Medicaid Program Integrity Manual
Chapter 5 - Unified Case Management System

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(Rev. 12467; Issued:01-18-24)

Transmittals for Chapter 5

5.0 - Purpose
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

For this Chapter, the Medicaid PIM defers to the UPIC Task Order Statement of Work, supplemental guidance provided by CMS, and the Medicare PIM at section 4.12 for most information on the use of UCM by the UPICs.

However, in some instances, there is specific guidance unique to the Medicaid environment and working with state Medicaid agencies (SMAs) that is being maintained in this manual at this time. Below are sections that include guidance that is unique to Medicaid investigations/audits. The associated section in the Medicare PIM is also cited, when applicable.

5.1 - Background
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

The UCM is a nationwide database that UPICs use to enter and update Medicare and Medicaid fraud, waste, and abuse leads, investigations, administrative actions, and referrals initiated by the UPICs.

The UCM shall also capture the UPIC's work related to administrative actions like post-payment reviews, pre-payment reviews, overpayments, etc., as well as referrals to other entities (SMAs, law enforcement, etc.). The UCM also has monitoring and reporting capabilities which facilitate oversight of the UPICs' workloads.

5.2 - Entry Requirements for Investigations
(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

For most of this information, please defer to section 4.12.2 of the Medicare PIM titled, "Initial Entry and Update Requirements for UPIC Leads and Investigations."

Guidance unique to Medicaid:

Investigative activities, such as on-site visits, interviews, etc. shall be captured in the "Plan of Action" section of UCM.

The UPIC shall take all appropriate administrative actions in accordance with this manual and in conjunction with the SMA.

5.3 - Creating Overpayment (OPT) Records
(Rev. 12467; Issued: 01-18-24, Effective: 02-19-24, Implementation: 02-19-24)

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), an OPT record will be opened for each MCO where the provider is enrolled, unless directed otherwise by the SMA.

In circumstances where the provider is being investigated/audited for both fee-for-service (FFS) claims and is enrolled in managed care, a separate OPT record will be opened for the FFS portion of the investigation/audit, along with the OPTs for each MCO, unless directed otherwise by the SMA.

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 'Revised Overpayment Amount' column and include the date of the revision in the 'Determination Date' column.

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 final revised amount (if revised) from the IFR that is listed in the FFR. If the FFR is later revised and the overpayment changes, the 'Revised Overpayment Amount' will be revised using the procedures above, and the federal share will be recalculated, and the amount will be entered in the 'Revised Federal Share' column.

For an FFR Addendum that has occurred after the FFR is issued to the SMA, the UPIC will update the financial amount by editing the original OPT record.

5.4 - Mandatory Fields in UCM for Medicaid

(Rev. 11948; Issued:04-13-23, Effective: 05-15-23; Implementation: 05-15-23)

There are some fields in UCM which are mandatory for investigations/audits that have a "Program Type" of 'Medicaid.' Currently, these include the fields listed below, although this list may change as needs arise. Please refer to the UCM User Manual and Release Notes for all changes and updates.

Mandatory Fields for the Case (CSE) Record:

1) Fraud Case Summary Section
   a) Case Close Reason (if closed as a lead)
   b) Medicaid/Medi-Medi Case Close Reasons (when closed as an investigation)

2) Plan of Actions Section

a) Any activities planned for the investigation shall be captured here. This may or may not include interviews with beneficiaries, providers, employees, etc.; on-site reviews; medical reviews, etc.

3) General Tab
   a) Program Type
   b) Data Source of Lead
   c) Stage Agency

4) Allegations Tab
   a) Provider Type (formerly Service Type)
   b) Medicaid Dollars at Risk:
      i. FFS
      ii. MCO

5) State Involvement Tab
   a) Date Lead Vetted with State
   b) State Response Date
   c) State Response Status

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12467MPI	01/18/2024	Updates of Chapter 1, Chapter 3, and Chapter 5 in Publication (Pub.) 100-15, Including Updates to the Definitions and Additional Clarification to the Proactive Project Development and Creation of Overpayment Records Guidance	02/19/2024	13403
R11948MP	04/13/2023	Updates of Publication (Pub.) 100-15, Including Revisions to Chapters 1 and 2, and the Addition of Chapters 3, 4, 5, and Appendices	05/15/2023	13141

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