CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 467	**Date: May 31, 2013**
	Change Request 8288

SUBJECT: Requirements for the Closing of Complaints After Transfer to the PSCs and ZPICs in the Office of the Inspector General (OIG) Hotline Complaint Database

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to clarify the procedures by which the ACs and MACs (hereinafter referred to as contractors) shall handle complaints that have been transferred to the PSCs and ZPICs in the OIG Hotline Database. The contractors shall not close complaints in the OIG Hotline Database that have been referred to the PSC or ZPIC.

EFFECTIVE DATE: December 1, 2012
IMPLEMENTATION DATE: July 1, 2013

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	4/4.6.2/Complaint Screening

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable.

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 467	Date: May 31, 2013	Change Request: 8288

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I. GENERAL INFORMATION

A. Background: The Internet Only Manual (IOM) Pub. 100-08, Medicare Program Integrity Manual, Chapter 4, section 4.6.2 – Complaint Screening - delineates the responsibility for the Beneficiary Contact Center (BCC), Program Safeguard Contractor (PSCs), Zone Program Integrity Contractors (ZPICs), Affiliated Contractors (ACs), and Medicare Administrative Contractors (MACs) (otherwise known as contractors) with regard to screening complaints alleging fraud and abuse. The manual states that the BCC, AC, and MAC shall be responsible for screening all complaints of potential fraud and abuse, and all advisements shall be forwarded immediately to the second-level screening staff at the AC or MAC for handling. If the AC or MAC determines that the complaint is potentially creditable allegation of fraud and abuse, the second-level screening staff shall forward the complaint to the PSC or the ZPIC Benefits Integrity (BI) unit for further development within 45 business days of receipt of the complaint, or within 30 business days of receiving medical records and/or other documentation, whichever is later.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8288.1	The ACs and MACs shall not close complaints in the OIG Hotline Database that have been referred to the PSC or ZPIC.	X	X		X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

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): Julie Payiatas, 415-744-3623 or juliana.payiatas@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
Not Applicable.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

4.6.2 - Complaint Screening

(Rev. 467, Issued: 05-31-13, Effective: 12- 1-12, Implementation; July 1, 2013)

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

A. Beneficiary Contact Center, Affiliated Contractor and Medicare Administrative Contractor Responsibilities

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

Initial Screening – Beneficiary Contact Center

The CSRs at the BCC shall try to resolve as many inquiries as possible in the Initial Screening with data available in their desktop system. The following are some scenarios that a CSR may receive and resolve in the initial phone call rather than refer to second-level screening (this is not an all-inclusive list):

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

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

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

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

Billing Errors - If the beneficiary states that he/she already contacted his/her provider and the provider admitted there was a billing error, and the check is still outstanding, the CSR shall follow the normal procedures for resolving this type of billing error.

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

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

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

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

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

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

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

Second-Level Screening – AC or MAC

When the complaint/inquiry cannot be resolved by the CSR at the BCC, the issue shall be referred for more detailed screening, resolution, or referral, as appropriate, to the AC or MAC. The second-level screening staff at the AC or MAC shall only screen potential fraud and abuse complaints with a paid amount of $100 or greater (include the deductible as payment) or 3 or more beneficiary complaints (regardless of dollar amount) on the same provider. Each complaint shall be tracked and retained for 1 year. If the beneficiary inquires about the complaint, advise the beneficiary that the complaint will be tracked and if additional complaints are received a more in-depth review will be opened. The second-level screening staff at the AC and MAC shall maintain a log of all potential fraud and abuse inquiries received from the initial screening staff. At a minimum, the log shall include the following information:

Beneficiary name

Provider name

Beneficiary HIC#

Nature of the Inquiry

Date received from the initial screening staff

Date referral is sent to the PSC or the ZPIC

Destination of the referral (i.e., name of PSC or the ZPIC)

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

Date inquiry is closed

The AC or MAC staff shall call the beneficiary or the provider, check claims history, and check provider correspondence files for educational/warning letters or contact reports that relate to similar complaints, to help determine whether or not there is a pattern of potential fraud and abuse. The AC or MAC shall request and review certain documents, as appropriate, from the provider, such as itemized billing statements and other pertinent information. If the AC or MAC is unable to make a determination on the nature of the complaint (e.g., fraud and abuse, billing errors) based on the aforementioned contacts and documents, the AC or MAC shall order medical records and limit the number of medical records ordered to only those required to make a determination. If the medical records are not received within 45 business days, the claim(s) shall be denied (if fraud is suspected when medical records are not received, these situations shall be referred to the PSC or the ZPIC BI unit. The second-level screening staff shall only perform a billing and document review on medical records to verify and validate that services were rendered. If fraud and abuse are suspected after performing the billing and document review, the medical record shall be forwarded to the PSC or the ZPIC BI unit for clinician review. If the AC or MAC staff determines that the complaint is not a fraud and/or abuse issue, and if the staff discovers that the complaint has other issues (e.g., medical review, enrollment, claims processing), it shall be referred to the

appropriate department. If the AC or MAC second-level screening staff determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or the ZPIC BI unit for further development within 45 business days of the date of receipt from the initial screening staff, or within 30 business days of receiving medical records and/or other documentation, whichever is later. The AC or MAC shall refer immediate advisements received by beneficiaries or providers and potential fraud or abuse complaints received by current or former provider employees immediately to the PSC or the ZPIC BI unit for further development.

The AC or MAC shall be responsible for downloading and screening complaints from the OIG Hotline Database, and for updating the database with the status of all complaints within their own jurisdiction by any numbers used in the tracking system. All OIG Hotline complaints uploaded into the OIG Hotline Database shall be reviewed, determinations shall be made, and final action shall be taken within 45-business days after the complaints have been uploaded into the OIG Hotline Database. The only exception to this requirement is that should the ACs and MACs need to request additional documentation, then the contractor shall complete its determination within 30 business days after receiving the additional documentation. The ACs and MACs shall use the date contained in the field “Date to RO” at the start of the 45-business day timeframe.

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

Once the complaint has been referred to the PSC or ZPIC, the ACs and MACs shall notate the OIG Hotline Database that the complaint has been referred to the PSC or ZPIC. These referrals shall be done in accordance with the timeframes established above.

If the AC and MAC receives a complaint through the OIG Hotline Database that has been erroneously assigned to the AC or MAC, the contractor shall transfer the erroneously assigned complaint to the appropriate AC or MAC within 10 business days from the date it determined that the complaint was erroneously assigned.

To transfer an erroneously assigned complaint, the AC and MAC shall send an e-mail to the correct contractor notifying it that a complaint is being reassigned in the OIG Hotline Database. The transferring contractor shall update the OIG Hotline Database to indicate that the complaint has been transferred by (1) notating the reason for the transfer in the “Please Note” field on the initial screen of the Database; (2) identifying the receiving contractor in the “Second Contractor Assigned Field;” and (3) noting the transfer date in the “Date Second Contractor Assigned” field. The transferring contractor shall retain a record of complaints transferred to another AC or MAC.

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

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

It appears that the provider may have attempted to obtain duplicate reimbursement (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to be paid twice). This does not include routine assignment violations. An example for referral might be that a provider has submitted a claim to Medicare, and then in 2 days resubmits the same claim in an attempt to bypass the duplicate edits and gain double payment. If the provider does this repeatedly and the AC or MAC determines this is a pattern, then it shall be referred.

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

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

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

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

Alleged alteration of claim history records to generate inappropriate payments.

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

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

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

Provider name, provider number, and address.

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

Type of service involved in the allegation.

Place of service.

Nature of the allegation(s).

Timeframe of the allegation(s).

Narration of the steps taken and results found during the AC's or 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 AC or MAC employee who received the complaint.

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

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

Provider name and address.

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

Type of service involved in the allegation.

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

Place of service.

Nature of the allegation(s).

Timeframe of the allegation(s).
Date of service, procedure code(s).

Name and telephone number of the AC or MAC employee who received the complaint.

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

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