CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 399	**Date: November 4, 2011**
	Change Request 7622

SUBJECT: Revision of PIM Chapter 3, Section 3.2.1 Setting Priorities and Targeting Reviews.

I. SUMMARY OF CHANGES: The Office of Financial Management has reorganized the Program Integrity Manual. The information in this request is for PIM Chapter 3, Section 3.2.1 Setting Priorities and Targeting Reviews. This language will make auditors aware they shall not target any providers for their preferred method of maintaining or submitting documentation.

EFFECTIVE DATE: December 5, 2011
IMPLEMENTATION: December 5, 2011

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	Chapter 3/3.2.1/N/A/Setting Priorities and Targeting Reviews

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 399	Date: November 4, 2011	Change Request:7622

SUBJECT: Revision of PIM Chapter 3, Section 3.2.1 Setting Priorities and Targeting Reviews

Effective Date:
December 5, 2011

Implementation Date:
December 5, 2011

I. GENERAL INFORMATION

A. Background:

The Office of Financial Management has reorganized the Program Integrity Manual. The information in this request is for PIM Chapter 3, Section 3.2.1 Setting Priorities and Targeting Reviews. This language will make auditors aware they shall not target any providers for their preferred method of maintaining or submitting documentation.

B. Policy:

Updates Section 3.2.1

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7622.1	MACs and Recovery Auditors shall NOT target a provider for review solely based on the provider's preferred method of maintaining or submitting documentation. For example, a MAC or Recovery Auditor shall NOT choose a provider for review based only on the fact that the provider uses an electronic health record or responds to documentation requests using the Electronic Submission of Medical Documentation (esMD) mechanism. (More information about esMD can be found in section (3.2.3.5).	X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Joyce Davis, 410-786-0877, Joyce.Davis1@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

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.

3.2.1 – Setting Priorities and Targeting Reviews

(Rev. 399, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

This section applies to MACs and Recovery Auditors, as indicated. Recovery Auditors perform targeted reviews consistent with their statements of work (SOWs).

The MACs have the authority to review any claim at any time, however, the claims volume of the Medicare Program doesn't allow for review of every claim. The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for improper payment.
The MACs shall develop a problem-focused, outcome-based MR strategy and Strategy Analysis Report (SAR) that defines what risks to the Medicare trust fund the MAC's MR programs will address and the interventions that will be implemented during the fiscal/option year as addressed in PIM chapter 7.

The MACs shall focus their edits where the services billed have significant potential to be non-covered or incorrectly coded. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate billing or improper payments. The MACs shall have in place a program of systematic and ongoing analysis of claims and data from Recovery Auditors and CERT, among other sources, in order to focus intervention efforts on the most significant errors.

The MACs shall initiate a targeted provider-specific prepayment review only when there is the likelihood of sustained or high level of payment error. MACs are encouraged to initiate targeted service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis.

The MACs have the discretion to select target areas because of:

- High volume of services;
- High cost;
- Dramatic change in frequency of use;
- High risk problem-prone areas; and/or,
- Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability. Probe reviews are not required when targeted areas are based on data from these entities.

In an effort to identify the claims most likely to contain improper billing, MACs are encouraged to use prepayment and postpayment screening tools or natural language coding software. MACs shall not deny a payment for a service simply because the claim fails a single screening tool

criterion. Instead, the reviewer shall make an individual determination on each claim. MACs have the discretion to post the screening tools in use to their Web site or otherwise disclose to the provider community. Recovery Auditors shall use screening tools and disclose their use to the provider community consistent with the requirements in their statements of work (SOWs).

MACs and Recovery Auditors shall NOT target a provider for review solely based on the provider's preferred method of maintaining or submitting documentation. For example, a MAC or Recovery Auditor shall NOT choose a provider for review based only on the fact that the provider uses an electronic health record or responds to documentation requests using the Electronic Submission of Medical Documentation (esMD) mechanism. (More information about esMD can be found in Section (3.2.3.5)