CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12772	**Date: August 9, 2024**
	Change Request 13719

SUBJECT: Updates of Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Chapter 9 in Publication (Pub.) 100-08, Including Complaint Referral Coordination Between Contractors

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update sections within Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Chapter 9 in Pub. 100-08. The updates in this CR include, but are not limited to, Unified Program Integrity Contractor (UPIC) coordination with the Medicare Administrative Contractors (MAC) for purposes of complaint referrals, guidance regarding inputting suppression and exclusion cases to the Recovery Audit Contractor Data Warehouse (RACDW), and various other minor updates to Pub 100-08.

This update does not affect the provider and/or beneficiary populations. Rather, this update is solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

EFFECTIVE DATE: September 20, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 20, 2024

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	1/TOC
R	1/1.3/1.3.6/Quality of Care Issues and Potential Fraud Issues
R	1/1.7/Program Integrity
R	1/1.8/Medical Review for Program Integrity (MR for PI)
R	2/2.4/Sources of Data for MACs and UPICs
R	3/3.4/Prepayment Review of Claims
R	4/4.3/4.3.2/4.3.2.4/Referrals to the UPIC
R	4/4.5/4.5.1/UPIC and I-MEDIC Responsibilities
R	9/9.4/Inputting Suppression and Exclusion Cases to the RACDW

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: 12772	Date: August 9, 2024	Change Request: 13719

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This update does not affect the provider and/or beneficiary populations. Rather, this update is solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update sections in Chapters 1, 2, 3, 4, and 9 in Pub. 100-08. Specifically, guidance in Chapter 4 is being revised to instruct the UPICs and MAC what actions shall occur in cases where a complaint is received for a provider and/or suppliers that has previously been referred to the UPIC. The updates in the remaining chapters are minor and primarily for purposes of re-wording, structure, and additional clarification.

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

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13719.1	The UPIC shall refer to section 4.9.4.2 in Chapter 4 of Pub. 100-08 for a discussion on program integrity (PI) interaction with									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Quality Improvement Organizations.									
13719.2	The UPIC shall be advised that the goal of the Medical Review for PI is to address situations of potential fraud, waste, and abuse.									UPICs
13719.3	The UPIC shall be advised that, while the MAC, Recovery Auditor, and UPIC should investigate reports from the Government Accountability Office, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG Office of Investigations, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not be used as a main									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	source for leads on fraud, waste or abuse cases.									
13719.4	The MAC shall be advised that if a provider/supplier is found to be previously referred to the UPIC and on an active Payment Suspension, it is important to appropriately close the complaint in the applicable system(s) (i.e., Next Generation Desktop (NGD), MAC system(s), etc.) and ensure the information is communicated to the UPIC.	X	X	X	X					
13719.4.1	The MAC shall continue to report new claims identified in subsequent complaints to the UPIC in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension.	X	X	X	X					
13719.4.2	The MAC shall close complaints in the applicable systems (i.e.,	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NGD, MAC systems(s); however, do not cancel them) with a note that references section 4.3.2.4 - Referrals to the UPIC of in Chapter 4 of Pub. 100-08 in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension.									
13719.4.3	The MAC shall not send any notification or communication to the beneficiary or provider in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension.	X	X	X	X					
13719.4.4	The MAC shall not conduct any additional research (calls to the provider and/or beneficiary, claims history reviews, other records or complaints	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reviews, additional documentation requests or, medical record requests) in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension.									
13719.4.5	The MAC shall refer the complaint to the applicable UPIC as through the process outlined in your Joint Operating Agreement in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension.	X	X	X	X					
13719.4.6	The MAC shall be advised that it is very important that UPICs are promptly notified of these subsequent complaints.	X	X	X	X					
13719.4.7	Each MAC shall work with its respective UPIC(s) to	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	identify what additional details are needed and how best to communicate these complaints since they will not be communicated via formal referral.									
13719.4.8	The MAC shall be advised that at a minimum, complaints that fall under this category shall be communicated monthly.	X	X	X	X					
13719.5	The UPIC shall not send acknowledgement within 15 calendar days of receipt of the complaint referral from the MAC screening staff unless it can be resolved sooner if the MAC refers a Durable Medicare Equipment (DME) provider/supplier that was previously referred to the UPIC, is under active investigation, is on an active Payment Suspension, has been referred to									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	law enforcement and is under active law enforcement investigation, or is under an active zone restriction.									
13719.6	The UPIC shall not send acknowledgement to the complainant, indicating that a referral is being made, if applicable, to the appropriate MAC unit for further action if the MAC refers a DME provider/supplier that was previously referred to the UPIC, is under active investigation, is on an active Payment Suspension, has been referred to law enforcement and is under active law enforcement investigation, or is under an active zone restriction.									UPICs
13719.7	The UPIC shall not send complaint resolution within seven (7) calendar days of									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	resolving the complaint investigation if the MAC refers a DME provider/supplier that was previously referred to the UPIC, is under active investigation, is on an active Payment Suspension, has been referred to law enforcement and is under active law enforcement investigation, or is under an active zone restriction.									
13719.8	The UPIC shall document the MAC referral/complaint in the active investigation file in Unified Case Management system as well as upload the referral/complaint in the Documents section of the active investigation file.									UPICs
13719.8.1	The UPIC shall consider interviewing beneficiaries that have filed a complaint should									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the UPIC need additional beneficiary interviews.									
13719.9	The UPIC shall input all claims requiring suppression and exclusion into the RACDW.									UPICs
13719.10	The UPIC shall refer to their specific suppression and/or exclusion requirements in Chapter 4 of Pub. 100-8.									UPICs
13719.11	The UPIC shall be advised that instances where a fraud/PI review is in progress require suppression.									UPICs

IV. PROVIDER EDUCATION TABLE

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

V. 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

VI. CONTACTS

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

VII. 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 1 – *Overview of Medical Review (MR) and Program Integrity (PI) Programs*

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(Rev. 12772; Issued: 08-09-24)

Transmittals for Chapter 1

1.3.6 - Quality of Care Issues and Potential Fraud Issues

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

Potential quality of care issues are not the responsibility of the MAC, CERT or Recovery Auditor, *UPIC*, and SMRC but they are the responsibility of the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. MACs, CERT, Recovery Auditor, *UPICs* and SMRC shall refer quality of care issues to the QIO, State licensing/survey and certification agency, or other appropriate entity in the service area. See chapter 3, section 3.1, for a discussion of how contractors should handle situations where providers are non-compliant with Medicare conditions of participation.

Contractors shall analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action shall be initiated. At any time, evidence of fraud shall result in referral to the *UPICs* for development. See chapter 4, section *4.9.4.2* for a discussion on *program* integrity interaction with QIOs.

1.7 - *Program* Integrity

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

A. Contractors to Which This Section Applies

This section applies to UPICs only.

B. General

In addition to reducing improper payments, CMS strives to protect the program from potential fraud. CMS contracts with Unified Program Integrity Contractors (UPICs) to identify and stop potential fraud.

The primary task of UPICs is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are identified. UPICs shall refer cases of potential fraud to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Office of Investigations (OI).

1.8 - Medical Review for *Program* Integrity (MR for *P*I)

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

A. Contractors to Which This Section Applies

This section applies to UPICs.

B. General

The goal of the MR for *P*I is to address situations of potential fraud, waste, and abuse (e.g., looking for possible falsification).

Information on maintaining the confidentiality of MR documents can be found in this chapter, section 1.6.

Medicare Program Integrity Manual

Chapter 2 – Data Analysis

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(Rev. 12772; Issued: 08-09-24)

2.4 – Sources of Data for MACs and UPICs

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

A. Contractors To Which This Section Applies

This section applies to MACs and UPICs**.** The sources of data for CERT and Recovery Auditors are specified in their SOWs.

B. General

The data sources that MACs and UPICs use will depend upon the issue(s) being addressed and the availability of existing data. CMS maintains numerous systems housing Medicare, Parts A, B, and D claims, Beneficiary Entitlement, Enrollment and Utilization data, Provider reference information. The IDR is the enterprise resource designed to house and unify the data from disparate systems to enable cross-cutting reporting and analysis. The IDR has been created with an aim toward reducing data redundancy, providing flexibility to satisfy changing business needs and serve as the relational data warehouse for core CMS data. The IDR provides the system platform and database structures which enable one store of data to meet the various needs of our MAC and UPIC community. The repository is leveraged by multiple reporting, analytical and operational production applications.

Systematic data analysis requires MACs and UPICs to have in place the hardware and software capability to profile providers in aggregate, by provider type, by common specialties among providers, or individually. Some of the provider information that should be used includes:

- Types of providers;
- Volume of business;
- Volume (or percentage) of Medicare/Medicaid patients;
- Prevalent types of services;
- Location;
- Relationships to other organizations;
- Types of ownership;
- Previous investigations by the UPIC;
- Size and composition of staff;
- Administrative costs;
- Claims history; and
- Other information needed to explain or clarify the issue(s) in question.

Where possible, the selection of providers should show a representative grouping, in order to accurately reflect the extent of program losses.

C. Primary Source of Data

Claims data is the primary source of information used to identify and target fraudulent, wasteful or abusive activities. Sources of claims data are:

- IDR--MACs and UPICs should utilize the reports accessible in the system platform and database structures. Reports include the following:

    - Claims Summary Information report (CSI) which used to be called Health Care Information System (HCIS),

    - Part B Analytics System Report (PBASR), which show comparative utilization ratios by code, MAC, and specialty,

    - Short Term Alternatives for Therapy Services (STATS) which shows Outpatient therapy professional and provider claims data,

    - IDR Analysis Reports which include analysis reports and IDR volume and statistics, and

    - Focused Medical Review (FMR) which shows Part B claims utilization and enrollment data.

The MACs and UPICs shall also use national data where available. National data for services billed by skilled nursing facilities (SNFs) and home health agencies (HHAs) is available at the CMS Data Center. When made available, contractors can access through CMS One Program Integrity (see below One PI) or the CMS Enterprise Portal.

- CMS One Program Integrity (One PI) – Serves as a system application, tool and databases providing access to the CMS IDR;

- Contractor Local Claims Data – Local data should be compiled in a way to identify which providers or type of service in the contractor's area may be driving any unusual utilization patterns;

- CMS Fraud Prevention System(FPS)--When access is available, MACs should consider periodically reviewing the information and data trends resulting from national predictive models contained in the FPS;

- CMS PBASR--The Report stores data sets that contain annual timeframes, and Healthcare Common Procedure Coding System HCPCs/CPT codes that correspond to provider/supplier disciplines. Each data set displays the allowed services, allowed charges, and payment amounts by HCPCs/CPT codes and prominent modifiers. The PBAR is only accessible through the Enterprise Portal; and

- CMS Claims Summary Information (CSI)——Files contain Medicare Part A (i.e., Inpatient, Skilled Nursing Facility, Home Health Agency (Part A & B) and Hospice) and Medicare Part B (i.e., Outpatient) information based on the type and State of the institutional provider. The data set names correspond with the provider type. Brief descriptions of the provider types and the selected reporting elements (e.g., units of service, billed charges, provider ZIP code, etc.) are provided. Access is through the One PI portal.

D. Secondary Sources of Data

The MACs and UPICs should consider other sources of data in determining areas for further

analysis. These include:

- OIG and Government Accountability Office (GAO) reports;
- Fraud Alerts;
- Beneficiary, physician and provider complaints;
- Appeals data from QICs, including appeals overturn rate for a particular type of claim;
- Referrals from the QIO, other contractors, CMS components, Medicaid fraud control units, Office of the U.S. Attorney, or other federal programs;
- Suggestions provided directly or implicit in various reports and other materials produced in the course of evaluation and audit activities, (e.g., contractor evaluations, State assessment, CMS-directed studies, contractor or State audits of providers);
- Referrals from medical licensing boards;
- Referrals from the CAC;
- Peer Review Reports such as the First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM) and Program to Evaluate Payment Patterns Electronic Report (PEPPER), and Comparative Billing Reports;
- Information on new technologies and new or clarified benefits;
- Provider cost reports;
- Provider Statistical and Reimbursement (PS&R) System data;
- Enrollment data;
- Overpayment data;
- Pricing, data analysis, and coding (PDAC) data;
- Referrals from other internal and/or external sources (e.g., MAC audit staff, audit staff or, MAC quality assurance (QA) staff);
- Medicare Learning Network – which includes MedLearn Matters articles and Quarterly Provider Compliance Newsletters;
- IBM Cognos support for the Part D and Drug Data Processing System (DDPS) using the Teradata data repository;
- CMS prepared data, such as a listing of distinct providers or suppliers and/or bills that require medical review.

While the MAC, Recovery Auditor, and UPIC should investigate reports from the GAO, congressional committees, Office of Inspector General Office of Audit Services (OIG OAS), OIG OI, newspaper and magazine articles, as well as local and national television and radio programs, highlighting areas of possible abuse, these types of leads should not *be used as a main* source for leads on fraud, waste or abuse cases.

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev. 12772; Issued: 08-09-24)

Transmittals for Chapter 3

3.4 - Prepayment Review of Claims

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

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 *Percent* 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 *percent* 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 *Percent* Prepayment Review

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

MACs have the discretion to conduct 100 *percent* prepayment review of providers. CMS considers 100 *percent* 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 *percent* prepayment review shall inform the CMS COR, Regional Office TM, and BFL in advance about any provider being placed on 100 *percent* 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 *percent* prepayment review.
- The length of time the provider is expected to be on 100 *percent* 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 *percent* prepayment review.

3. UPIC Initiated Prepayment Reviews

No UPIC shall initiate a 100 *percent* prepayment review without CMS approval. Therefore, the UPIC shall provide its COR and 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 BFL.

If the COR and BFL agree that 100 *percent* 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 BFL.

Medicare Program Integrity Manual
Chapter 4 - Program Integrity

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(Rev. 12772; Issued: 08-09-24)

Transmittals for Chapter 4

4.3.2.4 - Referrals to the UPIC

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

MACs that refer a complaint to the UPIC shall notify the UPIC via e-mail that a complaint is being referred as potentially fraudulent. The MAC shall develop a referral package (see below for what should be included in the referral package) for all complaints being referred to the UPIC and shall send the complaint via a secure method such as e-mail or mail directly to the UPIC.

Complaints shall be forwarded to the UPIC for further review under the circumstances listed below (this is not an exhaustive list):

- Claims may have been altered
- Claims have been up-coded to obtain a higher reimbursement amount and appear to be fraudulent or abusive;
- Documentation appears to indicate that the provider/supplier has attempted to obtain duplicate reimbursement (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to be paid twice). An example of an attempt to obtain duplicate reimbursement might be that a provider/supplier has submitted a claim to Medicare, and then in two (2) business days resubmits the same claim in an attempt to bypass the duplicate edits and gain double payment. This apparent double-billing does not include routine assignment violations. The MAC shall attempt to resolve all routine assignment violations. However, referral from the MAC to the UPIC shall be made in instances where the provider/supplier has repeatedly committed assignment violations, indicating a potential pattern;
- Potential misrepresentation with respect to the nature of the services rendered, charges for the services rendered, identity of the person receiving the services, identity of persons or doctor providing the services, dates of the services, etc.;
- Alleged submissions of claims for non-covered services are misrepresented as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs);
- Claims involving potential collusion between a provider/supplier and a beneficiary resulting in higher costs or charges to the Medicare program;
- Alleged use of another person's Medicare number to obtain medical care;
- Alleged alteration of claim history records to generate inappropriate payments;
- Alleged use of the adjustment payment process to generate inappropriate payments; or
- Any other instance that is likely to indicate a potential fraud, waste, and abuse situation.

Note: Since this is not an all-inclusive list, the UPIC has the right to request additional information in the resolution of the complaint referral or the subsequent development of a related case (e.g., provider/supplier enrollment information).

When the above situations occur requiring that the complaint be referred to the UPIC for review, the MAC shall prepare a referral package that includes, at a minimum, the following:

- Provider/supplier name, NPI, provider/supplier number, and address.
- Type of provider/supplier involved in the allegation and the perpetrator, if an employee of the provider/supplier.
- Type of service involved in the allegation.
- Place of service.
- Nature of the allegation(s).
- Timeframe of the allegation(s).
- Narration of the steps taken and results found during the MAC's screening process (discussion of beneficiary contact, if applicable, information determined from reviewing internal data, etc.).
- Date of service, procedure code(s).
- Beneficiary name, beneficiary HICN, telephone number.
- Name and telephone number of the MAC employee who received the complaint.

If a provider/supplier is found to be previously referred to the UPIC and on an active Payment Suspension, it is important to appropriately close the complaint in the applicable system(s) (i.e., Next Generation Desktop (NGD), MAC system(s), etc.) and ensure the information is communicated to the UPIC. The following actions shall occur in cases where a complaint is received for a provider/supplier previously referred to the UPIC and on an active Payment Suspension:

- *Continue to report new claims identified in subsequent complaints to the UPIC;*
- *Close complaints in the applicable system(s) (i.e., NGD, MAC system(s), etc.; however, do not cancel them) with a note that references this PIM section;*
- *Do not send any notification or communication to the beneficiary or provider;*
- *Do not conduct any additional research (calls to the provider and/or beneficiary, claims history reviews, other records or complaints reviews, additional documentation requests or, medical record requests);*
- *Refer the complaint to the applicable UPIC as through the process outlined in your JOA.*

It is very important that UPICs are promptly notified of these subsequent complaints. Each MAC should work with its respective UPIC(s) to identify what additional details are needed and how best to communicate these complaints since they will not be communicated via formal referral. At a minimum, complaints that fall under this category should be communicated monthly.

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

The MAC shall maintain a copy of all referral packages.

4.5.1 - UPIC and I-MEDIC Responsibilities

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

This section applies to the UPICs and the MACs.

When a 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 MAC refers a DME provider/supplier that was previously referred to the UPIC, is under active investigation, is on an active Payment Suspension, has been referred to law enforcement and is under active law enforcement investigation, or is under an active zone restriction, the UPIC shall not send the following letters to the beneficiary/complainant.

- ***Acknowledgement*** *within 15 calendar days of receipt of the complaint referral from the MAC screening staff unless it can be resolved sooner;*
- ***Acknowledgement*** *to the complainant, indicating that a referral is being made, if applicable, to the appropriate MAC unit for further action;*
- ***Complaint resolution*** *within seven (7) calendar days of resolving the complaint investigation.*

The UPIC shall document the MAC referral/complaint in the active investigation file (CSE) in UCM as well as upload the referral/complaint in the Documents section of the active CSE. Should the UPIC need additional beneficiary interviews, the UPIC should consider interviewing beneficiaries that have filed a complaint.

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 to lead screening, the I-MEDIC shall further screen the lead, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days.

The I-MEDIC shall track all complaints received by its complaint screening staff in an internal tracking system. All complaints that have escalated to a lead status shall be tracked 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.

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9.4 – Inputting Suppression and Exclusion Cases to the RACDW

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

The MAC, Supplemental Medical Review Contractor (SMRC), CERT, *and Unified Program Integrity Contractor (UPIC)* shall input all claims requiring suppression and exclusion into the RACDW. An exclusion is the permanent removal of a claim due to a previous review. A suppression is a temporary removal of a claim to an ongoing case development. *The UPIC shall refer to their specific suppression and/or exclusion requirements in IOM-100-8 Chapter 4.* The MAC can permanently exclude an individual claim or a series of claims, or suppress a provider's claim submission for a particular claim type for a period of time not to exceed one calendar year.

The following cases require **exclusion**:

- A medical review is in progress; or claims subjected to post payment review;
- Claims subjected to prepayment medical review;
- Claims originally denied and later paid by an appeal entity

The following cases require **suppression**:

- A fraud/*program* integrity review is in progress;
- The MAC or UPIC has been notified by an outside agency (law enforcement, Office of Inspector General (OIG), Department of Justice (DOJ)) that an investigation is ongoing.

The MACs shall not suppress or exclude claims that do not meet the above criteria. Claims on which the MAC is conducting education should not be suppressed.

The MACs shall enter suppression and/or exclusion records immediately after the need for these actions are identified. After the initial data input, contractors shall consistently monitor the RACDW and update on an as needed basis.

The MACs shall keep documentation on file that supports the information they added to the RACDW.

NOTE: The suppression or exclusion of an entire provider will require CMS approval. Additional direction can be found in the Medicare Program Integrity Manual (MPIM), Publication 100-08, Chapter 3, Section 3.5.2, and Chapter 4, Section 4.7.4.