| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-08 Medicare Program Integrity | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 902** | **Date: September 27, 2019** |
| | **Change Request 11425** |

**SUBJECT: Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update various sections within Chapters 3, 4, 8, 15, and Exhibits in Pub. 100-08.

**EFFECTIVE DATE: October 28, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 28, 2019**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 3/3.4/Prepayment Review of Claims |
| R | 4/4.1/Introduction |
| R | 4/4.2/Medicare Program Integrity |
| R | 4/4.2/4.2.1/Examples of Medicare Fraud |
| R | 4/4.2/4.2.2/Unified Program Integrity Contractor |
| R | 4/4.2/4.2.2/4.2.2.4/Procedural Requirements |
| N | 4/4.2/4.2.4/Investigations MEDIC |
| R | 4/4.4/4.4.1/Requests for Information From Outside Organizations |
| R | 4/4.4/4.4.3/Coordination with the Office of Inspector General |
| R | 4/4.6/4.6.2/4.6.2.5/UPIC and I-MEDIC Responsibilities |
| R | 4/4.6/4.6.3/Screening Leads |
| R | 4/4.6/4.6.4/Vetting Leads with CMS |
| R | 4/4.7/4.7.1/Conducting Investigations |
| R | 4/4.9/4.9.3/Guidelines for Incentive Reward Program Complaint Tracking |
| R | 4/4.9/4.9.4/Excluded Individuals |
| R | 4/4.9/4.9.6/Unified Program Integrity Contractor Responsibilities |
| R | 4/4.9/4.9.6/4.9.6.1/Guidelines for Processing Incoming Complaints |
| R | 4/4.9/4.9.6/4.9.6.2/Guidelines for Incentive Reward Program Complaint Tracking |
| R | 4/4.9/4.9.6/4.9.6.3/Overpayment Recovery |
| R | 4/4.10/Fraud Alerts |
| R | 4/4.13/Administrative Relief from Program Integrity Review in the Presence of a Disaster |
| R | 4/4.14/Provider/Supplier Contacts by the UPIC |
| R | 4/4.15/Case Coordination with UPICs |
| R | 4/4.18/4.18.1/Referral of Cases to the OIG/OI |
| R | 4/4.18/4.18.1/4.18.1.2/Immediate Advisements to the OIG/OI |
| R | 4/4.18/4.18.1/4.18.1.5/4.18.1.5.1/Continue to Monitor Provider and Document Case File |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 4/4.18/4.18.1/4.18.1.5/4.18.1.5.2/Take Administrative Action on Cases Referred to and Declined/Returned by OIG/OI |
| R | 4/4.18/4.18.1/4.18.1.5/4.18.1.5.3/Refer to Other Law Enforcement Agencies |
| R | 4/4.18/4.18.2/UPICs and QIOs |
| R | 4/4.19/Administrative Sanctions |
| R | 4/4.19/4.19.2/Authority to Exclude Practitioners, Providers, and Suppliers of Services |
| R | 4/4.19/4.19.2/4.19.2.2/Identification of Potential Exclusion Cases |
| R | 4/4.19/4.19.2/4.19.2.3/Denial of Payment to an Excluded Party |
| R | 4/4.19/4.19.4/4.19.4.1/Monthly Notification of Sanction Actions |
| R | 4/4.20/4.20.1/4.20.1.2/Administrative Actions |
| R | 4/4.20/4.20.4/CMS Generic Civil Monetary Penalty Case Contents |
| R | 4/4.23/Identity Theft Investigations and Victimized Provider Waiver of Liability Process |
| R | 4/4.26/Supplier Proof of Delivery Documentation Requirements |
| R | 4/4.26/4.26.2/Exceptions |
| R | 4/4.26/4.26.3/Proof of Delivery Requirements for Recently Eligible Medicare FFS Beneficiaries |
| R | 4/4.28/Joint Operating Agreement |
| R | 4/4.31/Vulnerabilities |
| R | 8/8.3/8.3.2/8.3.2.1/CMS Approval |
| R | 8/8.4/8.4.7/8.4.7.1/Recovery From Provider or Supplier |
| R | 15/15.27/15.27.3/Other Identified Revocations |
| N | Exhibits/44/44.1/SMRC – UPIC JOA |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## IV. ATTACHMENTS:

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 902 | Date: September 24, 2019 | Change Request: 11425 |
|---|---|---|---|

**SUBJECT: Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08**

**EFFECTIVE DATE: October 28, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 28, 2019**

## I. GENERAL INFORMATION

**A. Background:** The CMS is making revisions to Chapters 3, 4, 8, 15, and Exhibits in Pub. 100-08 based on updates to Unified Program Integrity Contractor (UPIC) and Investigations Medicare Drug Integrity Contractor (I-MEDIC) processes and procedures.

**B. Policy:** This CR does not involve any legislative or regulatory policies.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 11425.1 | The UPIC shall not initiate a 100 percent prepayment review without CMS approval, except 100 percent prepayment reviews associated with a Payment Suspension. | | | | | | | | | UPICs |
| 11425.1.1 | The UPIC shall provide its Contracting Officer's Representative (COR) and Investigations and Audits Group (IAG) Business Function Lead (BFL) a summary of the | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | investigation, any prior history (if applicable) with the provider/supplier in question, and any other relevant information in a format agreed upon by the COR and IAG BFL. | | | | | | | | | |
| 11425.1.2 | The UPIC shall include the case on the next case coordination meeting agenda for discussion and final approval, if the COR and IAG BFL agree that 100 percent prepayment review is appropriate. | | | | | | | | | UPICs |
| 11425.1.3 | The UPIC shall coordinate with its COR and IAG BFL if they have subsequent questions following the case coordination meeting. | | | | | | | | | UPICs |
| 11425.2 | The Investigations Medicare Drug Integrity Contractor's (I-MEDIC) primary purpose shall be to investigate Medicare Part C and D prescriber, pharmacy, and beneficiary suspected FWA, develop investigations | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | thoroughly and in a timely manner, and take immediate action to ensure that the Medicare Trust Fund is protected. | | | | | | | | | |
| 11425.2.1 | The I-MEDIC shall coordinate with staff from the CMS, CMS contractors, and other stakeholders as needed and as directed by the CMS COR, in collaboration with BFLs to perform this program integrity work. | | | | | | | | | UPICs |
| 11425.3 | The UPIC shall provide the Department of Justice with requested information and shall maintain cost information related to fulfilling data sharing requests. | | | | | | | | | UPICs |
| 11425.4 | The UPIC shall coordinate with the other UPICs to obtain the necessary data and consolidate the information into one comprehensive response for the requestor, when a request is received that crosses several UPIC jurisdictions. | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 11425.5 | The UPICs shall establish regular (i.e., monthly or quarterly) teleconference meetings with Regional LE from the Office of Inspector General (OIG) and CMS for the purpose of discussing various topics. | | | | | | | | | UPICs |
| 11425.5.1 | The UPIC shall set the agenda and prepare any additional documents or reports for the participants at least three (3) business days prior to the meeting. | | | | | | | | | UPICs |
| 11425.5.2 | The UPIC shall discuss the case with its COR/BFL to determine if it should be added to the next case coordination meeting with CMS, which the OIG expresses interest in a potential referral. | | | | | | | | | UPICs |
| 11425.6 | The I-MEDIC shall send an acknowledgement letter to the complainant within five (5) calendar days from the date that a complaint is received. | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 11425.6.1 | The I-MEDIC shall screen, resolve, or if warranted, escalate the complaint to the screening team at the I-MEDIC within 30 calendar days from the date of receipt. | | | | | | | | | UPICs |
| 11425.6.2 | The I-MEDIC shall further screen a complaint, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days from the date that a complaint has been escalated for screening. | | | | | | | | | UPICs |
| 11425.6.3 | The I-MEDIC shall track complaints received by its complaint screening staff in the Unified Case Managment (UCM) System. | | | | | | | | | UPICs |
| 11425.6.4 | The I-MEDIC shall send the complainant a resolution letter within five (5) calendar days of resolving the complaint investigation. | | | | | | | | | UPICs |
| 11425.7 | The UPIC shall contact its COR and IAG BFL for further guidance | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | when they identify specific concerns while screening a lead that warrants contact with a specific provider/supplier. | | | | | | | | | |
| 11425.8 | The UPIC shall notate the date the lead was initially vetted and approved by CMS in UCM, once a lead is approved by CMS. | | | | | | | | | UPICs |
| 11425.9 | The UPIC shall follow the investigation process, as described in section 4.7.1, Chapter 4 of Pub 100-08. | | | | | | | | | UPICs |
| 11425.10 | The UPICs shall follow the Administrative Relief from Program Integrity Review in the Presence of a Disaster process, as described in section 4.13, Chapter 4 of Pub 100-08. | | | | | | | | | UPICs |
| 11425.11 | The UPICs shall follow the case coordination process, as described in section 4.15, Chapter 4 of Pub 100-08. | | | | | | | | | UPICs |
| 11425.12 | The UPICs shall follow case referral process, as | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | described in section 4.18.1, Chapter 4 of Pub 100-08. | | | | | | | | | |
| 11425.13 | The UPICs shall follow the immediate advisement process, as described in section 4.18.1.2, Chapter 4 of Pub 100-08. | | | | | | | | | UPICs |
| 11425.14 | The UPIC shall not close a case simply because it is not accepted by OIG/Office of Investigations (OI). | | | | | | | | | UPICs |
| 11425.14.1 | The UPIC shall continue to monitor the situation and to document the file, noting all instances of suspected fraudulent activity, complaints received, actions taken, etc., since the subject is likely to continue to demonstrate a pattern of fraudulent activity. | | | | | | | | | UPICs |
| 11425.14.2 | The UPIC shall highlight the additional information collected and the increased amount of money | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | involved when resubmitting a case to OIG/OI. | | | | | | | | | |
| 11425.15 | The UPICs shall follow the Administrative Action on Cases Referred to and Declined/Returned by OIG/OI process, as described in section 4.18.1.5.2, Chapter 4 of Pub. 100-08. | | | | | | | | | UPICs |
| 11425.16 | The UPIC shall first implement any identified secondary administrative action, and then may refer the case to other LE agencies when the OIG/OI declines a case that the UPIC believes has merit. | | | | | | | | | UPICs |
| 11425.17 | The UPICs shall follow the Identity Theft Investigations and Victimized Provider Waiver of Liability process, as described in section 4.23, Chapter 4 of Pub. 100-08. | | | | | | | | | UPICs |
| 11425.18 | The UPICs shall have a Joint Operating Agreement with the Supplemental Medical Review Contractor. | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 11425.19 | The UPIC shall follow the CMS Approval process, as described in section 8.3.2.1, Chapter 4 of Pub. 100-08. | | | | | | | | | UPICs |
| 11425.20 | The UPIC shall provide its COR and IAG BFL a summary of the investigation, any prior history (if applicable), the medical review results (including denial reasons), and the extrapolated overpayment amount in a format agreed upon by the COR and IAG BFL for all extrapolation requests not associated with a Payment Suspension, once an overpayment has been determined to exist. | | | | | | | | | UPICs |
| 11425.20.1 | The UPIC shall include the case on the next case coordination meeting agenda for discussion and final approval if the COR and IAG BFL agree that an extrapolated overpayment is appropriate. | | | | | | | | | UPICs |
| 11425.20.2 | The UPIC shall coordinate with its | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | COR and IAG BFL if they have subsequent questions following the case coordination meeting. | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Jesse Havens, 410-786-6566 or jesse.havens@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Program Integrity Manual

## Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

**Table of Contents**

*(Rev.902, Issued: 09-27-19)*

## 3.4 - Prepayment Review of Claims

***(Rev.902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to MACs *and UPICs*.

### A. General

Non-random (targeted) review is defined as review conducted with a specific reason or logic to substantiate the cause for review. MACs are encouraged to initiate non-random service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors or other sources.

The MACs shall initiate targeted provider-specific prepayment review only when there is the likelihood of a sustained or high level of improper payments.

### B. 100% Prepayment Review and Random Review Instructions

Section 1302 of the Health Care and Education Reconciliation Act (HCERA) repealed section 1874A (h) of the Social Security Act which had placed restrictions on prepayment medical review. CMS review contractors shall comply with Section 1 random review and Section 2 100% prepayment review.

#### 1. Random Review

Random review is defined as review conducted without a specific reason or logic to substantiate the cause for review. MACs have the discretion to conduct random reviews of services; however, CMS does not recommend random reviews. MACs shall notify the CMS Contracting Officer's Representative (COR), Regional Office Technical Monitor (TM), and Business Function Lead (BFL) of its intent to conduct random review. The MAC shall describe what the intended result of the random review will be, an estimate of the number of claims to be reviewed randomly and the rationale as to why random review would be more effective than targeted review.

#### 2. 100% Prepayment Review

100% prepayment review is defined as review of every claim submitted by a targeted provider for a specific code (i.e., DRG, CPT, HCPCs). 100% prepayment review also includes review of every claim submitted by the targeted provider.

MACs have the discretion to conduct 100 % prepayment review of providers. CMS considers 100 % prepayment review to be appropriate when a provider has a prolonged time period of non-compliance with CMS policies. Any MAC that plans to conduct 100 % prepayment review shall inform the CMS COR, Regional Office TM, and BFL in advance about any provider being placed on 100 % prepayment review. In addition, the MAC shall provide

- The background information on attempts to educate the provider.
- The historical improper payment rate of the provider before beginning 100% prepayment review.

- The length of time the provider is expected to be on 100 % prepayment reviews.

- The estimated number of claims and the dollar value of claims expected to be reviewed per month.

- The criteria for removing the provider from 100 % prepayment review.

***3. UPIC Initiated Prepayment Reviews***

*No UPIC shall initiate a 100% prepayment review without CMS approval, except 100% prepayment reviews associated with a Payment Suspension. Therefore, the UPIC shall provide its COR and IAG BFL a summary of the investigation, any prior history (if applicable) with the provider/supplier in question, and any other relevant information in a format agreed upon by the COR and IAG BFL.*

*If the COR and IAG BFL agree that 100% prepayment review is appropriate, the UPIC shall include the case on the next case coordination meeting agenda for discussion and final approval. During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to these investigations. If the UPIC has subsequent questions following the case coordination meeting, the UPIC shall coordinate with its COR and IAG BFL.*

# Medicare Program Integrity Manual
## Chapter 4 - Program Integrity

**Table of Contents**
***(Rev.902, Issued: 09-27-19)***

## Transmittals for Chapter 4


*4.2.4 – Investigations MEDIC*
4.4.3 - *Coordination with the Office of Inspector General*
4.6.2.5 - *UPIC and I-MEDIC Responsibilities*
4.15 - *Case Coordination with UPICs*
4.18.1.5.2 - Take Administrative Action on Cases Referred to and *Declined/Returned* by OIG/OI
4.23 – Identity Theft *Investigations and Victimized Provider Waiver of Liability Process*

## 4.1 - Introduction

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

CMS Pub. 100-08, Program Integrity Manual (PIM), reflects the principles, values, and priorities of the Medicare Integrity Program (MIP). The primary principle of program integrity (PI) is to pay claims correctly. To meet this goal, Unified Program Integrity Contractors (UPICs), *Supplemental Medical Review Contractors (SMRC)* and Medicare Administrative Contractors (MACs) must ensure that Medicare pays the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The focus of the UPICs, *SMRCs* and MACs shall be to ensure compliance with Medicare regulations, refer suspected fraud and abuse to our Law Enforcement (LE) partners, and/or *recommend* revocation of providers that are non-compliant with Medicare regulation and policies. The Centers for Medicare & Medicaid Services (CMS) follows four parallel strategies in meeting this goal:

1. Prevent fraud through effective enrollment and education of providers/suppliers and beneficiaries;

2. Encourage early detection (through, for example, the Fraud Prevention System (FPS), medical review (MR) and data analysis);

3. Coordinate closely with partners, including other UPICs, *SMRCs,* MACs, LE agencies, and State *PI* units; and

4. Enact fair and firm enforcement policies.

The UPICs shall follow the PIM to the extent outlined in their respective task orders' Statement of Work (SOW). The UPICs shall only perform the functions outlined in the PIM as they pertain to their own operation. The UPICs, in partnership with CMS, shall be proactive and innovative in finding ways to enhance the performance of PIM guidelines.

For this entire chapter, any reference to UPICs shall also apply to *the Investigations Medicare Drug Integrity Contractor (I-MEDIC)*, unless otherwise noted or identified in the *Contractors'* SOW. MACs shall follow the PIM in accordance with their SOW.

## 4.2 - Medicare Program Integrity

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs, *SMRCs* and MACs, as indicated.

The primary goal of the UPIC is to identify cases of suspected fraud, waste and abuse, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. Payment suspension and denial of payments and the recoupment of overpayments are examples of the actions that may be taken in cases of suspected fraud. Once such actions are taken, cases where there is potential fraud are referred to *LE* for consideration and initiation of criminal or civil prosecution, civil monetary penalties *(CMP)*, or administrative sanction actions.

Preventing and detecting fraud, waste, and abuse involves a cooperative effort among beneficiaries; UPICs; *SMRCs;* MACs; providers/suppliers; quality improvement organizations (QIOs); and federal agencies such as CMS; the Department of Health and

Human Services (*DHHS*); the *Office* of Inspector General *(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 UPIC to follow a specific course of action or establish 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 UPIC makes the determination of potential fraud, waste, and/or abuse, the UPIC shall effectuate all appropriate administrative actions and refer the case to *LE*, if appropriate. When the UPIC makes the determination that a matter is not potential fraud, waste, and/or abuse, the UPIC shall close the matter, or de-escalate the matter to the appropriate unit at the MAC, QIO, or other entity, when appropriate.

## 4.2.1 - Examples of Medicare Fraud

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs, *SMRCs* and MACs.

The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. The violator may be a provider/supplier, a beneficiary, an employee of a provider/supplier, or some other person or business entity, including a billing service or a contractor employee.

Providers/suppliers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a range of administrative sanctions (such as exclusion from participation in the program) and *CMPs* may be imposed when facts and circumstances warrant such action.

Fraud may take such forms as (this is not an exhaustive list):

- Incorrect reporting of diagnoses or procedures to maximize payments;

- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;

- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service, or billing both Medicare and another insurer in an attempt to get paid twice;

- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;

- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);

- Unbundling or “exploding” charges;

- Completing Certificates of Medical Necessity for patients not personally and professionally known by the provider;

- Participating in schemes that involve collusion between a provider and a beneficiary, or between a supplier and a beneficiary;

- Participating in schemes that involve collusion between a provider and a MAC employee where the claim is assigned (e.g., the provider deliberately overbills for services, and the MAC employee then generates adjustments with little or no awareness on the part of the beneficiary);

- Billing based on “gang visits,” (e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients);

- Misrepresenting dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services;

- Billing non-covered or non-chargeable services as covered items;

- Repeatedly violating the participation agreement, assignment agreement, or the limitation amount;

- Knowingly *allowing* a beneficiary to use another person's Medicare card to obtain medical care;

- Giving false information about provider ownership; or

- Using the adjustment payment process to generate fraudulent payments.

Examples of cost report fraud include (this is not an exhaustive list):

- Incorrectly apportioning costs on cost reports;

- Including costs of non-covered services, supplies, or equipment in allowable costs;

- Providers making arrangements with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits;

- Billing Medicare for costs that were not incurred or were attributable to non-program activities, other enterprises, or personal expenses;

- Repeatedly including unallowable cost items on a provider's cost report for purposes of establishing a basis for appeal;

• Manipulating statistics to obtain additional payment, such as increasing the square footage in the outpatient areas to maximize payment;

• Claiming bad debts without first genuinely attempting to collect payment;

• Making improper payments to physicians for certain hospital-based physician arrangements;

• Paying amounts to owners or administrators that have been determined to be excessive in prior cost report settlements;

• Reporting days improperly that result in an overpayment if not adjusted;

• Depreciating assets that have been fully depreciated or sold;

• Using depreciation methods not approved by Medicare;

• Repaying interest expense for loans that were for an offset of interest income against the interest expense;

• Reporting program data where provider program amounts cannot be supported;

• Allocating costs improperly related to organizations that have been determined to be improper; or

• Manipulating accounting.

## 4.2.2 - Unified Program Integrity Contractor

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs.

The UPIC is responsible for preventing, detecting, and deterring fraud, waste, and abuse in both the Medicare program and the Medicaid program. The UPIC:

• Prevents fraud by identifying program vulnerabilities;

• Proactively identifies incidents of potential fraud, waste, and abuse 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/suppliers, CMS, OIG, and other sources. When appropriate, the UPIC may collaborate with CMS, State Medicaid Agency *(SMA),* and MFCU personnel;

• Explores all available sources of fraud leads in its jurisdiction, including the *SMA* and the Medicaid Fraud Control Unit (MFCU);

• Initiates appropriate administrative actions where there is reliable evidence of fraud, including, but not limited to, payment suspensions and revocations;

• Refers cases to the OIG/*Office of Investigations (OI)* for consideration of civil and criminal prosecution and/or application of administrative sanctions (see section 4.18 of this chapter, as well as PIM, chapter 8);

• Refers any necessary provider/supplier and beneficiary outreach to the provider outreach and education (POE) staff at the MAC;

• Initiates and maintains networking and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups;

• Partners with state Medicaid *PI* units to perform the above activities in suspected Medicaid fraud, waste, and abuse cases (including Medi-Medi cases); or

• Works closely with CMS on joint projects, investigations and other proactive, anti-fraud activities.

The UPIC is required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent, wasteful, or abusive billing practices based on the various leads they receive.

Proactive leads are leads identified or self-initiated by the UPIC. Examples of proactive leads include, but are not limited to: (1) UPIC data analysis that uncovers inexplicable aberrancies that indicate potentially fraudulent, wasteful, or abusive billing for specific providers/suppliers; (2) the discovery of a new lead by a UPIC during a provider/supplier or beneficiary interview; and (3) the combining of information from a variety of sources to create a new lead. The UPIC shall pursue leads identified through data analysis (UPICs shall follow PIM *Chapter* 2, *Section* 2.3 for sources of data), the Internet, the Unified Case Management system (UCM), news media, industry workgroups, conferences, etc. For workload reporting purposes, the UPIC shall only identify as proactive those investigations and cases that the UPIC self-initiated.

The UPIC shall take prompt action after scrutinizing billing practices, patterns, or trends that may indicate fraudulent billing, (i.e., reviewing data for inexplicable aberrancies and relating the aberrancies to specific providers/suppliers, identifying “hit and run” providers/suppliers, etc.).

Fraud leads from any external source (e.g., LE, CMS referrals, beneficiary complaints, and the FPS) are considered to be reactive and not proactive. However, taking ideas from external sources, such as Fraud Alerts, and using them to look for unidentified aberrancies within UPIC data is proactive.

### 4.2.2.4 - Procedural Requirements

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs and MACs, as indicated.

The MAC personnel conducting each segment of claims adjudication, MR, and professional relations functions shall be aware of their responsibility for identifying potential fraud, waste, or abuse and be familiar with internal procedures for forwarding

potential fraud, waste, or abuse instances to the UPIC. Any area within the MAC (e.g., MR, enrollment, screening staff) that refers potential fraud, waste, and abuse to the UPIC shall maintain a log of all these referrals. At a minimum, the log shall include the following information: provider/physician/supplier name, beneficiary name, Health Insurance Claim Number (HICN), nature of the referral, date the referral is forwarded to the UPIC, name and contact information of the individual who made the referral, and the name of the UPIC to *which* the referral was made.

The MAC shall provide written procedures for personnel in various contractor functions (claims processing, MR, beneficiary services, POE, cost report audit, etc.) to help identify potential fraud situations. The MAC shall include provisions to ensure that personnel shall:

- Refer potential fraud, waste, or abuse situations promptly to the UPIC;
- Forward complaints alleging fraud through the screening staff to the UPIC;
- Maintain confidentiality of referrals to the UPIC;
- Forward to the UPIC detailed documentation of telephone or personal contacts involving fraud issues discussed with providers/suppliers or provider/supplier staff, and retain such information in individual provider/supplier files; and
- The UPIC shall ensure the performance of the functions below and have written procedures for implementing these functions:

**Investigations*:***

- Keep educational/warning correspondence with providers/suppliers and other fraud documentation concerning specific issues in individual provider/supplier files so that *the* UPICs are able to easily retrieve such documentation*;*

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

- Conduct investigations (following a plan of action) and make the appropriate beneficiary and provider contacts.

**Communications/Coordination*:***

- Maintain communication and information flowing between the UPIC and the MAC MR staff, and as appropriate, MAC audit staff*;*

- Communicate with the MAC MR staff on all findings of overutilization and coordinate with the MAC POE staff to determine what, if any, education has been provided before any PI investigation is pursued*;*

- Obtain and share information on health care fraud issues/fraud investigations among MACs, UPICs, CMS, and LE*;*

- Coordinate, attend, and actively participate in fraud-related meetings/conferences and inform, as well as, include all appropriate parties in these meetings/conferences. These meetings/conferences include, but are not

limited to, health care fraud task force meetings, conference calls, and industry-specific events*;*

• Distribute Fraud Alerts released by CMS to their staff*;*

• Serve as a resource to CMS, as necessary; for example, serve as a resource to CMS on the *UCM*, provide ideas and feedback on Fraud Alerts and/or vulnerabilities within the Medicare or Medicaid programs*;*

• Report to the *Contracting Officer's Representative (COR)* and *the Investigations and Audits Group (IAG) Business Function Lead (BFL)* all situations that have been identified *in which* a provider consistently fails to comply with the provisions of the assignment agreement*; and*

• Coordinate and communicate with the MR units within the MACs to avoid duplication of work.

***Coordination with Law Enforcement:***

• Serve as a reference point for LE and other organizations and agencies to contact when they need help or information on Medicare fraud issues and do not know whom to contact*;*

• Hire and retain employees who are qualified to testify in a criminal and civil trial when requested by LE*;*

• Provide support to LE agencies for investigation of potential fraud, including those for which an initial referral to LE did not originate from the UPIC*;*

• Meet (in person or via telephone call) with OIG agents to discuss pending or potential cases, as necessary*;*

• Meet (in person or via telephone) when needed with the DOJ to enhance coordination on current or pending cases*;*

• Furnish all available information upon request to the OIG/OI with respect to excluded providers/suppliers requesting reinstatement*;*

• Notify, via e-mail, the COR and IAG BFL who will obtain approval or disapproval when the UPIC is asked to accompany the OIG/OI or any other LE agency onsite to a provider/supplier for the purpose of gathering evidence in a potential fraud case (e.g., executing a search warrant). However, LE must make clear the role of UPIC personnel in the proposed onsite visit. The potential harm to the case and the safety of UPIC personnel shall be thoroughly evaluated. The UPIC personnel shall properly identify themselves as UPIC employees and under no circumstances shall they represent themselves as LE personnel or special agents. Lastly, under no circumstances shall UPIC personnel accompany LE in situations *in which* their personal safety is in question*; and*

• Maintain independence from LE and do not collect evidence, i.e., request medical records or conduct interviews, at *LE's* request. The UPIC is expected to

follow the current vetting process and the requirements of PIM Sections 4.41 G, K and L. The UPIC shall consult with the BFLs and CORs if questions arise about complying with LE requests for medical records, conducting interviews, or refraining from specific administrative actions.

**Training*:***

• Work with the COR and IAG BFL to develop and organize external programs and perform training, as appropriate, for LE, ombudsmen, grantees (e.g., Senior Medicare Patrols), and other CMS health care partners (e.g., Administration on Aging, state MFCUs)*;*

• Help to develop fraud-related outreach materials (e.g., pamphlets, brochures, videos) in cooperation with beneficiary services and/or provider relations department of the MACs for use in their training. Submit written outreach material to the COR and IAG BFL for clearance*;*

• Assist in preparing and developing fraud-related articles for MAC newsletters/bulletins. Once completed, the UPIC shall submit such materials to the following email address: CPIFraudRelatedLeads@cms.hhs.gov, with a copy to the CORs and IAG BFLs*; and*

• Provide resources and training for the development of existing employees and new hires.

The MACs shall 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 (refer to § 4.19, for exceptions)*;*

• Ensure all instances *in which* 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 (refer to PIM, *Chapter 8); and*

• Ensure no payments are made to a Medicare provider/supplier that employs an excluded individual or entity.

### *4.2.4 Investigations MEDIC*

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*The Investigations MEDIC (I-MEDIC) is a task order under the UPIC Umbrella Statement of Work (USOW). The primary purpose of the I-MEDIC is to investigate Medicare Parts C and D prescriber, pharmacy, and beneficiary suspected FWA, develop investigations thoroughly and in a timely manner, and take immediate action to ensure that the Medicare Trust Fund is protected. The I-MEDIC shall coordinate with staff from the Centers for Medicare & Medicaid Services (CMS), CMS contractors, and other stakeholders as needed and as directed by the CMS Contracting Officer's Representative (COR), in collaboration with Business Function Leads (BFLs) to perform this program integrity work.*

## 4.4.1 - Requests for Information From Outside Organizations

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs.

Federal, state, and local LE agencies may seek beneficiary and provider/supplier 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 UPIC disclose beneficiary records or provider/supplier information, the responsive disclosure shall comply with applicable federal law as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Business Associate provision of the UPIC's contract. Federal law will dictate whether, and how much, requested information can be disclosed. The determination regarding disclosure will be contingent on the purpose for which it is sought and whether information is sought about beneficiaries or providers/suppliers. For example, certain general information that does not include specific beneficiary identifiers may be shared with a broader community, including private insurers. The information may include that of a general nature of how fraudulent practices were detected, the actions being taken, and aggregated data showing trends and/or patterns.

The UPIC may release information, in accordance with the requirements specified in Sections A – G below, to the following organizations:

- Other UPICs*;*
- Qualified Independent Contractors (QICs)*;*
- QIOs*;*
- State Attorneys General and State Agencies*;*
- MFCUs*;*
- OIG*;*
- DOJ*; and*
- FBI.

Requests for information from entities not listed above shall be submitted to the COR for approval, with a copy to the IAG BFL.

In deciding to share information voluntarily or in response to outside requests, the UPIC 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 Privacy 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, both statutes provide individuals with the right to know with whom their personal information has been shared, necessitating the tracking of any disclosures of information by the UPIC. The UPIC shall direct questions concerning what information may be disclosed under the Privacy Act or Privacy Rule to the CMS Regional Office Freedom of Information Act /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 [PHI]) by organizations subject to the Privacy Rule (which are called "covered entities"). As "business associates" of CMS, UPICs 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 for "law enforcement purposes" (45 CFR §164.512 (f)), provided the disclosure meets all the relevant prerequisite procedural requirements in those subsections.
Generally, PHI 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 DOJ, through its *U.S.* Attorneys' Offices and its headquarters-level litigating divisions; the FBI; the HHS OIG; and other federal, state, or local enforcement agencies, are acting in the capacity of health oversight agencies when they investigate fraud against Medicare, Medicaid, or other health care insurers or programs.

The Privacy Rule also permits disclosures for other LE purposes that are not health oversight activities but involve other specified LE 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 LE agency is detailed in 45 CFR §164.512(f). Furthermore, the Privacy Rule permits covered entities and business associates acting on their behalf to rely on the representation of public officials seeking disclosures of PHI for health oversight or LE purposes, provided that the identities of the public officials requesting the disclosure have been verified by the methods specified in the Privacy 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 identification assigned to the individual. For example, Medicare beneficiary data used by UPICs 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 *systems of record*, and a decision concerning the applicability of a routine use lies solely in the purview of the system's manager for each system of *record.* In instances where information is released as a routine use, the Privacy Act and Privacy Rule remain applicable. For example, the HHS has published a routine use that permits the disclosure of personal information concerning individuals to the DOJ,

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. Refer to 63 Fed. Reg. 38414 (July 16, 1998).

The 1994 Agreement and the 2003 form letter (refer to 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 (1) of 12 disclosure provisions apply. Two of these provisions, the "routine use" provision and/or another "law enforcement" provision, may apply to requests from the DOJ and/or the FBI.

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

Both the Fiscal Intermediary Shared System (FISS) #8 and #10, the Multi-Carrier System (MCS), and the VIPS Medicare System (VMS) 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, such 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 (1) of the 11 other exceptions to the Privacy Act applies.

The LE provision may apply to requests from the DOJ and/or the FBI. This provision permits disclosures "to another agency or to an instrumentality of any jurisdiction within or under the control of the *U.S.* for a civil or criminal LE 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 that maintains the record specifying the particular portion desired and the LE activity for which the record is sought."

The LE 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/supplier that are within the scope of the initial request do not have to be in writing. The *UPICs* shall refer requests that raise Privacy Act concerns and/or issues to the CORs for further consideration.

**A. Requests from Private, Non-*LE* Agencies**

Generally, UPICs may furnish information on a scheme (e.g., where it is operating *or* specialties involved). Neither the name of a beneficiary or suspect can be disclosed. If it is not possible to determine whether or not information may be released to an outside entity, the UPIC shall contact its COR and IAG BFL for further guidance.

**B. Requests from Other *UPICs***

The UPICs may furnish requested specific information concerning ongoing fraud investigations and individually identifiable PHI to any UPIC, *SMRC* or MAC. *The* UPICs, *SMRCs* and MACs 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 investigations already referred to the OIG/OI, the UPIC shall notify the OIG/OI of the *RFI* received from another UPIC and notify the requesting UPIC that the case has been referred to the OIG/OI.

**C. *RFI* from *QICs***

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

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 UPIC shall document the date of the QIC's request and send the requested information within seven (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 was made (if a message was left, it is defined as the date the message was left), the date the facsimile was received, or the date of the e-mail request.

**Note:** Individually identifiable beneficiary information shall not be included in an e-mail. If a QIC identifies a situation of potential fraud, waste, and abuse, it shall immediately refer all related information to the appropriate UPIC for further investigation. Refer to PIM Exhibit 38 for QIC task orders and jurisdictions.

**D. Requests from *QIOs* and State Survey and Certification Agencies**

The UPIC may furnish requested specific information concerning ongoing fraud investigations containing personally identifiable 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, UPICs shall refer the requestor to the OIG/OI.

**E. Requests from State Attorneys General and State Agencies**

The UPIC 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 *PHI* is requested, the disclosure shall comply with the Privacy Rule. (Refer to subsection H below and PIM Exhibit 25 for guidance on how requests should be structured to comply with the Privacy Rule.)

The UPIC may, at its discretion, share PIM 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, the UPIC shall refer the requestor to the OIG/OI.

**F. Requests from *MFCUs***

Under current Privacy Act requirements applicable to *PI* investigations, the UPIC may respond to requests from 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). Refer to *Subsection* H below for further information regarding the Privacy Act requirements. If individually identifiable PHI is requested, the disclosure shall comply with the Privacy Rule. Refer to subsection H below and PIM Exhibit 25 for guidance on how requests should be structured to comply with the Privacy Rule.

The UPIC may, at its discretion, share PIM Exhibit 25 with the requestors as a template to assist them in preparing their request. If the request concerns cases already referred to the OIG/OI, the UPIC shall refer the requestor to the OIG/OI.

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

The UPIC shall provide the OIG/OI with requested information and shall maintain cost information related to fulfilling these requests. *An RFI* shall consist of requests to run data for the OIG *(including OnePI national data for suppliers and entities whose billed claims span across multiple jurisdictions),* extract of records, or a request to furnish any documentation or reports (see below for requests for assistance). Such requested information may include LE requests for voluntary refund data (see section 4.16 of this chapter). The UPIC shall not fulfill a request if there is a substantial impact (i.e., 40 hours or more) on the budget without prior COR approval. The UPIC shall copy the IAG BFL on these requests for approval from the COR. 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/supplier. The request shall be completed with the utmost urgency. Priority I requests shall be fulfilled within thirty (30) calendar days when the information or material is contained in the UPIC's files unless an exception exists as described below.

The UPIC shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested within 30 calendar days or sooner, when possible. The MAC shall furnish requested information to the UPIC within 20 calendar days of receipt of the request from the UPIC unless there are extenuating circumstances. The MAC shall communicate any extenuating circumstances to the UPIC and the MAC COR as soon as they become known. The UPIC shall communicate these extenuating circumstances to its COR.

Periodically, there are instances *in which* the OIG/OI is in need of the requested information in a shorter timeframe than (30) calendar days. To account for these instances, the UPIC and MAC may add language to their Joint Operating Agreement *(JOA)* that allows for a shorter timeframe for the MAC to furnish the requested information (i.e. 48 hours, 72, hours, etc.). In these instances, the OIG/OI must provide justification as to why the requested information is needed in a shorter timeframe than the standard Priority I request.

Otherwise, the UPIC shall follow-up with other contractors, and document all communication with contractors to ensure the request is not delayed unnecessarily. If extenuating circumstances exist that prevent the UPIC from meeting the thirty (30) day timeframe, the UPIC shall inform the requestor what, if any, portion of the request can be provided within thirty (30) days. The UPIC shall notify the requesting office as soon as possible (but not later than thirty (30) days) after receiving the request. The UPIC shall also document all communication with the requesting office regarding the delay, and shall include an estimate of when all requested information will be supplied.

If the request requires that the UPIC access National Claims History (NCH) using Data Extract Software (DESY), the thirty (30) day timeframe for Priority I requests does not apply.

**Priority II –** This type of request is less critical than a Priority I request. *An RFI* shall consist of requests to run data for the OIG, extract of records, or a request to furnish any documentation or reports (see below for requests for assistance). Based on the review of its available resources, the UPIC shall inform the requestor what, if any, portion of the request can be provided. The UPIC shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested.

The UPICs shall respond to such requests within 45 calendar days or sooner, when possible. The MAC shall furnish requested information to the UPIC within 30 calendar days of receipt of the request from the UPIC unless there are extenuating circumstances. The MAC shall communicate any extenuating circumstances to the UPIC and the MAC COR as soon as they become known. The UPIC shall communicate these extenuating circumstances to its COR. The UPIC shall follow-up with other contractors, and document all communication with contractors to ensure the request is not delayed unnecessarily. If extenuating circumstances exist that prevent the UPIC from meeting the 45-day timeframe, the UPIC shall inform the requestor what, if any, portion of the request can be provided within 45 calendar days. The UPIC shall notify the requesting office as soon as possible (but not later than 45 calendar days) after receiving the request. The UPIC shall also document all communication with the requesting office regarding the delay, and shall include an estimate of when all requested information will be supplied.

**Request for Assistance *(RFA)* –** *An* LE RFA is a type of *RFI* and shall consist of any LE requests that do not include running data and reports but include requests such as the review and interpretation of medical records/medical documentation, interpretation of policies, and reviewing cost reports. The timeframes for RFIs specified in Priority I and II do not apply to RFAs. Due dates shall be negotiated with the requesting entity and documented appropriately along with the reasons for not meeting the agreed upon timeframes. The UPIC shall contact the COR if an agreement cannot be reached on the timeframe for completion. Disclosures of information to the OIG shall comply with the Privacy Rule and Privacy Act. When the OIG makes a data request, the UPIC shall track these requests and document the following: (1) nature/purpose of the disclosure (cite a specific investigation and have a general description); (2) what information was

disclosed; and (3) *the* name of the individual and the agency. The aforementioned information shall be maintained in a secure file and made available to CMS upon request through a secure means.

*The* CMS has established a level of effort limit of 40 hours for any individual request for support *RFIs and RFAs*. If the estimated level of effort to fulfill any one request is likely to meet or exceed this figure, the UPIC shall contact its COR for approval to proceed. A CMS representative will contact the OIG to explore the feasibility of other data search and/or production options.

The UPIC shall obtain approval from the COR regarding requests started by the UPIC that *it* subsequently *anticipates* will exceed that 40-hour level of effort. The UPIC shall not exceed the 40-hour level of effort until it receives COR approval.

**H. Procedures for Sharing CMS Data with the *DOJ***

In April 1994, CMS entered into an interagency agreement with the OIG and the DOJ that permitted UPICs to furnish information that previously had to be routed through OIG (refer to PIM Exhibit 16) including data related to the investigation of health care fraud matters directly to the DOJ that previously had to be routed through OIG (refer to PIM Exhibit 35). This agreement was supplemented on April 11, 2003, when in order to comply with the HIPAA Privacy Rule, the DOJ issued procedures, guidance, and a form letter for obtaining information (refer to PIM Exhibit 25). CMS and the DOJ have agreed that the DOJ's requests for individually identifiable health information will follow the procedures that appear on the form letter (refer to 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 requestor 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. The UPIC shall familiarize itself with the instructions contained in this document. Data requests for individually identifiable PHI related to the investigation of health care fraud matters will come directly from those individuals at the FBI or the DOJ who are involved in the work of the health care oversight agency (including, for example, FBI agents, Assistant *U.S.* Attorneys, or designees such as analysts, auditors, investigators, or paralegals). 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; determine the nature and extent of a provider's/supplier's voluntary refund(s); or conduct a random sample of claims for MR. The LE agency should begin by consulting with the appropriate Medicare contractor (usually the UPIC, but possibly also the MAC) 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 MAC.

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

*The UPIC shall provide the DOJ with the requested information and shall maintain cost information related to fulfilling these requests. An RFI shall consist of requests to run data for the DOJ (including national data for suppliers and entities whose claims billings span across multiple jurisdictions), extract of records, or a request to furnish any documentation or reports.*

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

If the DOJ confirms that claims data are necessary, the DOJ will prepare a formal request letter to the UPIC with existing DOJ guidance (Exhibit *25*).

The UPIC shall provide data to the DOJ, when feasible, in a format to be agreed upon by the UPIC and the DOJ. Expected time frames for fulfilling the DOJ claims-level data requests will depend on the respective source(s) and duration of time for which data are sought, with the exception of emergency requests, which require coordination with Headquarters, the DOJ, and CMS staff. These are as follows:

**Emergency Requests** - Require coordination with Headquarters DOJ and CMS staff.

**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/supplier. A *RFI* shall consist of requests to run data for the DOJ, extract of records, or a request to furnish any documentation or reports (see below for requests for assistance). The request shall be completed with the utmost urgency. Priority I requests shall be fulfilled within thirty (30) calendar days when the information or material is contained in the UPIC's files unless an exception exists as described below.

The UPIC shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested within 30 calendar days or sooner, when possible. The MAC shall furnish requested information to the UPIC within 20 calendar days of receipt of the request from the UPIC unless there are extenuating circumstances. The MAC shall communicate any extenuating circumstances to the UPIC and the MAC COR as soon as they become known. The UPIC shall communicate these extenuating circumstances to its COR.

Periodically, there are instances *in which* the DOJ is in need of the requested information in a shorter timeframe than (30) calendar days. To account for these instances, the UPIC and MAC may add language to their *JOA* that allows for a shorter timeframe for the MAC to furnish the requested information (i.e. 48 hours, 72, hours, etc.). In these instances, the DOJ must provide justification as to why the requested information is needed in a shorter timeframe than the standard Priority I request.

Otherwise, the UPIC shall follow-up with other contractors, and document all communication with contractors to ensure the request is not delayed unnecessarily. If extenuating circumstances exist that prevent the UPIC from meeting the thirty (30) day timeframe, the UPIC shall inform the requestor what, if any, portion of the request can be provided within thirty (30) days. The UPIC shall notify the requesting office as soon as possible (but not later than thirty (30) days) after receiving the request. The UPIC shall also document all communication with the requesting office regarding the delay, and shall include an estimate of when all requested information will be supplied.

If the request requires that the UPIC access NCH using DESY, the thirty (30) day timeframe for Priority I requests does not apply.

**Priority II Requests –** This type of request is less critical than a Priority I request. *An RFI* shall consist of requests to run data for the DOJ, extract of records, or a request to furnish any documentation or reports (see below for requests for assistance). Based on the review of its available resources, the UPIC shall inform the requestor what, if any, portion of the request can be provided. The UPIC shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested.

The UPIC shall respond to such requests within 45 calendar days or sooner, when possible. The MAC shall furnish requested information to the UPIC within 30 calendar days of receipt of the request from the UPIC unless there are extenuating circumstances. The MAC shall communicate any extenuating circumstances to the UPIC and the MAC COR as soon as they become known. The UPIC shall communicate these extenuating circumstances to *its* COR. The UPIC shall *follow-up* with other contractors, and document all communication with contractors to ensure the request is not delayed unnecessarily. If extenuating circumstances exist that prevent the UPIC from meeting the 45-day timeframe, the UPIC shall inform the requestor what, if any, portion of the request can be provided within 45 calendar days. The UPIC shall

notify the requesting office as soon as possible (but not later than 45 calendar days) after receiving the request. The UPIC shall also document all communication with the requesting office regarding the delay, and shall include an estimate of when all requested information will be supplied.

***RFA*** **–** A LE RFA is a type of *RFI* and shall consist of any LE requests that do not include running data and reports, but include requests such as the review and interpretation of medical records/medical documentation, interpretation of policies, and reviewing cost reports. The timeframes for RFIs specified in Priority I and II do not apply to RFAs. Due dates shall be negotiated with the requesting entity and documented appropriately along with the reasons for not meeting the agreed upon timeframes. The UPIC shall contact the COR if an agreement cannot be reached on the timeframe for completion.

Disclosures of information to the DOJ shall comply with the Privacy Rule and Privacy Act. When DOJ makes a data request, the UPIC shall track these requests and document the following: (1) nature/purpose of the disclosure (cite a specific investigation and have
a general description); (2) what information was disclosed; and (3) name of the individual and the agency. The aforementioned information shall be maintained in a secure file and made available to CMS upon request through a secure means.

*The* CMS has established a level of effort limit of 40 hours for any individual request for support (RFIs and RFAs). If the estimated level of effort to fulfill any one request is likely to meet or exceed this figure, the *PI* contractor shall contact its COR for approval to proceed. A CMS representative will contact the OIG to explore the feasibility of other data search and/or production options.

The UPIC shall obtain approval from the COR regarding requests started by the UPIC that *it* subsequently anticipates will exceed that 40-hour level of effort. The UPIC shall not exceed the 40-hour level of effort until it receives COR approval.

### I. Duplicate/Similar *RFIs*

If the UPIC receives duplicate or similar *RFIs* from OIG and DOJ, the UPIC shall notify the requestors. If the requestors are not willing to share the information, the UPIC shall ask the COR and IAG BFL for assistance.

### J. Reporting Requirements for the DOJ and OIG

For each data request received from the DOJ and the OIG, the UPIC 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;
- The cost of furnishing a response to each request*; and*
- The date completed.

### K. *LE* Requests for *MR*

The UPIC shall not send document request letters or go onsite to providers/suppliers to obtain medical records solely at the direction of LE. However, if LE furnishes the medical records and requests the UPIC to review and interpret medical records for them, the UPIC shall require LE 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, what is the allegation, and what should the reviewer be looking for in the medical record);
- The volume of records furnished;
- The due date; and

- The format required for response.

The UPIC shall present the written request to the COR, and copy its IAG BFL prior to fulfilling the request. Each written request will be considered on a case-by-case basis todetermine whether the UPIC has resources to fulfill the request. If so, the request may be approved.

If LE requests the UPIC to perform MR on all investigations the UPIC initiates, the UPIC shall perform MR if it deems it necessary, on a case-by-case basis. The UPIC shall inform the COR and copy its IAG BFL of such requests by LE.

It is recommended that the MR Manager be included in the evaluation of the Request for MR to provide input as to:

- The resources required;
- The resources available; and
- Recommended revisions to the volume of records to be reviewed that will still provide a statistically and clinically significant sample to support the purpose or allegation in the request and provide for the best use of MR resources.

**L. *LE* Requests for UPIC Audits of Medicare Provider Cost Reports Relating to Fraud**

If LE requests the UPIC to perform an audit of a Medicare provider's cost report for fraud, the UPIC shall consult with the MAC to inquire if an audit of the cost report has already been performed. The UPIC shall also consult with the COR and IAG BFL. The UPIC shall provide its COR and copy its IAG BFL with the basis for the LE request and a detailed cost estimate to complete the audit. If the COR approves the audit, the UPIC shall perform the audit within the timeframe and cost agreed upon with LE.

**M. Requests from *LE* for Information Crossing Several UPIC Jurisdictions**

If a UPIC receives a *RFI* from LE that crosses several UPIC zones, the UPIC shall contact its COR and IAG BFL. In the event that multiple zones are providing information in connection with the request, each UPIC shall enter a separate entry into the *UCM* as described in *Section 4.12* of this chapter. The COR and IAG BFL may assign a lead UPIC to process these requests *that will coordinate with the other UPICs to obtain the necessary data and consolidate the information into one comprehensive response for the requestor. The lead UPIC may be the UPIC that initially received the request; however, the nature of the RFI should be considered when assigning a lead UPIC.*

## 4.4.3 - *Coordination with the Office of Inspector General*

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*The UPICs shall establish regular (i.e., monthly or quarterly) teleconference meetings with Regional LE from OIG and CMS for the purpose of discussing:*

- *the status of referrals and immediate advisements;*
- *any relevant updates to previously discussed cases (i.e., contractor identified spikes in billing, change to the operational status of a provider, patient harm situations, etc.);*
- *data analysis projects (i.e., planned data projects, results of recently completed data projects, etc.); and*
- *areas of interest to CMS, OIG, or other regional partners.*

*Other agenda topics may include a discussion regarding areas of concern in the UPIC and/or Regional LE respective region, case/project developments (including planned provider onsite reviews to ensure the proposed activities do not negatively affect any ongoing LE efforts), and other topics. In preparation for the meeting, the UPIC shall set the agenda and prepare any additional documents or reports for the participants at least three (3) business days prior to the meeting.*

*However, at no time shall a referral be made as a result of discussions during these regular meetings. If OIG expresses interest, the contractor shall discuss the case with its COR/BFL to determine if it should be added to the next case coordination meeting with CMS.*

### 4.6.2.5 – *UPIC and I-MEDIC Responsibilities*

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies *to the UPICs.*

When the complaint is received from the MAC screening staff, the UPIC shall further screen the complaint, resolve the complaint, or make referrals, as needed, to the appropriate entity.

The MAC shall screen and forward the complaints within 45 business days from the date of receipt by the screening staff, or within 30 business days of receiving medical records and/or other documentation, whichever is later, to the UPIC. The UPIC shall send the acknowledgement letter within 15 calendar days of receipt of the complaint referral from the MAC screening staff, unless it can be resolved sooner. The letter shall be sent on UPIC letterhead and shall contain the telephone number of the UPIC analyst handling the case.

If the UPIC staff determines, after screening the complaint, that it is not a potential fraud, waste, and/or abuse issue, but involves other issues (e.g., MR, enrollment, claims processing), the complaint shall be referred *back* to the MAC area responsible for screening. The MAC screening staff shall track the complaints returned by the UPIC. However, the UPIC shall send an acknowledgement to the complainant, indicating that a referral is being made, if applicable, to the appropriate MAC unit for further action. The UPIC shall track complaints referred by the MAC screening area in the UPIC's internal tracking system. The UPIC shall send the complainant a resolution letter within seven (7) calendar days of resolving the complaint investigation.

*This section applies to the I-MEDIC.*

When a complaint is received by the *I-MEDIC complaint screening staff, an acknowledgement letter shall be sent to the complainant within five (5) calendar days. The I-MEDIC complaint screening staff shall screen, resolve, or if warranted, escalate the complaint to the screening team at the I-MEDIC within 30 calendar days from the date of receipt.*

*Once a complaint has been escalated for screening, the I-MEDIC shall further screen the complaint, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days.*

*The I-MEDIC shall track complaints received by its complaint screening staff in the UCM.*

*The I-MEDIC complaint screening staff shall send the complainant a resolution letter within five (5) calendar days of resolving the complaint investigation.*

## 4.6.3 Screening Leads

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs.

Screening is the initial step in the review of a lead (described in section 4.2.2 of this chapter) to determine the need to perform further investigation based on the potential for fraud, waste, or abuse. Screening shall be completed within *45* calendar days after receipt of the lead.

The receipt date of the lead is generally determined by the date the UPIC receives a complaint. If the lead resulted from data analysis conducted by the UPIC, the receipt of the lead shall be the date the lead was

referred from the UPIC data analysis department to its investigation or screening unit. For a new lead that is identified from an active or current UPIC investigation, the receipt of the lead shall be the date the new lead was identified by the UPIC investigator.

Note: If criteria for an IA are met during evaluation of the lead, the UPIC shall forward the IA to LE and continue to screen the lead, if deemed appropriate.

Activities that the UPIC may perform in relation to the screening process include, but are not limited to:

- Verification of provider's enrollment status;
- *Coordination with the MAC on prior activities (i.e., prior medical reviews, education, appeals information, etc.);*
- Data analysis;
- Contact with the complainant, when the lead source is a complaint;
- Beneficiary interviews; *and*
- Site verification to validate the provider's/supplier's practice location.

Any screening activities shall not involve contact with the subject provider/supplier or implementation of any administrative actions (i.e., post-payment reviews, prepayment reviews/edits, payment suspension, and revocation). However, if the lead is based solely on a potential assignment violation issue, the UPIC may contact the provider directly to resolve only the assignment violation issue. If there are circumstances noted in UCM that would raise additional concerns, the UPIC shall contact its COR and IAG BFL for further guidance. If the lead involves potential patient harm, the UPIC shall immediately notify CMS within two (2) business days.

After completing its screening, the UPIC shall close the lead if it does not appear to be related to fraud, waste, or abuse. Prior to closing the lead, the UPIC shall take any appropriate actions (i.e., referrals to the MAC, RA, state, or QIO). For example, if a lead does not appear to be related to potential fraud, waste, or abuse but the lead needs to be referred to the MAC, the date that the UPIC refers the information to the MAC is the last day of the screening.

At a minimum, the UPIC shall document the following information in its case file:

- The date the lead was received and closed;
- Lead source (e.g., beneficiary, MAC, provider/supplier);
- Record the name and telephone number of the individual (or organization), if applicable, that provided the information concerning the alleged fraud or abuse;
- Indicate the provider's/supplier's name, address, and ID number;
- Start and end date of the screening;
- Description of the actions/activities performed;
- Start and end date of each action/activity;
- A brief description of the action taken to close the lead (e.g., reviewed records and substantiated amounts billed). Ensure that sufficient information is provided to understand the reason for the closeout;
- The number of leads received to date regarding this provider/supplier, including the present lead. This information is useful in identifying providers/suppliers that are involved in an undue number of complaints; and

- Any documentation associated with the UPIC's activities (i.e., referrals to other entities).

Additionally, if the screening process exceeds *45* calendar days, the UPIC shall document the reasons, circumstances, dates, and actions associated with the delay to its COR and IAG BFL within its monthly reporting in CMS ARTS.

*If the UPIC identifies specific concerns while screening a lead that warrants contact with a specific provider/supplier, the UPIC shall contact its Contract Office Representative (COR) and Investigations and Audits Group (IAG) Business Function Lead (BFL) for further guidance (e.g., UPIC determines that provider/supplier contact is needed in order to determine if the case warrants further investigation).*

## 4.6.4 - Vetting Leads with CMS

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

All leads and any new subjects that the UPIC determines warrant further investigation shall be vetted through CMS for approval before transitioning to an investigation. The UPIC shall vet all applicable *National Provider Identifiers (NPIs)* and Provider Identifiers associated with the provider or supplier's tax-identification number, when initially vetting the lead with CMS. The UPIC shall submit the lead to CMS within two (2) business days of the UPIC determining that the lead should be transitioned into an investigation. For the submission to CMS, the UPIC shall use the designated CMS Vetting Form, which shall include, at a minimum, NPI, name, and practice location.

The UPIC shall only open investigations on leads that are approved by CMS. *Once the lead is approved by CMS, the UPIC shall notate the date the lead was initially vetted and approved by CMS in UCM.* If the UPIC is instructed by CMS to close the lead without further action, the UPIC shall do so within two (2) business days. If the screening results in a new investigation or becomes part of an existing investigation, the aforementioned screening information shall become part of the investigation file. If, during the course of a UPIC investigation, it is determined that additional NPIs should be incorporated into the ongoing investigation, the UPIC shall vet each additional NPI with CMS utilizing the approved CMS process described above before implementing any investigative actions (noted in section 4.7 of this chapter) on the additional NPIs. For any new investigations, the *UPIC* shall complete the appropriate updates in the *UCM* within seven (7) calendar days.

If multiple contractors become involved with the investigation, the UPIC that initially vetted the lead with CMS shall become the lead contractor, unless otherwise specified by CMS. The lead contractor shall notify all applicable contractors of the date the lead was vetted and approved by CMS for investigation. Therefore, no additional vetting is required by the other participating contractors. The other participating contractors shall also notate the date the lead was initially vetted and approved by CMS in their applicable case tracking system(s).

## 4.7.1 – Conducting Investigations

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPIC shall, unless otherwise advised by CMS, use one or more of the following investigative methods (this is not an exhaustive list):

- *Revised screening activities noted above;*
- *Contact with the subject provider or ordering/referring providers via telephone or on-site visit;*
- *Medical record requests and reviews (as defined in PIM, chapter 3);*
- *Prepayment medical reviews associated with a limited claim count (i.e., 25-50 claims) or targeted review (i.e., specific CPT codes) (as defined in PIM, chapter 3);*
- *Implementation of auto-denial edits; and*

- *Recommendation of other administrative actions (as defined in PIM chapters 3, 8, and 15) to CMS. These items will include any administrative actions identified below to be discussed during the case coordination meetings.*

*Additionally, the UPICs shall coordinate with LE partners prior to making contact with any provider/supplier, when it knows there is or was a LE case on the provider/supplier. The UPIC shall review the Unified Case Management (UCM) system prior to contacting any provider/supplier to verify the following:*

- *There are no current or prior requests for information from LE;*
- *There are no other current or prior coordination activities with LE concerning the provider; and*
- *The CMS vetting response indicates there is no current LE activity associated with the provider/supplier.*

*If the UPIC identifies prior LE activity within the past 24 months, the UPIC shall communicate with the LE contact person identified in the UCM to determine if making contact with a provider/supplier will impact its case. If the UPIC is not able to identify the LE contact person in UCM, the UPIC shall consult with its IAG BFL for further guidance. Once the UPIC contacts LE, it shall document the results of the conversation, including the date, time, name of the individual, and the specific LE agency in UCM prior to contacting the provider/supplier. If the UPIC has attempted to contact LE on multiple occasions within five (5) business days, but does not receive a response, the UPIC shall notify its COR and IAG BFL for CMS escalation to the appropriate LE contacts.*

*For any investigative activities that require approval by CMS (i.e., Payment Suspension, Requests for Anticipated Payment (RAP) suppression, or revocation/deactivation requests), the UPIC shall submit those requests through its current processes (i.e., via UCM) and coordinate subsequent actions with the appropriate points of contact within IAG or the Provider Enrollment and Oversight Group (PEOG), respectively.*

After reviewing the provider's/supplier's background, specialty, and profile, the UPIC decides whether the situation involves potential fraud, waste, or abuse, or may be more accurately categorized as a billing error. For example, records might indicate that a physician has billed, in some instances, both Medicare and the beneficiary for the same service. Upon review, the UPIC may determine that, rather than attempting to be paid twice for the same service, the physician made an error in his/her billing methodology. Therefore, this error would be considered a determination of incorrect billing, rather than potential fraud, waste, or abuse involving intentional duplicate billing. If the UPIC determines that an overpayment exists solely on data analysis, the UPIC shall obtain COR and IAG BFL approval prior to initiating the overpayment.

## 4.9.3 - Guidelines for Incentive Reward Program Complaint Tracking

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

If the UPIC receives a related complaint and the complainant is eligible for *the* IRP, the UPIC shall notate the IRP in the *UCM* and coordinate with its COR and IAG BFL when issuance of the award is identified.

## 4.9.4 - Excluded Individuals

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The following individuals are not eligible to receive a reward under the IRP:

• An individual who was, or is, an immediate family member of an officer or employee of *DHHS*, its UPICs, *SMRCs*, MACs, or subcontractors, the Social Security Administration (SSA), the OIG, a *SMA*, the DOJ, the FBI, or any other federal, state, or local *LE* agency at the time he/she came into possession, or divulged information leading to a recovery of Medicare funds. Immediate family is as defined in 42 CFR 411.12(b), which includes any of the following:

•

- Husband or wife*;*
- Natural or adoptive parent, child, or sibling*;*
- Stepparent, stepchild, stepbrother, or stepsister*;*
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in- law, or sister-in-law*; and*
- Grandparent or grandchild.

• Any other federal or state employee, UPIC, *SMRCs,* MAC, or subcontractor, or DHHS grantee, if the information submitted came to his/her knowledge during the course of his/her official duties*;*
• An individual who received a reward under another government program for the same information furnished*;*
• An individual who illegally obtained the information he/she submitted*; and.*
• An individual who participated in the sanctionable offense with respect to which payment would be made.

## 4.9.6 - Unified Program Integrity Contractor Responsibilities

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

For UPICs, *SMRCs,* and MACs, the IRP responsibilities explained below shall be worked out in the *JOA.*

### 4.9.6.1 - Guidelines for Processing Incoming Complaints

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

On or after July 8, 1998, any complaints received that pertain to a potentially sanctionable offense as defined by §§1128, 1128A, or 1128B of the Act, or that pertain to those who have otherwise engaged in sanctionable fraud, waste, and/or abuse against the Medicare program under title XVIII of the Act, are eligible for consideration for reward under the IRP. While the complainant may not specifically request to be included in the IRP, the UPIC should consider the complainant for the reward program. Complaints may originate from a variety of sources such as the OIG Hotline, the UPIC, customer service representatives, etc. *The* UPICs, *SMRCs* and MACs shall inform their staff of this program, so they will respond to or refer questions correctly. *Exhibit 5 of the* PIM provides IRP background information to assist staff who handle inquiries. *The* UPICs, *SMRCs* and MACs shall treat all complaints as legitimate until proven otherwise. They shall refer incoming complaints to the UPIC for further screening. Complaints shall either be resolved by the UPIC, if determined to be a sanctionable offense, referred to the OIG for investigation. Complaints that belong in another UPIC's zone shall be recorded and forwarded to the appropriate UPIC. All information shall be forwarded to them according to existing procedures.

If an individual registers a complaint about a Medicare Managed Care provider, UPICs and MACs shall record and forward all information to:

Centers for Medicare & Medicaid Services Centers for
Medicare Management Performance Review Division
Mail Stop C4-23-07 7500 Security
Blvd.
Baltimore, MD 21244

### 4.9.6.2 - Guidelines for Incentive Reward Program Complaint Tracking

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPICs shall continue to track all incoming complaints potentially eligible for reward in their existing internal tracking system. The following complainant information shall be included:

• Name;
• *HICN* or Social Security number (for non-beneficiary complaints);

- Address;
- Telephone number; or
- Any other requested identifying information needed to contact the individual. The UPIC shall refer cases to the OIG for investigation if referral criteria are met according to PIM Chapter 4, §4.18.1 - Referral of Cases to the Office of the Inspector General (OIG). The case report shall also be forwarded to the OIG.

The UPIC shall enter all available information into the IRP tracking database. Information that shall be maintained on the IRP tracking database includes:

- Date the case is referred to the OIG*;*
- OIG determination of acceptance*;*
- If accepted by OIG, the date and final disposition of the case by the OIG (e.g., CMP, exclusion, referral to DOJ)*; and*
- Any provider identifying information required in the *UCM*, e.g., the Unique Physician Identification Number (UPIN).

The OIG has 90 calendar days from the referral date to make a determination for disposition of the case. If no action is taken by the OIG within the 90 calendar days, the UPIC should begin the process for recovering the overpayment and issuance of the reward, if appropriate.

### 4.9.6.3 - Overpayment Recovery

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPIC and *SMRCs* shall initiate overpayment recovery actions according to PIM Chapter 3, if it is determined an overpayment exist. Only MACs shall issue demand letters and recoup the overpayment.

## 4.10 - Fraud Alerts

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs.

Fraud Alerts are issued when circumstances arise that indicate a need to advise the UPICs, *SMRCs,* MACs, *LE*, state Medicaid agencies, and other appropriate stakeholders about an activity that resulted in the filing of inappropriate and potentially false Medicare claims. If the UPIC identifies the need for a Fraud Alert, it shall provide the COR and IAG BFL a summary of the circumstances. *The* CMS will evaluate the need to issue a Fraud Alert. All Fraud Alerts will be disseminated by CMS to the appropriate stakeholders and supplied to the UPICs in the *UCM*. Once the information is disseminated, the UPIC may send any questions related to the Fraud Alert to the COR and IAG BFL.

## 4.13- Administrative Relief from Program Integrity Review in the Presence of a Disaster

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*This applies to the UPICs*.

*The UPICs shall be aware of Federal Emergency Management Agency (FEMA) declared natural disasters that occur in their jurisdiction(s). In the immediate aftermath of these occurrences, the UPICs shall assess the circumstances with each provider in declared disaster areas before pursuing investigative activities.*

*Due to the nature of fraud, waste and abuse that exists in the Medicare program and the potential for emerging trends specific to FEMA declared natural disasters, contractors should remain vigilant in their oversight, monitoring, and proactive/reactive analysis but follow the guidance identified below:*

1) *Should the contractor confirm that medical record loss resulted from this disaster to the point where administrative relief from medical review requirements is necessary to allow the provider sufficient time to retrieve copies of, or restore damaged, medical documentation, the contractors shall delay the request for medical records for a period of 60-days beginning on the date designated by FEMA/as advised by COR/IAG BFL and ending as directed by their COR/IAG BFL. The contractors are permitted to respond to inquiries, requests, or complaints that are submitted by a provider or beneficiary during this 60-day period;*

2) *The contractors shall consult with their COR and BFL on any time sensitive issues that must be resolved involving contact with a provider or beneficiary in the areas affected by FEMA declared natural disasters;*

3) *The contractors shall closely monitor Technical Direction Letters (TDLs) and Change Requests (CRs) issued to the MACs related to FEMA designated disaster relief efforts. The contractors shall consult with the COR and BFL on any questions resulting from MAC TDLs or CRs; and*

4) *The contractors are reminded to contact their COR and BFL prior to granting specific relief based on any TDL guidance or PIM requirement. Each contractor shall maintain a list of cases/investigations/complaints to which any exception is granted or applied and must include the basis (TDL or PIM reference) and the actual exception applied.*

*During a governmentally declared disaster, whether manmade or otherwise, the UPIC shall continue every effort to identify cases of potential fraud, waste, and abuse. If* the UPIC suspects fraud of a provider/supplier who cannot furnish medical records in a timely manner due to a disaster, the UPIC shall ensure that the provider/supplier is not attempting to harm the Medicare Trust Fund by taking an unreasonable amount of time to furnish records. The UPIC shall request and review verification documentation in all instances where fraud is suspected.

In the case of complete destruction of medical records/documentation *in which* backup records exist, the UPIC shall accept reproduced medical records from microfiche, microfilm, or optical disk systems that may be available in larger facilities, in lieu of the original document. In the case of complete destruction of medical records *in which* no backup records exist, the UPICs shall consult with its COR and IAG BFL to determine the appropriateness of the request to reconstruct the medical records. If the COR and IAG BFL determine that *MR* is appropriate, the UPIC shall instruct providers/suppliers to reconstruct the records as completely as possible with whatever original records can be salvaged. Providers/suppliers should note on the face sheet of the completely or partially reconstructed medical record: “This record was reconstructed because of disaster.”

## 4.14 - Provider/Supplier Contacts by the UPIC

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs.

A UPIC may determine that the resolution of an investigation does not warrant administrative action and that an educational meeting with the provider/supplier is more appropriate. The UPIC shall inform the provider/supplier of the questionable or improper practices, the correct procedure to be followed, and that continuation of the improper practice may result in administrative actions. The UPIC shall document contacts and/or warnings with written reports and correspondence to the provider/supplier and place them in the investigation file *in the UCM*.

If the provider/supplier continues aberrant billing practices, the UPIC shall initiate the appropriate administrative actions. If the UPIC meets with a provider/supplier, the UPIC shall prepare a detailed report for the investigation file *in the UCM*. The report shall include the information in A, B, and C below*:*

**A. Background of Provider/Supplier (Specialty)**

The UPIC shall include a list of all enterprises in which the subject had affiliations, the states where the provider/supplier is licensed, all past complaints, and all prior educational contacts/notices.

**B. Total Medicare Earnings**

The UPIC shall include a report of the subject provider's/supplier's total Medicare earnings for the past 12 months.

The report shall include the following:

- Earnings for the procedures or services in question;
- Frequency of billing for these procedures/services; and
- Total number of claims submitted for these procedures/services.

**C. Extent of Review Performed**

The UPIC shall include in the detailed report, to be placed in the investigative file, the number and type of reviews performed, as well as the specific information outlined below:

- A report of the review process, including methodologies utilized, reason for the review, and findings;
- Any administrative actions implemented (e.g., overpayments identified); and
- Recommendation(s).

**D. Report of Meeting**

The UPIC shall include information pertaining to the meeting(s) conducted with the provider/supplier. This report shall include the following:

- Minutes from the meeting describing the problems and/or aberrancies discussed with the provider/supplier and the education provided to the provider/supplier to correct those problems based on the UPIC's *MR; and*
- Copies of educational materials given to the provider/supplier before, during, or subsequent to the meeting.

**E. Written Correspondence Regarding Non-compliance**

Per the abuse of billing authority under 42 C.F.R. § 424.535(a)(8)(ii) for a pattern or practice of submitting claims that do not meet Medicare requirements and in an effort to fully inform providers of the potential administrative actions that may be imposed based on continued violations of Medicare policy, the below statement should be included in all post payment correspondence that include an error rate, and if applicable, other communications that identify non-compliant billings and inform the provider/supplier of their non-compliance with Medicare requirements:

> In addition, we remind you that our regulation at 42 CFR § 424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR § 424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider's or supplier's Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

## *4.15 - Case Coordination with UPICs*

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*UPICs shall discuss their top investigations with CMS during regularly scheduled case coordination meetings.*

*The purpose of these meetings is to ensure that the contractor's top investigations are shared with all relevant stakeholders to ensure the appropriate parties handle a specific case as expeditiously as possible. In addition, CPI identified the following types of investigations that shall be discussed during the case coordination meetings:*

- *Immediate Advisements (IA);*
- *Extrapolated Overpayment Requests (not associated with a Payment Suspension);*
- *100% Prepayment Review Requests;*
- *Payment Suspension Requests;*
- *RAP Suppressions;*
- *Revocation Requests;*
- *Potential Referrals to Law Enforcement.*

### 4.18.1 Referral of Cases to the OIG/OI

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*The UPIC shall identify cases of potential fraud and shall make referrals of such cases, as appropriate, to the OIG/OI, regardless of dollar thresholds or subject matter. Matters shall be referred when the UPIC 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.*

*If the UPIC believes a case should be referred to LE, the UPIC shall discuss the matter with its IAG BFL. If the IAG BFL agrees that referral to LE is appropriate, the UPIC shall update the UCM appropriately to ensure the provider/supplier is included in the next case coordination meeting discussion for final approval. If it is determined an investigation should be referred to LE, the UPIC shall refer the matter to the designated OIG/OI Special Agents-in-Charge (SAC), Department of Justice Assistant United States Trial Attorneys, or other parties identified during the case coordination discussion. In such instances, the UPIC shall make immediate referrals to the designated parties within seven (7) calendar days, unless otherwise specified by its COR and IAG BFL.*

*Referrals to LE shall include all applicable information that the UPIC has obtained through its investigation at the time of the referral. The UPIC shall utilize the "LE Referral Template" available in PIM Exhibit 16.1 Additionally, if the referral is related to a multi-jurisdiction or national provider/supplier, the UPIC shall coordinate and collect all applicable investigative information from the other UPICs that have an open investigation on that same provider/supplier. The UPIC shall then send one comprehensive referral with all the UPICs' investigative findings to LE. Once the referral package is complete, the UPIC shall submit the referral to LE and copy its COR and IAG BFL. Upon submission of the referral to LE, the UPIC shall request written and/or email confirmation from LE acknowledging receipt of the referral. UCM shall be updated with the date the referral was sent, the name of the agent acknowledging receipt of the referral, and the date of receipt. In the event that written confirmation is not received, the UPIC shall notify the COR and IAG BFL.*

*As previously instructed, the UPIC shall continue to refrain from implementing any additional administrative actions against the provider/supplier without CMS approval during the 60-day window OIG/OI and/or DOJ has to respond to the referral. If the UPIC has any questions related to referrals, the UPIC shall coordinate with its COR and IAG BFL.*

*If OIG/OI and/or DOJ declines the case, the UPIC shall notify its COR and respective CPI points of contact within two (2) business days in order to move forward with the secondary administrative actions identified*

*during the case coordination meeting. Following this notice, the UPIC shall work with its COR, respective BFL, or IAG suspension team member on developing the appropriate documentation for the designated secondary actions.*

*Regarding LE Referrals that are declined and/or returned to the I-MEDIC to take appropriate administrative action to the extent possible, should there be an outstanding overpayment that the Medicare Part C Plan Sponsor(s) could develop, upon receipt of LE's Referral declination/return, the I-MEDIC shall notify the appropriate Medicare Part C Plan Sponsor(s) of the status of the LE Referral and the outstanding overpayment, and advise the Medicare Part C Plan Sponsor(s) to move forward with the overpayment recovery efforts.*

*This notification shall take place within five (5) business days upon receipt of the declination/return of the LE Referral. In addition, the I-MEDIC shall document this communication in the UCM REF record, indicating the date of the LE Referral declination/return, outstanding overpayment amount, if appropriate. The I-MEDIC shall also document the Medicare Part C Plan Sponsors impacted, the date the notification was issued to the Medicare Part C Plan Sponsors, as well as the point-of-contact at the Medicare Part C Plan Sponsor(s) who received the notification. Upon submission of this notification to the Medicare Part C Plan Sponsor(s), the I-MEDIC shall close the REF record as required.*

### 4.18.1.2- Immediate Advisements to the OIG/OI

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPIC shall notify the OIG/OI of an immediate advisement *as quickly as possible, but not more than four (4) business days after* identifying a lead or investigation that meets the following criteria. The UPIC shall maintain internal documentation on these advisements when it receives allegations with one or more of the following characteristics:

- Indications of UPIC or MAC employee fraud
- Allegations of kickbacks or bribes, discounts, rebates, and other reductions in price
- Allegations of a crime committed by a federal or state employee in the execution of their duties
- Indications of fraud by a third-party insurer that is primary to Medicare
- *Confirmation of forged documentation during the course of an investigation, which may include, but is not limited to:*
    - *identification of forged documents through medical review; and/or*
    - *attestation from provider confirming forged documentation.*
- *Allegations and subsequent verification of services not rendered as a result of any of the following:*
    - *medical review findings;*
    - *interviews or attestations from a minimum of three (3) beneficiaries indicating that they did not receive services; and/or*
    - *attestations from referring/ordering providers indicating they did not refer/order a service (e.g., confirmation of no relationship with the beneficiary prior to service, or confirmed impossible day billings).*
- *Confirmed complaints from current or former employees that indicate the provider in question inappropriately billed Medicare for all or a majority of its services. Confirmation would be required though one of the following:*
    - *minimum of three (3) beneficiary interviews confirming the inappropriate billing;*
    - *provider attestation(s) confirming the inappropriate billing; or*
    - *medical review findings.*
- *Confirmation of beneficiary recruitment into potentially fraudulent schemes (e.g., telemarketing or solicitation schemes);*
- *Substantiated identity theft of a provider's Medicare number, a beneficiary's Medicare number, or selling or sharing of beneficiary lists;*

- *Confirmed indication of patient harm (e.g., through medical review findings or confirmation of issues identified during an onsite visit or interviews with providers or beneficiaries).*

*IAs should be referred to the OIG/OI only when the above criteria are met, unless prior approval is given by the COR and IAG BFL.*

*Should local LE have specific parameters or thresholds in place that do not allow them to accept certain IAs, the UPIC shall notify its COR/BFL and request exemption from the applicable IA criteria in that particular jurisdiction.*

*When IA criteria are met, the UPICs shall perform an initial assessment to identify and document dollars currently pending payment to the provider, and/or if RAP claim payment is pending, if applicable. Should high dollar amounts be identified with either scenario, the UPIC shall notify CMS immediately, but not to exceed two (2) business days from date of identification.*

*Once the criteria for an IA are met, the UPIC shall notify the OIG/OI via phone or email to determine if a formal IA referral should be sent to the OIG/OI. The UPIC shall document this communication in UCM. The UPIC shall also send notification to its COR and IAG BFL of the potential IA. If the UPIC does not receive a response from the OIG/OI within two (2) business days (5 business days for the I-MEDIC), it shall notify its COR and BFL team and await further instructions. If the OIG/OI confirms that a formal IA should be sent, the UPIC shall provide all available documentation to the OIG/OI within four (4) business days of receiving the response from OIG/OI. Upon submission of the IA to the OIG/OI, the UPIC shall request written and/or email confirmation from the OIG/OI acknowledging receipt of the IA. Simultaneously, the I-MEDIC shall notify the CMS identified Strike Force points of contacts, if the notification includes providers/suppliers located within a Strike Force jurisdiction. Additionally, the UPIC shall notify and send a copy of the IA to its COR/BFL and the case coordination team, at CPIMCCNotifications@cms.hhs.gov, the same day the advisement is made to OIG/OI. If the OIG/OI determines that a formal IA is not needed, the UPIC shall advise its COR/BFL and immediately continue its investigation. In instances where an IA is related to a Plan employee whistleblower, the I-MEDIC does not have to notify the case coordination team of the IA nor does the IA have to be discussed at a case coordination meeting. Rather, the I-MEDIC shall close the complaint upon acceptance and/or declination of the IA due to these complaint types being outside of the I-MEDIC's SOW.*

*In this notification to CMS, the UPIC shall advise if it has any other potential administrative actions it may want to pursue related to the provider(s)/supplier(s). If so, the IA will then be added to the next case coordination meeting agenda for discussion and final approval. If the UPIC has no additional administrative actions that require approval, the provider(s)/supplier(s) identified in an accepted IA shall be added to the UPIC's next scheduled case coordination meeting.*

*If the IA is related to a provider/supplier that spans multiple jurisdictions, the UPIC shall send a notification to the other UPIC and/or I-MEDIC Program Directors on the same date the formal IA is sent to OIG/OI. The UPIC shall copy its COR/BFL on such communication. Upon receipt of the notification from the primary UPIC, the other UPICs and/or I-MEDIC shall provide confirmation to the primary UPIC and its COR/BFL that the notification has been received, and it is ceasing activity as instructed below. Upon receipt of acceptance or declination of the IA from the OIG/OI, the primary UPIC shall notify the other UPIC and/or I-MEDIC Program Directors of the outcome.*

*Upon identification and submission of an IA to the OIG/OI, unless otherwise directed, all impacted UPICs and/or I-MEDIC shall cease all investigative and administrative activities, with the exception of screening activities, data analysis, etc., until the OIG/OI responds with its acceptance or declination of the IA. If the UPIC does not receive an immediate response from the OIG/OI, the UPIC shall contact OIG/OI after two (2) business days from the date of the IA notification and document the communication in the UCM system. If the UPIC does not receive a response from the OIG/OI within five (5) business days from the date of the IA notification, the UPIC shall contact its COR/BFL for further guidance.*

*If the OIG/OI declines or accepts the IA, the UPIC shall document the decision in UCM and follow the processes described in Chapter 4, § 4.6.4 and § 4.7 of the PIM, unless otherwise directed by CMS.*

*Additionally, until the necessary updates are made in the UCM, if the UPIC submits an IA based on the updated criteria, it shall select all six (6) IA options on the "External Stakeholders" page of the UCM, and notate the justification of the IA in the Record Summary section of the UCM.*

*During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to the IA. If the UPIC has questions following the case coordination meeting, the UPIC shall coordinate with its COR and IAG BFL.*

### 4.18.1.5.1 - Continue to Monitor Provider and Document Case File

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*Unless no additional administrative action and/or investigation is warranted, the* UPIC shall not close a case simply because it is not accepted by OIG/OI. Since the subject is likely to continue to demonstrate a pattern of fraudulent activity, they shall continue to monitor the situation and to document the file, noting all instances of suspected fraudulent activity, complaints received, actions taken, etc. This will strengthen the case if it is necessary to take further administrative action or there is a wish to resubmit the case to OIG/OI at a later date. If the UPICs do resubmit the case to OIG/OI, they shall highlight the additional information collected and the increased amount of money involved.

### 4.18.1.5.2 - Take Administrative Action on Cases Referred to and *Declined/Returned* by OIG/OI

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPICs take immediate action to implement appropriate administrative remedies, including the suspension or denial of payments, and the recovery of overpayments (see PIM, chapter 3). Because the case has been rejected by LE, UPICs shall consult with the COR, BFL, or Suspension SME concerning the imposition of suspension. They pursue administrative and/or civil sanctions by OIG where LE has declined a case.

### 4.18.1.5.3 - Refer to Other Law Enforcement Agencies

***(Rev.902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

If the OIG/OI declines a case that the UPIC believes has merit, the UPIC *shall first implement any identified secondary administrative action, and then* may refer the case to other *LE* agencies, such as the FBI, *DEA,* Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), RRB/OIG, and/or the MFCU.

## 4.18.2 - UPICs and QIOs

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

Communication with the QIO is essential to discuss the potential impact of efforts to prevent abuse, as well as ensure efforts are made to improve quality of care and access to such care. If potential patient harm is discovered during the course of screening a lead or through the investigation process, the UPIC *or SMRC* shall refer those instances to the QIO, state medical board, or state licensing agency. In addition to making the appropriate referrals, the UPIC *or SMRC* shall notify the COR and IAG BFL within two (2) business days once the potential patient harm issue is discovered.

If the UPIC *or SMRC* refers a provider to the State licensing agency or medical society (i.e., those referrals that need immediate response from the *s*tate licensing agency), the UPIC *or SMRC* shall also send a copy of the referral to the QIO.

If a claim has been reviewed by the QIO, the decision made is final and binding on CMS. *T*he specific decision rendered by the QIO shall not be overturned by the UPIC *or SMRC*.

## 4.19 - Administrative Sanctions

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The term “sanctions” represents the full range of administrative remedies and actions available to deal with questionable, improper, or abusive practices of practitioners, providers, and suppliers under the Medicare and Medicaid programs or any state health care programs as defined under §1128(h) of the Act. There are two purposes for these sanctions. First, they are designed to be remedial, to ensure that questionable, improper, or abusive practices are dealt with appropriately. Practitioners, providers, and suppliers are encouraged to correct their behavior and operate in accordance with program policies and procedures. Second, the sanctions are designed to protect the programs by ensuring that improper payments are identified and recovered and that future improper payments are not made.

The primary focus of this section is sanctions authorized in §1128 and §1128A of the Act (exclusions and CMPs). Other, less severe administrative remedies may precede the more punitive sanctions affecting participation in the programs. The corrective actions *UPICs*, *SMRCs,* and MACs shall initially consider are:

- Provider education and warnings;
- Revocation of assignment privileges*;*
- Suspension of payments (refer to PIM, chapter 3, §3.9ff)*;*
- Recovery of overpayments (refer to PIM, chapter 3, §3.8ff); *and*
- Referral of situations to state licensing boards or medical/professional societies.

## 4.19.2 - Authority to Exclude Practitioners, Providers, and Suppliers of Services

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

Section 1128 of the Act provides the Secretary of DHHS the authority to exclude various health care providers, individuals, and businesses from receiving payment for services that would otherwise be payable under Medicare, Medicaid, and all federal health care programs. This authority has been delegated to the OIG.

When an exclusion is imposed, no payment is made to anyone for any items or services in any capacity (other than an emergency item or service provided by an individual who does not routinely provide emergency health care items or services) furnished, ordered, or prescribed by an excluded party under the Medicare, Medicaid, and all federal health care programs. In addition, no payment is made to any business or facility, e.g., a hospital, that submits claims for payment of items or services provided, ordered, prescribed, or referred by an excluded party.

The OIG also has the authority under §1128(b)(6) of the Act to exclude from coverage items and services furnished by practitioners, providers, or other suppliers of health care services who have engaged in certain forms of program abuse and quality of care issues. In order to prove such cases, the *UPICs* shall document a long-standing pattern of care *in which* educational *efforts* have failed to change the abusive pattern. Isolated instances and statistical samples are not actionable. Medical doctors must be willing to testify.

Authority under §1156 of the Act is delegated to OIG to exclude practitioners and other persons who have been determined by a QIO to have violated their obligations under §1156 of the Act. To exclude, the violation of obligation under §1156 of the Act must be a substantial violation in a substantial number of cases or a gross and flagrant violation in one or more instances. Payment is not made for items and services furnished by an excluded practitioner or other person. Section 1156 of the Act also contains the authority to impose a monetary penalty in lieu of exclusion. Section 1156 exclusion actions and monetary penalties are submitted by QIOs to the OIG/OI.

Payment is not made for items and services furnished by an excluded practitioner or other person.

## 4.19.2.2 - Identification of Potential Exclusion Cases

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

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

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

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

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

If a case involves the furnishing of items or services in excess of the needs of the individual or of a quality that does not meet professionally recognized standards of health care, *the* UPIC shall make every effort to obtain reports confirming the medical determination of *its MR* from one or more of the following:

- The QIO for the area served by the provider/supplier*;*
- State or local licensing or certification authorities*;*
- QIO committees*;*
- State or local professional societies*; or*

- Other sources deemed appropriate.

## 4.19.2.3 - Denial of Payment to an Excluded Party

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The *UPICs* shall not recommend payments to the MAC, and MACs shall not make payment on any excluded individual or entity for items or services furnished, ordered, or prescribed in any capacity on or after the effective date of exclusion, except in the following cases:

- For inpatient hospital services or post-hospital SNF care provided to an individual admitted to a hospital or SNF before the effective date of the exclusion, make payment, if appropriate, for up to 30 days after that date*;*

- For home health services provided under a plan established before the effective date of exclusion, make payment, if appropriate, for 30 days after the date on the notice*; and*

- For emergency items and services furnished, ordered, or prescribed (other than an emergency item or service furnished, ordered, or prescribed in a hospital emergency room) payment may be made to an excluded provider on or after the effective date of exclusion.

## 4.19.4.1 - Monthly Notification of Sanction Actions

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The Medicare Exclusion Database *(MED)* is a standard format, cumulative exclusion database that contains information on all exclusions and reinstatement actions in Medicare, Medicaid, and other Federal health care programs. CMS receives this information from the *OIG* monthly.

The UPICs*, SMRCs* and MACs shall use the information contained in the MED and the *Government Accountability Office (GAO)* Debarment list to:

- Determine whether a physician/practitioner/provider or other health care supplier who seeks approval as a provider of services in the Medicare/Medicaid programs is eligible to receive payment*; and*

- Ensure that sanctioned providers are not being inappropriately paid.

The dates reflected on the MED are the effective dates of the exclusion. Exclusion actions are effective 20 days from the date of the notice. Reinstatements or withdrawals are effective as of the date indicated.

The MED shows the names of a number of individuals and entities where the sanction period has expired. These names appear on the MED because the individual or entity has not been granted reinstatement. Therefore, the sanction remains in effect until such time as reinstatement is granted.

The UPICs*, SMRCs* and MACs shall check their systems to determine whether any physician, practitioner, provider, or other health care worker or supplier is being paid for items or services provided subsequent to the date they were excluded from participation in the Medicare program. In the event a situation is identified *in which* inappropriate payment is being made, the *contractors* shall notify OIG and take appropriate action to correct the situation. *In addition*, UPICs shall consider the instructions contained in the CMP section of the PIM (PIM, chapter 4, §4.20).

The UPICs *and SMRCs* shall work with *the* MACs to document a process in the JOA to make the MAC aware of any payments to an excluded provider.

The MACs shall ensure that no payments are made after the effective date of a sanction, except as provided for in regulations at 42 CFR 1001.1901(c) and 489.55.

The MACs shall check payment systems periodically to determine whether any individual or entity who has been excluded since January 1982 is submitting claims for which payment is prohibited. If any such claims are submitted by any individual in any capacity or any entity who has been sanctioned under §§1128, 1862(d), 1156, 1160(b) or 1866(b) of the Act, UPICs shall forward them to OIG/OI.

*In addition*, MACs shall refer to the RO all cases that involve habitual assignment violators. In cases where there is an occasional violation of assignment by a provider, they shall notify the provider in writing that continued violation could result in a penalty under the *CMP* Law.

## 4.20.1.2 - Administrative Actions

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The UPICs*, SMRCs* and MACs shall ensure that the program rules and regulations are being appropriately followed. If violations are noted (either through internal reviews or through a complaint process), MACs shall take the appropriate steps to inform and educate the provider of the non-compliance and encourage future compliance.

If, after a period of time, there is no significant change by the provider (the non- compliance continues), then a final warning notice of plans to propose a corrective action (such as a CMP) shall be issued by the MAC. This notice shall be sent by certified mail (return receipt required) to ensure its receipt by the provider. The notice shall indicate that previous notifications sent to the provider failed to correct the problem, and that this is a final warning. Additionally, it shall indicate that any further continuation of the non- compliance will result in the matter being forwarded to CMS or the OIG for administrative enforcement. While not specifically assessing a monetary penalty amount, the notice shall indicate that this is one type of sanction that may be applied.

## 4.20.4 - CMS Generic Civil Monetary Penalty Case Contents

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

The following information, if available, shall be included as part of the CMP case package and made available upon request by CMS:

1. Background information:

    a. All known identification numbers (NPI, *Provider Transaction Access Number (*PTAN*),* etc.)*;*

    b. Provider's first and last name or entity name (if subject is an entity, also include the full name of the principal operator)*;*

    c. Provider/supplier's address (street, city, state, and zip code). If violator is an entity, identify address where principal operator personally receives his/her mail*;*

2. Copies of any interviews, reports, or statements obtained regarding the violation*;*

*3.* Copies of documentation supporting a confirmation of the violation*;*

4. Copies of all applicable correspondence between beneficiary and provider*;*

5. Copies of all applicable correspondence (including telephone contacts) between the MAC and provider*;*

6. Copies of provider's applicable bills to beneficiaries and/or MACs, and associated payment histories*;*

*7.* Copies of any complaints regarding provider and disposition of the complaint*;*

8. Copies of all publications (e.g., bulletins, newsletters) sent to provider by the UPIC, *SMRCs* or MAC who discuss the type of violation being addressed in the CMP case*;*

9. Copies of any monitoring reports regarding the provider*; and*

10. Name and telephone number of UPIC contact.

## 4.23 – Identity Theft *Investigations and Victimized Provider Waiver of Liability Process*

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to the UPICs.

*For purposes of this chapter, a "compromised number" is a beneficiary or provider/supplier number that has been stolen and used by unauthorized entities or individuals to submit claims to, i.e., bill, the Medicare program.*

*The UPICs shall investigate the alleged theft of provider identities. An example of provider identity theft may include a provider's identity having been stolen and used to establish a new Medicare enrollment, a new billing number (reassignment) under an existing Medicare enrollment, or updating a current Medicare provider identification number with a different electronic funds transfer (EFT) payment account which may cause inappropriate Medicare payments to unknown person(s), a potential Medicare overpayment and eventually, U.S. Department of Treasury (UST) debt issues for the victimized provider.*

*The UPICs shall discuss the identity theft case with the COR and IAG BFL. If claims are still being submitted and Medicare payments are being made, the UPIC should pursue strategies to prevent likely overpayments from being disbursed, such as prepayment reviews, auto-denial edits, Do Not Forward (DNF) requests, or immediate payment suspensions. The purpose of these administrative actions is to stop the payments. The UPICs are not authorized to request the MAC to write-off any overpayments related to the ID theft. Prior to any enrollment actions, the UPIC should be aware of the suspected victim's reassignments and consider the effect of Medicare enrollment enforcement actions on the alleged ID theft victim's current employments.*

*If an actual financial harm exists as a result of the ID theft (i.e., existence of Medicare debt or overpayment determination), the UPIC will follow the Victimized Provider Project (VPP) procedures, which include the following:*

- *At the point in which a UPIC begins to investigate provider ID theft complaints and incurred debt, it sends a letter acknowledging receipt of the complaint, informing the provider that CMS is investigating the complaint and reviewing materials submitted, and designating a VPP point of contact at the UPIC;*

- *The next steps in this process include, but may not be limited to, the following:*

    - *Check if the case in question is in the UCM system. Vet the provider(s) with the DHHS - OIG or other appropriate LE agency to ensure that the contractor's investigative process will not interfere with prosecution;*
    - *A VPP case package must then be completed by the UPIC using the templates provided in the VPP information packet;*
    - *Describe the case and how the provider's ID was stolen or compromised. List all overpayment(s) for which the provider is being held liable. Clearly indicate those paid*

*amounts that are in DNF and/or on payment suspension status and the amounts that were paid with an actual check or EFT to the fraudulent bank account;*

- *Provide legitimate and compromised/stolen 855 forms with provider enrollment and reassignment of benefits information in order to verify legitimate PTAN(s)/NPI(s) and identify the fraudulent ones;*
- *Get signed provider victim attestation statement(s) about the ID theft from the provider(s)/supplier(s).*
- *Provide a police report or any LE account if any, from the alleged victim provider;*
- *Provide financial background information, such as*
  - *IRS Form 1099 or W-2; and*
  - *Overpayment requests/debt collection notices.*
- *Include any trial, DOJ and OIG documents like OIG proffers, indictment, judgments and sentencing documents; and*
- *Based on the information gathered and the investigation conducted, the UPIC will state its recommendation as part of the package and provide the reason for the recommendation. Two recommendations are possible:*
  - *Hold provider harmless and relieve provider of federal debt; OR*
  - *Hold provider liable for debt.*

*The UPIC will submit the complete VPP packet to the CMS CPI VPP team. In ID theft cases in which the victimized providers are located in multiple states and served by different UPICs, the UPIC jurisdiction in which the perpetrator's trial was located will be the lead UPIC that will coordinate with the other UPICs and submit a completed VPP packet to the CMS CPI VPP team.*

*The VPP team will validate and remediate all facts and information submitted by the UPIC. Part of the VPP team review may involve consultation with the HHS Office of General Counsel. This consultation may include, but may not be limited to, consideration of supporting documentation or lack thereof to support a decision that the provider is an actual victim of ID theft as well as compliance with federal statutes and regulations related to ID theft policies, debt collection and waiver of liabilities.*

*The VPP team will make a final determination if the alleged ID theft victim is a true victim and approve a waiver of Medicare liabilities reported under the ID theft victim.*

*When calculating the actual overpayments related to the fraudulent claims under each provider victim, there may be situations in which discrepancies exist between LE and contractor loss calculation data. In these situations, the final figures used in making liability determinations should come from MAC data on amounts paid out in the name of the victimized providers using the cleared payments transmitted to the fraudulent bank accounts established in the DOJ case.*

*Once a final decision is made by the VPP team, the UPIC or Lead UPIC, will be informed.*

*If the provider victim is determined to be a true victim of ID theft, the UPIC will send out a letter using the template in the VPP packet informing the provider of the favorable decision and that the overpayment will not be assessed against the ID victim. The UPIC will inform the MAC that CMS has confirmed the ID theft and determined that the ID theft victim's overpayment will be adjusted down. The MAC will reach out to CMS Office of Financial Management (OFM) for specific guidance on this adjustment. The MAC will follow the process for making adjustments to the claims system and recall the debt registered under the victimized provider from the UST.*

*If CMS has decided that insufficient information exists to relieve the provider of the financial liability for the overpayment(s) and affected claims, the UPIC will send out a letter using the template on the VPP packet recommending that the provider exercise his/her appeal rights by following the appeals process.*

*The debt related to the ID theft case is not written-off and will be reassigned by the MAC, with approval from CMS' OFM, to an account under the established ID theft scheme perpetrator's identity.*

## 4.26 – Supplier Proof of Delivery Documentation Requirements

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs. This section is applicable to DME MACs, RACs, SMRC, and CERT *MR* contractors, as noted in Ch. 5, Section 5.8. Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery documentation must be maintained in the supplier's files for *seven* years (starting from the date of service).

Section 1833(e) grants Medicare contractors the authority to request any information necessary to determine the amounts due. This includes proof of delivery in order to verify that the beneficiary received the DMEPOS item and thus to determine the amounts due to the provider. Proof of delivery is also one of the supplier standards as noted in 42 CFR § 424.57(c)(12). If the UPIC has reason to be concerned that Medicare was billed for an item that was not received (such as a complaint from a beneficiary about non-receipt), the UPIC shall request proof of delivery from the supplier. Proof of delivery documentation must be made available, within the prescribed timeframes, to the UPIC upon request. For any items that do not have proof of delivery from the supplier, such claimed items shall be denied by the UPIC and overpayments recovered. Suppliers that consistently do not provide documentation to support that their items were delivered may be referred to the OIG or NSC for investigation and/or imposition of sanctions.

## 4.26.2 – Exceptions

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs. This section is applicable to DME MACs, RACs, SMRC, and CERT *MR* contractors, as noted in Ch. 5, Section 5.8.

Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from an inpatient facility that does not qualify as the beneficiary's home. A supplier may deliver a DME, prosthetics, or orthotics item—but not supplies-- to a beneficiary in an inpatient facility that does not qualify as the beneficiary's home, for the purpose of fitting or training the beneficiary in the proper use of the item. This delivery may be done up to two (2) days prior to the beneficiary's anticipated discharge to their home. The supplier must bill the date of service on the claim as the date of discharge and the supplier must ensure that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge. The item must be medically necessary on the date of discharge, i.e., there is a physician's order and corroborating medical documentation to support a stated initial date of need that is no later than the date of discharge for home use, and the item must be for subsequent use in the beneficiary's home. (See IOM Pub. 100-04, Chapter 20, Section 110.3, for the policy and billing procedures regarding the circumstances under which a supplier may deliver durable medical equipment, prosthetics, and orthotics - but not supplies - to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary's home.) (See IOM Pub. 100-04, Chapter 20, Section 110.3.1 for the full list of the conditions that must be met to bill under this policy.)

No billing may be made for any day prior to the date of discharge. A supplier may not bill for drugs or other DMEPOS items used by the beneficiary prior to the beneficiary's discharge from a stay in an inpatient facility that does not qualify as the beneficiary's home. Billing the DME MAC for surgical dressings, urological supplies, or ostomy supplies that are provided during a stay in an inpatient facility that does not qualify as the beneficiary's home is not allowed. These items are payable to the facility under Part A of Medicare. This prohibition applies even if the item is worn home by the beneficiary from the inpatient facility. Any attempt by the supplier and/or facility to substitute an item that is payable to the supplier for an item that, under statute, should be provided by the facility, may be considered to be fraudulent.

To allow payment for the first immunosuppressive drug claim after the beneficiary is discharged from an inpatient stay, the immunosuppressive drug may be mailed by a supplier no earlier than two (2) days before a beneficiary is discharged from an inpatient facility. The supplier must enter the date of discharge as the

date of service on the claim. (See IOM Pub. 100-04, Chapter 17, Section 80.3.3 for additional billing instructions.) Note that this is an optional, not mandatory, process. If the supplier chooses not to mail the immunosuppressive drug(s) prior to the beneficiary's date of discharge from the hospital, they may wait for the beneficiary to be discharged before delivering the drugs, and follow all applicable Medicare and DME MAC rules for immunosuppressive drug billing (for example, the date of service will be the date of delivery).

Delivery of the immunosuppressive drugs may be made to the beneficiary's home (i.e., his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution— such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) but not a hospital or skilled nursing facility). In certain cases, a beneficiary who has received a transplant does not return home immediately after discharge. In order to ensure timely beneficiary access to prescribed immunosuppressive medications at the time of discharge, suppliers may deliver the initial prescriptions of a beneficiary's immunosuppressive drugs to an alternate address, such as the inpatient hospital that performed the transplant or alternative location where the beneficiary is temporarily staying (e.g., temporary housing), instead of delivering the drugs to the beneficiary's home address.

Note that this is an optional, not mandatory, process. If the supplier ships immunosuppressive drugs to an alternate address, all parties involved, including the beneficiary and the transplant facility, must agree to the use of this approach. The supplier will not receive additional payment for delivery to an alternate location.

Separate payment will also not be available from either Medicare or the beneficiary if, for any reason, redelivery is necessary. All other applicable Medicare and DME MAC billing requirements continue to apply. This provision may be used with the early delivery provision described in the preceding paragraphs of this section and is also limited to prescriptions that will be billed on the first claim that the supplier submits for the beneficiary after the beneficiary is discharged from an inpatient hospital.

Early and/or direct delivery to the transplant facility does not change the facility's responsibility to provide all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay.

(See IOM Pub. 100-04, Chapter 17, Section 80.3.3 for additional information.)

## 4.26.3 Proof of Delivery Requirements for Recently Eligible Medicare FFS Beneficiaries

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs. **[This section is applicable to DME MACs, RACs, SMRC, and CERT *MR* contractors, as noted in Ch. 5, Section 5.8.]**

Medicare does not automatically assume payment for a DMEPOS item that was covered prior to a beneficiary becoming eligible for the Medicare FFS program. When a beneficiary receiving a DMEPOS item from another payer becomes eligible for the Medicare FFS program, the beneficiary may continue to receive such items only if

Medicare requirements are met for such DMEPOS items. The DME MAC shall educate the supplier community that the supplier must submit an initial or new claim for the item and the necessary documentation to support Medicare payment, upon request, even if there is no change in the beneficiary's medical condition. The first day of the first rental month in which Medicare payments are made for the item serves as the start date of the reasonable useful lifetime and period of continuous use. The contractor shall consider the proof of delivery requirements met for this type of beneficiary by instructing the suppler to obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item. The DME MAC shall educate the supplier that the supplier must also attest to the fact that the item meets Medicare requirements.

## 4.28 – Joint Operating Agreement

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs, *SMRCs,* MACs, RACs, and QICs, as indicated.

A JOA is a document developed between two entities (CMS contractors) that delineates the roles and responsibilities of each entity regarding their interactions with each other on CMS contracts.

*The* UPICs shall have JOAs with the following entities:

- *SMRC (refer to PIM Exhibit 46 for a sample JOA between the UPIC and the SMRC);*
- QICs (refer to PIM Exhibit 45 for a sample JOA between the UPIC and the QIC)*;*
- RACs (refer to PIM Exhibit 44 for a sample JOA between the UPIC and the RAC)*;*
- State agencies (refer to the UPIC USOW and the Medicaid Policies and Procedures Manual (PPM), which is an appendix of the UPIC USOW)*;*
- MACs*;*
- Pricing, Data Analysis, and Coding Contractor (PDAC)*;*
- National Supplier Clearinghouse (NSC)*;*
- National Benefit Integrity Medicare Drug Integrity Contractor*; and*
- *I-MEDIC*

As it applies to the UPIC's task orders, the JOA with the MACs shall, at a minimum, provide information on assigned responsibilities, timeframes, processes and procedures, and coordination. Additional detail related to this information is referenced in the UPIC USOW.

Periodically, there are instances *in which* the UPIC is in need of the requested information in a shorter timeframe than *30* calendar days. To account for these instances, the UPIC*s* and MAC*s* may add language to their *JOA* that allows for a shorter timeframe for the MAC to furnish the requested information (i.e. 48 hours, 72, hours, etc.).

## 4.31 – Vulnerabilities

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

This section applies to UPICs and *SMRCs*.

Program vulnerabilities are identified flaws or weaknesses in policy and/or regulatory authority that increases the likelihood of significant inappropriate payments being made to a broad provider/supplier population. Program vulnerabilities can be identified through a variety of sources such as the *C*hief *F*inancial *O*fficer's audit, Fraud Alerts, the *GAO*, the *OIG,* data driven studies, and UPIC and Medicare contractor operations.

Program Integrity *c*oncerns are issues CPI and/or the UPICs/*SMRCs* have identified through their own analysis and have the ability to mitigate through existing operations. Examples of *PI c*oncerns include, but are not limited to: routine changes and implementation of new billing codes (i.e. ICD-10, HCPCs, CPT codes, etc.) that may lead to questionable billing practices, reports/complaints of a potential fraud schemes that can be addressed in CMS regulations or policy guidance, or identified concerns and significant mitigating changes to enrollment processes.

The UPICs *and SMRC* shall discuss potential *p*rogram *v*ulnerabilities with the COR(s) and BFL(s) during the established recurring workload meetings. Program *v*ulnerabilities should be submitted sooner if the UPIC/*SMRC* believes it requires immediate consideration. The BFL will validate the lead to determine whether the potential issue is a *p*rogram *v*ulnerability, a *PI* Concern, or another type of issue that may need to be addressed. Should the BFL need additional information, the UPIC shall submit an overview of *the* potential *p*rogram *v*ulnerability, program impact, and proposed action to the COR(s) and BFL(s) via email.

Should the COR(s) and BFL(s) agree that the identified issue is a *p*rogram *v*ulnerability, the UPIC/*SMRC* shall submit the proposed *p*rogram *v*ulnerability to the vulnerability mailbox at CPIVulnerabilityIntake@cms.hhs.gov, using the Vulnerability Template.

Additionally, all *p*rogram *v*ulnerabilities that are submitted to the mailbox shall be documented in the UPIC/*SMRC* program vulnerability report. If the UPIC/*SMRC* believes the proposed program vulnerability has potential Medicaid impact, the UPIC/*SMRC* shall document this in the submission to the vulnerability mailbox.

Should the COR(s) and BFL(s) determine that the identified issue is a *PI c*oncern, the COR(s) and BFL(s) shall advise the UPIC/*SMRC* to mitigate the concern through *its* existing operations. Issues not considered to be *p*rogram *v*ulnerabilities or *PI c*oncerns will be addressed on a case by case basis.

**Vulnerability Template**

**Date Submitted:**

**Submitted by**

Name: Organization:
Phone: Email:

**Vulnerability**

Vulnerability

Name:

Description:

Proposed Action:

Source (i.e. person/organization that first identified it):

FPS Model-Related (Y/N):
* If yes, simultaneously report the information consistent with requirements of the FPS.

List Attachments:

# Medicare Program Integrity Manual

## Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation

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## 8.3.2.1 – CMS Approval

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

*If the UPIC believes that a UPIC-initiated Payment Suspension and/or RAP suppression is a viable option for an investigation, they shall update UCM appropriately to ensure the case is included on the next case coordination meeting agenda for discussion. For national or multi-regional suspensions, only the lead UPIC shall discuss the suspension at the case coordination meeting.*

*During the case coordination meeting, if CMS agrees that the criteria for Payment Suspension and/or RAP suppression is met, CMS will instruct the UPIC to submit the Payment Suspension request(s) and RAP suppression request(s) with the completed Administrative Action Review (AAR) form to IAG through the UCM. The IAG Payment Suspension team member will review the submissions and make a formal determination as to whether a Payment Suspension and/or RAP suppression is a viable option.*

*During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to these investigations. If the UPIC has questions following the case coordination meeting, the UPIC shall coordinate with its COR, IAG BFL, and IAG suspension team member.*

When a payment suspension is approved by CPI, the *UPIC* shall inform the respective MAC of this action and the MAC shall effectuate the suspension of payments to the provider unless prior notice of the payment suspension is necessary. When prior notice is necessary, the MAC shall effectuate the suspension of payment in concert with the established date from the payment suspension notice. The MACs shall ensure that all money on the payment floor is not released to the provider after the effective date of the suspension and the money is withheld in accordance with the payment suspension rules and regulations. MACs shall provide an accounting of the money withheld on day one of the payment suspension to the *UPIC*. The *UPIC* shall enter this amount in the FID as the first monetary entry.

Unless otherwise specified, when a payment suspension is imposed, no payments are to be released to the provider as of the effective date of the payment suspension. This includes payments for new claims processed, payments for adjustments to claims previously paid, interim PIPs, and RAPs. If it is discovered that money is released to the provider after the effective date of the payment suspension, the MAC or *UPIC* shall contact CPI for guidance.

## 8.4.7.1 - Recovery From Provider or Supplier

***(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)***

Once an overpayment has been determined to exist, the *UPIC* shall *provide its COR and IAG BFL* a summary of the investigation, any prior history (if applicable), the medical review results (including denial reasons), and the extrapolated overpayment amount in a format agreed upon by the *COR and IAG BFL for all extrapolation requests not associated with a Payment Suspension.*

*If the COR and IAG BFL agree that an extrapolated overpayment is appropriate, the UPIC shall include the case on the next case coordination meeting agenda for discussion and final approval. During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions associated with the investigations. If the UPIC has subsequent questions following the case coordination meeting, the UPIC shall coordinate with its COR and IAG BFL.*

The contractor shall include in the overpayment demand letter information about the review and statistical sampling methodology that was followed. Only MACs shall issue demand letters and recoup the overpayment. In the Final Review Results sent to the provider/supplier, the contractor shall include information about the review and statistical sampling methodology that was utilized for estimation.

The explanation of the sampling methodology that was followed shall include all of the following:

- A description of the universe, the sample frame, and the sampling methodology,
- A definition of the sampling unit,
- The sample selection procedure followed, and the numbers and definitions of the strata and size of the sample, including allocations, if stratified,
- The time period under review,
- The overpayment estimation, the overpayment estimation methodology, and the calculated sampling error; and
- The amount of the actual overpayment/underpayment from each of the claims reviewed.

The contractor shall also include a list of any problems/issues identified during the review and any recommended corrective actions.

# Medicare Program Integrity Manual
## Chapter 15 - Medicare Enrollment

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## 15.27.3 - Other Identified Revocations

*(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)*

**MDPP Supplier Revocation for Use of an ineligible coach**

1. General Procedures

42 CFR §424.205(h)(v) established a new revocation reason specifically for MDPP suppliers for a specific circumstance in which the MDPP supplier knowingly permitted an ineligible coach to furnish MDPP services to beneficiaries, despite being previously removed from the MDPP supplier's roster through a CAP.

If a MAC or ZPIC suspects this scenario, it shall develop a case file - including the reason(s) - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group (PEOG). The contractor shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to the contractor for additional development, or
- Consider approving the contractor's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (MAC) is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the MAC receives a direct request from a ZPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its PEOG Business Function Lead (PEOG BFL) if it is unsure whether the ZPIC received prior PEOG approval for the revocation.

**2. Revocation Request Data**

The revocation request shall contain the following information:

- Provider/supplier name; administrative location(s); community setting(s) if applicable type (e.g., DMEPOS supplier); Provider Transaction Access Number; National Provider Identifier; applicable Medicare Administrative Contractor
- Name(s), e-mail address(es), and phone number(s) of investigators
- Tracking number

- Provider/supplier's billing status (Active? Inactive? For how long?)

- Whether the provider/supplier is a Fraud Prevention System provider/supplier

- Source/Special Project

- Whether the provider/supplier is under a current payment suspension

- Legal basis for revocation

- Relevant facts

- Application of facts to revocation reason

- Any other notable facts
- Effective date (per 42 CFR § 424.535(g))
- Supporting documentation
- Photos (which should be copied and pasted within the document)

3. Effective Dates

If revoked under this authority, the MDPP supplier does not have CAP rights. The revocation becomes effective 30 days after the contractor sends notice of the revocation.

4. Reenrollment Bar

   As stated in 42 CFR §424.205(h), if an MDPP supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

5. Processing information

   Refer to 15.27.2.E-H for additional processing information that also apply to this revocation reason.

# Medicare Program Integrity Manual
# Exhibits

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## Transmittals for Exhibits

*44.1 – SMRC – UPIC JOA*

*Exhibit 44.1*
*(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)*

# Joint Operating Agreement

***Between***

***XXX***
***In its capacity as the Supplemental Medical Review Contractor (SMRC)***

***And***

***XXX***
***In its capacity as the Unified Program Integrity Contractor XXX***

*Prepared by:*
*XXX*

## Revision History

| Version | Date | Changed By | Description of Change | Signature Required |
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# *1. Introduction*

## *1.1-Purpose of the Supplemental Medical Review Contractor*

*The purpose of the SMRC is to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the Medical Review (MR) functions primarily for Medicare Fee-for-Service (FFS); other product line analysis is limited and may include Medicaid FFS, private and group health insurance lines of business and Prescription Drug Plan (Part D). One of the primary tasks will be conducting large volumes of nationwide MR as directed by the Centers for Medicare & Medicaid Services (CMS). The MR will be performed on Medicare FFS claims for Part A, Part B, and DMEPOS programs. These medical review activities will assess compliance with Medicare's coding, coverage, billing, and payment requirements and identify claims improperly paid. The SMRC will recommend recoupment and/or adjustment for claims identified as improperly paid. Having a centralized MR resource that can perform large volume of MR nationally shall allow for a timely and consistent execution of MR review, activities, and decisions. The SMRC shall select subject claims, perform research and/or data analysis, and conduct reviews in a manner that will minimize provider and supplier burden.*

## *1.2-Purpose of the SMRC Joint Operating Agreement*

*The purpose of this no-cost Agreement is to set forth the terms and conditions pursuant to which the Parties will coordinate efforts to maintain consistency of the Medicare program in accordance with the provisions of their respective CMS contract ("CMS Contract"). The term of this Agreement shall commence on the Effective Date and continue until either Party's CMS Contract expires, or it is terminated by either Party upon thirty (30) days written notice to the other Party.*

## *1.3-Scope*

*This Agreement is intended to serve as a framework for the collaborative measures the Parties will take to implement, maintain, and advance their mutually shared goal of preserving the integrity of the Medicare program; it is not intended to be a comprehensive description of the Parties' working relationship. This Agreement does not create any affirmative duties, rights or legal obligations between the Parties, nor does it give any person or entity their successors and permitted assigns, any right, remedy or claim in it. Each Party has a contractual relationship with CMS and each party shall be solely responsible to CMS for its performance under this JOA and the terms of this Agreement shall not alter or amend a Party's CMS Contract. If there are any conflicts between the terms of this Agreement and a Party's CMS Contract, the terms of the Party's CMS Contract shall take precedence. The terms of this Agreement shall be interpreted so as to resolve any conflict between it and a Party's CMS Contract, and, if necessary, this Agreement shall be amended to reconcile any unresolved conflict with a Party's CMS Contract.*

## *1.4-Joint Operating Agreement Participants and Roles*

*The term "JOA Participants" refers to the SMRC, CMS, and Unified Program Integrity Contractor (UPIC).*

### *1.4.1-Supplemental Medical Review Contractor's Role*

*The SMRC will perform research and analysis, MR, statistical sampling, and extrapolation. The SMRC will specifically include the following activities:*

- *Perform Medicare Part A and Part B (including DME) post payment MR in accordance with CMS instructions including expedited reviews. The list of providers will be sent via secure email provided in Section 4.3;*
- *For post payment medical review, develop and send a letter for the solicitation of medical records and supporting documentation needed to support the claims, when necessary;*
- *Perform claim re-reviews for claims reviewed initially by the SMRC;*

- *Perform statistical sampling and extrapolation to assess overpayment or potential overpayment(s) made on claims;*
- *Access the Recovery Auditor Data Warehouse (RDW) prior to selecting claims for review to ensure they are not excluded or suppressed;*
- *Upload all claim samples identified into the RDW;*
- *Review all services in accordance with the applicable statutes, CMS guidelines, and coverage requirements;*
- *Recommend claim denial for any claim when a provider fails to send medical records or supporting documentation;*
- *Maintain a tracking system to reflect and identify MR activities for all claims;*
- *Ensure coordination of efforts and prevent duplication of activities or interference with an existing investigation or corrective action plan;*
- *Ensure each MR is conducted by a Registered Nurse (RN);*
- *Ensure each coding review is conducted by a Certified Professional Coder (CPC) or Certified Coding Specialist (CCS) with an active certification;*
- *Ensure records are maintained confidentially in accordance with the Statement of Work (SOW) and applicable regulations;*
- *Participate in Administrative Law Judge (ALJ) hearings as a participant or party, as appropriate, to defend positions or provide testimony;*
- *Provide education on eligible claims to providers as requested for those claims reviewed by SMRC; and*
- *Participate in discussion periods with providers as requested for those claims reviewed by SMRC that are eligible for Discussion & Education (D&E).*

*The SMRC does not have responsibility for:*

- *Claims processing and adjudication activities;*
- *Performing redeterminations related to appealed initial determinations conducted by the SMRC; and*
- *Cost report audit activities.*

### *1.4.2-Unified Program Integrity Contractor's Role*

*The UPICs role and responsibilities include:*

- *Fraud, waste and abuse investigations and program integrity related data analysis; and*
- *Pre and post payment claim review for program integrity purposes.*

### *1.4.3-Centers for Medicare & Medicaid Services' Role*

*CMS' Contracting Officers' Representative (COR), Contract Specialist, and Contracting Officer have overall responsibility for the SMRC. The Contract Specialist and Contracting Officer, Office of Acquisitions and Grants Management (OAGM), in coordination with the COR, are the only persons authorized to:*

- *Enter into and commit or bind the government by contract for supplies and services;*
- *Accept nonconforming work or waive any requirement of the contracts;*
- *Authorize reimbursement to the contractor for any costs incurred during the performance of the contract; and*
- *Modify any term or condition of the contract (that is, make any changes in the SOW, modify or extend the period of performance, change the delivery schedule).*

## *1.5-Liability*

*Each Party is indemnified and protected by limitations on liability according to the terms of its respective contract with CMS.*

*Except with respect to a breach of the confidentiality provision set forth in section 1.6 below, titled "Mutual Confidentiality", this JOA shall not be construed to give rise to any binding obligation, rights, duty or liability, of any kind whatsoever, of any Party to this JOA to any other party.*

***1.6-Mutual Confidentiality***

*The parties understand, acknowledge and agree that each party's inventions, discoveries, proprietary information and trade secrets are of critical importance to its ongoing operations and prospects. During the course of performing services for CMS according to their respective contracts, described above, the parties will likely have access to information that is confidential and proprietary to the other party. In addition, each party may create inventions, make discoveries, write software or code, develop file layouts, methodologies or processes, and create applications during the course of the parties' relationship.*

*Examples of proprietary information and trade secrets include, but are not limited to, discoveries, improvements, processes, developments, designs, know-how, data, file layouts, documentation, computer programs (including but not limited to all source code for those programs) and formulae.*

*Each Party agrees to hold the other party's Confidential Information to at least the same level of protection against unauthorized disclosure or use as the receiving party normally uses to protect its own information of a similar character, but in no event less than reasonable care.*

*Neither party shall disclose to any person in any manner, either before, during or after the term of this JOA, proprietary or trade secret information (as hereafter defined) except to the extent necessary for the performance of each party's duties under this JOA, or as required by CMS pursuant to each party's contract with CMS, as applicable. Each party shall not use proprietary/trade secret information of the other for any other purpose whatsoever. Each party agrees to cooperate with the other party, and to use its best efforts, to prevent the unauthorized disclosure, use or reproduction of any proprietary/trade secret information of the other.*

*Nothing in this Agreement shall prohibit or limit a party's use of information (including, but not limited to, ideas, concepts, know-how, techniques, and methodologies) (i) previously known to that party, prior to its receipt from the disclosing party, (ii) independently developed without use of the Confidential Information, (iii) acquired by it from a third party which was not, to the recipient's knowledge, under an obligation to the disclosing party not to disclose such information, or (iv) which is or becomes publicly available through no breach of this Agreement by the receiving party.*

*The obligation to protect Confidential Information shall survive the expiration or termination of this JOA.*

***1.7-Independent Contractors***

*The parties each recognize and agree that they are independent contractors. There is no privity of contract between these Parties. Nothing contained in this Agreement shall be construed to make any party an agent, servant, partner, employee of or joint venture of or with any other party. No party has the right or authority to interfere with or in any manner influence, direct or control the decision-making process, evaluations, judgments or reviews of any other. No party shall have any right or authority, whether express or implied, to assume or create any obligation, duty, or responsibility whatsoever on behalf of any other party.*

***1.8-Privacy***

*The parties agree that issues pertaining to the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule) published in April 2003 are covered by the two organizations' independent contracts with CMS.*

*When future privacy regulations are published, the two organizations will review that information and address any impact to joint processes in subsequent versions of the JOA. The parties agree that issues pertaining to the confidentiality, privacy, and security of Medicare data are covered by the two independent contracts with CMS.*

### *1.9 Funding*

*Nothing in this JOA will obligate either party to perform any tasks that are outside the current scope of work, unless CMS directs such tasks and provides adequate funding.*

## *2. Communication*

### *2.1-Contact Information*

*Contact information for all parties is provided in Appendix A, Master Contact List.*

### *2.2-Point of Contact Roles*

*To ensure that communication is properly directed, CMS, the UPIC and the SMRC will identify (in Appendix A, Master Contact List) representative(s) to serve as:*

- ***JOA Point of Contact (POC)**: Each party will designate a representative responsible for serving as the lead company/agency POC in establishing and maintaining the JOA content, and in leading resolution of any JOA-related issues that may arise. Additional information regarding maintenance of the JOA is included in Section 2.5, Maintenance of the JOA.*
- ***JOA Signatory**: Each party will designate a representative who is responsible for providing final approval and signature for updates to the JOA.*
- ***Information Technology (IT) POC**: Each party will designate a representative to act as a focal point for the exchange of information relevant to systems configuration, operation, and communications.*

### *2.3-Joint Operating Agreement Meetings*

*The SMRC and UPIC will assess for and discuss any JOA updates during the monthly workgroup meetings. The SMRC and UPIC JOA meetings will provide a forum for communication among the SMRC and UPIC JOA participants. The SMRC COR and the UPIC COR are to be notified of all SMRC and UPIC JOA conference calls since they are optional participants.*

## *2.4-Workgroup Meetings*

*Workgroups will be formed based on input from JOA Participants to provide focused attention on key topics. Changes in participants in the workgroups will not necessitate a change in the JOA. These workgroup meetings will take place by conference calls.*

*SMRC and UPIC Coordination Workgroup: On an ongoing basis, this workgroup will meet at least monthly on the same date/time each month to facilitate coordination of activities related, but not limited to, workload, re-reviews, discussion and education sessions, overpayments and appeals. In addition to this workgroup, representatives may interact, as needed, in smaller workgroups to focus on specific areas, such as overpayments and appeals.*

*Additional Meetings: The SMRC and UPIC JOA POC will schedule additional conference calls as requested by the JOA Participants.*

*Agenda: The SMRC JOA POC will distribute the Agenda to all members by e-mail in advance of the next meeting. The SMRC JOA POC will solicit Agenda items from SMRC and UPIC JOA participants approximately one week prior to the meeting. The meetings may include (along with other agenda items) high-level data analysis findings, statistical reports, recommendations, review activities, and action items.*

*Participation: Workgroup participation will include representation from CMS, the UPIC, and SMRC. At minimum, JOA Participants will include the UPIC Operations, UPIC JOA POC, SMRC Program Manager (PM), SMRC JOA POC, CMS SMRC COR/ACOR/BFL, and CMS UPIC COR/ACOR/BFLs and others as applicable.*

*JOA Improvements: Continuous improvement of the JOA will be an agenda item for discussion at each meeting. Additional information regarding initiating and controlling changes to the JOA is described in Section 2.5, Maintenance of the JOA.*

*Minutes: SMRC will take Minutes during each workgroup meeting and distribute them by e-mail to all participants within ten business days of the meeting. SMRC will also track all action items in the minutes and report on them at each workgroup meeting.*

### *2.5-Maintenance of the JOA*

*JOA POCs are invited to initiate continuous improvements to the JOA. Any such suggestions will be discussed at the next regularly scheduled JOA meeting or through special sessions as necessary.*

*Change Suggestions: All suggestions are to be sent to the SMRC JOA POC. Within seven business days, the SMRC JOA POC will distribute a draft to CMS and the UPIC JOA POCs. Feedback is to be provided within seven business days. The SMRC JOA POC will then distribute a final draft to CMS and the UPIC JOA POC. If no issues are identified within seven business days, the updates will be considered accepted. The SMRC JOA POC will disseminate information regarding the updates to CMS and the UPIC JOA POC annual reviews, 14 business days will be allowed to review changes and make updates for the annual JOA reviews.*

*Tracking Changes: Changes to the JOA are identified in the Change History Log on the second page of this document and are controlled by a version number in the upper right corner of each page of the document. Changes to the appendices to this document are also controlled by a version number in the lower left corner of each appendix.*

*Signature of JOA: For those changes to the body of the JOA that are determined by the SMRC CMS COR and BFLs to be significant (as identified in the Change History Log on the second page of this document), new approvals will be collected. Approvals are not necessary for changes to the appendices (such as the Appendix A, Master Contact List). Approval of the first JOA will adhere to the following procedure: All parties to the JOA are to sign the first jointly approved version of the JOA and subsequent changes using Appendix B, Joint Operating Agreement Approval Signature Form. Such signed documents will be distributed to the relevant POCs for the parties identified in Appendix A, Master Contact List.*

### *2.6-Dispute Resolution Process*

*Disputes/issues will be escalated, if necessary, for resolution by the following process:*

1. *The SMRC and the UPIC counterparts will first attempt to resolve the issue.*
2. *If the SMRC and the UPIC counterparts are unable to come to a resolution, the matter will be brought to the attention of the SMRC JOA POC and the UPIC JOA POC (as identified in Appendix A, Master Contact List).*
3. *If the SMRC JOA POC and the UPIC JOA POC are unable to come to a resolution, the matter will be escalated to the SMRC PM and the UPIC Project Manager (as identified in Appendix A, Master Contact List).*

4. *If the SMRC PM and the UPIC Project Manager are unable to come to a resolution, the SMRC PM will bring this matter to the attention of the SMRC CMS COR and the UPIC Project Manager will bring this matter to the attention of the UPIC CMS COR (as identified in Appendix A, Master Contact List).*
5. *If the dispute between the SMRC and the UPIC cannot be resolved, the issues will be directed, in writing, to the CMS CORs and BFLs for resolution by a JOA Alternative Dispute Resolution Team.*

### *2.7-Mailing Information*

*All information mailed between the UPIC and SMRC will be sent by delivery service (FedEx®, United Parcel Service of America [UPS®], or DHL Worldwide Express [DHL®]) and shipped to the addresses specified below:*

*UPIC Company Name*
*Attn: Department*
*Mailing Address*
*City, State Zip Code*

*The sender will e-mail the intended recipient a confirmation e-mail containing an inventory of the shipment contents, encryption information (if applicable), and tracking number of the package. The recipient will confirm receipt of the package upon arrival. Refer to Section 3.2, Systems, regarding security.*

## *3. Systems*

### *3.1-Data Files*

*The CMS has directed the SMRC to perform data analysis activities to support MR and overpayment extrapolation. These activities will require the SMRC to obtain data from various resources, including, but not limited to, CMS' One Program Integrity (One PI) Shared Systems database, CMS' National Claims History (NCH) database, and RDW. If data is needed from the UPICs, this will be discussed during the workgroup meeting.*

### *3.2-Security*

*Each party agrees to adhere to the security requirements in the Business Partner System Security Manual (BPSSM). Both parties agree to work together on all aspects of security in the BPSSM, or as otherwise issued via Technical Direction Letter or other means by CMS, that require the joint cooperation of both parties. Mail and email exchanges containing Personally Identifiable Information (PII) will follow the requirements as outlined by the most current version of the ARS which states the PII must be secured in an attachment that has been zipped using FIPS 140-2 validated software (i.e. SecureZip). Each party further agrees to adhere to CMS JSM/TDL-09323 and CMS JSM/TDL-11141: Guidelines for Implementing the Centers for Medicare & Medicaid Services' (CMS) Revised Information Security Incident Handling and Breach Analysis/Notification Procedures.*

## *4. Processes*

### *4.1-Misdirected Communications*

*Misdirected communications may include written, e-mail, or facsimile inquiries received from providers. Unless otherwise addressed in this JOA, any misdirected communications will be forwarded to the appropriate party (SMRC or UPIC) following the process outlined in Section 2.7 Mailing Information.*

### *4.2-Collaboration*

*The SMRC will send the UPIC file of providers/suppliers on review via email at xxxx@xxxxxx.xx*

### *4.3-Ad Hoc Reports*

*Ad hoc reports may be requested by either the UPIC or SMRC via the Ad Hoc Request Form (Appendix C xxx). The completed form must be faxed or emailed to the appropriate JOA POC. All requests will be evaluated by the receiving contractor for approval based upon feasibility and cost of implementation. The receiving contractor may directly contact the requesting individual to clarify data requests as needed. The SMRC and UPIC JOA POCs or authorized individual will coordinate with the requestor when these reports are available.*

### *4.4-Fraud Referral*

*The SMRC will document their findings in a standard format, and, when appropriate, refer the case to the Center for Program Integrity (CPI)/Unified Program Integrity Contractor (UPIC) for development through the current process in place with CMS. The SMRC will remain accessible to the referral agency to facilitate their investigation, and to prepare potential cases for litigation or prosecution. SMRC referrals to UPIC xx of potential fraudulent activities should be sent to the UPIC xx at: UPICxxLead@admedcorp.com*

### *4.5-Process Improvement*

*Where appropriate and feasible, the parties will provide recommendations on process refinements. Such changes will be presented and approved through the process described in Section 2.5 regarding changes to the JOA.*

*Appendix A. Master Contact List*

## *Table A-1. Supplemental Medical Review Contractor*

| POC Role | Representative | Contact Number | E-mail |
|---|---|---|---|
| JOA POC | | | |
| Project Manager | | | |
| MR Director | | | |
| Information Security Manager | | | |
| MR Manager | | | |
| Operations Manager | | | |
| Liaison, Hearing & Appeals Coordinator | | | |

## *Table A-2. Unified Program Integrity Contractor xx*

| POC Role | Representative | Contact Number | E-mail |
|---|---|---|---|
| UPIC JOA POC | | | |
| UPIC Operations POC | | | |
| UPIC Appeals Manager | | | |
| UPIC Appeals Manager | | | |
| UPIC Overpayment team leader—Audit | | | |
| UPIC Overpayment team Leader—Recoupment | | | |
| UPIC POE Manager | | | |
| JOA Signatory | | | |
| JOA Signatory | | | |

## *Table A-3. Centers for Medicare & Medicaid Services*

| | | | |
|---|---|---|---|
| SMRC COR | | | |
| SMRC ACOR/BFL | | | |
| Contracting Officer | | | |
| Contracting Specialist | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## *Appendix B. JOA Approval Signature Form*

*Company/Entity Name:*
*Signatory Name (Printed):*
*Signatory Signature:* _____
*Date:* ____/____/____

*Company/Entity Name:*
*Signatory Name (Printed):*
*Signatory Signature:* _____

*Date:* ____/____/____

*Company/Entity Name:*
*Signatory Name (Printed):*
*Signatory Signature:* _____
*Date:* ____/____/____