stay Review

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

The contractor shall determine whether the length-of-stay for PPS cost outlier claims and specialty hospital/unit claims, when selected for medical review, is appropriate and medically necessary. Identify cases of potential delayed discharge. For example, the beneficiary was medically stable, and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the safety or health of the beneficiary (see §4110).

If Medicare payment is applicable to only part of the stay, review the covered portion of the stay and enough of the rest of the medical record (if necessary) to answer any specific questions that may arise from review of the covered part of the stay. If a beneficiary became Medicare eligible during a hospital stay, review enough of the medical record prior to the initiation of Medicare benefits to acquire sufficient information to make a determination. Do not perform lengthy reviews of non-covered care. In PPS waived/excluded areas, length-of-stay review is performed for all inpatient admissions that are selected for medical review.

The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers. However, the contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments. Where it is determined that a beneficiary's stay was unnecessarily long, and potentially represents fraud or abuse, the contractor shall make a referral to the PSC/ZPIC.

6.5.7 - Readmission Reviews

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Readmission review involves admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (see §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

A. Medical Review Procedures for Readmission Claims

When performing review of a claim associated with a readmission, as described above, the contractor shall follow the procedures outlined in §6.5 of this chapter and its subsections to make medical review determinations and any necessary adjustments to the claim under review, as it would any other acute IPPS hospital or LTCH claim.

B. Referral to the QIO

The contractor shall refer all readmission cases selected as part of medical review to the quality improvement organization (QIO).

6.5.8 - Transfer Reviews

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Transfers are identified by the code entered on the bill and by the entries in the medical record. Transfers are planned admissions to a second hospital/excluded unit. Transfer review involves transfers between hospitals (e.g., from a PPS hospital to either a second

PPS hospital or a second specialty hospital/unit) and transfers within a PPS hospital to an excluded unit in the same hospital.

A. Medical Review Procedures for Transfer Claims

When reviewing a claim associated with a transfer, as described above, the contractor shall follow the procedures outlined in §6.5 of this chapter and its subsections to make medical review determinations and any necessary adjustments to the claim under review, as it would any other acute IPPS hospital or LTCH claim.

B. Referral to QIO

The contractor shall refer all transfer cases selected as part of medical review to the QIO. The QIO has the authority to review the FI/MACs determination, along with the medical record for the previous admission to determine whether the readmission resulted from a premature discharge from the hospital. If it determines that it did, the QIO may deny one or both of the claims, in accordance with Pub. 100-10, chapter 4, §4240.

6.5.9 – Circumvention of PPS

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

If you suspect, during review of a claim associated with a transfer or readmission, that a provider of Medicare services took an action with the intent of circumventing PPS (as described in §1886(f)(2) of the Act) and that action resulted in unnecessary admissions, premature discharges and readmissions, multiple readmissions, or other inappropriate medical or other practices with respect to beneficiaries or billing for services, you shall make a referral to the QIO and your benefit integrity contractor.

Exhibit 1 - Definitions

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A

Abuse

Billing Medicare for services that are not covered or are not correctly coded.

Affiliated Contractor (AC)

A Medicare carrier, Fiscal Intermediary (FI), or other contractor such as a Durable Medical Equipment Medicare Administrative Contractor (DME MAC), which shares some or all of the Program Safeguard Contractor's (PSC's) jurisdiction; Affiliated Contractors perform non-PSC Medicare functions such as claims processing.

B-C

Carrier

The Carrier is an entity that has entered into a contract with CMS to process Medicare claims under Part B for non-facility providers (e.g., physicians, suppliers, laboratories). *DME MACs* are those carriers that CMS has designated to process DME, prosthetic, orthotic and supply claims.

Case

A case exists when the PSC, ZPIC or Medicare contractor BI unit has referred a fraud allegation to law enforcement, including but not limited to, documented allegations that: a provider, beneficiary, supplier, or other subject has a) engaged in a pattern of improper billing, b) submitted improper claims with actual knowledge of their truth or falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

Contractor

Contractor includes all intermediaries, carriers, *DME MAC*, RHHIs, MACs, ZPICs, and PSCs.

Centers for Medicare & Medicaid Services (CMS)

CMS administers the Medicare program. CMS' responsibilities include management of AC and Medicare contractor claims payment, managing PSC, ZPIC, AC, and Medicare contractor fiscal audit and/or overpayment prevention and recovery, and the development and the monitoring of payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. CMS was formerly known as the Health Care Financing Administration (HCFA).

Closed Case

A FID case shall be closed when no further action will be required of the PSC, ZPIC, or Medicare contractor BI unit by the law enforcement agency(ies) working the case and when the law enforcement agency(ies) has ended all its activity on the case. Note that even after the case is closed, there may still be administrative actions that the PSC, ZPIC, or Medicare contractor BI unit will take.

D-E

Department of Justice (DOJ)

Attorneys from DOJ and United States Attorney's Offices have criminal and civil authority to prosecute those providers who de-fraud the Medicare program.

Demand Bill or Demand Claim

A demand bill or demand claim is a complete, processable claim that must be submitted promptly to Medicare by the physician, supplier or provider at the timely request of the beneficiary, the beneficiary's representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary's subrogee. A demand bill or demand claim is requested usually, but not necessarily, pursuant to notification of the beneficiary (or representative or subrogee) of the fact that the physician, supplier or provider expects Medicare to deny payment of the claim. When the beneficiary (or representative or subrogee) selects an option on an advance beneficiary notice that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill or claim must be submitted.

F

Federal Bureau of Investigation (FBI)

Along with OIG, the FBI investigates potential health care fraud. Under a special memorandum of understanding, the FBI has direct access to contractor data and other records to the same extent as OIG.

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

G-H

I

Intermediary

The intermediary is a public or private agency or organization that has entered into an agreement with CMS to process Medicare claims under both Part A and Part B for institutional providers (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPT, occupational therapy, speech pathology providers, and ESRD facilities). Regional home health intermediaries (RHHIs) are those FIs that CMS has designated to process Medicare claims received from home health and hospice providers.

J-K-L

Local Coverage Determinations (LCDs)

The *LCDs* are those policies used to make coverage and coding decisions in the absence of specific statute, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

M

Medicare Contractor (Benefit Integrity)

Medicare contractors include all intermediaries and carriers that have not transitioned their benefit integrity work to a PSC.

Medicare Contractor (Medical Review)

Medicare contractors include intermediaries, carriers and MACs.

Misrepresented

A deliberate false statement made, or caused to be made, that is material to entitlement or payment under the Medicare program.

N

Noncovered (Not Covered)

Noncovered services are those for which there is no benefit category, services that are statutorily excluded (other than §1862 (A)(1)(a)), or services that are not reasonable and necessary under §1862 (A)(1)(a).

O

Office of Audit Services (OAS)

The OAS conducts comprehensive audits to promote economy and efficiency and to prevent and detect fraud, abuse, and waste in operations and programs. OAS may request data for use in auditing aspects of Medicare and other Health and Human Service (HHS) programs and is often involved in assisting OIG/OI in its role in investigations and prosecutions.

Office of Counsel to the Inspector General (OCIG)

The OCIG is responsible for coordinating activities that result in the negotiation and imposition of Civil Monetary Penalties (CMPs), assessments, and other program exclusions. It works with the Office of Investigations (OIG), Office of Audit Services (OAS), CMS, and other organizations in the development of health care fraud and exclusions cases.

Office of Inspector General (OIG)

The OIG investigates suspected fraud or abuse and performs audits and inspections of CMS programs. In carrying out its responsibilities, OIG may request information or assistance from CMS, its PSCs, its ZPICs (Zone Program Integrity Contractors), Medicare contractors, and QIOs. OIG has access to CMS's files, records, and data as well as those of CMS's contractors. OIG investigates fraud, develops cases, and has the authority to take action against individual health care providers in the form of CMPs and program exclusion, and to refer cases to the DOJ for criminal or civil action. OIG concentrates its efforts in the following areas:

- Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether criminal, civil, or administrative remedies are warranted;
- Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;

- Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- Collecting and analyzing Medicare contractor, AC, Medicare contractor, and State Medicaid agency-produced information on resources and results; and,
- Participating with other government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

Office of Investigations (OI)

The Office of Investigations (OI), within OIG, is staffed with professional criminal investigators and is responsible for all HHS criminal investigations, including Medicare fraud. OIG/OI investigates allegations of fraud or abuse whether committed by PSCs, ZPICs, ACs, Medicare contractors, grantees, beneficiaries, or providers of service (e.g., fraud allegations involving physicians and other providers, contract fraud, and cost report fraud claimed by hospitals).

The OIG/OI presents cases to the United States Attorney's Office within the Department of Justice (DOJ) for civil or criminal prosecution. When a practitioner or other person is determined to have failed to comply with its obligations in a substantial number of cases or to have grossly and flagrantly violated any obligation in one or more instances, OIG/OI may refer the case to OCIG for consideration of one or both of the following sanctions:

- An exclusion from participation in the Medicare program or any State health care programs as defined under §1128(h) of the Social Security Act (the Act);or
- The imposition of a monetary penalty as a condition to continued participation in the Medicare program and State health care programs.

Offset

The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

P

Program Safeguard Contractor (PSC)

The PSC is a contractor dedicated to program integrity that handles such functions as audit, medical review and potential fraud and abuse investigations consolidated into a

single contract. They are being replaced with Zone Program Integrity Contractors (ZPICs)

Providers

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, etc.). For purposes of this manual, the term provider is generally used to refer to individuals or organizations that bill carriers, intermediaries, *DME MACs*, and RHHIs. If references apply to only specific providers (e.g., physicians), the specific provider will be identified.

Q- R

Quality Improvement Organization (QIO)

The Peer Review Improvement Act of 1982 established the utilization and quality control peer review organization (PRO) program. The PRO name has changed to quality improvement organization. CMS contracts with independent physician organizations in each state to administer the QIO program. *Their purpose is to ensure that the provisions of the Peer Review Improvement Act of 1982 are met. Under their contracts with CMS, QIOs are required to perform quality of care reviews of the medical services provided to Medicare beneficiaries in settings including, but not limited to: physician offices, acute care hospitals, specialty hospitals (for example psychiatric and rehabilitation hospitals), and ambulatory surgical centers. In the inpatient setting, QIOs also perform provider-requested higher-weighted DRG reviews for acute inpatient prospective payment system (IPPS) hospitals and long-term care hospital (LTCH) claims.*

Recoupment

The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

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 first hand, 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; or
- Recommendations for suspension by 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.

S

Services

Medical care, items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPH or SNF facilities. (42CFR 400.202). In other sections of Medicare manuals and remittance advice records, the term item/service is used. However, throughout this manual we will use the term service to be inclusive of item/service. See §1861 of Title 18 for a complete description of services by each provider type.

Suspension of Payment

Suspension of payment is defined in the regulation 42CFR 405.370 as "the withholding of payment by the carrier or intermediary from a provider or supplier of an approved Medicare payment amount before a determination of the amount of overpayment exists." In other words, ACs or Medicare contractors have received processed and approved claims for a provider's items or services; however, the provider has not been paid and the amount of the overpayment has not been established.

T-U-V-W-X