CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 118 **Date: AUGUST 12, 2005**

CHANGE REQUEST 3896

SUBJECT: Various Benefit Integrity (BI) Clarifications

I. SUMMARY OF CHANGES: Various BI changes were made to chapters 1, 3, and 4 of the Program Integrity Manual (PIM). GTL was changed to Primary GTL and Co-GTL was changed to Associate GTL. Senior Medicare Patrol was added to the Harkin Grantee sections of the PIM to reflect that Harkin Grantees also go by Senior Medicare Patrol.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: September 12, 2005
IMPLEMENTATION DATE: September 12, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/1.2.1/Goal of MR Program
R	3/3.1/Introduction
R	3/3.8/Overpayment Procedures
R	3/3.9.2.6/Disposition of the Suspension
R	4/Table of Contents
R	4/4.2/The Medicare Fraud Program
R	4/4.2.2/Program Safeguard Contractor and Medicare Contractor Benefit Integrity Unit
R	4/4.2.2.1/Organizational Requirements
R	4/4.2.2.3.1/Training for Law Enforcement Organizations
R	4/4.2.2.4/Procedural Requirements
R	4/4.4.1/Requests for Information From Outside Organizations
R	4/4.4.1.1/Sharing Fraud Referrals Between the Office of the Inspector General and the Department of Justice
R	4/4.6.2/Complaint Screening
R	4/4.7/Investigations
R	4/4.7.1/Conducting Investigations
R	4/4.8/Disposition of Cases
R	4/4.8.1/Reversed Denials by Administrative Law Judges on Open Cases

R	4/4.10.1 Types of Fraud Alerts
R	4/4.10.4/Coordination
R	4/4.11.2/Investigation, Case, and Suspension Entries
R	4/4.11.2.5/Update Requirements for Cases
R	4/4.11.2.8/Closing Investigations
R	4/4.11.2.12/Deleting Investigations, Cases, or Suspensions
R	4/4.11.3.1/Access
R	4/4.12/Harkin Grantees or Senior Medicare Patrol – Complaint Tracking System
R	4/4.12.1/Harkin Grantees or Senior Medicare Patrol Project Description
R	4/4.12.2/Harkin Grantees Tracking System Instructions
R	4/4.12.3/System Access to Metaframe and Data Collection
R	4/4.12.4/Data Dissemination/Aggregate Report
R	4/4.18.1/Referral of Cases to the Office of the Inspector General/Office of Investigations
R	4/4.18.1.2/Immediate Advisements to the OIG/OI
R	4/4.18.1.3.2/Denial of Payments for Cases Referred to and Accepted by OIG/OI
R	4/4.18.1.5.2/Take Administrative Action on Cases Referred to and Refused by OIG/OI
R	4/4.18.2/Referral to State Agencies or Other Organizations
R	4/4.18.3/Referral to Quality Improvement Organizations
R	4/4.20.3.1/Referral Process to CMS
R	4/4.20.3.2/Referrals to OIG
R	4/4.24/Breaches of Assignment Agreement by Physician or Other Supplier
R	4/4.27/Annual Deceased-Beneficiary Postpayment Review
R	4/4.31/Vulnerability Report
R	Exhibits/Table of Contents
R	Exhibits/Exhibit 27/National Medicare Fraud Alert
R	Exhibits/Exhibit 28/Restricted Medicare Fraud Alert
N	Exhibits/Exhibit 38/Qualified Independent Contractor (QIC) Jurisdiction (as of March 2005)

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 118	Date: August 12, 2005	Change Request 3896

SUBJECT: Various Benefit Integrity (BI) Clarifications

I. GENERAL INFORMATION

A. Background: Various BI sections of the Program Integrity Manual (PIM) were clarified. Also, Government task leader (GTL) was changed to Primary GTL and Co-GTL was changed to Associate GTL throughout the PIM. The Division of Benefit Integrity and Law Enforcement Liaison (DBILEL) was changed to Division of Benefit Integrity Management Operations (DBIMO) to reflect the recent change in the name of the division.

B. Policy: N/A

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
							Shared System Maintainers				Other
		PSC	FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3896.1	GTL was changed to Primary GTL and Co-GTL was changed to Associate GTL.	X									
3896.2	Contractor MR staff shall coordinate and communicate with their associated PSCs or Medicare contractor BI units to ensure coordination of efforts and to prevent inappropriate duplication of review activities.	X	X	X	X	X					
3896.3	PSCs and Medicare contractor BI units shall communicate with the affiliated contractor (AC) and Medicare contractor medical review staff on all findings of overutilization and coordinate with the AC or Medicare contractor medical review staff to determine what, if any, education shall be provided before any BI investigation is pursued.	X				X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
			FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
		PSC					FISS	MCS	VMS	CWF	
3896.4	PSCs and Medicare contractor BI units shall notify law enforcement of their intention to collect outstanding overpayments in cases in which they are aware of a pending investigation.	X				X					
3896.5	After suspension has been removed, contractors and PSCs shall apply the amount withheld first to the Medicare overpayment and then to reduce any other obligation to CMS or to DHHS.	X	X	X	X	X					
3896.6	ACs and Medicare contractors shall maintain a log of all referrals to the PSC and Medicare contractor BI unit. At a minimum, the log shall include the following information: Provider/physician/supplier name, beneficiary name, HIC number, nature of the referral, date the referral is forwarded to the PSC or Medicare contractor BI unit, name and contact information of the individual who made the referral, and the name of the PSC or Medicare contractor BI unit for whom the individual works.		X	X	X	X					
3896.7	Two bullets were added in PIM chapter 4, §4.2.2.1 for those allegations or cases having the greatest program impact: 1) law enforcement requests for assistance that involve responding to court-imposed deadlines; 2) law enforcement requests for assistance in ongoing investigations that involve national interagency (HHS-DOJ) initiatives or projects.	X				X					
3896.8	One bullet was added to PIM chapter 4, §4.2.2.4 under "PSCs and Medicare contractor BI units shall ensure the performance of the functions below and have written procedures for these functions." Therefore, PSCs and Medicare contractor BI units shall, subject to the requirements in PIM chapter 4, §4.4.1, provide support to law enforcement agencies for investigations of potential fraud and abuse,	X				X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
			FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
		PSC					FISS	MCS	VMS	CWF	
	including investigations for which an initial referral to law enforcement did not originate from the PSC or Medicare contractor BI unit.										
3896.9	PSCs and Medicare contractor BI units shall follow the revisions to HIPAA requirements in PIM chapter 4, §4.4.1.	X				X					
3896.10	PSCs and Medicare contractor BI units shall ensure that before making an unannounced visit where fraud is suspected, obtain approval from the GTL (if a PSC) or RO (if a Medicare contractor BI unit) and the OI field office, and ensure that any other investigative agency is consulted with regarding the plan.	X				X					
3896.11	The PSCs shall document the date of a qualified independent contractor's (QIC's) request for information and send/transmit the requested information within 7 calendar days of the date of the QIC's request.	X									
3896.12	PSCs and Medicare contractor BI units shall follow the revisions in PIM chapter 4, §4.4.1H for fulfilling DOJ requests.	X				X					
3896.13	If law enforcement requests the PSC to perform an audit of a provider's Medicare cost report for fraud, the PSC shall consult with the GTL.	X									
3896.14	PSC analysis, reporting, and tracking (ART) was changed to CMS ART in PIM chapter 4, §4.11.2.8.	X									
3896.15	The PSC or Medicare contractor BI unit shall immediately advise OIG/OI when it receives allegations specified in PIM chapter 4, §4.18.2.	X				X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
							Shared System Maintainers				Other
		PSC	FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3896.16	If the PSC wants to follow up with the AC on referrals to the QIO concerning overpayments, the PSC should include this in the Joint Operating Agreement (JOA).	X									
3896.17	If the physician response to the contractor letter explaining his/her assignment obligations and possible sanctions is unsatisfactory and the physician persists in billing the patient for the charges that gave rise to the complaint or fails to make any refund due, the PSC or Medicare contractor BI unit shall develop (including completion of the Form SSA-2808, if received) and refer the case to the RO.	X				X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 12, 2005 **Implementation Date:** September 12, 2005 **Pre-Implementation Contact(s):** Kimberly Downin, Kimberly.downin@cms.hhs.gov **Post-Implementation Contact(s):** Kimberly Downin, Kimberly.downin@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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1.2.1 - Goal of MR Program

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Under GPRA, CMS has a goal to reduce the Medicare fee-for-service paid claims error rate. Contractors are not required to establish a baseline error rate or calculate a contractor specific error. The CERT Program will provide the baseline measurements. The goal of the MR program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR program, contractors:

- Proactively identify potential MR related billing errors concerning coverage & coding made by providers through analysis of data. (e.g., profiling of providers, services, or beneficiary utilization) and evaluation of other information (e.g., complaints, enrollment and/or cost report data) (IOM Pub.100-08, chapter 2, describes these activities in further detail.);

- Take action to prevent and/or address the identified error. Errors identified will represent a continuum of intent; (IOM Pub.100-08, chapter 3, describes these actions in further detail.)

- Place emphasis on reducing the paid claims error rate by educating the individual billing entities (i.e., providers, suppliers, or other approved clinician) that pose the greatest vulnerability to the Medicare program based on their claims submission errors; and

- Publish LCDs to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute.

Providers may conduct self-audits to identify coverage and coding errors using the Office of Inspector General (OIG) Compliance Program Guidelines at http://www.os.dhhs.gov/oig/modcomp/index.htm. Contractors must follow IOM Pub. 100-08, chapter 4, section *4.16*, in handling any voluntary refunds that may result from these provider self-audits.

Most errors do not represent fraud. Most errors are not acts that were committed knowingly, willfully, and intentionally. However, in situations where a provider has repeatedly submitted claims in error, the MR unit shall follow the procedures listed in IOM Pub.100-08, chapter 3, §3.1. For example, some errors will be the result of provider misunderstanding or failure to pay adequate attention to Medicare policy. Other errors will represent calculated plans to knowingly acquire unwarranted payment. Contractors shall take action commensurate with the error made. Contractors shall evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction. See IOM Pub. 100-08, chapter 3, §3.1.

3.1 – Introduction

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims processing rules, conditions of participation, etc.). If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.

Contractor medical review (MR) staff shall coordinate and communicate with their associated PSCs or Medicare contractor BI units to ensure coordination of efforts and to prevent inappropriate duplication of review activities.

A variety of interventions may be necessary in order to correct inappropriate behaviors. Contractors should use feedback and/or education as part of their intervention. Contractors should make sure that administrative actions are commensurate with the seriousness of the problem identified, after a limited probe is done to understand the nature and extent of the problem. Serious problems should be dealt with using the most substantial administrative actions available, such as 100 percent prepayment review, payment suspension, and use of statistical sampling for overpayment estimation of claims. Small and isolated problems should be dealt with through feedback and reevaluation after education. At any time, evidence of fraud should result in referral to the BI for development.

3.8 – Overpayment Procedures

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs shall refer all identified overpayments to the AC who shall send the demand letter and recoup the overpayment.

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, request recovery of the overpayment. PSCs and Medicare contractor BI units *shall* notify law enforcement of their intention to collect outstanding overpayments in cases in which they are aware of a pending investigation. There may be situations where OIG/OI or other law enforcement agencies might recommend that overpayments are postponed or not collected; however, this must be made on a case-by-case basis, and only when recovery of the overpayment would undermine the specific law enforcement actions planned or currently taking place. Medicare contractor BI units refer such requests to the RO (for PSCs, such requests are referred to the *Primary* GTL, *Associate* GTL, and SME). If delaying recoupment minimizes eventual recovery, delay may not be appropriate. Medicare contractor BI units must forward any correspondence received from law enforcement requesting the overpayment not be recovered to the RO (PSCs forward this to the *Primary* GTL, *Associate* GTL, and SME). The RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) will decide whether or not to recover.

If a large number of claims are involved, contractors consider using statistical sampling for overpayment estimation to calculate the amount of the overpayment. (See PIM Chapter 3, §3.10)

3.9.2.6 – Disposition of the Suspension

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Payments for appropriate Medicare claims that are withheld during a suspension should not exceed the suspected amount of overpayment. Contractors and PSCs shall maintain an accurate, up-to-date record of the amount withheld and the claims that comprise the suspended amount. Contractors and PSCs shall keep a separate accounting of payment on all claims affected by the suspension. They shall keep track of how much money is uncontested and due the provider. The amount needs to be known as it represents assets that may be *applied to reduce or eliminate* any overpayment. (See PIM, chapter 3, §3.8.) Contractors and PSCs shall be able to provide, upon request, copies of the claims affected by the suspension. After the suspension has been removed, they shall apply the amount withheld first to the *Medicare* overpayment *and then to reduce any other obligation to CMS or to DHHS*. Contractors shall remit to the provider all monies held in excess of the amount the provider owes. If the provider owes more money than was held in suspension, the contractor shall initiate recoupment action.

Medicare Program Integrity Manual
Chapter 4 – Benefit Integrity

Table of Contents
(Rev. 118, Issued: 08-12-05)

4.2 - The Medicare Fraud Program

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The primary goal of the PSC and the Medicare contractor BI unit is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped. Suspension and denial of payments and the recoupment of overpayments are an example of the actions that may be taken. All cases of potential fraud are referred to the Office of Inspector General (OIG), Office of Investigations field office (OIFO) for consideration and initiation of criminal or civil prosecution, civil monetary penalty, or administrative sanction actions. AC and Medicare contractor personnel conducting each segment of claims adjudication, Medical Review (MR), and professional relations functions shall be aware of their responsibility for identifying fraud and be familiar with internal procedures for forwarding potential fraud cases to the PSC and the Medicare contractor BI unit. Any area within the AC (e.g., medical review, enrollment, second level screening staff) that refers potential fraud and abuse to the PSC shall maintain a log of all these referrals, and all areas within the Medicare contractor shall maintain a log of all potential fraud and abuse referrals to the Medicare contractor BI unit. At a minimum, the log shall include the following information: provider/physician/supplier name, beneficiary name, HIC number, nature of the referral, date the referral is forwarded to the PSC or Medicare contractor BI unit, name *and contact information* of the individual who made the referral, *and the name of the PSC or Medicare contractor BI unit for whom the individual works.*

Preventing and detecting potential fraud involves a cooperative effort among beneficiaries, PSCs, ACs, Medicare contractors, providers, quality improvement organizations (QIOs), state Medicaid fraud control units (MFCUs), and Federal agencies such as CMS, the Department of Health and Human Services (DHHS), OIG, the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ).

Each investigation is unique and shall be tailored to the specific circumstances. These guidelines are not to be interpreted as requiring the PSCs and Medicare contractor BI units to follow a specific course of action or establishing any specific requirements on the part of the government or its agents with respect to any investigation. Similarly, these guidelines shall not be interpreted as creating any rights in favor of any person, including the subject of an investigation.

When the PSC or Medicare contractor BI unit has determined that a situation is not fraud, it shall refer these situations to the appropriate unit at the PSC, AC, or Medicare contractor.

4.2.2 - Program Safeguard Contractor and Medicare Contractor Benefit Integrity Unit

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSC and Medicare contractor BI unit is responsible for preventing, detecting, and deterring Medicare fraud. The PSC and Medicare contractor BI unit:

- Prevents fraud by identifying program vulnerabilities.
- Proactively identifies incidents of *potential* fraud that exist within its service area and takes appropriate action on each case.
- Investigates (determines the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources.
- Explores all available sources of fraud leads in its jurisdiction, including the MFCU and its corporate anti-fraud unit.
- Initiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud.
- Refers cases to the Office of the Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions (see PIM, chapter 4, §§4.18ff, 4.19ff, and 4.20ff).
- Provides outreach to providers and beneficiaries.
- Initiates and maintains networking and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups.

The PSCs and Medicare contractor BI units are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent billing practices.

Proactive (self-initiated) leads may be generated and/or identified by any internal PSC, AC, or Medicare contractor component, not just the PSC and Medicare contractor BI units (e.g., claims processing, data analysis, audit and reimbursement, appeals, medical review, enrollment). However, the PSCs and Medicare contractor BI units shall pursue leads through data analysis (PSCs shall follow chapter 2, §2.3 for sources of data), the Internet, the fraud investigation database (FID), news media, etc.

The PSCs and Medicare contractor BI units shall take prompt action after scrutinizing billing practices, patterns, or trends that may indicate fraudulent billing, i.e., reviewing data for inexplicable aberrancies (other than the expected) and relating the aberrancies to specific providers, identifying “hit and run” providers, etc. PSCs and Medicare contractor BI units shall meet periodically with staff from their respective internal components and

PSCs shall also meet with AC staff to discuss any problems identified that may be a sign of potential fraud.

Fraud leads from any external source (e.g., law enforcement, CMS referrals, beneficiary complaints) are considered to be reactive and not proactive. However, taking ideas from external sources, such as non-restricted fraud alerts and using them to look for unidentified aberrancies within PSC or Medicare contractor data is proactive.

4.2.2.1 - Organizational Requirements

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Organizationally, each Medicare contractor that has not transitioned to a PSC shall have a component responsible for the detection, development, and initiating corrective action of fraud cases. Staff supervised by a full-time unit manager shall conduct required fraud activities. This group is referred to as the Benefit Integrity unit. It may consist of employees who work full-time on Medicare fraud issues or employees who work part-time on Medicare and part-time on BI or fraud for the Medicare contractor's private line of business. If an employee works on both Medicare and private-side cases, the Medicare contractor shall not mix Medicare and private-side data. Staff from the BI unit shall identify themselves to providers with their name and the name of the PSC or Medicare contractor when making contact with providers suspected of committing fraud. If workload supports a full-time unit, it shall be a separate and distinct unit within the Medicare contractor organization and may not be combined with the MR and corporate-side PI units, i.e., it shall handle only Medicare cases. Multi-state Medicare contractors shall maintain at least one contact at each site. Separate time records shall be maintained on any part-time staff assigned to the BI unit. Large Medicare contractors shall, however, establish separate distinct BI units. Regardless of the number of personnel in the BI unit, all necessary action shall be taken to ensure the integrity of Medicare payments. This means that an effective Medicare payment safeguard program shall be in place.
Full PSCs are not required to separate their MR and BI units. However, all BI information shall be kept confidential and secure and shared with MR only on a need-to-know basis.

The PSC and Medicare contractor BI unit managers shall have sufficient authority to guide BI activities. The managers shall be able to establish, control, evaluate, and revise fraud-detection procedures to ensure their compliance with Medicare requirements.

The PSC and Medicare contractor BI unit manager shall prioritize work coming into the PSC or Medicare contractor BI unit to ensure that investigations and cases with the greatest program impact*/and or urgency* are given the highest priority. Allegations or cases having the greatest program impact would include cases involving:

- Patient abuse *or harm*.
- Multi-state fraud.
- High dollar amounts of potential overpayment.
- Likelihood for an increase in the amount of fraud or enlargement of a pattern.
- Fraud complaints made by Medicare supplemental insurers. PSCs, ACs, and Medicare contractors shall give high priority to fraud complaints made by Medicare supplemental insurers. If a referral by a Medigap insurer includes investigatory findings indicating fraud stemming from site reviews, beneficiary

interviews and/or medical record reviews, PSCs and Medicare contractor BI units shall 1) conduct an immediate data run to determine possible Medicare losses, and 2) refer the case to the OIG.

- *Law enforcement requests for assistance that involve responding to court-imposed deadlines.*

- *Law enforcement requests for assistance in ongoing investigations that involve national interagency (DHHS -DOJ) initiatives or projects.*

4.2.2.3.1 - Training for Law Enforcement Organizations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The FBI agents and DOJ attorneys need to understand Medicare. PSCs and Medicare contractors BI units shall conduct special training programs for them upon request. PSCs and Medicare contractors should also consider inviting *appropriate* DOJ, OIG, and FBI *personnel* to existing programs intended to orient employees to PSC or Medicare contractor operations, or to get briefings on specific cases or Medicare issues.

4.2.2.4 - Procedural Requirements

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Contractors shall provide written procedures for Medicare contractor BI unit personnel and for personnel in other Medicare contractor components (claims processing, MR, beneficiary services, intermediary audit, etc.) to help identify potential fraud situations. Include provisions to ensure that personnel shall:

- Refer potential fraud cases promptly to the BI unit.
- Forward complaints alleging fraud through the second level screening staff to the BI unit.
- Maintain confidentiality of referrals to the BI unit so that the civil rights of those involved are protected.
- Forward to the BI unit documentation of the details of telephone or personal contacts involving fraud issues discussed with providers or provider staff, and retain such information in individual provider files.

In addition, PSCs and Medicare contractor BI units shall ensure the performance of the functions below and have written procedures for these functions:

- Keep educational/warning correspondence with providers and other fraud documentation concerning specific issues in individual provider files (refer to §4.2.2.4.2 for retention of this documentation), so that PSCs and Medicare contractors are able to retrieve such documentation easily.
- Maintain communication and information flowing between the PSC or Medicare contractor BI unit, and the PSC, AC, or Medicare contractor MR staff, and as appropriate, intermediary audit staffs.
- *Communicate with the AC or Medicare contractor medical review staff on all findings of overutilization and coordinate with the AC or Medicare contractor medical review staff to determine what, if any, education has been provided before any BI investigation is pursued.*
- Obtain and share information on health care fraud issues/fraud investigations among carriers (including durable medical equipment regional carriers (DMERCs)), fiscal intermediaries (including rural home health intermediaries (RHHIs)), PSCs, CMS, and law enforcement.
- Serve as a reference point for law enforcement and other organizations and agencies to contact when they need help or information on Medicare fraud issues and do not know whom to contact.

- Coordinate and attend fraud-related meetings/conferences and inform all appropriate parties about these meetings/conferences. These meetings/conferences include, but are not limited to, health care task force meetings and conference calls.

- Distribute fraud alerts to the appropriate parties. Share PSC and Medicare contractor BI unit findings on fraud alerts with PSCs and Medicare contractors within the appropriate jurisdiction and CMS.

- Work with the *Primary* GTL, *Associate* GTL, and SME (if a PSC) and CMS RO (if a Medicare contractor) to develop and organize external programs and perform training as appropriate for law enforcement, ombudsmen, grantees (e.g., Harkin Grantees *or Senior Medicare Patrol*) and other CMS health care partners (e.g., AoA, state MFCU).

- Serve as a resource to CMS as necessary. For example, serve as a resource to CMS on the FID, including FID training.

- Help to develop fraud-related outreach materials (e.g., pamphlets, brochures, videos) in cooperation with beneficiary services and/or provider relations departments of the ACs and Medicare contractors, for use in their training. Submit written outreach material to the CMS RO (if a Medicare contractor) and the *Primary* GTL, *Associate* GTL, and SME (if a PSC) for clearance.

- Assist in preparation and development of fraud-related articles for AC and Medicare contractor newsletters/bulletins. The PSC and Medicare contractor BI unit shall send CMS CO a copy of these newsletters/bulletins to the following address:

  Centers for Medicare & Medicaid Services (CMS)
  Re: Newsletter/Bulletin Articles
  Division of Benefit Integrity *Management Operations*
  Mail Stop C3-02-16
  7500 Security Boulevard
  Baltimore, Maryland 21244

- Provide resources and training for the development of internal and new hire fraud training.

- Take appropriate administrative action on cases not accepted by OIG or other investigative agencies. At a minimum, provide information for recovery of identified overpayments and other corrective actions discussed in PIM, chapter 3, §8ff and §9ff.

- *Subject to the requirements in PIM, chapter 4, §4.4.1, provide support to law enforcement agencies for investigation of potential fraud and abuse, including*

investigations for which an initial referral to law enforcement did not originate from the PSC or Medicare contractor BI unit.

- Properly prepare and document cases referred to OIG/OI; two copies of a summary *report of investigation* shall be included with each fraud referral made to the OIG. The referral format listed in PIM Exhibits 16.1 and 16.2 shall be followed, unless written guidance is provided by the applicable OIG/OI office and approved by the *Primary* GTL, *Associate* GTL, and SME (if a PSC) or the applicable CMS RO (if a Medicare contractor BI unit). PSCs and Medicare contractor BI units shall maintain files on the written guidance provided by the OIG/OI.

- Meet (in-person or telephone call) quarterly, or more frequently if necessary, with OIG agents to discuss pending or potential cases.

- Meet (in-person or telephone) regularly with DOJ to enhance coordination with them on current or pending cases.

- Furnish all available information upon request to OIG/OI with respect to excluded providers requesting reinstatement.

- Ensure that all cases that have been identified where a provider consistently fails to comply with the provisions of the assignment agreement are reported by the PSC to the *Primary* GTL, *Associate* GTL, and SME; and reported by the Medicare contractor BI unit to the RO.

- Maintain documentation on the number of investigations alleging fraud, the number of cases referred to OIG/OI (and the disposition of those cases), processing time of investigations, and types of violations referred to OIG (e.g., item or service not received, unbundling, waiver of co-payment).

- Conduct investigations (including procedures for reviewing questionable billing codes), make beneficiary contacts (see PIM, chapter 4, §4.7.1 for details concerning investigations), and refer cases to and from the MR unit within your organization.

- Ensure that before making an unannounced visit where fraud is suspected, obtain approval from the *Primary* GTL (if a PSC) or RO (if a Medicare contractor BI unit), and the OI field office, and ensure that any other appropriate investigative agency is *consulted with regard to* the plan. PSC and Medicare contractor BI unit staff shall never engage in covert operations (e.g., undercover or surveillance activities). If OIG does not give approval, discuss this with the *Primary* GTL (if a PSC) or RO (if a Medicare contractor) and they will make the final decision.

- Obtain approval by e-mail, letter, or telephone call, and express any concerns (if a telephone call, follow up with a letter or e-mail) to the *Primary* GTL (if a PSC) or

to the RO (if a Medicare contractor BI unit) when the PSC or Medicare contractor BI unit is asked to accompany the OI or any other law enforcement agency when they are going onsite to a provider for the purpose of gathering evidence in a fraud case (e.g., executing a search warrant). However, law enforcement must make clear the role of PSC or Medicare contractor BI unit personnel in the proposed onsite visit. The potential harm to the case and the safety of PSC or Medicare contractor BI unit personnel shall be thoroughly evaluated. PSC or Medicare contractor BI unit personnel shall properly identify themselves as PSC or Medicare contractor BI unit employees, and under no circumstances shall they represent themselves as law enforcement personnel or special agents. Lastly, under no circumstances shall PSC or Medicare contractor BI unit personnel accompany law enforcement in situations where their personal safety is in question.

The ACs ensure the performance of the functions below and have written procedures for these functions:

- Ensure no payments are made for items or services ordered, referred, or furnished by an individual or entity following the effective date of exclusion (see PIM, chapter 4, §4.19ff for exceptions).

- Ensure all instances where an excluded individual or entity that submits claims for which payment may not be made after the effective date of the exclusion are reported to the OIG (see PIM, chapter 4, §4.19ff).

- Ensure no payments are made for an excluded individual or entity who is employed by a Medicare provider or supplier.

4.4.1 - Requests for Information From Outside Organizations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Federal and state *and local* law enforcement agencies may seek *beneficiary and provider* information to further their investigations or prosecutions of individuals or businesses alleged to have committed *health care* fraud *and other crimes for which medical records may be sought as evidence*. *When these agencies request that a PSC or Medicare contractor BI unit disclose beneficiary records or provider information, the responsive disclosure shall comply with applicable federal law as required by the HIPAA Business Associate provision of the PSC or Medicare contractor BI unit's contract. Federal law will dictate whether, and how much, requested information can be disclosed and disclosure will be contingent on the purpose for which it is sought, and whether information is sought about beneficiaries or providers.* Certain *general* information*, for example, which does not include specific beneficiary identifiers may be shared* with a broader community (including private insurers), such as the general nature of how fraudulent practices were detected, the actions being taken, and aggregated data showing trends and/or patterns.

In deciding to share information voluntarily or in response to outside requests, the PSC or Medicare contractor BI unit shall carefully review each request to ensure that disclosure would not violate the requirements of the Privacy Act of 1974 (5 U.S.C. 552a) and/or the Privacy Rule (45 CFR, Parts 160 and 164) implemented under the HIPAA.

Both the Privacy Act and the Rule seek to strike a balance that allows the flow of health information needed to provide and promote high quality health care while protecting the privacy of people who seek this care. In addition, they provide individuals with the right to know with whom their personal information has been shared and this, therefore, necessitates the tracking of any disclosures of information by the PSC or Medicare contractor BI unit. PSC and Medicare contractor BI unit questions concerning what information may be disclosed under the Privacy Act or Privacy Rule shall be directed to regional office Freedom of Information Act (FOIA)/privacy coordinator. Ultimately, the authority to release information from a Privacy Act System of Records to a third party rests with the system manager/business owner of the system of records.

The HIPAA Privacy Rule establishes national standards for the use and disclosure of individuals' health information (also called protected health information) by organizations subject to the Privacy Rule *(which are called "covered entities"). As a "business associate" of CMS, PSCs and Medicare contractor BI units are contractually required to comply with the HIPAA Privacy Rule. The Privacy Rule* restricts the disclosure of any information, in any form, that can identify the recipient of medical services unless that disclosure is expressly permitted under the Privacy Rule. *Two of the circumstances in which the Privacy Rule allows disclosure are for "health oversight activities" (45 CFR 164.512(d)) and "law enforcement purposes" (45 CFR 164.512 (f)), provided the disclosure meets all the relevant prerequisite procedural requirements in those subsections. Generally, protected health information may be disclosed to a health*

oversight agency (as defined in 45 CFR 164.501) for purposes of health oversight activities authorized by law, including administrative, civil, and criminal investigations necessary for appropriate oversight of the health care system (45 CFR 164.512(d)). The Department of Justice (DOJ), through its United States Attorneys' Offices and its headquarters-level litigating divisions, the FBI, the Department of Health and Human Services Office of Inspector General (DHHS -OIG), and other federal, state, or local enforcement agencies, are acting in the capacity of health oversight agencies when they are investigating fraud against Medicare, Medicaid, or other health care insurers or programs.

The Rule also permits disclosures for other law enforcement purposes that are not health oversight activities but involve other specified law enforcement activities for which disclosures are permitted under HIPAA, which include a response to grand jury or administrative subpoenas and court orders, and for assistance in locating and identifying material witnesses, suspects, or fugitives. The complete list of circumstances that permit disclosures to a law enforcement agency is detailed in 45 CFR 164.512(f). Furthermore, the Rule permits covered entities, and business associates acting on their behalf, to rely on the representation of public officials seeking disclosures of protected health information for health oversight or law enforcement purposes provided that the identities of the public officials requesting the disclosure have been verified by the methods specified in the Rule (45 CFR 164.514(h)).

The Privacy Act *of 1974 protects information about an individual that is collected and maintained by a federal agency in a system of records.* A "record" is any item, collection, or grouping of information about an individual that is maintained by an agency. This includes, but is not limited to, information about educational background, financial transactions, medical history, criminal history, or employment history that contains a name or an identifying number, symbol, or other identifying particulars assigned to the individual. The identifying particulars can be a finger or voiceprint or a photograph. A "system of records" is any group of records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual. *For example, Medicare beneficiary data used by the PSC or Medicare contractor BI unit are maintained in a CMS "system of records" covered by the Privacy Act.*

Information from some systems of records may be released only if the disclosure would be consistent with "routine uses" that CMS has issued and published. Routine uses specify who may be given the information and the basis or reason for access that must exist. Routine uses vary by the specified system of records, and a decision concerning the applicability of a routine use lies solely in the purview of the system's manager for each system of records. In instances where information is released as a routine use, the Privacy Act and Privacy Rule remain applicable. The Federal Register system of records notices maintained by CMS may be found on the Web site at *http://www.cms.hhs.gov/privacyact/tblsors.asp*. *For example, the Department of Health and Human Services has published a routine use which permits the disclosure of personal information concerning individuals to the Department of Justice, as needed for*

the evaluation of potential violations of civil or criminal law and for detecting, discovering, investigating, litigating, addressing, or prosecuting a violation or potential violation of law, in health benefits programs administered by CMS. See 63, Fed. Reg. 38414, (July 16, 1998).

A. Requests from Private, Non-Law Enforcement Agencies

Generally, PSCs and Medicare contractor BI units may furnish information on a scheme (e.g., where it is operating, specialties involved). Neither the name of a beneficiary or suspect can be disclosed. If it is not possible to determine whether or not information is releasable to an outside entity, Medicare contractors shall contact the CMS RO for further direction. Similarly, PSCs shall contact their *Primary* Government Task Leader (GTL), *Associate* GTL, and SME for any further guidance.

B. Requests from Medicare Contractors and Program Safeguard Contractors

The PSCs and Medicare contractor BI units may furnish requested specific information on ongoing fraud investigations and on individually identifiable protected health information to any PSC, AC, or Medicare contractor BI unit. PSCs, ACs, and Medicare contractor BI units are "business associates" of CMS under the Privacy Rule and thus are permitted to exchange information necessary to conduct health care operations. If the request concerns cases already referred to the OIG/OI, PSCs or Medicare contractor BI units shall refer the requesting PSC or Medicare contractor BI unit to the OIG/OI.

C – Requests for Information from Qualified Independent Contractors

When a Qualified Independent Contractor (QIC) receives a request for reconsideration on a claim arising from a PSC review determination, it shall first coordinate with the AC to obtain any and all records and supporting documentation that the PSC provided to the AC in support of the AC's first level appeals activities (redeterminations). As necessary, the QIC may also contact the PSC to discuss materials obtained from the AC and/or obtain additional information to support the QIC's reconsideration activities. The QIC shall send any requests to the PSC for additional information via electronic mail, facsimile, and/or telephone

***NOTE:** Iindividually identifiable beneficiary information should not be given in an e-mail.*

These requests should be minimal. The QIC shall include in its request a name, phone number, and address to which the requested information shall be sent and/or follow-up questions shall be directed. The PSC shall document the date of the QIC's request and send/transmit the requested information within 7 calendar days of the date of the QIC's request. The date of the QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the e-mail request.

If a QIC identifies a situation of potential fraud and abuse, they shall immediately refer any all related information to the appropriate PSC for further investigation.

Refer to PIM, Exhibit 38, for QIC task orders and jurisdictions.

D. Quality Improvement Organizations and State Survey and Certification Agencies

The PSCs and Medicare contractor BI units may furnish requested specific information on ongoing fraud investigations and on individually identifiable protected health information to the QIOs and State Survey and Certification Agencies. The functions QIOs perform for CMS are required by law, thus the Privacy Rule permits disclosures to them. State Survey and Certification Agencies are required by law to perform inspections, licensures, and other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards, thus the Privacy Rule permits disclosures to them. If the request concerns cases already referred to the OIG/OI, PSCs and Medicare contractor BI units shall refer the requestor to the OIG/OI.

E. State Attorneys General and State Agencies

The PSCs and Medicare contractor BI units may furnish requested specific information on ongoing fraud investigations to state Attorneys General and to state agencies. Releases of information to these entities in connection with their responsibility to investigate, prosecute, enforce, or implement a state statute, rule or regulation may be made as a routine use under the Privacy Act of 1974, as amended; 5 USC §552a(b)(3) and 45 CFR Part 5b Appendix B (5). If individually identifiable protected health information is requested, the disclosure shall comply with the Privacy Rule. See *subsection H* below and PIM Exhibit 25, for guidance on how requests should be structured to comply with the Privacy Rule. PSCs and Medicare contractor BI units may, at their discretion, share Exhibit 25 with the requestor as a template to assist them in preparing their request. If the request concerns cases already referred to the OIG/OI, PSCs and Medicare contractor BI units shall refer the requestor to the OIG/OI.

F. Request from Medicaid Fraud Control Units

Under current Privacy Act requirements applicable to program integrity investigations, PSCs and Medicare contractor BI units may respond to requests from Medicaid Fraud Control Units (MFCUs) for information on current investigations. Releases of information to MFCUs in connection with their responsibility to investigate, prosecute, enforce, or implement a state statute, rule or regulation may be made as a routine use under the Privacy Act of 1974, as amended; 5 USC §552a(b)(3) and 45 CFR Part 5b Appendix B (5). See subsection H below for further information regarding the Privacy Act requirements. If individually identifiable protected health information is requested, the disclosure shall comply with the Privacy Rule. See *subsection H* below and PIM Exhibit 25, for guidance on how requests should be structured to comply with the Privacy

Rule. PSCs and Medicare contractor BI units may, at their discretion, share Exhibit 25 with the requestor as a template to assist them in preparing their request. If the request concerns cases already referred to the OIG/OI, PSCs and Medicare contractor BI units shall refer the requestor to the OIG/OI.

G. Requests from OIG/OI for Data and Other Records

The PSCs and Medicare contractor BI units shall provide the OIG/OI with requested information, and shall maintain cost information related to fulfilling these requests. If major/costly systems enhancements are required to fulfill a request, the PSCs shall discuss the request with the *Primary* GTL, *Associate* GTL, and SME before fulfilling the request, and the Medicare contractor BI units shall discuss the request and the cost with the RO before fulfilling the request. These requests generally fall into one of the following categories:

Priority I – This type of request is a top priority request requiring a quick turnaround. The information is essential to the prosecution of a provider. Information or material is obtained from the PSC's or Medicare contractor BI unit's files. Based on review of its available resources, the PSC or Medicare contractor BI unit shall inform the requestor what, if any, portion of the request can be provided. The PSC or Medicare contractor BI unit shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested.

The PSCs and Medicare contractors BI units shall respond to such requests within 30 days whenever possible. If that timeframe cannot be met, the PSC or Medicare contractor BI unit shall notify the requesting office as soon as possible (but not later than 30 days) after receiving the request. PSCs and Medicare contractor *BI* units shall include an estimate of when all requested information will be supplied. This timeframe applies to all requests with the exception of those that require Data Extract Software System (DESY) access to NCH.

Priority II – This type of request is less critical than a Priority I request. Development requests may require review or interpretation of numerous records, extract of records from retired files in a warehouse or other archives, or soliciting information from other sources. Based on the review of its available resources, the PSC or Medicare contractor BI unit shall inform the requestor what, if any, portion of the request can be provided. The PSC or Medicare contractor BI unit shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested.

The PSCs and Medicare contractor BI units shall respond to such requests within 45 calendar days, when possible. If that timeframe cannot be met, the PSC or Medicare contractor BI unit shall notify the requesting office within the 45-day timeframe, and include an estimate of when all requested information will be supplied. This timeframe applies to all requests with the exception of those that require DESY access to national claims history (NCH).

Disclosures of information to the OIG/OI shall comply with the Privacy Rule and Privacy Act. To comply with the Privacy Act, the OIG/OI must make all data requests using the form entitled, Federal Agreement (Office of Inspector General) for Release of Data with Individual Identifiers (see Exhibit 37). To comply with the Privacy Rule, the paragraph below should be added to the form. If the OIG/OI requests protected health information that is not in a data format, e.g., copies of medical records that the PSC has in its possession, the OIG/OI should include the paragraph in its written request for the information.

The information sought in the request is required to be produced to the Office of Investigations pursuant to the Inspector General Act of 1978, 5 U.S.C. App. The information is also sought by the Office of Inspector General in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.501; 164.512(a); and 164.512(d). If the OIG provides language other than the above, the PSC shall contact the *Primary* GTL, *Associate* GTL, and SME. The Medicare contractor BI unit shall contact the RO.

H – Procedures for Sharing CMS Data With the Department of Justice

In April 1994, CMS entered into an interagency agreement with the DHHS Office of the Inspector General and the DOJ that permitted CMS contractors (PSCs and Medicare contractor BI units) to furnish information, including data, related to the investigation of health care fraud matters directly to DOJ that previously had to be routed through OIG (see PIM Exhibit 35). This agreement was supplemented on April 11, 2003, when in order to comply with the HIPAA Privacy Rule, DOJ issued procedures, guidance, and a form letter for obtaining information (see PIM Exhibit 25). CMS and DOJ have agreed that DOJ requests for individually identifiable health information will follow the procedures that appear on the form letter (see PIM Exhibit 25). The 2003 form letter must be customized to each request. The form letter mechanism is not applicable to requests regarding Medicare Secondary Payer (MSP) information, unless the DOJ requester indicates he or she is pursuing an MSP fraud matter.

The PIM, Exhibit 25, contains the entire document issued by the DOJ on April 11, 2003. PSCs and Medicare contractor BI units shall familiarize themselves with the instructions contained in this document. Data requests for individually identifiable protected health information related to the investigation of health care fraud matters will come directly from those individuals at FBI or DOJ who are involved in the work of the health care oversight agency (including, for example, *from an FBI agent,* AUSAs, *or designee such as an* analyst, *auditor,* investigator, or paralegal). For example, data may be sought to assess allegations of fraud; examine billing patterns; ascertain dollar losses to the Medicare program for a procedure, service, or time period; or conduct a random sample of claims for medical review. The law enforcement agency should begin by consulting with the appropriate Medicare contractor (usually the PSC, but possibly also the carrier, fiscal intermediary, or CMS) to discuss the purpose or goal of the data request. Requests

for cost report audits and/or associated documents shall be referred directly to the appropriate FI.

The PSCs and Medicare contractor BI units shall discuss the information needed by DOJ and determine the most efficient and timely way to provide the information. When feasible, the PSC and Medicare contractor BI unit will use statistical systems to inform DOJ of the amount of dollars associated with their investigation, and the probable number of claims to expect from a claims level data run. PSCs and Medicare BI units shall obtain and transmit relevant statistical information to DOJ (as soon as possible but no later than five (5) working days) and advise DOJ of the anticipated volume, format, and media to be used (or alternative options, if any) for fulfilling a request for claims data.

The DOJ will confirm whether a request for claims data remains necessary based on the results of statistical analysis. If so, DOJ will discuss with CMS issues involving the infrastructure and data expertise necessary to analyze and further process the data that CMS will provide to DOJ.

If DOJ confirms that claims data are necessary, DOJ will prepare a formal request letter to the PSC or Medicare contractor BI unit with existing DOJ guidance (Exhibit 25).

The PSCs and Medicare contractor BI units will provide data to DOJ, when feasible in a format to be agreed upon by the PSCs or Medicare contractor BI units and DOJ. Expected time frames for fulfilling DOJ claims level data requests will depend on the respective source(s) and duration of time for which data are sought, as follows:

- *PSC or Medicare contractor BI unit data requests that do not require coordination with other Medicare contractors and/or CMS shall be provided within 30 days of the request. (Changes to Exhibit 25 will be forthcoming by DOJ, but this timeframe and the timeframe below shall be followed and not the timeframe specified in the current Exhibit 25.)*

- *PSC or Medicare contractor BI unit data requests that require coordination with other Medicare contractors and/or CMS (except for the bullet directly below) shall be provided within 45 days of the request.*

- *PSCs or Medicare contractor BI units data requests that require Data Extract Software System (DESY) access to the National Claims History (NCH) files will have an undetermined response time.*

- *Emergency requests require coordination with Headquarters DOJ and CMS staff.*

Once the *format is agreed upon*, the law enforcement agency will send the signed 2003 form letter, identifying the appropriate authority under which the information is being sought and specifying the details of the request to the PSC or Medicare contractor BI

unit. A request for data that is submitted on the 2003 form letter is considered to be a Data Use Agreement (DUA) with CMS. In order for CMS to track disclosures that are made to law enforcement and health oversight agencies, PSCs and Medicare contractor BI units shall send a copy of all requests for data to the CMS Privacy Officer at the following address:

Centers for Medicare & Medicaid Services
Director of Division of Privacy Compliance Data Development
and CMS Privacy Officer
Mail Stop N2-04-27
7500 Security Blvd.
Baltimore, MD. 21244

CMS has established a cost limit of $200,000 for any individual data request. If the estimated cost to fulfill any one request is likely to meet or exceed this figure, a CMS representative will contact the requestor to explore the feasibility of other data search and/or production options. Few, if any, individual DOJ requests will ever reach this threshold. In fact, an analysis of DOJ requests fulfilled by CMS' central office over the course of 1 year indicates that the vast majority of requests were satisfied with a minimum of expense. Nevertheless, CMS recognizes that PSCs and Medicare contractor BI units may not have sufficient money in their budgets to respond to DOJ requests. In such cases, Medicare contractor BI units are advised to submit to CMS a Supplementary Budget Request (SBR). PSCs shall contact their *Primary* GTLs, *Associate GTLs*, and SMEs. To facilitate CMS' ability to track the frequency and burden of DOJ requests, the Medicare contractor BI unit shall maintain and submit to CMS, on a quarterly basis, a log of DOJ data requests that has been itemized to show costs for filling each request. This report should be in the form of an Excel spreadsheet (see PIM Exhibit 26) and shall include, at a minimum, the following fields:

1. Medicare contractor name and identification number

2. Date of DOJ request

3. Nature of DOJ request and DOJ tracking number, if provided

4. Cost to fulfill request

5. Medicare contractor's capacity to fill request, including date of SBR submission, if necessary

The report shall be sent to the following address:
Director, Division of Benefit Integrity *Management Operations*
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C3-02-16
Baltimore, Maryland 21244

I. Law Enforcement Requests for Medical Review

The PSCs and Medicare contractor BI units shall not send document request letters or go on site to providers to obtain medical records solely at the direction of law enforcement. However, if law enforcement furnishes the medical records and requests the PSC or Medicare contractor BI unit to review and interpret medical records for them, the PSC and Medicare contractor BI unit shall require law enforcement to put this request in writing. At a minimum, this request shall include the following information:

- The nature of the request (e.g., what type of service is in question and what should the reviewer be looking for in the medical record)
- The volume of records furnished
- Due dates
- Format required for response

The PSC shall present the written request to the *Primary* GTL, *Associate GTL*, and SME and the Medicare contractor BI unit shall present the written request to their RO prior to fulfilling the request. Each written request will be considered on a case-by-case basis to determine whether the request will be approved.

J – Law Enforcement Requests for PSC Audits of Medicare Provider Cost Reports Relating to Fraud

If law enforcement requests the PSC to perform an audit of a Medicare provider's cost report for fraud, the PSC shall consult with the AC to inquire if an audit of the cost report has already been performed. The PSC shall also consult with the Primary GTL, Associate GTL, and SME. The PSC shall provide the Primary GTL, Associate GTL, and SME with the basis for the law enforcement request and a detailed cost estimate to complete the audit. If the Primary GTL, Associate GTL, and SME approve the audit, the PSC shall perform the audit within the timeframe and cost agreed upon with law enforcement.

K – Requests from Law Enforcement for Information Crossing Several PSC Jurisdictions

If a PSC receives a request from law enforcement for information that crosses several PSC jurisdictions, the PSC shall respond back to the requestor specifying that they will be able to assist them with the request that covers their jurisdiction. However, for the information requested that is covered by another PSC jurisdiction, the PSC shall provide the requestor with the correct contact person for the inquiry, including the person's name and telephone number. Furthermore, the PSC shall inform the requestor that the Director of the Division of Benefit *Integrity Management Operations* at CMS CO is the contact person in case any additional assistance is needed. The PSC shall also copy their GTLs

and SMEs on their response back to law enforcement for these types of cross jurisdictional requests.

L. Privacy Act Responsibilities

The 1994 Agreement and the 2003 form letter (see PIM Exhibits 35 and 25 respectively) are consistent with the Privacy Act. Therefore, requests that appear on the 2003 form letter do not violate the Privacy Act. The Privacy Act of 1974 requires federal agencies that collect information on individuals that will be retrieved by the name or another unique characteristic of the individual to maintain this information in a system of records.

The Privacy Act permits disclosure of a record, without the prior written consent of an individual, if at least one of twelve disclosure provisions apply. Two of these provisions, the "routine use" provision and/or another "law enforcement" provision, may apply to requests from DOJ and/or FBI.

Disclosure is permitted under the Privacy Act if a routine use exists in a system of records.

Both the Intermediary Medicare Claims Records, System No., 09-70-0503, and the Carrier Medicare Claims Records, System No. 09-70-0501, contain a routine use that permits disclosure to:

"The Department of Justice for investigating and prosecuting violations of the Social Security Act to which criminal penalties attach, or other criminal statutes as they pertain to Social Security Act programs, for representing the Secretary, and for investigating issues of fraud by agency officers or employees, or violation of civil rights."

The CMS Utilization Review Investigatory File, System No. 09-70-0527, contains a routine use that permits disclosure to "The Department of Justice for consideration of criminal prosecution or civil action."

The latter routine use is more limited than the former, in that it is only for "consideration of criminal or civil action." It is important to evaluate each request based on its applicability to the specifications of the routine use.

In most cases, these routine uses will permit disclosure from these systems of records; however, each request should be evaluated on an individual basis.

Disclosure from other CMS systems of records is not permitted (i.e., use of such records compatible with the purpose for which the record was collected) unless a routine use exists or one of the 11 other exceptions to the Privacy Act applies.

The law enforcement provision may apply to requests from the DOJ and/or FBI. This provision permits disclosures "to another agency or to an instrumentality of any jurisdiction within or under the control of the United States for a civil or criminal law

enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought."

The law enforcement provision may permit disclosure from any system of records if all of the criteria established in the provision are satisfied. Again, requests should be evaluated on an individual basis.

To be in full compliance with the Privacy Act, all requests must be in writing and must satisfy the requirements of the disclosure provision. However, subsequent requests for the same provider that are within the scope of the initial request do not have to be in writing. PSCs shall refer requests that raise Privacy Act concerns and/or issues to the *Primary* GTL, *Associate* GTL, and SME for further consideration, and Medicare contractor BI units shall refer requests to their CMS RO.

M – Duplicate Requests for Information

The DOJ and the OIG will exchange information on cases they are working on to prevent duplicate investigations. If the PSC or Medicare contractor BI unit receives duplicate requests for information, the PSC or Medicare contractor BI unit shall notify the requestors. If the requestors are not willing to change their requests, the PSC or Medicare contractor BI unit shall ask the *Primary* GTL, *Associate* GTL, and SME (if a PSC) or CMS RO employee (if a Medicare contractor BI unit) for assistance.

N. Reporting Requirements

For each data request received from DOJ, PSCs and Medicare contractor BI units shall maintain a record that includes:

- The name and organization of the requestor
- The date of the written request (all requests must be in writing)
- The nature of the request
- Any subsequent modifications to the request
- Whether the RO, *Primary* GTL, *Associate* GTL, and SME had to intervene on the outcome (request fulfilled or not fulfilled)
- The cost of furnishing a response to each request

The Medicare contractor shall report the data to the RO when requested by the RO. This data will be used to assess budget requirements.

4.4.1.1 - Sharing Fraud Referrals Between the Office of the Inspector General and the Department of Justice

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs and Medicare contractor BI units shall include two copies of the summary *report of investigation* with each fraud referral made to the OIG. As of October 18, 1999, the OI will provide *one* copy of the *summary report of investigation along with* all related information within 5 working days to the FBI Headquarters. The referral information received from the PSC *or* Medicare contractor BI unit includes all the information relevant to the potential fraud case. The OI will copy the PSC or Medicare contractor BI unit fraud referral to the FBI and will notify the FBI of any action they will take on the referral. The OI field offices will no longer forward health care fraud referrals directly to the local FBI field office. The OI will notify PSCs and Medicare contractor BI units of its decision on the fraud referral, with specific instructions on all matters related to the referral, within 90 calendar days.

Upon receipt of fraud referrals, the OI regional field offices are required to perform one or more of the following:

- Open an investigation
- Return the matter to the PSC or Medicare contractor BI unit for further development
- Forward the referral to the local FBI office or other law enforcement agency for investigation
- Close the case with no action necessary and refer the case back to the PSC or Medicare contractor BI unit for administrative action

The PSC or Medicare contractor BI unit shall follow the instructions in PIM, Chapter 4, §4.18.1, to follow up with the OI to determine their decision after the 90-calendar-day period. The PSC or Medicare contractor BI unit is encouraged to have dialogue with law enforcement during investigations, and to discuss fraud referrals at periodic meetings. If the OI does not give the PSC or Medicare contractor BI unit a definite answer after the 90-day period, the PSC or Medicare contractor BI unit shall contact the RO to help obtain the needed information, and the PSC shall contact the *Primary* GTL, *Associate* GTL, and SME. The FBI will notify the PSC or Medicare contractor BI unit of their action on the PSC or Medicare contractor BI unit fraud referral within 45 calendar days from the day the FBI receives referral from the OI. However, if the PSC or Medicare contractor BI unit has not received feedback at the end of the 45-calendar-day period, the PSC or Medicare contractor BI unit may contact the applicable local FBI field office for a status. The PSC or Medicare contractor BI unit shall not contact the FBI Headquarters for a status of the fraud referral. In the case of multiple providers or servicing PSCs or Medicare contractor

BI units, the FBI will notify the PSC or Medicare contractor BI unit that initiated the referral as to the decision.

4.6.2 - Complaint Screening

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

This section delineates the responsibility for PSCs, ACs, and Medicare contractors with regard to screening complaints alleging fraud and abuse. This supersedes any language within the Joint Operating Agreements (JOAs).

A. Medicare Contractor and Affiliated Contractor Responsibilities

The AC and the Medicare contractor shall be responsible for screening all complaints of potential fraud and abuse. This screening shall occur in the two phases described below.

Initial Screening

Customer service representatives (CSRs) shall try to resolve as many inquiries as possible in the Initial Screening with data available in their desktop system. The CSRs shall send an acknowledgement or resolution letter for written requests within 45 calendar days of the receipt date stamped in the mailroom, unless the written request can be acknowledged or resolved over the telephone. The following are some scenarios that a CSR may receive and resolve in the initial phone call rather than refer to second-level screening (this is not an all-inclusive list):

- Lab Tests – CSRs shall ask the caller if they recognize the referring physician. If they do, remind the caller that the referring physician may have ordered some lab work for them. The beneficiary usually does not have contact with the lab because specimens are sent to the lab by the referring physician office. (Tip: ask if they remember the doctor withdrawing blood or obtaining a tissue sample on their last visit.)

- Anesthesia Services - CSRs shall check the beneficiary claims history for existing surgery or assistant surgeon services on the same date. If a surgery charge is on file, explain to the caller that anesthesia service is part of the surgery rendered on that day.

- Injections - CSRs shall check the beneficiary claim history for the injectable (name of medication) and the administration. Most of the time, administration is not payable (bundled service) (Part B only). There are very few exceptions to pay for the administration.

- Services for Spouse - If the beneficiary states that services were rendered to his/her spouse and the Health Insurance Claim Numbers (HICNs) are the same, with a different suffix, the CSR shall initiate the adjustment and the overpayment process.

- Billing Errors - If the beneficiary states that he/she already contacted his/her provider and the provider admitted there was a billing error, and the check is still

outstanding, the CSR shall follow the normal procedures for resolving this type of billing error.

- Services Performed on a Different Date - The beneficiary states that service was rendered, but on a different date. This is not a fraud issue. An adjustment to the claim may be required to record the proper date on the beneficiary's file.

- Incident to Services - Services may be performed by a nurse in a doctor's office as "incident to." These services are usually billed under the physician's provider identification number (PIN) (e.g., blood pressure check, injections, etc.). These services may be billed under the minimal Evaluation and Management codes.

- Billing Address vs. Practice Location Address - The CSR shall check the practice location address, which is where services were rendered. Many times the Medicare Summary Notice will show the billing address and this causes the beneficiary to think it is fraud.

- X-rays with Modifier 26 - The CSRs shall ask the caller if he/she recognizes the referring physician. If so, the CSR shall explain to the caller that whenever modifier 26 is used, the patient has no contact with the doctor. The CSR shall further explain that the provider billing with modifier 26 is the one interpreting the test for the referring physician.

Initial Screening activities shall be charged to Activity Code 13002 (Beneficiary and Provider Written Inquiries), Activity Code 13003 (Beneficiary and Provider Walk-in Inquiries), Activity Code 13005 (Beneficiary Telephone Inquiries), or Activity Code 33001 (Provider Telephone Inquiries), whichever is the most applicable. In fiscal year 2004, there is a separate Activity Code for Provider Written Inquiries (33002) and Provider Walk-in inquiries (33003). The current Beneficiary Inquiries Manual Instructions will be revised and the FY2004 Budget and Performance Requirements will be developed to reflect the following Performance Priorities: 1) Telephones, 2) Second Level Screening, 3) Written, and 4) Walk-in, and 5) Customer Service Plan Activities.

The CSRs shall use proper probing questions and shall utilize claim history files to determine if the case needs to be referred for second-level screening.

Any provider inquiries regarding potential fraud and abuse shall be forwarded immediately to the second-level screening staff for handling.

Any immediate advisements (e.g., inquiries or allegations by beneficiaries or providers concerning kickbacks, bribes, a crime by a Federal employee, indications of contractor employee fraud (e.g., altering claims data or manipulating it to create preferential treatment to certain providers; improper preferential treatment in collection of overpayments; embezzlement)) shall be forwarded immediately to the second-level screening staff for handling.

The initial screening staff shall maintain a log of all potential fraud and abuse inquiries. At a minimum, the log shall contain the following information:

- Beneficiary name
- Provider Name
- Beneficiary HIC#
- Nature of the Inquiry
- Date of the Inquiry
- Internal Tracking Number
- Date Referred to the Second Level Screening Staff
- Date Closed

Second-Level Screening

When the complaint/inquiry cannot be resolved by the CSR, the issue shall be referred for more detailed screening, resolution, or referral, as appropriate, within the AC or Medicare contractor. If the second level screening staff is able to resolve the inquiry without referral, they shall send a resolution letter, unless it can be resolved by telephone, within 45 calendar days of receipt from the initial screening staff, or within 30 calendar of receiving medical records and/or other documentation, whichever is later. The second-level screening staff shall maintain a log of all potential fraud and abuse inquiries received from the initial screening staff. At a minimum, the log shall include the following information:

- Beneficiary name
- Provider name
- Beneficiary HIC#
- Nature of the Inquiry
- Date received from the initial screening staff
- Date referral is forwarded to the Medicare contractor BI unit or the date it is sent to the PSC
- Destination of the referral (i.e., name of PSC or Medicare contractor BI unit)

- Documentation that an inquiry received from the initial screening staff was not forwarded to the PSC or Medicare Contractor BI Unit and an explanation why (e.g., inquiry was misrouted or inquiry was a billing error that should not have been referred to the second-level screening staff)

- Date inquiry is closed

The AC or Medicare contractor staff shall call the beneficiary or the provider, check claims history, and check provider correspondence files for educational/warning letters or contact reports that relate to similar complaints, to help determine whether or not there is a pattern of potential fraud and abuse. The AC or Medicare contractor shall request and review certain documents, as appropriate, from the provider, such as itemized billing statements and other pertinent information. If the AC or Medicare contractor is unable to make a determination on the nature of the complaint (e.g., fraud and abuse, billing errors) based on the aforementioned contacts and documents, the AC or Medicare contractor shall order medical records and limit the number of medical records ordered to only those required to make a determination. If the medical records are not received within 45 calendar days, the claim(s) shall be denied (if fraud is suspected when medical records are not received, these situations shall be referred to the PSC or Medicare contractor BI). The second-level screening staff shall only perform a billing and document review on medical records to verify and validate that services were rendered. If fraud and abuse is suspected after performing the billing and document review, the medical record shall be forwarded to the PSC (if BI work was transitioned to a PSC) or Medicare contractor BI unit for clinician review. If the AC or Medicare contractor staff determines that the complaint is not a fraud and/or abuse issue, and if the staff discovers that the complaint has other issues (e.g., medical review, enrollment, claims processing), it shall be referred to the appropriate department. In these instances, the AC or Medicare contractor shall also be responsible for acknowledging these complaints, and sending appropriate resolution letters to the beneficiary or complainant. If the AC or Medicare contractor second-level screening staff determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or Medicare contractor BI unit for further development within 45 calendar days of the date of receipt from the initial screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later. The AC or Medicare contractor shall refer immediate advisements received by beneficiaries or providers and potential fraud or abuse complaints received by current or former provider employees immediately to the PSC or Medicare contractor BI unit for further development.

The AC or Medicare contractor shall be responsible for screening all Harkin Grantees *or Senior Medicare Patrol* complaints for fraud. If after conducting second level screening, the AC or Medicare contractor staff determines that the complaint is a potential fraud and abuse situation, the complaint shall be sent to the PSC or Medicare contractor BI unit within 45 calendar days of the date of receipt from the initial screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later. The complainant shall be clearly identified to the PSC or Medicare contractor BI

unit as a Harkin Grantees *or Senior Medicare Patrol* complaint. The AC or Medicare contractor shall be responsible for entering all initial referrals identified in the second-level screening area and any updates received from the PSC or Medicare contractor BI unit into the Harkin Grantees Tracking System (HGTS).

The AC or Medicare contractor shall be responsible for downloading and screening complaints from the OIG Hotline Database, and for updating the database with the status of all complaints. If the AC or Medicare contractor determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or Medicare contractor BI unit for further development within 45 calendar days of receipt, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later, just like all other complaints. The PSC or Medicare contractor BI unit shall be responsible for updating the valid cases that have been referred. PSCs and Medicare contractors shall control all OIG Hotline referrals by the OIG Hotline number (the "H" or "L" number) as well as by any numbers used in the tracking system. PSCs and Medicare contractors shall refer to this number in all correspondence to the RO.

Complaints shall be forwarded to the Medicare contractor BI unit or PSC for further investigation under the following circumstances (this is not intended to be an all inclusive list):

- Claims forms may have been altered or upcoded to obtain a higher reimbursement amount.

- It appears that the provider may have attempted to obtain duplicate reimbursement (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to be paid twice). This does not include routine assignment violations. An example for referral might be that a provider has submitted a claim to Medicare, and then in two days resubmits the same claim in an attempt to bypass the duplicate edits and gain double payment. If the provider does this repeatedly and the AC or Medicare contractor determines this is a pattern, then it shall be referred.

- Potential misrepresentation with respect to the nature of the services rendered, charges for the services rendered, identity of the person receiving the services, identity of persons or doctor providing the services, dates of the services, etc.

- Alleged submission of claims for non-covered services are misrepresented as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs).

- Claims involving potential collusion between a provider and a beneficiary resulting in higher costs or charges to the Medicare program.

- Alleged use of another person's Medicare number to obtain medical care.

- Alleged alteration of claim history records to generate inappropriate payments.

- Alleged use of the adjustment payment process to generate inappropriate payments.

- Any other instance that is likely to indicate a potential fraud and abuse situation.

When the above situations occur, and it is determined that the complaint needs to be referred to the PSC or Medicare contractor BI unit for further development, the AC or Medicare contractor shall prepare a referral package that includes, at a minimum, the following:

- Provider name, provider number, and address.

- Type of provider involved in the allegation and the perpetrator, if an employee of the provider.

- Type of service involved in the allegation.

- Place of service.

- Nature of the allegation(s).

- Timeframe of the allegation(s).

- Narration of the steps taken and results found during the AC's or Medicare contractor's screening process (discussion of beneficiary contact, if applicable, information determined from reviewing internal data, etc.).

- Date of service, procedure code(s).

- Beneficiary name, beneficiary HICN, telephone number.

- Name and telephone number of the AC or Medicare contractor employee who received the complaint.

NOTE: Since this is not an all-inclusive list, the PSC or Medicare contractor BI unit has the right to request additional information in the resolution of the complaint referral or the subsequent development of a related case (e.g., provider enrollment information).

When a provider inquiry or complaint of potential fraud and abuse or immediate advisement is received, the second-level screening staff will not perform any screening, but will prepare a referral package and send it immediately to the PSC or Medicare contractor BI unit. The referral package shall consist of the following information:

- Provider name and address.

- Type of provider involved in the allegation and the perpetrator, if an employee of a provider.

- Type of service involved in the allegation.

- Relationship to the provider (e.g., employee or another provider).

- Place of service.

- Nature of the allegation(s).

- Timeframe of the allegation(s).

- Date of service, procedure code(s).

- Name and telephone number of the AC or Medicare contractor employee who received the complaint.

The AC and Medicare contractor shall maintain a copy of all referral packages.

The AC or Medicare contractor shall report all costs associated with second-level screening of inquiries for both beneficiaries and providers in Activity Code 13201. Report the total number of second-level screening of beneficiary inquiries that were open and closed (report the same complaint only once) in workload column 1; report the total number of medical records ordered for beneficiary inquiries that were open and closed (report the same complaint only once) in workload column 2; and report the total number of potential fraud and abuse beneficiary complaints identified and referred to the PSC or Medicare contractor BI unit in workload column 3. The AC or Medicare contractor shall keep a record of the cost and workload for all provider inquiries of potential fraud and abuse that are referred to the PSC or Medicare contractor BI unit in Activity Code 13201/01.

NOTE: The same complaint shall only be counted once in the same month. However, it is possible that the same complaint will be counted more than once from month to month (e.g., counted as opened in October; pending in November; and closed in December). Open indicates any complaints opened and pending in the reporting month.

B – Program Safeguard Contractor and Medicare Contractor Benefit Integrity Unit Responsibilities

At the point the complaint is received from the AC or Medicare contractor screening staff, it shall be the responsibility of the PSC or Medicare contractor BI unit to further

investigate the complaint, resolve the complaint investigation, or make referrals as needed to appropriate law enforcement entities or other outside entities.

It shall be the responsibility of the PSC or the Medicare contractor BI unit to send out acknowledgement letters for complaints received from the AC or Medicare contractor. The AC or Medicare contractor shall be responsible for screening and forwarding the complaints within 45 calendar days from the date of receipt by the second level screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later, to the PSC or Medicare contractor BI unit. The PSC or Medicare contractor BI unit shall send the acknowledgement letter within 15 calendar days of receipt of the complaint referral from the AC or Medicare contractor second-level screening staff, unless it can be resolved sooner. The letter shall be sent out on PSC or Medicare contractor BI unit letterhead and shall contain the telephone number of the PSC or Medicare contractor BI unit analyst handling the case.

If the PSC or Medicare contractor BI unit staff determines, after investigation of the complaint, that it is not a fraud and/or abuse issue, but has other issues (e.g., medical review, enrollment, claims processing, etc.), it shall be referred to the AC or Medicare contractor area responsible for second-level screening, or if applicable, the appropriate PSC unit for further action. This shall allow the AC or Medicare contractor screening area to track the complaints returned by the PSC or Medicare contractor BI unit. However, the PSC or Medicare contractor BI unit shall send an acknowledgement to the complainant, but indicate that a referral is being made, if applicable, to the appropriate PSC, or to the appropriate AC or Medicare contractor unit for further action.

The PSC or Medicare contractor BI unit shall be responsible for communicating any updates as a result of their investigation on Harkin Grantees *or Senior Medicare Patrol* complaints to the AC or Medicare contractor second-level screening staff, who shall update the database accordingly.

The PSC or Medicare contractor BI unit shall be responsible for updating valid cases that have been referred from the OIG Hotline Database by the AC or Medicare contractor second-level screening area.

The PSC or Medicare contractor BI unit shall be responsible for sending the complainant a resolution within 7 calendar days of the resolution on the complaint investigation and/or case in accordance with PIM Chapter 4, §4.8.

4.7 - *Investigations*

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

An investigation is the analysis performed on both proactive and reactive leads (e.g., complaints, data analysis, newspaper articles) in an effort to substantiate the lead or allegation as a case. However, not all investigations will result in cases.

When PSCs or Medicare contractor BI units receive an allegation of fraud, or identify a potentially fraudulent situation, they shall investigate to determine the facts and the magnitude of the alleged fraud. They shall also conduct a variety of reviews to determine the appropriateness of payments, even when there is no evidence of fraud. Prioritization of the investigation workload is critical to ensure that the resources available are devoted primarily to high-priority investigations. (Complaints by current or former employees require immediate advisement to the OIG/OI. OIG/OI may request that PSCs or Medicare contractor BI units perform only limited internal investigation and then immediately refer the case to them.)

The PSCs and Medicare contractor BI units shall maintain files on all investigations. The files shall be organized by provider or supplier and shall contain all pertinent documents, e.g., original referral or complaint, investigative findings, reports of telephone contacts, warning letters, documented discussions, *any data analysis or analytical work involving the potential subject or target of the investigation,* and decision memoranda regarding final disposition of the investigation (refer to §4.2.2.4.2, for retention of these documents).

Under the terms of their contract, PSCs shall investigate potential fraud on the part of providers, suppliers, and other entities who receive reimbursement under the Medicare program for services rendered to beneficiaries. PSCs shall refer potential fraud cases to law enforcement and provide support for these cases. In addition, PSCs may provide data and other information related to potential fraud cases initiated by law enforcement when the cases involve entities *or individuals* who receive reimbursement under the Medicare program for services rendered to beneficiaries.

The work a PSC performs under its contract does not extend to investigations of ACs and Medicare contractors. PSCs are not authorized to assist a law enforcement agency that may be investigating allegations of fraud or other misconduct against an AC or a Medicare contractor. Requests for assistance of this nature shall be directed to the CMS CO Contractor Compliance Officer, Acquisitions and Grants Group.

4.7.1 – Conducting Investigations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

When the complaint cannot be dismissed by the AC or Medicare contractor second-level screening staff as an error or a misunderstanding, *unless otherwise advised by law enforcement,* PSCs and Medicare contractor BI units shall use one or more of the following investigative methods to determine whether or not there is a pattern of submitting false claims. (The list is not intended to be all-inclusive.)

- Review a small sample of claims submitted within recent months. Depending on the nature of the problem, the PSC or Medicare contractor BI unit may need to request medical documentation or other evidence that would validate or cast doubt on the validity of the claims.

- Interview by telephone a small number of beneficiaries. Do not alarm the beneficiaries or imply that the provider did anything wrong. The purpose is to determine whether there appear to be other false claims or if this was a one-time occurrence.

- Look for past contacts by the PSC or the Medicare contractor BI unit, or the MR unit concerning comparable violations. Also, check provider correspondence files for educational/warning letters or for contact reports that relate to similar complaints. Review the complaint file. Discuss suspicions with MR and audit staff, as appropriate.

- Perform data analysis (PSCs shall follow Chapter 2, §2.3 for sources of data).

- Review telephone calls or written questionnaires to physicians, confirming the need for home health services or DME.

- Perform random validation checks of physician licensure.

- Review original CMNs.

- Perform an analysis of high frequency/high cost, high frequency/low cost, low frequency/low cost, and low frequency/high cost procedures and items.

- Perform an analysis of local patterns/trends of practice/billing against national and regional trends, beginning with the top 30 national procedures for focused medical review and other kinds of analysis that help to identify cases of fraudulent billings.

- Initiate other analysis enhancements to authenticate proper payments.

- Perform a compilation of documentation, e.g., medical records or cost reports.

Using internal data, PSCs and Medicare contractor BI units may determine the following:

- Type of provider involved in the allegation and the perpetrator, if an employee of the provider.
- Type of services involved in the allegation.
- Places of service.
- Claims activity (including assigned and non-assigned payment data in the area of the fraud complaint).
- The existence of statistical reports generated for the Provider Audit List (PAL) or other MR reports, to establish if this provider's practice is exceeding the norms established by their peer group (review the provider practice profile).
- Whether there is any documentation available on prior complaints. Obtain the appropriate Form CMS-1490s and/or 1500s, UB-92s, electronic claims and/or attachments. Review all material available.

NOTE: Due to evidentiary requirements, do not write on these forms/documents in any manner.

After reviewing the provider's background, specialty and profile, PSCs and Medicare contractor BI units decide whether the situation, *is potential fraud or* may be more accurately categorized as a billing error. For example, records indicate that a physician has billed, in some instances, both Medicare and the beneficiary for the same service. Upon review, a PSC or Medicare contractor BI unit determines that, rather than attempting to be paid twice for the same service, the physician made an error in his/her billing methodology. Therefore, this would be considered a determination of improper billing, rather than fraud involving intentional duplicate billing.

The purpose of these activities is to decide whether it is reasonable to spend additional investigative resources. If there appears to be a pattern, the PSC and Medicare contractor BI unit shall discuss it with OIG/OI at the onset of the investigation. The PSC and Medicare contractor BI unit shall discuss with OIG/OI the facts of the investigation and obtain OIG’s recommendation on whether or not the investigation should be further developed for possible case referral to OIG/OI.

Once a case has been referred to law enforcement, the PSC and Medicare contractor BI unit shall not contact the provider or their office personnel. If there is belief that provider contact is necessary, the PSC and Medicare contractor BI unit shall consult with OIG/OI. OIG/OI will consider the situation and, if warranted, concur with such contact.

Additionally, if the suspect provider hears that its billings are being reviewed or learns of the complaint and contacts the PSC or the Medicare contractor BI unit, they shall report such contact immediately to OIG/OI.

NOTE: If investigations do not result in a case, the PSC and Medicare contractor BI unit shall take all appropriate action in order to prevent any further payment of inappropriate claims and to recover any overpayments that may have been made (the PSC and Medicare contractor BI unit shall refer to chapter 3, §3.8ff for overpayments).

4.8 - Disposition of Cases

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

A case exists when the PSC 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 a) engaged in a pattern of improper billing, b) submitted improper claims with *suspected* knowledge of their falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. This definition of a case includes any and all allegations (regardless of dollar threshold or subject matter) where PSC or Medicare contractor BI unit staff verify to their own satisfaction that there is potential Medicare fraud (the allegation is likely to be true) and a referral to law enforcement has been performed. PSCs and Medicare contractor BI units do not prove fraud; such action is within the purview of the Department of Justice. Immediate advisements shall not be considered cases (see PIM Chapter 4, §4.18.1.2).

The PSCs and Medicare contractor BI units shall summarize the case and shall send two copies of the summary *report of investigation*, with the case file, to OIG/OI. PSCs and Medicare contractor BI units shall ensure that case material is filed in an organized manner (e.g., chronological order, all pages attached with prongs or other binding material, and in the same order as summarized). When necessary, include copies of the claims (with attachments) at issue as well as copies of documentation of all educational/warning contacts with the provider that relate to this issue. See PIM Chapter 4, §4.18.1ff (Referral of Cases to Office of Inspector General/Office of Investigations) for further instruction on referrals to OIG/OI.

There may be instances when law enforcement requests that an investigation be referred before completion of the PSC or Medicare contractor BI unit investigation and case referral package. When this occurs, the PSC and Medicare contractor BI unit shall request law enforcement to send a letter or e-mail requesting immediate referral and acknowledging that the PSC or Medicare contractor BI unit did not complete their investigation and referral package. However, the PSC and Medicare contractor BI unit shall continue their investigation even though an expedited referral has been made to law enforcement in order to determine the appropriate administrative actions.

Once the case has been referred to OIG/OI, inform the complainant within 7 calendar days that the case has been referred to OIG/OI, and that further requests concerning the matter should be referred to OIG/OI. However, some cases may be sensitive and the complainant is not to be informed of the referral to OIG/OI. The PSC and Medicare contractor BI unit shall contact OIG/OI before responding to the complainant if the case is a sensitive one. Otherwise, provide the complainant with the address of OIG/OI and the name of a contact person.

Also, PSCs and Medicare contractor BI units should notify the complainant within 7 calendar days of OIG/OI completing the case. OIG/OI will make a determination as to whether or not the case is to be referred to the FBI or other law enforcement agency for

disposition. If adverse action is subsequently taken against the provider, explain to the complainant the action taken. Thank the complainant for his/her interest and diligence.

4.8.1 – Reversed Denials by Administrative Law Judges on Open Cases

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

If a case is still pending at the OIG, FBI, or AUSA, and denials are reversed by an Administrative Law Judge (ALJ), PSCs and Medicare contractor BI units should recommend to CMS that it consider protesting the ALJ's decision to pay to the DHHS Appeals Council, which has the authority to remand or reverse the ALJ's decision. PSCs and Medicare contractor BI units should be aware, however, that ALJs are bound only by statutory and administrative law (federal regulations), CMS rulings, and National Coverage Determinations.

The New York and Dallas ROs coordinate these protests. Medicare contractor BI units shall consult with their ROs before initiating a protest of an ALJ's decision, and PSCs shall consult with their *Primary* GTL, *Associate* GTL, and SME. They should be aware that the Appeals Council has only 60 days in which to decide whether to review an ALJ's decisions. Thus, CMS needs to protest the ALJ decision within 30 days of the decision, to allow the Appeals Council to review within the 60-day limit. PSCs and Medicare contractor BI units shall notify all involved parties immediately if they learn that claims/claim denials have been reversed by an ALJ in a case pending prosecution.

4.10.1 - Types of Fraud Alerts

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Below are the various types of Fraud Alerts that are issued:

A. National Medicare Fraud Alert

The most commonly issued Fraud Alert is the National Medicare Fraud Alert (NMFA). (See PIM Exhibit 27 for the NMFA template). NMFAs do not identify specific providers or other entities suspected of committing fraud. They focus on a particular scheme or scam and are intended to serve as a fraud detection lead.

The CO issues an NMFA when a fraudulent or abusive activity is perceived to be, or has the potential for being widespread, i.e., crossing PSC or Medicare contractor BI unit jurisdictions. These Alerts are numbered sequentially. Because CMS and OIG use a comparable numbering system, CMS National Medicare Fraud Alerts are identified as "CMS NMFA," followed by the Alert number appearing in the bottom left-hand corner. OIG Alerts are identified by "OIG," followed by the Alert number appearing in parenthesis in the bottom left-hand corner. The National Medicare Fraud Alert shall be put on the blue CMS fraud stationery. Medicare contractor BI units and PSCs shall distribute Alerts to all agencies in their jurisdiction within 15 working days of receipt by the PSC or Medicare contractor BI unit.

Draft National Medicare Fraud Alerts to CO shall be password protected and e-mailed to the CMS CO Director of the Division of Benefit Integrity *Management Operations*.

An NMFA shall contain the two following disclaimers, in bold print:

Distribution of this Fraud Alert is Limited to the Following Audience:

> Regional offices, Medicare Contractor Benefit Integrity units, program safeguard contractors, Medicare Integrity Program units, quality improvement organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service**,** the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspectors, the Internal Revenue Service, State surveyors, State Attorneys General, and the State Medicaid program integrity directors.
>
> This Alert is provided for educational and informational purposes only. It is intended to assist interested parties in obtaining additional information concerning potential fraud and to alert affected parties to the nature of the suspected fraud. It is not intended to be used as a basis for denial of claims or any adverse action against any provider or supplier. Such decisions must be made based on facts developed independent of this Alert.

The NMFA does not include a sanitized version, because it does not identify specific providers or entities. The sharing of NMFAs with individuals or groups that are not on the approved distribution list will be left to the discretion of the Medicare contractors BI units and/or PSCs. However, if the Medicare contractor BI units or PSCs choose to share the NMFAs beyond the approved list, the discovery and detection methodology sections shall not be included. These sections shall be disclosed only to the entities appearing on the audience line of the Fraud Alert.

B. Restricted Medicare Fraud Alert

The CMS issues an RMFA when specific providers are identified as being suspected of engaging in fraudulent or abusive practices or activities. PSCs and Medicare contractor BI units prepare this type of Alert (see PIM Exhibit 28 for the RMFA template) when advising other Medicare carriers, intermediaries, PSCs, QIOs, MFCUs, OIG, DCIS, FBI, or DOJ of a particular provider or providers suspected of fraud. These Alerts are numbered sequentially. Because CMS and OIG use a comparable numbering system, CMS Restricted Medicare Fraud Alerts are identified by "CMS RMFA," followed by the Alert number appearing in the bottom left-hand corner. Distribution is limited to PSCs, Medicare contractors, CMS, QIOs, OIG/OI, DCIS, FBI, MFCUs, U.S. Postal Service, IRS, and the Offices of the U.S. Attorney. The CO will issue each Medicare contractor BI unit and PSC one copy of an RMFA along with a sanitized version. Each Medicare contractor BI unit and PSC shall distribute said Alert to the agencies in their jurisdiction for reproduction on the red CMS fraud stationery within 15 working days of receipt by the PSC or Medicare contractor BI unit.

Draft restricted Medicare Fraud Alerts shall be e-mailed password protected via the secure e-mail system. If problems occur with the secure e-mail system, RMFAs shall be mailed to the following address:

Centers for Medicare & Medicaid Services
OFM/PIG/DBI*MO*
Mail Stop C3-02-16
7500 Security Blvd.
Baltimore, MD 21244
Attention: Fraud Alert Lead

The envelope shall be marked "personal and confidential" and "do not open in mailroom." All RMFAs shall be password protected when mailed on diskette or CD-ROM. The content of this Alert is not disclosable to the public even under the Freedom of Information Act. Public disclosure of information protected by the Privacy Act has serious legal consequences for the disclosing individual. It is intended solely for the use of those parties appearing on the audience line. It contains the names and other identifying information of provider or suppliers who are suspected of fraud.

A restricted Medicare Fraud Alert shall contain the following disclaimer exactly as below:

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this Alert.

Distribution is limited to the following audience:

Regional offices, Medicare Contractor Benefit Integrity units, program safeguard contractors, quality improvement organizations, Medicaid Fraud Control units, the Office of the Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspector offices, the Internal Revenue Service, and the State Medicaid Program Integrity Directors.

NOTE: The RMFAs will be distributed to Medicare Integrity Program units on a need to know basis.

C. CMS Central Office Alert

The PSCs and Medicare contractor BI units shall prepare a CO Alert when:

- The PSCs or Medicare contractor BI units need to notify CMS of a scheme that is about to be publicized on the national media
- The case involves patient abuse or a large dollar amount (approximately $1 million or more or potential for widespread abuse), or
- The issues involved are politically sensitive, e.g., congressional hearings are planned to accept testimony on a fraudulent or abusive practice

The Alert shall be prepared and submitted in the same manner as a NMFA but the audience line reads “CO Only.” This Alert shall be addressed to: the CMS CO Division of Benefit Integrity *Management Operations* (DBI*MO*) Director, the CO PIG Director, the CO PIG Deputy Director, and the CO Fraud Alert Lead.

D – Program Safeguard Contractor or Medicare Contractor BI Unit Alert

- Initially, this Alert generally is sent to the CO as a draft NMFA or RMFA.
- If CMS reviews the Alert and determines that it does not meet the NMFA or RMFA criteria, CMS will deny clearance and issuance.
- The CMS notifies the PSC or Medicare contractor BI unit of the Alert denial.
- If the PSC and Medicare contractor BI unit do not provide CMS with any additional information to justify reconsideration, the denial is final. However, the

PSC and Medicare Contractor BI Unit may issue denied Alerts as PSC/Medicare contractor BI unit Alerts.

- The PSC and contractor BI unit shall provide the CO Fraud Alert lead with a copy of this Alert.

E – Waiver Alerts

On occasion, the OIG waives Medicare exclusions imposed on healthcare providers. Generally, the waiver is granted if the provider is the sole community physician or sole source of essential specialized services in the community.

The CMS' Program Integrity Group will be notified by the OIG of these waivers. Upon receipt of this notification, CMS will issue a Waiver Alert to all PSCs and Medicare contractor BI units. The alert will include a copy of the OIG letter granting the waiver to the provider. The OIG letter may include exceptions to the waiver (e.g., the provider's waiver is limited to certain localities).

Upon receipt of the Waiver Alert, PSCs and Medicare contractor BI units shall provide this information to their respective ACs or Medicare contractor unit to ensure that Medicare payments are not denied inappropriately.

Additionally, CMS will post a remark to the Medicare Exclusion Database (MED) indicating that a Waiver Alert has been issued. PSCs and Medicare contractor BI units shall also monitor the MED for consistency.

4.10.4 - Coordination

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Before preparing an Alert, the PSC or Medicare contractor BI unit shall consult with the applicable RO and/or, PSC network, *Primary* GTL, *Associate* GTL, SME, and Medicare contractor BI unit manager. The PSC or Medicare contractor BI unit shall determine whether or not a similar Alert has been issued by contacting PSCs or Medicare contractor BI units in contiguous jurisdictions. If so, that Alert shall be used and the name and address of your organization shall be added to the contact section. The PSC and Medicare contractor BI unit shall forward the draft to CMS Program Integrity Group or the *Primary* GTL, *Associate* GTL, and SME (if a PSC) for review and clearance. The Program Integrity Group reviews the draft, acknowledges the Alert, and notifies the PSC or Medicare contractor BI unit whether:

- A National Medicare Fraud Alert will be issued
- A Restricted Medicare Fraud Alert will be issued, or
- The Alert should be issued as a PSC or Medicare contractor BI unit Alert

The CO keeps the PSC or Medicare contractor BI unit informed of the progress of the Alert throughout the clearance process.

4.11.2 – Investigation, Case, and Suspension Entries

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

It is not appropriate for an OIG or FBI agent, DOJ, or an Assistant United States Attorney (AUSA), to request that a PSC or Medicare contractor BI unit not enter or update an investigation, case, or payment suspension initiated by the PSC or Medicare contractor BI unit in the FID, except in rare circumstances. PSCs and Medicare contractor BI units shall inform law enforcement agents making such requests that they are required by CMS to maintain the FID and that they do not have the discretion to do otherwise. The PSC or Medicare contractor BI unit shall contact the *Primary* GTL, *Associate* GTL, and SME (if a PSC) or RO employee (if a Medicare contractor BI unit) in order to resolve the matter.

However, information regarding law enforcement activities that are, or could be considered to be, of a sensitive nature, including but not limited to, planned search warrants, undercover operations and activities, and executed search warrants, where only some of the search warrants have been executed, shall not be entered into the FID.

4.11.2.5 - Update Requirements for Cases

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

For cases referred to the OIG, the FBI, or other law enforcement agency, updates to the FID case shall be made at least every 3 months (1 month is a maximum of 31 days). If problems are encountered which undermine the PSCs' or Medicare contractor BI units' ability to get updated information, this shall be discussed with the appropriate *Primary* GTL, *Associate* GTL, and SME (if a PSC) or RO employee (if a Medicare contractor BI unit).

As applicable, the following tabs/sections shall be updated:

- Referrals accepted by OIG or FBI are assigned a case number by the OIG or FBI. It shall be the responsibility of the PSC or Medicare contractor BI unit to obtain and enter the case number into the FID Case Information tab;

- The Case Narrative section in the FID Case Information tab shall clearly identify the alleged fraudulent activity, all investigation actions, and referral activities performed on the case by the PSC or Medicare contractor BI unit. The sooner comprehensive case information is entered into FID, the more efficiently other PSCs, Medicare contractors, CMS, Medicaid, and law enforcement agencies can react to the case and perform related trend-data analysis;

- The PSC or Medicare contractor BI unit shall enter updated summary information in the FID Actions tab after the case is referred to the OIG/FBI. The status of the case and, when appropriate, actions taken by law enforcement shall be entered into the FID. If the PSC or Medicare contractor BI unit is not able to obtain status on cases referred to and accepted by law enforcement, this shall be brought to the attention of the appropriate *Primary* GTL, *Associate* GTL, and SME (if a PSC) or RO employee (if a Medicare contractor BI unit). All corrective and/or administrative actions taken by the AC, PSC, or Medicare contractor shall be entered into the FID;

- Contact with the FBI or an AUSA regarding their actions on a case;

- Capturing and documenting subsequent law enforcement referrals (e.g., OIG declines case, PSC or Medicare contractor BI unit refers case to FBI, FBI accepts case);

- Keeping apprised of MR/provider audit and reimbursement actions if they are taking actions on a case;

- Updating the amount being withheld, denied, or paid;

- Entering information on convictions/sentences; and/or,

- Adding to the case narrative section in the Case Information tab, to incorporate any updated information summarized in the Actions tab.

It is extremely important to document in the FID any consultations with law enforcement as well as administrative actions and associated monetary assessments by the PSC, Medicare contractor BI unit, or law enforcement. PSCs and Medicare contractor BI units shall be responsible for providing such documentation.

4.11.2.8 – Closing Investigations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Investigations shall be closed when they are no longer reported as an investigation on *CMS* analysis, reporting and tracking (ART) or the Medicare contractor BI unit has determined that it will not result in a case (refer to §4.7.2 for a definition of when to close an investigation). The investigation that does not result in referral of a case shall be closed by entering the following action in the ACTIONS Tab in order to indicate that the investigation has been closed:

ACTIONS Tab:

- Action Taken by: Contractor

- Action: Investigation Closed

The PSC or Medicare contractor BI unit shall also enter administrative actions, if any, it has taken as part of disposition of the investigation.

4.11.2.12 – Deleting Investigations, Cases, or Suspensions

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Investigations, cases, or suspensions can be deleted from the FID only by users with the "File Manager" (system administrator) designation. As applicable and necessary, the *Primary* GTL, *Associate* GTL, and SME or CMS RO will contact and discuss with the PSC or Medicare contractor BI unit the need to correct and/or delete an investigation, a case, or suspension from the database. In the event that a PSC or Medicare contractor decides that an investigation, a case, or suspension should be deleted from the FID, the investigation number, case number, or suspension number shall be forwarded to the FID mailbox at FID@cms.hhs.gov.

4.11.3.1 - Access

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

If PSCs, Medicare contractor BI units, and others eligible to access the FID have never applied for access to the FID system and require authorization, an "Application for Access to CMS Computer Systems" shall be completed, submitted, and approved.

This form may be acquired from http://www.cms.hhs.gov/mdcn/access.pdf. It shall be submitted to the appropriate RACF (Resource Access Control Facility) Group Administrator for all CMS central and regional offices, Medicare contractor BI unit users, or to the CO *Primary* GTL for PSCs or to the CMS Division of Benefit Integrity *Management Operations* for all law enforcement personnel or other users.

The CMS Remote Access Guide can be found at the following website: http://www.cms.hhs.gov/mdcn/cmsremoteaccessguide.pdf.

For those individuals who have received prior authorization, but are experiencing authorization lapses or password problems, the same contacts referenced above shall be contacted. Internet access problems shall be directed to the CMS IT Service Desk, at (410) 786-2580 or 1-800-562-1963.

4.12 - Harkin Grantees *or Senior Medicare Patrol* - Complaint Tracking System

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

This section provides instructions for implementing the Harkin Grantees Tracking System (HGTS).

4.12.1 - Harkin Grantees *or Senior Medicare Patrol* Project Description

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The Harkin Grantees *or Senior Medicare Patrol* (named after Senator Tom Harkin) are part of a broad initiative to combat waste, fraud, and abuse within the Medicare program. The anti-abuse initiative is supported by the partnership between the Department of Health and Human Services, Office of Inspector General, and the Administration on Aging (AOA).

The Harkin Grantees *or Senior Medicare Patrol* are senior volunteers who focus on detecting and reporting fraudulent or improper Medicare activities, primarily in home health care, nursing facilities, hospice, and durable medical equipment suppliers.

4.12.2 - Harkin Grantees Tracking System Instructions

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The AC or Medicare contractor second-level screening staff shall be responsible for collecting, tracking, and reporting the administrative and monetary results of fraud and abuse complaints generated by the Harkin Grantees *or Senior Medicare Patrol* state projects, including those complaints referred to the PSC or Medicare contractor BI unit. The AC or Medicare contractor second-level screening staff shall develop aggregate reports available to the Harkin Grantees *or Senior Medicare Patrol* state project coordinators every 6 months.

The Harkin Grantees *or Senior Medicare Patrol* State/local contact information is available at http://www.aoa.gov/smp/index.asp

4.12.3 - System Access to Metaframe and Data Collection

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The Harkin Grantees Tracking System migrated from the Winframe to the Metaframe server. Access the Metaframe system as follows:

Download the new Citrix Client and upgrade. Download the Client software:
http://download2.citrix.com/files/en/products/client/ica/current/ica32.exe

Each AC and Medicare contractor shall designate a person in the second-level screening staff to input the complaint into the HGTS database located on the Metaframe system. These designees shall enter data on a continuous basis related to complaints generated by the Harkin Grantees *or Senior Medicare Patrol* state projects.

The Harkin Grantees *or Senior Medicare Patrol* will report their complaints according to their usual procedure, using the model complaint form (PIM Exhibit 32).

Upon receiving Harkin Grantees *or Senior Medicare Patrol* complaints, the AC or Medicare contractor second-level screening staff shall enter the following information into the Metaframe database fields.

- Project number
- Date of Report
- Provider Number
- Provider Name
- Provider City
- Provider State
- AC or Medicare Contractor Number
- Overpayment Identified
- Overpayment Recovered
- Action Taken
- Further Explanation

If the PSC or Medicare contractor BI unit completes the complaint review, they shall provide the above information, as applicable, to the AC or Medicare contractor second-level screening staff for input.

4.*12*.4 - Data Dissemination/Aggregate Report

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The AC or Medicare contractor second-level screening staff shall compile information in the database into an aggregate report. The AC or Medicare contractor shall distribute the aggregate report to the Harkin Grantees *or Senior Medicare Patrol* state project coordinators every 6 months. Aggregate reports shall be distributed by the second week

of July (covering January - June data) and the second week of January (covering July - December data).

The January through June/July through December report cycle shall be continuous until further instruction.

The AC and Medicare contractors second-level screening staff shall forward copies of the aggregate reports to the CMS CO Director of the Division of Benefit Integrity *Management Operations*.

4.18.1 - Referral of Cases to the Office of the Inspector General/Office of Investigations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs and Medicare contractor BI units shall identify cases of suspected fraud and shall make referrals of all such cases to the OIG/OI, regardless of dollar thresholds or subject matter. Matters shall be referred when the PSC or Medicare contractor BI unit has documented allegations, including but not limited to: a provider, beneficiary, supplier, or other subject, a) engaged in a pattern of improper billing, b) submitted improper claims with *suspected* knowledge of their falsity, or c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. In cases where providers' employees submit complaints, such cases shall be forwarded to the OIG immediately.

When a case has been referred to OIG/OI, OIG/OI has 90 calendar days to accept the referral, refer the case to the DOJ (for example, the FBI, AUSAs, etc.), or to reject the case. If the PSC or Medicare contractor BI unit does not hear from OIG/OI within the first 90 calendar days following referral, and repeated attempts by the PSC or Medicare contractor BI unit to find out the status of the case are unsuccessful, the PSC or Medicare contractor BI unit shall contact the FBI (if the FBI does not have the case referral, the PSC and Medicare contractor BI unit shall refer the case to them) and/or refer the case to any other investigative agency with interest in the case. The PSC or Medicare contractor BI unit shall follow up on this second referral to the FBI and any other investigative agency within 45 calendar days. Refer to the FID section of the PIM for the requirements on entering and updating referrals in the FID. If OIG/OI or other law enforcement agencies will not give a definite answer, contact the *Primary* GTL, *Associate* GTL, and SME (if a PSC) or RO (if a Medicare contractor BI unit) for assistance. If OIG/OI or other law enforcement agencies do not accept the case or are still unwilling to render a decision on the case, even after the intercession of the *Primary* GTL/*Associate* GTL/ SME or RO, PSCs and Medicare contractor BI units shall proceed with action to ensure the integrity of the Medicare Trust Fund (e.g., PSCs and Medicare contractor BI units shall discuss it with the AUSA and/or the OIG prior to taking administrative action).

The OIG/OI will usually exercise one or more of the following options when deciding whether to accept a case:

- Conduct a criminal and/or civil investigation
- Refer the case back to the PSC or Medicare contractor BI unit for administrative action/recovery of overpayment with no further investigation
- Refer the case back to the PSC or Medicare contractor BI unit for administrative action/recoupment of overpayment after conducting an investigation or after consulting with the appropriate AUSA's office

- Refer the case back to the PSC or Medicare contractor BI unit for administrative action/recoupment of overpayment after the AUSA's office has declined prosecution

- Refer the case to another law enforcement agency for investigation

Where OIG/OI conducts an investigation, OIG/OI will usually initiate ongoing consultation and communication with the PSC or Medicare contractor BI unit to establish evidence (i.e., data summaries, statements, bulletins) that a statutory violation has occurred.

In addition to referral of such cases to the OIG, PSCs and Medicare contractor BI units shall also identify and take additional corrective action and prevent future improper payment (for example, by placing the provider's or supplier's claims on prepayment review). In every instance, whether or not the investigation is a potential case and law enforcement referral, the first priority is to minimize the potential loss to the Medicare Trust Fund and to protect Medicare beneficiaries from any potential adverse effect. Appropriate action varies from case to case. In one instance, it may be appropriate to suspend payment pending further development of the case. In another instance, suspending payment may alert the provider to detection of the fraudulent activity and undermine a covert operation already underway, or being planned, by federal law enforcement. PSCs and Medicare contractor BI units shall continue to monitor the need for administrative action prior to the elapsing of the 90 days and thereafter, and consult with OIG or other law enforcement agencies before taking such measures. The OIG may provide the PSC or Medicare contractor BI unit with information that shall be considered in determining what corrective action should be taken. If law enforcement is unwilling to render a decision on administrative action or advises the PSC or Medicare contractor BI unit against taking administrative action, the PSC shall contact the *Primary* GTL, *Associate* GTL, and SME and the Medicare contractor shall contact the RO. The *Primary* GTL, *Associate* GTL, and SME for a PSC and the RO for a Medicare contractor will decide whether or not to take administrative action.

The PSC or Medicare contractor BI unit shall alert *and coordinate with* OIG/OI, FBI, the civil and criminal divisions in the U.S. Attorney's Office, and the RO, of contemplated suspensions, denials, and overpayment recoveries where there is reliable evidence of fraud and a referral pending with the OIG/OI or FBI, or a case pending in a U.S. Attorney's Office *that may be known or unknown to the PSC or Medicare contractor BI unit*.

If the case is the focus of a national investigation, PSCs and Medicare contractor BI units shall not take action without first consulting with the *Primary* GTL, *Associate* GTL, and SME (if a PSC) or the RO (if a Medicare contractor BI unit), and the agency that has the lead for the investigation.

4.18.1.2 - Immediate Advisements to the OIG/OI

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSC or Medicare contractor BI unit shall immediately advise OIG/OI when it receives allegations with one or more of the following characteristics *and maintain internal documentation on these advisements*:

- Indications of PSC, AC, or Medicare contractor employee fraud.
- Cases involving an informant that is an employee or former employee of the suspect physician or supplier.
- Involvement of providers who have prior convictions for defrauding Medicare or who are currently the subject of an OIG fraud investigation.
- Situations involving the subjects of current program investigations.
- Multiple carriers involved with any one provider (OIFO coordinates activities with all involved carriers).
- Cases with, or likely to get, widespread publicity or involving sensitive issues.
- Allegations of kickbacks or bribes or a crime by a federal employee.
- Indications that organized crime may be involved.
- Indications of fraud by a third-party insurer that is primary to Medicare.

The PSCs and Medicare contractor BI units shall not expend resources attempting to investigate the allegation until so directed by CMS and/or the OIG. For example, if a PSC or Medicare contractor BI unit receives an allegation of kickbacks, the PSC or Medicare contractor BI unit shall immediately advise the OIG of the allegation, but shall not initiate an independent PSC or Medicare contractor BI unit query until requested to do so by the OIG and guidance on the parameters of the query are provided by the OIG.

When an “immediate advisement” is required, all available documentation received with the allegation shall be forwarded, unless otherwise directed by OIG. However, the initial forwarding of the applicable information does not equate to the PSC or Medicare contractor BI unit completing the full referral package as defined in the PIM (see PIM Exhibit 16.1), and does not equate to a case referral to law enforcement.

Refer to the FID section of the PIM for entering immediate advisements into the FID.

4.18.1.3.2 - Denial of Payments for Cases Referred to and Accepted by OIG/OI

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Where it is clear that the provider has not furnished the item or services, denial is the appropriate action. (See PIM Exhibit 14.) Before recommending denying payments, PSCs consult with their *Primary* GTL, *Associate* GTL, and SME, and Medicare contractor BI units consult with their RO.

4.18.1.5.2 - Take Administrative Action on Cases Referred to and Refused by OIG/OI

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs and Medicare contractor BI units take immediate action to implement appropriate administrative remedies, including the suspension or denial of payments, and the recovery of overpayments (see PIM, chapter 3, §3.8ff). Because the case has been rejected by law enforcement, PSCs shall consult with the *Primary* GTL, *Associate* GTL, and SME, and Medicare contractor BI units shall consult with their RO concerning the imposition of suspension. They pursue administrative and/or civil sanctions by OIG where law enforcement has declined a case.

A. Denial/Referral Action for Erroneous Payment(s), Cases Not Meeting the Referral Threshold

Many instances of erroneous payments cannot be attributed to fraudulent intent. There will also be cases where there is apparent fraud, but the case has been refused by law enforcement. Where there is a single claim, deny the claim and collect the overpayment. Where there are multiple instances, deny the claims, collect the overpayment, and warn the provider. PSCs and Medicare contractor BI units shall refer the provider, as appropriate, to provider relations, medical review, audit, etc.

4.18.2 - Referral to State Agencies or Other Organizations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs and Medicare contractor BI units shall refer instances of apparent unethical or improper practices or unprofessional conduct to state licensing authorities, medical boards, the QIO, or professional societies for review and possible disciplinary action. If a case requires immediate attention, they shall refer it directly to the state licensing agency or medical society and send a copy of the referral to the QIO.

Some state agencies may have authority to terminate, sanction, or prosecute under state law. It may be appropriate to refer providers to the state licensing agency, to the MFCU, or to another administrative agency that is willing and able to sanction providers that either bill improperly or mistreat their patients (see PIM, chapter 4, §4.18.1.5.3 and §4.19ff). This option is strongly recommended in instances where federal law enforcement is not interested in the case.

In each state there is a Medicare survey and certification agency. It is typically within the Department of Health. The survey agency has a contract with CMS to survey and certify institutional providers as meeting or not meeting applicable Medicare health and safety requirements, called Conditions of Participation. Providers not meeting these requirements are subject to a variety of adverse actions, ranging from bans on new admissions to termination of their provider agreements. These administrative sanctions are imposed by the RO, typically after an onsite survey by the survey agency.

Ordinarily, PSCs and Medicare contractor BI units do not refer isolated instances of questionable professional conduct to medical or other professional societies and state licensing boards. However, in flagrant cases, or where there is a pattern of questionable practices, a referral is warranted. The MR and BI units shall confer before such referrals, to avoid duplicate referrals. There is no need to compile sufficient weight of evidence so that a conclusive determination of misconduct is made prior to the referral. Rather, PSCs Medicare contractor BI units ascertain the probability of misconduct, gather available information, and leave any further investigation, review, and disciplinary action to the appropriate professional society or state board. Consultation and agreement between the MR and BI unit shall precede any referral to these agencies.

The PSC shall work closely with their *Primary* GTLs, *Associate* GTLs, and SMEs and Medicare contractor BI units shall work closely with their RO BI coordinator on these referrals. The BI coordinator shall involve the necessary staff in CMS.

Concurrently, PSCs or Medicare contractor BI units shall notify OIG/OI of any referral to medical or other professional societies and state licensing boards in cases involving unethical or unprofessional conduct. They shall include with the notification to OIG/OI copies of all materials referred to the society or board. PSCs or Medicare contractor BI units shall send OIG/OI a follow-up report on significant developments. They shall notify OIG/OI about possible abuse situations when it appears that a harmful medical practice or a sanctionable practice is occurring or has occurred.

Notice of suspension should also be given to the Medicaid SURs since a significant percent of Medicare beneficiaries are eligible for both Medicare and Medicaid and Medicaid is paying co-payments.

4.18.3 - Referral to Quality Improvement Organizations

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

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 and the QIO to:

- Ensure that an LMRP does not set up obstacles to appropriate care
- Articulate the program safeguard concerns or issues related to QIO activities
- 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 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 and the QIO have determined to be mutually beneficial.

It is essential that the PSC manager maintain an ongoing dialogue with his/her counterpart(s) at other PSCs, 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 should maintain an ongoing dialogue with the QIOs. Intermediaries may make referrals to the QIO for review of inpatient claims when outpatient claims reveal a problem provider. If the PSC 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 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.

The PSC shall coordinate the review of Part A acute care inpatient hospital claims and long term care hospital PPS claims (i.e., long term acute care, not SNFs) for benefit integrity purposes with the QIO. The PSC 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 investigation indicates a need to review Part A acute care inpatient PPS hospital medical records or long term care hospital PPS claim medical records, the PSC shall request the medical records directly from the provider and have them sent directly to the PSC. Upon receipt of the records, the PSC shall perform a billing and document review of the medical record. The PSC shall also review the medical records for medical necessity, as well as, any indications of potential fraud and abuse. The PSC shall not initiate any payment determination, provider education, overpayment calculation, or overpayment request based on these medical records. QIOs will conduct or initiate these activities as appropriate.

Following PSC review of the Part A acute care inpatient PPS hospital claims or long term care hospital PPS claims and medical records, if the PSC determines that no potential fraud and abuse has been committed, or if the PSC determines that potential fraud and abuse is likely but law enforcement rejects the case, the PSC shall refer the provider and medical records back to the QIO for further medical review, provider education, or the initiation of overpayment calculation, payment determination, and overpayment request. *If the PSC wants to follow up with the AC on such referrals concerning the overpayments, the PSC should include this in the JOA.*

If after the PSC reviews the Part A acute care inpatient PPS hospital claims or long term care hospital PPS claims and medical records, the PSC determines that potential fraud and abuse is likely, the PSC shall coordinate the case with law enforcement (per Law Enforcement Memorandum of Understanding). If law enforcement accepts the case, law enforcement may then coordinate directly with the QIO for any further medical review.

The PSC shall not involve the QIO in reviews at other types of hospitals.

4.20.3.1 - Referral Process to CMS

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Compliance is promoted through both administrative and formal legal actions. Administrative compliance action shall first be attempted by ACs and Medicare contractors through education and warning letters that request the provider to comply with Medicare's rules and regulations. If the provider fails to take corrective action and continues to remain non-compliant, the AC shall make a referral to the PSC who shall forward it to the *Primary* GTL, *Associate* GTL, and SME and the CMS CO Director of the Division of Benefit Integrity *Management Operations* (see PIM Chapter 4, §4.20.3.2). The Medicare contractor shall make a referral to the Medicare contractor BI unit who shall prepare a referral of a CMP case and shall forward it to its respective CMS RO component that has oversight of the Medicare Integrity Program and CMS CO DBI*MO* (see PIM Chapter 4, §4.20.3.2).

It is important for ACs and Medicare contractors to promote program compliance in their respective jurisdictions. The ACs and Medicare contractors shall ensure that all materials presented to providers through education, published bulletins, or written communication are clear and concise and accurately represent the facts of compliance versus non-compliance. Providers shall also be allowed the opportunity to present additional facts that may represent mitigating circumstances. PSCs and Medicare contractor BI units shall consider this information in an objective manner before proceeding with a CMP referral to CMS.

When a PSC or Medicare contractor BI unit elects to make a CMP referral to CMS, the initial referral package shall consist of a brief overview of the case; supportive documentation is not required at such time. The initial referral package shall consist of:

1. Identification of the provider, including the provider's name, address, date of birth, Social Security number, Medicare identification number(s), and medical specialty. If the provider is an entity, include the names of its applicable owners, officers, and directors.

2. Identification of the CMP authorities to be considered (use the authorities identified in PIM Chapter 4, §4.20.2.1).

3. Identification of any applicable Medicare manual provisions.

4. A brief description of how the violations identified above were discovered, and the volume of violations identified.

5. Total overpayments due the program or the beneficiary(ies), respectively.

6. A brief chronological listing of events depicting communication (oral and written) between the AC or Medicare contractor and the provider.

7. A brief chronological listing of bulletins addressing the non-compliant area (starting with the bulletin released immediately prior to the first incident of non-compliance by the provider).

8. Any additional information that may be of value to support the referral.

9. The name and phone number of contacts at the PSC or Medicare contractor BI unit.

Upon receipt of the above information, CMS staff will review the materials and conduct follow-up discussions with the PSC or Medicare contractor BI unit regarding the referral. Within 90 days of receipt of the referral, CMS will notify the PSC or Medicare contractor BI unit of its decision to accept or decline the referral.

If CMS declines the referral, the PSC or Medicare contractor shall communicate this to the AC or the appropriate Medicare contractor unit to continue in their efforts to educate and promote compliance by the provider. The PSC or Medicare contractor BI unit shall also consider other (less severe) administrative remedies, which, at a minimum, may include revocation of assignment privileges, establishing prepayment or postpayment medical reviews, and referral of situations to state licensing boards or medical/professional societies, where applicable. In all situations where inappropriate Medicare payments have been identified, ACs and Medicare contractors shall initiate the appropriate steps for recovery.

If CMS accepts the referral, the PSC and Medicare contractor BI unit shall provide any supportive documentation that may be requested, and be able to clarify any issues regarding the data in the case file or PSC, AC, and Medicare contractor processes.

4.20.3.2 - Referrals to OIG

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Upon discovery of any case that may implicate any of the OIG's delegated CMP authority, regardless of whether there is any other pending activity, or whether the fraud case was closed, the PSC or Medicare contractor BI unit shall contact the OIG/OI Field Office to discuss the potential case. If this contact results in a referral, the PSC or Medicare contractor BI unit shall follow the same referral format as described in PIM, chapter 4, §4.18.1.4. If a referral is not made or a referral is declined, the PSC or Medicare contractor BI unit shall consider other administrative remedies, which, at a minimum, may include revocation of assignment privileges, establishing prepayment or postpayment medical reviews, and referral of situations to sate licensing boards or medical/professional societies, where applicable. In all situations where appropriate Medicare payments have been identified, ACs and Medicare contractors shall initiate the appropriate steps for recovery.

The PSC and Medicare contractor BI unit shall send to the OIG all cases, as appropriate, where an excluded provider or individual has billed or caused to be billed to the Medicare

or Medicaid program for the furnishing of items or services after exclusion. Such misconduct is sanctionable under §1128A(a)(C)(1) of the Social Security Act.

The PSC or Medicare contractor BI unit shall send to CMS DBI*MO* all cases where the PSC or the Medicare contractor BI unit believes that misuse has occurred of the Medicare name, symbols, emblems, or other violations as described in §1140 of the Social Security Act and in 42 CFR 1003.102(b)(7). CMS will be responsible for referring these types of cases to OIG. All such cases shall be sent to the following CMS address:

Centers for Medicare & Medicaid Services
Division of Benefit Integrity *Management Operations*
Mail Stop C3-02-16
7500 Security Blvd
Baltimore, MD 21244

4.24 - Breaches of Assignment Agreement by Physician or Other Supplier

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

A. Criminal Penalty

The law provides that any person who accepts an assignment of benefits under Medicare, and who "knowingly, willfully, and repeatedly" violates the assignment agreement, shall be guilty of a misdemeanor and subject to a fine of not more than $2,000, or imprisonment of not more than 6 months, or both.

B. Administrative Sanction

The CMS may revoke the right of a physician (or other supplier, or the qualified reassignee of a physician or other supplier) to receive assigned benefits, if the physician (or other party) who has been notified of the impropriety of the practice:

- Collects or attempts to collect more than the Medicare-allowed charge as determined for covered services after accepting assignment of benefits for such items or services, or

- Fails to stop collection efforts already begun or to refund monies incorrectly collected.

C. Civil Monetary Penalties (CMPs)

The statute provides for CMPs of up to $2,000 per item or service claimed against any person who violates an assignment agreement.

D. Action by ACs or Medicare Contractors on Receipt of Initial Complaint

Upon receipt of the initial assignment agreement violation complaint or complaints against a physician, ACs and Medicare contractors shall develop the facts to ascertain whether the allegation is valid, regardless of whether the complaint is referred from an SSA FO, an OIFO, a beneficiary, or the RO.

If a violation has occurred, the AC or Medicare contractor shall contact the physician in person, by phone, or by mail to explain the obligations assumed in accepting assignment and to obtain his/her assurance that improperly collected monies are being refunded and that further billings in violation of the assignment agreement will cease. The AC or Medicare contractor shall inform the physician of the possible criminal penalty discussed in subsection A (above), the possible administrative sanction (i.e., revocation of the assignment privilege) discussed in subsection B, and the possible CMPs discussed in subsection C. The dates and other particulars of the contact with the physician shall be recorded.

The AC or Medicare contractor shall supplement any personal or phone contact with a letter to the physician explaining his/her assignment obligations and the possible sanctions. The AC or Medicare contractor shall close the case with that letter if the physician response is satisfactory.

A satisfactory response shall include, at a minimum, the following:

- The physician acknowledges the obligations of the assignment agreement and agrees:
    - To make any necessary refund
    - To credit the refund due against other amounts owed, and
    - To stop further incorrect billing and to refund or credit any amount due the complainant as verified by the AC or Medicare contractor.

If the physician response is unsatisfactory, the AC or Medicare contractor shall refer the case to the PSC or the Medicare contractor BI unit for further action. The action taken by the PSC or Medicare contractor BI unit depends on the circumstances. If the physician persists in billing the patient for the charges that gave rise to the complaint or fails to make any refund due, the PSC or Medicare contractor BI unit shall *develop (including completion of the SSA-2808, if received)* (see PIM Chapter 4, §4.24H) and refer the case to the RO for initiation of steps to revoke the physician's assignment privilege. However, the RO may find it desirable to give the physician further written warning before undertaking such action.

If the physician, after having been warned, has violated his/her assignment agreement in connection with additional claims, see subsection E, below.

E. Action by Program Safeguard Contractor or Medicare Contractor Benefit Integrity Unit When Violations Occur After Warning

Upon receipt of a new assignment violation complaint(s) after a physician has been given the warning described in subsection D, the PSC or Medicare contractor BI unit shall develop the facts and shall refer the case to the RO with a report, regardless of whether the complaint is referred from an SSA FO, OIFO, or RO. PSCs or Medicare contractor BI units may wish to substitute an oral report to the RO in situations where the PSC or Medicare contractor BI unit has resolved the repeat violation. The RO considers whether to initiate action to revoke the physician's assignment privilege.

F. Procedure for Revoking Assignment Privilege

The RO may revoke assignment privileges when prosecution is inappropriate or not feasible. The RO notifies the physician of the proposed revocation of his right to receive assigned benefits and gives him/her 15 days to submit a statement, including any

pertinent evidence, explaining why his/her right to payment should not be revoked. After the statement is received, or the 15-day period expires without the filing of the statement, the RO determines whether to revoke the physician's right to receive payment. If the determination is to revoke the physician's right to receive payment, the RO notifies the AC or Medicare contractor to suspend payment on all assigned claims received after the effective date of the revocation. The RO also notifies the physician of the revocation, and of his/her right to request a formal hearing on the revocation within 60 days. (The RO may extend the period for requesting a hearing.)

If the physician requests a formal hearing (to be conducted by a member of the Hearing Staff of the Office of Budget and Administration, CMS) and the hearing officer reverses the revocation determination, the RO instructs the AC or Medicare contractor to pay the physician's claims.

If the hearing officer upholds the revocation determination, or if no request for a hearing is filed during the period allowed, the RO instructs the AC or Medicare contractor to make any payments otherwise due the physician to the beneficiary who received the services or to another person or organization authorized under the law and regulations to receive the payments. (See the IOM, *Claims Processing Manual, Pub. 100-04, chapter 1, §30.2* for payment to a representative payee or legal representative.) If the beneficiary is deceased, ACs or Medicare contractors shall make payment in accordance with the requirements of the *IOM, Claims Processing Manual, Pub. 100-04, chapter 1,* §§*30.2.15, 50.1.3-50.1.6* to the person who paid the claim, to the legal representative of the beneficiary's estate, or to his/her survivors. (ACs or Medicare contractors shall not make payment to the physician.) The revocation remains in effect until the RO finds that the reason for the revocation has been removed and there is reasonable assurance that it will not recur. The RO's decision to continue the revocation is not appealable.

When the right of a person or organization to receive assigned payment is revoked, the revocation applies to any benefits payable to that person or organization throughout the country. The RO is responsible for notifying those ACs or Medicare contractors who are likely to receive claims.

See *IOM, Pub. 100-04, chapter 1, §§30.2-30.2.8.3* for the effect of revocation of a physician's or other person's assignment privileges on the right of a hospital or other entity to accept assignment for his/her services. This section also contains information concerning the effect of revocation of a hospital's or other entity's assignment privileges on the right of a physician or other person for whom it has been billing to bill for his/her own services.

G. Other Considerations

Because of the government's responsibility to prosecute persons who repeatedly violate the assignment agreement, effective monitoring of such offenses is very important. The factors involved in each case may vary, and PSCs and Medicare contractor BI units shall discuss with the RO, OIFO as appropriate, any situation where the PSCs and Medicare

contractor BI units believe that legal or administrative action is necessary. In addition, PSCs and Medicare contractor BI units shall utilize the specific control measures and referral procedures in accordance with RO/OIG-OI direction. The RO may review the AC's or Medicare contractor's actions to assure that assignment violations are being properly tracked and reported.

The ACs and Medicare contractors shall notify physicians and other suppliers of the implications of §1842(b)(3)(ii) of the Act, since the penalties for violations of the assignment agreement are significant. ACs and Medicare contractors shall use the language contained in these letters, or similar language, when contacting providers regarding assignment violation. ACs and Medicare contractors shall ensure that all physicians are made aware of the penalties that can be imposed. This deters assignment violations and works against a defense by physicians that they had no knowledge of these laws.

H. Form for Reporting Assignment Agreement Violations

Form SSA-2808, Notice of Reported Assignment Agreement Violation, is specifically designed for SSA FOs and ACs and Medicare contractors to use in handling assignment agreement violations. SSA FOs use this form for referral and control of complaints. ACs and Medicare contractors use it to report action on complaints.

SSA FOs are responsible for completing sections one and two completely and clearly. They are to forward the original plus one copy and a second copy is to be sent to the servicing RO. A third copy is kept by the SSA FO for control and follow-up purposes. A fourth copy is sent to the appropriate RO for informational purposes.

In the event that there is an undue delay (in excess of 45 days) by the AC or Medicare contractor in processing complaints, the SSA FO sends periodic interim reports (monthly) to beneficiaries/complainants informing them that as soon as action is taken, notification will be sent to them. This action precludes excessive inquiries to the AC or Medicare contractor. If an SSA FO wishes to determine the status of the complaint, it contacts the RO.

The ACs or Medicare contractors shall complete section 3 of the Form SSA-2808 and forward a copy to the RO when appropriate action is completed. The RO notifies the originating SSA FO of the action taken.

4.27 - Annual Deceased-Beneficiary Postpayment Review

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The PSCs and Medicare contractor BI units shall identify and initiate actions to recover payments with a billed date of service that is after the beneficiary's date of death. The identification of improperly paid claims shall be performed at a minimum on an annual fiscal year basis for beneficiaries who died the previous fiscal year. In addition, the PSCs shall forward the identified overpayments to the AC for recoupment. The associated overpayment recoupment shall be initiated as soon as administratively possible.

EXAMPLE: Services rendered to beneficiaries who died during fiscal year 2002 - PSCs and Medicare contractor BI units must identify improperly paid services. Upon identification, PSCs and Medicare contractors will refer this information to their respective AC or appropriate area within the Medicare contractor for recoupment. ACs and Medicare contractors must issue associated overpayment demand letters as soon as administratively possible.

The PSCs, ACs, and Medicare contractors are not required to perform medical review for paid claims with dates of service after a beneficiary's date of death. PSCs and Medicare contractor BI units shall identify the service that has been rendered after the beneficiary's date of death, and refer it to their respective AC or appropriate area within the Medicare contractor. Subsequent notification to the provider that an improper payment has been made, for which recovery is being sought, shall be initiated by the AC or the Medicare contractor.

At a minimum, PSCs and Medicare contractor BI units shall identify deceased beneficiaries and associated improperly paid claims by using one of the following two options:

- Utilize Internal Beneficiary Eligibility Records - This option involves performing a data extract against eligibility files for all beneficiaries within the PSC's or Medicare contractor BI unit's jurisdiction and identifying those beneficiaries who have died during the applicable fiscal year. Once the list of deceased beneficiaries has been identified, PSCs and Medicare contractor BI units utilize the claims processing history files to identify any services/claims containing a paid date of service that is after the CWF-posted date of death.

- Utilize External Beneficiary Eligibility Records - This option allows PSCs and Medicare contractor BI units to utilize a CMS-created annual computer file of all deceased beneficiaries. On an annual calendar year basis, CMS creates computer file*s* of all Medicare beneficiaries who died in the preceding *2* calendar year*s*. *These* computer file*s* should be available for PSCs and Medicare contractor BI units to download from the Data Center by mid-February of each year. PSCs and Medicare contractor BI units then review the format for this file to determine if any changes have been made from the previous fiscal year file. *There have been known instances where a beneficiary's date of death is reported in both calendar*

year files. If such a situation is determined, the PSC or Medicare contractor BI unit shall use the latest calendar year file as the date of death. In accordance with the Health Insurance Portability and Accountability Act of 1996, a security firewall has been installed to protect the privacy rights of deceased beneficiaries. This firewall prevents unauthorized users from gaining access to the files of deceased beneficiaries. Due to the confidential information within these files, PSCs and Medicare contractor BI units will not be able to access them without their secured authorized identification code being included in the CMS-allowed-access list associated with the files.

To have access to these files, the PSC and Medicare contractor BI unit shall submit the name of the person(s) who will be accessing the files, their CMS mainframe user identification number, the PSC or Medicare contractor name and contractor number, the PSC Task Order number, and a telephone number. Only the person(s) identified will be allowed access to the files. Submit this information via e-mail to the CO Director of the Division of Benefit Integrity *Management Operations*.

The annual computer files are located on CMS's mainframe computer and may be found using the dataset naming convention "c@pig.#dbpc.deceased.benes.dodyyyy", where "yyyy" is equal to the calendar year in which the beneficiaries died. The format for this file is a text file and may also be found using "c@pig.#dbpc.deceased.benes.format". For example, computer file "c@pig.#dbpc.deceased.benes.dod2001" contains information on all Medicare beneficiaries who died during calendar year 2001. Computer file "c@pig.#dbpc.deceased.benes.dod.2002" contains information on all Medicare beneficiaries who died during calendar year 2002. Download both computer files and manipulate the data to determine those beneficiaries who died during fiscal year 2002 (October 1, 2001 - September 30, 2002). Then utilize the claims processing history files to identify any services/claims containing a paid date of service that is after the posted date of death.

The PSCs and Medicare contractor BI units may consider conducting analyses to determine if healthcare providers continue to bill inappropriately after the results of this review have been completed (i.e., overpayments have been demanded and education regarding inappropriate billings have taken place). The PSCs and Medicare contractor BI units may consider developing an investigation on providers whose pattern of billings remains noncompliant.

On an annual basis, PSCs and Medicare contractor BI units shall submit a report on the accounting of the improper payments identified by the PSC or Medicare contractor BI unit and respective overpayments recouped by the AC and Medicare contractor. This report shall be due on December 5th of each year and sent to the *Primary* GTL. The report shall also be sent *via e-mail to the CO Director of the Division of Benefit Integrity Management Operations.*

4.31 – Vulnerability Report

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Program vulnerabilities can be identified through a variety of sources such as the Chief Financial Officer's Audit, Fraud Alerts, the General Accounting Office, the Office of Inspector General (OIG), and PSC and Medicare contractor operations, as examples. PSCs and Medicare contractor BI units shall submit any identified program vulnerabilities to RO and CO on a quarterly basis (i.e., 1/15, 4/15, 7/15, and 10/15). The identified vulnerabilities shall also include recommendations for resolving the vulnerability, any action taken to resolve the vulnerability, and shall describe the detection methodology.

The PSC and Medicare contractor BI unit shall send a copy of the identified vulnerabilities to the *Primary* GTL, *Associate* GTL, and RO. The PSC and Medicare contractor BI unit shall also send the CO a copy of the identified vulnerabilities to the following address: **vulnerability@cms.hhs.gov**

Medicare Program Integrity Manual

Exhibits

Table of Contents
(Rev. 118, Issued: 08-12-05)

Exhibit 27 - National Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

NATIONAL MEDICARE FRAUD ALERT TEMPLATE

Distribution of this Fraud Alert is Limited to the Following Audience: CMS regional offices, *Medicare Contractor* Benefit Integrity units, program safeguard contractors, Medicare Integrity Program (MIP) units, *quality improvement* organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State *Medicaid Program Directors*

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION *METHODOLOGY*:

FID CASE (S):

STATUS:

CONTACT:

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

CMS NMFA *DATE*

Exhibit 28 - Restricted Medicare Fraud Alert

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

RESTRICTED MEDICARE FRAUD ALERT TEMPLATE

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this alert. Distribution is Limited to the Following Audience: CMS regional offices, Medicare *contractor* Benefit Integrity units, program safeguard contractors, *quality improvement* organizations, Medicaid Fraud Control units, the Office of Inspector General, the Defense Criminal Investigation Service, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney offices, U.S. Postal Inspector offices, and the Internal Revenue Service*, and the State Medicaid Program Integrity Directors*

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION *METHODOLOGY*:

FID CASE (S):

STATUS:

CONTACT:

NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT PURSUANT TO EXEMPTION (b) (2), (b)(5) AND (b)(7)(E) OF THE FOIA. ITS CONTENTS SHOULD NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN APPROVAL OF THE BENEFITS INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

Exhibit 38 - Qualified Independent Contractor (QIC) Jurisdictions (as of March 2005)

(Rev. 118, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Task Order	*Contractor*	*Covered States*
Part A EAST QIC	*Maximus, Inc.*	*Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, Washington DC*
Part A WEST QIC	*First Coast Service Options, Inc. (FCSO)*	*Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, American Samoa*
Administrative QIC (AD QIC)	*Q2A*	*N/A-Administrative QIC does not process reconsiderations.*