MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 17 – EXHIBITS

(Rev. 1, Issued: 09-23-11)

Transmittals for Chapter 17

THIS GLOSSARY IS A LIST OF GENERAL DEFINITIONS AS THEY ARE COMMONLY USED IN THE MEDICAID INTEGRITY PROGRAM.

17000 – GLOSSARY OF TERMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

ABUSE: 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 recipient practices that result in unnecessary cost to the Medicaid program. 42 CFR § 455.2.

ACCEPTED REFERRAL: Referral of a potentially fraudulent Medicaid provider to the State's Medicaid Fraud Control Unit (MFCU) that is accepted by the MFCU.

ADMINISTRATIVE ACTION: Provider sanction, payment suspension or other action taken by the State against a Medicaid provider before a determination of Medicaid fraud, waste or abuse or overpayment has been made.

ALGORITHM: A set of well-defined rules or procedures for solving a problem in a finite number of steps.

ARTIFICIAL INTEGELLIGENCE: An algorithm or set of algorithms that can make decisions in a logical way.

AUDIT: An assessment, evaluation, inspection, or investigation of services rendered or items furnished by a Medicaid provider.

AUDIT, COMPREHENSIVE: Examinations of the adequacy, legality, and efficiency of the application of public funds. Such examinations involve not only individual fiscal transactions but also the financial management, internal controls, policies, and operating environments governing such transactions.

AUDIT, COST REPORT: An examination of financial transactions, accounts, and reports as they relate to the cost report submitted by a provider in order to evaluate the provider's compliance with applicable Medicaid laws, regulations, manual instructions, and directives and to verify the accuracy and applicability of the costs.

AUDIT, DESK: An audit that is wholly or principally carried out in the office(s) of the auditor.

AUDIT, FIELD: An audit that is carried out at the office(s) of the organization being audited or includes a substantial "on-site" component.

AUDIT, FOCUSED: A review of services rendered or items furnished by a Medicaid provider that is limited in scope to a specific set of services or items or particular inappropriate billing practices.

AUDIT, PROVIDER SELF: An audit that is carried out wholly or principally by the provider being audited.

CASE: An investigation by a Medicaid Program Integrity office, a Medicaid Fraud Control Unit, or other Agency, to determine whether there has been a violation by a Medicaid provider of Medicaid laws, rules, or regulations or accepted standards.

CIVIL MONEY PENALTIES: Any monetary penalty, imposed by either CMS or OIG against individuals/entities for conduct that violates Federal and/or State statutes and regulations governing the Medicaid program. 42 CFR Part 402.

CLAIM: A request for payment for services and benefits rendered by a Medicaid provider, also known as bills or invoices.

COLLECTIONS: Cash recovered in reimbursement of overpayments or other cash received as a result of Medicaid program integrity activities.

COMPREHENSIVE MANAGED CARE: Managed care plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations) that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract. 42 CFR Part 438.

COST AVOIDANCE: An action or intervention that reduces or eliminates a cost or outlay that would have occurred if not for that action or intervention.

COST REPORT: Report required from providers on an annual basis in order to make a proper determination of reimbursement rate under the Medicaid program based on the expenses incurred by the provider in the course of supplying services.

CREDENTIALING: Review procedures conducted for the purpose of determining whether a potential or existing provider meets certain standards that are a prerequisite for them to begin or continue participation in a given health care plan.

DATA MINING: The analysis of large volumes of data maintained in databases or data warehouses using query tools, algorithms, and models to identify patterns, trends, and relationships or correlations among the data and to develop useful information for investigative and management purposes.

DATA REPOSITORY PLATFORM: A logical partitioning of data where multiple databases that apply to specific applications or sets of applications reside. A central place where data is stored and maintained.

DATA WAREHOUSE: A relational database designed for query and analysis, rather than for transaction processing. It usually contains historical data derived from transaction data, but can include data from other sources. It separates analysis workload from transaction workload and enables an organization to consolidate data from several sources.

DECISION SUPPORT SYSTEMS (DSS): A systematic collection of data, techniques, and supporting software and hardware by which an organization gathers and interprets relevant information from business and the environment and turns it into a basis for making management decisions.

DETECTION: Activities such as data mining, auditing, surveillance utilization and reviews or other methods, aimed at identifying possible fraud, waste, and abuse in the Medicaid program.

DISTINCT PROGRAM INTEGRITY MODEL: Organizational structure in which a distinct Medicaid program integrity unit exists within the State. Medicaid Integrity activities such as prevention, detection, audit and investigation lie wholly within the State Medicaid Agency but are not necessarily centralized in a Medicaid "Program Integrity Unit."

DOLLARS IDENTIFIED FOR RECOVERY: Represents the dollar amount of claims inappropriately paid as identified by data mining, audit, surveillance utilization review or other methods.

DOLLARS RECOVERED: Represents total dollar amount of overpayments actually recovered by the State (as opposed to dollars identified or an agreement by the provider to refund the program).

EDITS: "Front end" reviews or controls in the Medicaid Management Information Systems (MMIS) that examine the information in each claim in relation to certain Medicaid policies and to other claims, and cause the claim to be paid, pended, or denied.

ENCOUNTER DATA: Data related to the services and items received by a Medicaid recipient in an encounter with or visit to a Medicaid provider through managed care. Also referred to as "shadow claims".

ENROLLMENT: The process of admitting (or not admitting) a prospective provider or recipient into the Medicaid program or a component of the program, such as managed care.

EXCLUDED INDIVIDUALS OR ENTITIES: Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid and other Federal or State health care programs. Exclusions may occur due to OIG sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the State Medicaid Agency.

EXCLUDED PARTIES LIST SYSTEM (EPLS): An electronic, web-based system maintained by the General Services Administration (GSA) that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. Can be found at http://www.epls.gov.

EXPENDITURE: Refers to funds spent as reported by the State.

EXTRAPOLATION: The process of predicting a future cost (or other measure) using current data or results from the past.

FEE-FOR-SERVICE (FFS): Traditional method of payment for medical services where payment is made to providers for each service rendered.

FRAUD: 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. Includes any act that constitutes fraud under applicable Federal or State law. 42 CFR 455.2.

INVOLUNTARY DISENROLLMENT: Administrative action by a State to terminate a provider's participation in the Medicaid program due to noncompliance with Medicaid rules, regulations, payment policy and/or quality of care standards.

JUDGMENT: A court's final determination on an appeal of the rights and obligations of the parties in a case.

LIST OF EXCLUDED INDIVIDUALS AND ENTITIES (LEIE): List maintained by OIG of individuals and business excluded from participating in Federally funded health care programs available at http://www.oig.hhs.gov/fraud/exclusions.html.

MANAGED CARE: A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider. 42 CFR Part 438.

MANAGED CARE ORGANIZATION (MCO): An organization or entity that has a comprehensive risk contract under Medicaid to provide benefits to Medicaid clients. 42 CFR Part 438

MANAGED CARE OVERSIGHT: Management and/or supervision of managed care organizations to ensure compliance with Medicaid rules, regulations, and policies.

MEDICAID FRAUD CONTROL UNITS (MFCUs): A functional entity, usually located in the offices of the State Attorney General, or other Department designated by the State that investigates and prosecutes Medicaid fraud cases and reviews complaints alleging abuse or neglect of patients in health care facilities receiving Medicaid payments. MFCUs operate under a Memorandum of Understanding with the State

Medicaid Agency and are subject to oversight by the DHHS' OIG. MFCUs must meet the requirements of 42 CFR Part 1007.

MEDICAID INTEGRITY: Planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse.

MEDICAID INTEGRITY PROGRAM (MIP): A program established by the Deficit Reduction Act (DRA) of 2005 at section 1936 of the Social Security Act (Act). MIP provides the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, identify, and recover inappropriate Medicaid payments. The two main operational responsibilities under the program are: 1) reviewing the actions of those furnishing items or providing services under Medicaid and 2) providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS): An automated claims processing and information retrieval system required under the Medicaid program that produces service utilization and management information.

MEDICAID RAC PROGRAM: Recovery audit contractor administered by a State to identify overpayments and underpayments and recoup overpayments. They are typically paid through contingency fee arrangements.

MEDICARE RAC PROGRAM: Recovery audit contractor program administered by CMS to identify overpayments and underpayments and recoup overpayments under the Medicare program.

NATIONAL PRACTITIONER DATABANK : A computerized data bank maintained by the federal government that contains information on physicians who have paid malpractice claims or against whom certain disciplinary actions have been taken.

OFFSET: Withholding of funds from future provider payments to recover overpayments identified through Medicaid program integrity activities.

OVERPAYMENT: Any payment made to a Medicaid provider in excess of the payment to which the provider was entitled under State or federal laws and regulations.

PARTICIPATING PROVIDER: Provider that actively bills the Medicaid program.

PREDICTIVE MODEL: A mathematical or statistical method for analyzing a body of data and predicting or forecasting future results or behavior.

PREVENTION: Activities to minimize the risk of fraud, waste, or abuse entering the payment system and activities used to educate Medicaid program staff and providers.

PRIMARY CARE CASE MANAGEMENT (PCCM): The health care management activities of a provider that contracts with the State to provide primary health care

services and to arrange and coordinate other preventive, specialty, and ancillary health services reimbursed on a FFS basis. 42 CFR Part 438.

PRIOR AUTHORIZATION: A formal process by which, as a precondition for provider reimbursement, providers or clients must obtain approval for certain medical services, equipment, or supplies (based on medical necessity) before the services are provided to clients.

PROPRIETARY DATABASE: A copyrighted database accessible by subscription.

PROVIDER: Any person or entity enrolled in the Medicaid program that provides services and/or furnishes items that are billable under Medicaid.

PROVIDER EDUCATION/COMMUNICATIONS: Activities designed to educate and communicate with providers about Medicaid rules, regulations, and policies to ensure quality of care and payment integrity.

PROVIDER PAYMENT SUSPENSION: The withholding of payment by a State Medicaid Agency to a provider or supplier before a determination of the amount of the overpayment exists.

RAMS II: An advanced version of the mainframe Surveillance and Utilization Review Subsystem (SURS) system developed by a MMIS contractor.

RECIPIENT: An individual who receives benefits under the Medicaid program.

RECOVERY: Collections and offsets received from providers as a result of overpayments or other State program integrity activities. Does not include third party liability (TPL) or prior authorizations.

REFERRAL: Information on potential provider fraud that is forwarded from the State Medicaid Agency to the Medicaid Fraud Control Unit (MFCU) or other State or federal investigative Agency.

RETURN ON INVESTMENT (ROI): Savings/collections attributable to Medicaid program integrity efforts per dollar invested.

SAMPLING: Random selection of a subset of a population.

SANCTION: A penalty assessed on a Medicaid provider for a violation or violations of Medicaid laws, rules, regulations, or policies. May be in the form of a fine, suspension, termination, exclusion, civil monetary penalty, requirement for correction action, or other remedy/action.

SETTLEMENT: A negotiated agreement to collect identified overpayments from a Medicaid provider.

SINGLE STATE AGENCY (SSA): The single Agency within the State responsible for the administration of the State Medicaid plan on behalf of the State.

STANDARD OPERATING PROCEDURE: An established procedure to be followed in a given situation.

STATISTICAL ANALYSIS: Process of examining data to draw conclusions or make inferences about a population based on a sample or subset of the population.

STRATEGIC PLAN: A document used by an organization to align its policies and budget structure with organizational priorities, missions, and objectives. Should include a mission Statement, a description of the Agency's long-term goals and objectives, and strategies or means the Agency plans to use to achieve these goals and objectives. May also identify external factors that could affect achievement of long-term goals.

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS): A component of the Medicaid Management Information System designed to process information on medical and health care services to assist Medicaid program managers in identifying possible fraud and abuse by providers and Medicaid clients. State SURS staffs perform data mining and other research for post-pay utilization review of providers and clients in order to identify questionable patterns of service delivery and utilization.

SURS I: The early version of the mainframe-based SURS system developed in the late 1970's/early 1980's.

SURS II: An updated version of the mainframe-based SURS-I system.

SURS, ADVANCED: Advanced versions of the mainframe-based SURS-I and SURS-II systems.

SURS, PC-BASED: A client-server, PC-based system that can be operated through a dedicated network and that provides a place to store extensive SURS data, process SURS runs, and store reports. More user-friendly than traditional mainframe SURS (i.e., uses "point-and-click" technology and is capable of performing several functions at the same time) and allows users to perform analyses from desktops and receive relatively quick results.

SURS, CS-BASED: An advanced version of the PC-based SURS system.

TERMINATED PROVIDER: A provider who has been terminated from Medicaid program participation by the State Medicaid Agency due to program integrity concerns.

THIRD PARTY LIABILITY (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.

TIP: Complaint of suspected Medicaid provider fraud, waste or abuse.

TOTAL RECOVERIES: Dollars recovered by the State from overpayments, settlements/judgments, and other collections (excluding TPL and prior authorization).

WITHDRAWN PROVIDER: A provider who has withdrawn from participation in the Medicaid program.

17005 – MEDICAID PROGRAM INTEGRITY MANUAL ACRONYMS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Algorithm Findings Report (AFR)
American Academy of Professional Coders (AAPC)
Audit Medicaid Integrity Contractors (Audit MICs)
Business Partners Security Manual (BPSSM)
Center for Program Integrity (CPI)
Centers for Medicare & Medicaid Services (CMS)
Certified Professional Coder (CPC)
Children's Health Insurance Program (CHIP)
Civil Monetary Penalties (CMPs)
Civil Monetary Penalty (CMP)
CMS integrated IT Investment and System Life Cycle Framework for Security (CMS ILC)
Commercial Off-the-Shelf (COTS)
Comprehensive Medicaid Integrity Plan (CMIP)
Conflicts of interest (COI)
Core Security Requirements (CSR)
Corrective action plan (CAP)
Current Dental Procedures (CDT) Codes
Current Procedural Terminology (CPT)
Deficit Reduction Act (DRA)
Department of Justice (DOJ)
Diagnosis Related Group (DRG)
Division of Audits & Accountability (DAA)
Division of Field Operations (DFO)
Division of Fraud Research & Detection (DFRD)
Division of Medicaid Integrity Contracting (DMIC)
Draft audit reports (DARs)
Education Medicaid Integrity Contractors (Education MICs)

Federal Acquisition Regulations (FAR)
Federal financial participation (FFP)
Federal fiscal year (FFY)
Federal Information Processing Standard (FIPS)
Fee for Service (FFS)
Final audit report (FAR)
Fiscal Year (FY)
Food and Drug Administration (FDA)
Fraud, waste, and abuse (FWA)
Generalized Linear Models (GLM)
Generally Accepted Government Auditing Standards (GAGAS or Yellow Book)
Healthcare Common Procedure Coding System (HCPCS)
Joint Operating Agreement (JOA)
Managed Care (MC)
Managed Care Entity (MCE)
Medicaid Fraud Control Unit (MFCU)
Medicaid Integrity Contractor (MIC)
Medicaid Integrity Contractors (MICs)
Medicaid Integrity Group (MIG)
Medicaid Integrity Institute (MII)
Medicaid Integrity Program (MIP)
Medicaid Statistical Information System (MSIS)
Memoranda of Understanding (MOUs)
Minimum Description Length (MDL)
National Advocacy Center (NAC)
National Association for Medicaid Program Integrity (NAMPI)
National Correct Coding Initiative (NCCI)
National Drug Codes (NDC)
National Institute of Standards and Technology (NIST)
National Plan and Provider Enumeration System (NPPES)
National Provider Identifier (NPI)
Non-negative Matrix Factorization (NMF)
Nursing facility (NF)
Office of Inspector General (OIG)
Office of Management and Budget (OMB)
Oracle Business Intelligence (BI)
Oracle Business Intelligence Enterprise Edition (OBIEE)
Oracle Data Miner (ODM)
Patient Protection and Affordable Care Act (Affordable Care Act)
Payment Accuracy Improvement Groups (PAIG)
Payment Error Rate Measurement (PERM)
Program Integrity (PI)

Provider Compliance Group (PCG)
Provider enrollment and Disclosures (PED)
Quarterly Medicaid Statement of Expenditures For the Medical Assistance Program (Form CMS 64)
Recovery Audit Contractors (RACs)
Return on investment (ROI)
Review Team Leader (RTL)
Revised DAR (RDAR)
Social Security Act (the Act)
State Liaisons (SL)
State Performance Integrity Assessments (SPIAs)
Statistical Analysis Software (SAS)
Subject Matter Experts (SME)
Support Vector Machines (SVM).
Surveillance Utilization Review Subsystem (SURS)
Technical Advisory Group (TAG)
Technical assistance (TA)
Third Party Liability (TPL)
Title XIX of the Social Security Act (Medicaid)

17010 – STATE MEDICAID DIRECTOR LETTERS AUTHORED BY MIG (IN WHOLE OR IN PART)

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SMDL 06-021, State False Claims Acts.
This State Medicaid Director Letter (SMDL) was issued September 19, 2006, to encourage States to implement a State False Claims Act. Section 6031 under section 1936 of the Act encourages and provides incentive for adoption of State False Claims Acts by decreasing the Federal medical assistance percentage by 10 percentage points for recoveries from legal actions brought pursuant to such laws. Section 6031, became effective January 1, 2007, also equally rewards those State False Claims Acts already in place that meet specified requirements.
http://www.cms.gov/smdl/downloads/SMD091906.pdf

SMDL 06-025, Employee Education About False Claims Recovery.
This SMDL was issued December 13, 2006, to offer guidance to State Medicaid agencies on the implementation of Section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act (the Act), and relates to "Employee Education About False Claims Recovery." The SMDL included a State plan preprint, and the SMDL clarified definitions incorporated in the State plan preprint.
http://www.cms.gov/smdl/downloads/SMD121306.pdf

SMDL 07-003, Final Guidance Regarding Employee Education For False Claims Recovery.
This SMDL was issued March 22, 2007, to offer additional guidance to State Medicaid agencies on the implementation of section 6032 under section 1936 of the Act. The SMDL included frequently asked questions (FAQs) to supplement the guidance that CMS provided in SMDL 06-024. States had also requested an official description of the Federal False Claims Act for purposes of uniformity. The Department of Justice had provided that description, which was also included in this SMDL.
http://www.cms.gov/smdl/downloads/SMD032207.pdf
http://www.cms.gov/smdl/downloads/SMD032207Att1.pdf
http://www.cms.gov/smdl/downloads/SMD032207Att2.pdf

SMDL 07-012, Tamper Resistant Prescription Pads.
This SMDL was issued August 17, 2007, to offer guidance to State Medicaid agencies on section 7002(b) of the US Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 regarding the use of tamper resistant prescription pads, required for all Medicaid prescriptions as of October 1, 2008. The SMDL also sets forth the three characteristics for a Medicaid prescription to be considered compliant with the requirement.
http://www.cms.gov/SMDL/downloads/SMD081707.pdf

SMDL 08-002, Cooperation with the Medicaid Integrity Program (MIP).
This SMDL was issued April 28, 2008, to provide a Medicaid State Plan amendment (SPA) preprint that States may use to comply with the requirements of sections 1936 and 1902(a)(69) of the Social Security Act (the Act) (section 6034 of the Deficit Reduction Act of 2005 (DRA)). Section 6034 under section 1936 of the Act requires that States amend their States plans assuring compliance with any requirements determined by the Secretary to be necessary to carry out the MIP established under section 1936 of the Act. The SMDL included a State plan preprint that States could have used to implement this provision.
http://www.cms.gov/SMDL/downloads/SMD042808.pdf

SMDL 08-003, Excluded Providers.
This SMDL was issued June 12, 2008, to provide guidance to State Medicaid agencies clarifying CMS policy on States' obligations to screen for excluded individuals and entities prior to and during provider enrollment; reminding States of the obligation to report to the Health and Human Service Office of Inspector General (OIG) both convictions related to the Medicaid program and sanctions imposed by the State Medicaid Agency on Medicaid providers; and reminding States of the consequences set forth in Federal laws and regulations for failure to prevent Medicaid participation by excluded individuals and entities.
http://www.cms.gov/smdl/downloads/SMD061208.pdf

SMDL 09-001, Provider Exclusions.
This SMDL was issued January 16, 2009, to advise State Medicaid agencies of their obligation to direct providers to screen the providers' employees and contractors for excluded persons. The SMDL also clarifies Federal laws and regulations prohibiting

Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs; and reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities.
http://www.cms.gov/SMDL/downloads/SMD011609.pdf

SMDL 10-014, Extended Period for Collection of Provider Overpayments.
This SMDL was issued July 13, 2010, to provide initial guidance on Section 6506 of the Patient Protection and Affordable Care Act, which is entitled, "Overpayments." This section was effective March 23, 2010, the date of enactment, and provides an extension of the period for collection of overpayments. For overpayments identified prior to the effective date, the previous rules on discovery of overpayments will be in effect. Section 6506 also extends the period pertaining to overpayments made due to fraud, which is defined in Federal regulations at 42 CFR sections 433.304 and 455.2. Specifically, when a State has been unable to recover overpayments due to fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share. Previously, there had been no specific exception for fraud recoveries in the statute.
http://www.cms.gov/smdl/downloads/SMD10014.pdf

SMDL 10-021, Recovery Audit Contractors (RACs) for Medicaid.

This SMDL was issued October 1, 2010, to provide preliminary guidance to States on the implementation of the Affordable Care Act (P. L. 111-148). Specifically, it provided initial guidance on section 6411 of the Affordable Care Act, *Expansion of the Recovery Audit Contractor (RAC) Program*, which amends section 1902(a)(42) of the Act. States were advised that they should attest that they would establish a Medicaid RAC program by submitting a State Plan Amendment (SPA) to CMS no later than December 31, 2010, or indicate that they would be seeking to be excepted from one or more of the proposed provisions, or indicate that they would be seeking a complete exception from establishing a Medicaid RAC program. CMS initially expected States to fully implement their RAC programs by April 1, 2011. However, on February 1, 2011, CMS issued an Informational Bulletin stating that the proposed April 1, 2011 implementation date would be delayed, in part, to ensure that State would be able to comply with the provisions of the final regulations.
http://www.cms.gov/smdl/downloads/SMD10021.pdf

17015 – SAMPLE AUDIT NOTIFICATION LETTER

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE AUDIT NOTIFICATION LETTER

AUDIT MIC LETTERHEAD

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

< Date >

Provider Number:
License Number:

< Provider Name >
< Provider Street Address >
< Provider City, State, Zip >

Dear < >:

This is to inform you that you or your facility has been selected for an audit of claims billed to Medicaid with dates of services from < > through < >. The objective of our audit is to determine whether the <type of services> claims were billed and paid in accordance with applicable Federal and <State> Medicaid laws, regulations, policies, and rules.

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program, through which the Centers for Medicare & Medicaid Services (CMS) shall conduct reviews and audits of claims submitted by Medicaid providers. As a Medicaid provider and a recipient of funds under the <State name> Medicaid program, you are subject to these reviews and audits. The DRA authorizes CMS to utilize contractors, including <Audit MIC name>, to conduct such reviews and audits.

In accordance with the DRA and other applicable Federal laws, you are required to provide CMS and its contractor, <Audit MIC name>, with timely, unrestricted access to all documents and records that relate in any way to Medicaid claims and payments.

To facilitate the audit, we are requesting that certain information/records, as shown in the enclosed document, be assembled and provided to <Audit MIC name>. The documents must be legible and arranged in an orderly manner. Be aware that this list is not all-inclusive and that <Audit MIC name> may request additional documentation necessary to conduct and complete its audit. The requested information should be forwarded to the <Audit MIC name> office at the following address within <# of days> business days from the date of this letter.

<Audit MIC Name >
< MIC Street Address >
< MIC City, State, Zip >

Any applicable State sanctions may be imposed against you if you fail to provide the information that is requested. Depending on the laws in your State, sanctions may include, but not be limited to, vendor hold and/or exclusion from participation as a provider in the <State> Medicaid program, until the matter is resolved. Additionally, payments for services for which you fail to produce records to <Audit MIC name> will be recovered from you.

<Auditor name> from <Audit MIC name> will be contacting you in the near future to schedule a telephone entrance conference. We ask that at least the <insert persons you need at entrance> and

17020 – SAMPLE LETTER FOR PI REVIEW

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SMD SAMPLE NOTICE LETTER

CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICAID INTEGRITY GROUP

Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244

[date]

[name]
[title]
[agency]
[address]
[address]

Dear Mr. /Ms. *[name]*:

This letter is to inform you that we plan to conduct a review of *[state name]*'s Medicaid program integrity procedures and processes during the week of *[date]* at your offices in *[city]*. A team from the Medicaid Integrity Group (MIG), led by *[name of Review Team Leader]* from our *[city]* Field Office, will conduct the review. You are welcome to attend the review entrance conference which has been scheduled for 9:00 AM on Monday, *[date]*.

We will make an assessment of the effectiveness of *[state name]*'s program integrity efforts. In addition, we will determine whether *[state name]*'s program integrity policies and procedures comply with Federal statutory and regulatory requirements. We are also interested in learning about effective State program integrity practices.

We have enclosed a copy of our review guide modules and a questionnaire. The information and materials requested on these documents will assist us in completing the review as efficiently as possible. Please note that your responses to the questions should be entered directly into the documents.

The FY*[year]* MCE Questionnaire should be sent to all managed care entities (MCEs) providing Medicaid services under contract or other agreement with the State Medicaid agency. Please forward all MCE responses to the FY*[year]* MCE Questionnaire to Mr./Ms. *[name of Review Team Leader]* by *[date]*. This information will be used to select MCEs to interview during the onsite review. We will ask the selected MCEs for additional information prior to the review.

Please provide responses to the following items by *[date]*:

- FY*[year]* Review Guide PI Module
- FY*[year]* Review Guide PED Module
- FY*[year]* Review Guide MC Module
- FY*[year]* Charts for All Modules

17025 – SAMPLE CLOSE OUT LETTER

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE MIC CLOSE OUT LETTER

AUDIT MIC LETTERHEAD

Provider No:

<Provider Name>
<Provider Address>

Dear Provider:

(Contractor Name) has conducted an audit on behalf of the Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity Program. This audit examined claims for <audit issue> for the time period <date 1> through <date 2>.

Based upon this audit, CMS has determined no further action is necessary at this time.. You should retain the records pertaining to the items and services that were the subject of this audit in accordance with applicable [State] and federal law. <Cite>. You are advised that all the claims that were the subject of this audit may be re-audited or reinvestigated at a future date by [name of applicable State], the CMS, or other state or federal agencies or authorities.

Thank you for your cooperation during this audit.

Sincerely,

<Name>
Audit MIC

cc: <State POC>

Bcc: DMIC POC
DFO POC
DFRD POC

17030 – SAMPLE MEMORANDUM OF UNDERSTANDING (MOU)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE

MEMORANDUM OF UNDERSTANDING BETWEEN

<STATE> MEDICAID FRAUD CONTROL UNIT

AND

CENTERS FOR MEDICARE AND MEDICAID SERVICES,
MEDICAID INTEGRITY GROUP

I. PURPOSE

This Memorandum of Understanding (MOU) is entered into by the <State> Medicaid Fraud Control Unit (MFCU), and the Centers For Medicare & Medicaid Services, Medicaid Integrity Group (CMS-MIG) in order to efficiently and effectively further their intention to combat Medicaid fraud, waste and abuse, and protect the integrity of the Medicaid Program.

II. DEFINITION

"Audit MIC" refers to a contractor of CMS-MIG that, pursuant to sections 6034(b)(2) and (3) of the Deficit Reduction Act of 2005 (42 U.S.C. § 1396u-6(c)(2)(B)), will conduct post-payment Medicaid provider audits and, as appropriate, identify Medicaid overpayments.

III. SCOPE

The scope of this MOU is limited to those referrals received by MFCU from the Department of Health and Human Services, Office of the Inspector (OIG) that OIG itself received from an Audit MIC, and the interactions that relate to those referrals. This MOU does not address the Audit MIC or CMS-MIG's responsibilities to respond to MFCU requests that are not related to referrals that originated with an Audit MIC. In addition, MFCU and CMS-MIG recognize that Audit MICs are neither required nor expected to perform case development activities.

IV. TERMS

CMS-MIG agrees:

1) To create and follow processes providing that OIG will share with MFCU all referrals it receives from the Audit MICs concerning allegations of fraud against MFCU's State Medicaid program within 14 days of OIG's receipt of such referrals, subject to certain possible law enforcement exceptions (e.g., a Federal grand jury investigation).

17035 – SAMPLE JOINT OPERATING AGREEMENT (JOA)

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

SAMPLE

Framework for Joint Operating Agreements (JOAs)
Between Audit Medicaid Integrity Contractors (MICs)
and State Medicaid Agencies (SMAs)

PURPOSE OF JOA *(required)*
In accordance with the Deficit Reduction Act (DRA) of 2005, the Centers for Medicaid & Medicare Services, Medicaid Integrity Group (CMS-MIG) is obligated to engage MICs to audit claims for payment for items or services under a State plan, and identify overpayments to individuals or entities receiving Federal funds. The JOA is an agreement between <Audit MIC name> and <State Medicaid Agency> designed to promote cooperation and collaboration between the parties, and to establish guidelines, duties, and shared expectations of how each will conduct business with each other. The JOA provides the framework for sharing information in order to complete CMS-MIG-mandated audits successfully and in a timely way, to decrease unnecessary duplication of effort by clarifying roles and responsibilities between the parties, and to improve the integrity of the Medicaid program as a whole.
(Note that because of its unique role in the process, CMS-MIG, while not a party to the agreement must approve the agreement before the MIC may sign it.)

ROLE OF AUDIT MEDICAID INTEGRITY CONTRACTORS *(required)*
The obligation of the <Audit MIC name> pursuant to its contract with CMS-MIG is to conduct audits that examine payments made to individuals or organizations providing services or items under Title XIX of the Social Security Act, as amended. As appropriate, the audits may result in the identification of potential overpayments. The types of audits to be conducted include audits of Medicaid providers, including individual practitioners, institutions, and other providers, cost report audits, and audits of managed care organizations as directed by CMS-MIG. In the course of these audits, medical documentation and other supporting information will be reviewed for paid Medicaid claims of services or items furnished under the state plan in accordance with Title XIX of the Social Security Act, as amended. <Audit MIC name> is free to set forth a detailed listing of <Audit MIC name>'s responsibilities in the JOA.

ROLE OF STATE MEDICAID AGENCY (SMA) *(required)*
The State Medicaid Agency will review and vet audit subjects; and review draft audit reports provided to it by CMS-MIG and/or the MIC. The State will participate in various communications efforts with <Audit MIC name>. The State will also assist <Audit MIC name> by providing <Audit MIC name> with information regarding the State's Medicaid laws, regulations, and policies; and provider contact information for audit subjects. In accordance with its Medicaid State Plan Amendment regarding the Medicaid Integrity Program, the State must comply with any requirements determined by CMS-MIG to be necessary for carrying out MIC audits, pursuant to Section 1902(a)(69) of the Social Security Act.

ROLE OF CMS-MIG *(required)*
CMS-MIG will exercise oversight and approval authority over the entirety of the <Audit MIC name>'s auditing processes. <Audit MIC name> will not proceed with any audit unless the proposed audit has first been approved by CMS-MIG. All audit protocols utilized by <Audit MIC name> including State protocols which <Audit MIC name> proposes to adopt, must be approved by CMS-MIG. All draft and final audit findings completed by <Audit MIC name> will be presented to CMS-MIG, which will review them, receive input from both the State and the provider who is the subject of the audit, and direct <Audit MIC name> to make changes as appropriate. Upon transmittal of a final audit report to the State, the State will be responsible for repaying the Federal share of any identified overpayment amount to CMS-MIG pursuant to 42 CFR § 433.316(a) and (e). As described below, CMS-MIG will be the point of contact for resolution of disputes between the <Audit MIC name> and the State.

17040 – SPEAKER REQUEST FORM

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

CMS SPEAKING REQUEST FORM

Save this document to your local drive. Fill it out as completely as possible, noting required fields, and save again to your local system. Please then return the completed document to the individual that sent it to you via email. Please note that ALL fields are important to complete, but those with asterisks (*) are required to process your request. ***Email this document to:*** *OASpeechRequest@cms.hhs.gov – you may also call 202-205-6306.*

** Name of event:*
** Specific Date/Time of Request:*
** Sponsoring organization:*
* Sponsor's Mailing Address
** Street:*
** City, State Zip:*
** Sponsor's main phone #:*
** Brief description of sponsoring organization (please include website address):*

Location of event site:
Building or Hotel:
** Street Address:*
** City, State:*
** Zip Code:*
(we cannot process your request without the location's zip code)

Point of contact:
** Name:*
** Phone:*
Email:

Event Information
** Event description (e.g. annual meeting, conference, seminar, board meeting):*

** Speech format (e.g. keynote address, seminar, panel participant):*

Length of speech:

Length of Q&A session:

** Proposed theme or topic for speech:*

Audience
** Number of attendees expected for this speech:*
** Attending Audience (who will hear the speech):*
** Target Audience (if different):*
(The attending audience may be cardiologists but the content is "heart disease" therefore the Target audience is "People with Heart Disease")
Event open to public or is Invitation only: ☐ Public ☐ Invitation only *Event open to press:* ☐ Yes ☐ No

Speakers
Are you requesting a specific CMS speaker? ☐ Yes ☐ No
If yes, Who?

Are there Other CMS officials speaking at the event? ☐ Yes ☐ No

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1MPI	09/23/2011	Initial Publication of Manual	09/23/2011	NA

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