CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 670	**Date: August 19, 2016**
	Change Request 9396

SUBJECT: Update of Payment Suspension Instructions

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to revise the payment suspension instructions in chapter 8 of Pub. 100-08. This CR also revises the model payment suspension letters in Exhibit 16 to conform with the changes made to the payment suspension instructions in chapter 8.

EFFECTIVE DATE: November 23, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 23, 2016
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	8/Table of Contents
R	8/8.2/Overpayment Procedures
R	8/8.2.1/Overpayment Assessment Procedures
R	8/8.2.1.1/Definition of Overpayment Assessment Terms
R	8/8.2.2/Assessing Overpayment When Review Was Based on Statistical Sampling for Overpayment Estimation
R	8/8.2.3/Assessing Overpayment or Potential Overpayment When Review Was Based on Limited Sample or Limited Sub-sample
R	8/8.2.3.1/Contractor Activities to Support Assessing Overpayment
R	8/8.2.3.2/Conduct of Expanded Review Based on Statistical Sampling for Overpayment Estimation and Recoupment of Projected Overpayment by Contractors
R	8/8.2.3.3/Reserved for Future Use
R	8/8.2.4/Coordination with Audit and Reimbursement Staff
R	8/8.3/Suspension of Payment
R	8/8.3.1/When Suspension of Payment May Be Used
R	8/8.3.1.1/Credible Allegation of Fraud Exists Against a Provider - Fraud Suspensions
R	8/8.3.1.2/Reliable Information that an Overpayment Exists - General Suspensions
R	8/8.3.1.3/Reliable Information that the Payments to Be Made May Not Be Correct - General Suspensions
R	8/8.3.1.4/Provider Fails to Furnish Records and Other Requested Information - General Suspensions
R	8/8.3.2/Procedures for Implementing a Payment Suspension
R	8/8.3.2.1/CMS Approval
R	8/8.3.2.2/The Notices Involving Payment Suspensions
R	8/8.3.2.2.1/Issuing a Prior Notice versus Issuing a Concurrent Notice
R	8/8.3.2.2.2/Content of Payment Suspension Notice
R	8/8.3.2.2.3/Shortening the Notice Period for Cause
R	8/8.3.2.2.4/Mailing the Notice to the Provider
R	8/8.3.2.2.5/Opportunity for Rebuttal
R	8/8.3.2.3/Claims Review During the Payment Suspension Period
R	8/8.3.2.3.1/Claims Review
R	8/8.3.2.3.2/Case Development – Program Integrity

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/8.3.2.4/Duration of the Payment Suspension
R	8/8.3.2.5/Terminating the Payment Suspension
R	8/8.3.2.6/Disposition of the Withheld Funds
R	8/8.3.2.7/Contractor Suspects Additional Improper Claims
R	8/8.3.3/Suspension Process for Multi-Region Issues (National Payment Suspensions)
R	8/8.3.3.1/DME Payment Suspensions (MACs and ZPICs)
R	8/8.3.3.2/Non-DME National Payment Suspensions (MACs and ZPICs)
R	Exhibits/Table of Contents
R	Exhibits/16 - Model Payment Suspension Letters

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: 670	Date: August 19, 2016	Change Request: 9396

SUBJECT: Update of Payment Suspension Instructions

EFFECTIVE DATE: November 23, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 23, 2016

I. GENERAL INFORMATION

A. Background: Chapter 8 of Pub. 100-08 contains instructions regarding overpayment assessment procedures, payment suspensions, and the use of statistical sampling for overpayment estimation. This CR revises the payment suspension instructions in chapter 8 of Pub. 100-08 and revises the model payment suspension letters in Exhibit 16 to conform with the changes made to the payment suspension instructions in chapter 8.

As stated in this CR, requests for suspension of payment ("payment suspension") may be approved when there is reliable information that an overpayment exists, when payments to be made may not be correct, or when there is a credible allegation of fraud existing against a provider. The process by which the Zone Program Integrity Contractor (ZPIC) notifies and coordinates with the Medicare Administrative Contractor (MAC) to implement a Centers for Medicare & Medicaid Services (CMS)-approved suspension of payment shall be documented in the Joint Operating Agreement between the MAC and the ZPIC. The ZPIC shall advise and coordinate the imposition of a payment suspension with the appropriate MAC when a payment suspension has been approved by CMS. The ZPIC shall perform the necessary medical review and development of overpayments for payment suspensions that have received CMS approval, when appropriate.

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	
9396.1	The ZPIC shall refer the overpayments described in section 8.2 of chapter 8 to the MAC only after the investigation has been vetted with CMS; also, if a ZPIC is making a referral to law enforcement, it shall refrain from referring the overpayment determination to the MAC during specified times noted in Pub. 100-08, chapter 4, section 4.18.									ZPICs
9396.2	The ZPIC shall--(1) advise and coordinate the imposition									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	of a payment suspension with the appropriate MAC when a payment suspension has been approved by CMS, and (2) perform the necessary medical review and development of overpayments for payment suspensions that have received CMS approval, when appropriate.									
9396.3	The ZPIC shall refer all payment suspensions to CMS/Center for Program Integrity (CPI) via the Fraud Investigation Database (FID) for approval; the ZPIC shall notify its appropriate CPI Contracting Officer's Representative/Business Function Lead (BFL) of the submission by providing the FID number via e-mail.									ZPICs
9396.4	If a payment suspension is approved for a home health agency, all requests for anticipated payments (RAPs) shall be suppressed (disapproved) in accordance with 42 CFR § 409.43(c)(2); the ZPIC shall make this request to CPI as part of its request for a payment suspension.	X		X						ZPICs
9396.4.1	If the ZPIC determines that a RAP suppression is appropriate, it shall submit to CMS the applicable information described in section 8.3.1 of chapter 8.									ZPICs
9396.5	If, under section 8.3.1.1(A) of chapter 8, the MAC identifies the potential fraud issue from a complaint, the MAC shall refer its information to the respective ZPIC for development.	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9396.6	For initial ZPIC requests to suspend payments, the ZPIC shall inform its assigned BFL of the potential suspension; after informing the BFL about the suspension, the contractor shall submit the payment suspension request via the FID if the contractor determines such action is warranted.									ZPICs
9396.6.1	The ZPIC shall prepare and submit, if appropriate, a payment suspension referral package to CPI via the FID for all requests received from (but not limited to) the parties identified in section 8.3.1.1(B) of chapter 8.									ZPICs
9396.7	For all fraud suspensions, the ZPIC shall submit requests to CPI via the FID within 14 calendar days before the suspension expires.									ZPICs
9396.8	As described in sections 8.3.1.2 through 8.3.1.4 of chapter 8, the MAC shall refer its information to the respective ZPIC for development of a potential suspension; the ZPIC shall refer a payment suspension to CPI for consideration.	X	X	X	X					ZPICs
9396.9	The ZPIC shall request all initial payment suspensions via the FID, provide all required information in the respective fields, and upload all required attachments.									ZPICs
9396.10	For general suspensions as described in section 8.3.2.1, the ZPIC shall complete its statistical sampling and have its medical records request letter prepared prior to the submission of the suspension									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	request into the FID; a copy of the medical record request letter shall be included as supporting documentation when the suspension request is submitted into the FID.									
9396.11	The ZPIC shall request all extensions to payment suspensions and all terminations of payment suspensions via the FID, provide all required information in the respective fields, and upload all required attachments; the ZPIC shall make the request for an extension or termination at least 14 calendar days before the anticipated expiration of the payment suspension.									ZPICs
9396.12	The ZPIC shall not take steps to implement any of the suspension actions described in section 8.3.2.1 of chapter 8 without the explicit approval of CPI.									ZPICs
9396.13	When a payment suspension is approved by CPI, the ZPIC 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.	X	X	X	X					ZPICs
9396.13.1	When prior notice is necessary, the MAC shall effectuate the suspension of payment in concert with the established date from the payment suspension notice.	X	X	X	X					
9396.13.2	The MAC 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	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	withheld in accordance with the payment suspension rules and regulations.									
9396.13.3	The MAC shall provide an accounting of the money withheld on day one of the payment suspension to the ZPIC; the ZPIC shall enter this amount in the FID as the first monetary entry.	X	X	X	X					ZPICs
9396.13.4	If it is discovered that money is released to the provider after the effective date of the payment suspension, the ZPIC shall contact CPI for guidance.									ZPICs
9396.13.5	The MAC shall note that if a payment suspension is approved, this edit of withholding of Medicare funds takes precedent over any other edits withholding money in the MAC systems; when it is time to terminate the payment suspension, the withheld funds must be first be applied to the Medicare overpayment(s) and any excess is then applied to any other outstanding overpayments or debts owed to CMS or HHS in accordance with 42 CFR § 405.372(e), unless otherwise directed by CMS.	X	X	X	X					
9396.14	The ZPIC shall use the exhibits referenced in section 8.3.2.2 of chapter 8 as the model notices when preparing the draft notices for CMS approval.									ZPICs
9396.14.1	The ZPIC shall ensure that the draft payment suspension notice includes, at a minimum, the information described in section 8.3.2.2.2									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of chapter 8.									
9396.15	If CPI approves waiver of the prior notice requirement, the ZPIC shall send the provider notice concurrent with implementation of the payment suspension, but no later than 5 calendar days, after the payment suspension is imposed; if additional time is needed to release the notice, the ZPIC shall confer with CPI for guidance.									ZPICs
9396.16	As stated in section 8.3.2.2.4 of chapter 8, the ZPIC shall send all payment suspension notices via United States Postal Service certified mail or utilizing other commercial mail carriers that allow the tracking of the correspondence to ensure receipt by the provider.									ZPICs
9396.17	In the case of fraud suspensions, the ZPIC shall send an informational copy of the payment suspension notice to the Office of Inspector General, Federal Bureau of Investigation, or the Assistant United States Attorney for its file, if law enforcement has been previously involved and/or has an active investigation/case on the provider; the ZPIC shall also upload the signed copies of all notices released to the provider into the FID.									ZPICs
9396.18	If a provider submits a rebuttal timely, a timely determination and written response by the ZPIC is required in accordance with 42 CFR §405.375; if a provider does not respond in									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	a timely manner, the ZPIC shall submit a written response to the provider within 30 calendar days from the receipt date of the rebuttal.									
9396.18.1	The ZPIC shall forward the provider's rebuttal statement and any pertinent information to CPI via the FID within 1 business day of receipt.									ZPICs
9396.18.2	The ZPIC shall evaluate the information presented and then draft a response addressing each item mentioned in the rebuttal and submit it to CPI for approval via the FID no later than 10 calendar days from receipt.									ZPICs
9396.18.3	As stated in section 8.3.2.2.5 of chapter 8, if a full response cannot be drafted in the required timeframe, the ZPIC shall draft an interim response for release that is approved by CPI.									ZPICs
9396.19	In all cases involving a post-payment review, the ZPIC shall follow the rules of reopening as defined in 42 CFR § 405.980 and inform the provider that the claims are reopened in accordance with the regulations when requesting records and supportive information.									ZPICs
9396.20	If CPI approves a general suspension, it will be for a 180 calendar day period; the ZPIC shall complete its medical review and any subsequent activities (i.e., statistical sampling extrapolation, draft overpayment determination notice, etc.) during the initial									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	180 days of a general suspension.									
9396.20.1	If an extension is required, the ZPIC shall request an extension of an additional 180 calendar days if time is needed to complete the overpayment determination.									ZPICs
9396.21	The ZPIC shall account for binding revised determinations or binding reconsiderations in its overpayment determination in accordance with 42 CFR § 405.984.									ZPICs
9396.22	Under section 8.3.2.4(C) of chapter 8, the ZPIC shall prepare a "draft extension notice" (in accordance with section 8.3.2.2 of chapter 8) and submit it via the FID, along with any other supportive information, to CPI for approval at least 14 calendar days before the payment suspension is set to expire.									ZPICs
9396.22.1	The ZPIC shall ensure that the draft notice described in section 8.3.2.4(C) of chapter 8 follows the model language provided in the exhibits and includes, at a minimum, the information identified in section 8.3.2.4(C).									ZPICs
9396.22.2	Upon approval of the notice from CPI, the ZPIC shall provide a copy of the signed notice to CPI via the FID.									ZPICs
9396.23	As discussed in section 8.3.2.5 of chapter 8, the ZPIC shall recommend to CPI that the payment suspension be terminated prior to the payment suspension expiring;									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the ZPIC shall provide this request via the FID at least 14 calendar days prior to the anticipated payment suspension expiration date.									
9396.23.1	As discussed in section 8.3.2.5 of chapter 8, the ZPIC shall prepare a "draft termination notice" (in accordance with section 8.3.2.2 of chapter 8) and send it, along with a draft overpayment notice(s) and any other supportive information, to CPI for approval.									ZPICs
9396.23.2	Upon approval of the termination notice by CPI, the ZPIC shall provide a copy of the signed notice via the FID to CPI.									ZPICs
9396.24	As stated in section 8.3.2.6 of chapter 8, the MAC shall coordinate the issuance of the demand for the overpayment(s) and termination of the payment suspension with respect to approved action by CPI.	X	X	X	X					ZPICs
9396.25	For national payment suspensions involving durable medical equipment (DME) suppliers that are enrolled in multiple jurisdictions, the ZPIC that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension if the payment suspension is approved.									ZPICs
9396.25.1	For ZPIC-initiated DME payment suspensions, each ZPIC shall be responsible for - -(1) ensuring that the payment suspension edit has									ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	been initiated in its respective DME MAC jurisdiction and has communicated this to the lead ZPIC; and (2) providing timely updates on the withheld money in its corresponding DME MAC jurisdiction to the lead ZPIC for input in the FID payment suspension module, and in accordance with the FID requirements.									
9396.26	For national payment suspensions involving national providers (such as chain hospitals, chain skilled nursing facilities, franchised clinics, laboratories, etc.) that are enrolled in multiple jurisdictions, the ZPIC that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension.									ZPICs
9396.27	For ZPIC-initiated non-DME payment suspensions, each ZPIC shall be responsible for -- (1) ensuring that the payment suspension edit has been initiated in its respective MAC jurisdiction and has communicated this to the lead ZPIC; and (2) providing timely updates on the withheld money in its respective zone to the Lead ZPIC, so it can update the FID payment suspension module in accordance with the FID requirements.									ZPICs

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:

"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): Frank Whelan, 410-786-1302 or frank.whelan@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 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates

Table of Contents
(Rev.670, Issued: 08-19-16)

8.2 – Overpayment Procedures

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

This section applies to Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs). Hereinafter, Program Safeguard Contractors (PSCs) shall be included in the term ZPICs.

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

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, *contractors shall* request recovery of the overpayment. *The* ZPIC shall *refer such overpayments to the MAC only after the investigation has been vetted with CMS (see Pub. 100-08, chapter 4, section 4.6.4). In addition, if a ZPIC is making a referral to law enforcement, it shall refrain from referring the overpayment determination to the MAC during specified times noted in Pub. 100-08, chapter 4, section 4.18.* If a large number of claims are involved, contractors consider using statistical sampling for overpayment estimation to calculate the amount of the overpayment. (See *section 8.4 of this chapter*.)

Contractors have the option to request the periodic production of records or supporting documentation for a limited sample of submitted claims from providers or suppliers to which amounts were previously overpaid to ensure that the practice leading to the overpayment is not continuing. The *MAC* may take any appropriate remedial action described in this chapter if a provider or supplier continues to have a high level of payment error. Offer the provider a consent settlement based on the potential projected overpayment amount.

8.2.1 – Overpayment Assessment Procedures

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

After an overpayment determination is made concluding an incorrect amount of money has been paid, contractors must assess an overpayment. The assessment options vary depending upon the type of sample used when identifying beneficiary claims for inclusion in the *postpayment* review. Whenever possible, CMS encourages contractors to report postpayment savings in terms of:

- Actual overpayment;
- Settlement based overpayment, or
- Extrapolated overpayments.

A. Example Format of An Overpayment Worksheet (also see Exhibit 46)

Provider*/Supplier* Name	
Provider*/Supplier National Provider Identification Number (*NPI*)* or *Provider Transaction Access Number (PTAN)*	
Reason for Review	
Type of Sample Reviewed: Statistical Sampling for Overpayment Estimation	
Explanation of Sampling Methodology:	

Number of Claims in Sample	
Number of Claims in Universe	
Amount of Overpayment (after allowance for deductible and coinsurance)	
Claims Reviewed	
Billed Amount	
Allowed Amount	
Rationale for Denial	
§1879 Determinations	
§1870 Determinations	
Total Actual Overpayment	
Overpayment extrapolated over the universe	

8.2.1.1 – Definition of Overpayment Assessment Terms

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A. Actual Overpayment

An actual overpayment is, for those claims reviewed, the sum of payments (based on the amount paid to the provider*/supplier* and Medicare approved amounts) made to a provider*/supplier* for services which were determined to be medically unnecessary or incorrectly billed.

B. Projected Overpayment

A projected overpayment is the numeric overpayment obtained by projecting an overpayment from statistical sampling for overpayment estimation to all similar claims in the universe under review.

8.2.2 – Assessing Overpayment When Review Was Based on Statistical Sampling for Overpayment Estimation

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

If contractors use statistical sampling for overpayment estimation of claims, they follow instructions in *section* 8.4 *of this chapter* to calculate the valid projected overpayment. They document the sampling methodology when review is based on statistical sampling for overpayment estimation. They notify the provider*/supplier* of the overpayment and refer the case to overpayment staff to make payment arrangements with the *provider/supplier* to collect the overpayment.

8.2.3 – Assessing Overpayment or Potential Overpayment When Review Was Based on Limited Sample or Limited Sub-sample

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

If a limited sample or limited sub-sample of claims is chosen for review, there are *two* overpayment assessment options for contractors:

- Refer to overpayment staff for recoupment of the actual overpayment for the claims reviewed; *or*
- Conduct an expanded review based on statistical sampling for overpayment estimation instructions in *section* 8.4 *of this chapter* and recoup the projected overpayment.

8.2.3.1 – Contractor Activities to Support Assessing Overpayment

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A. Step 1

The first step in assessing an overpayment is for contractors to document for each claim reviewed the following:

- The amount of the original claim;
- The allowed amount;
- The rationale for denial;
- The §1879 determination for each assigned claim in the sample denied because the service was not medically reasonable and necessary (or the §1842(1) provider*/supplier* refund determination on non-assigned provider*/supplier* claims denied on the basis of §1862 (a)(1)(A)) (refer to Exhibit 14.1 *of this manual*);
- The §1870 determination for the provider*/supplier* for each overpaid assigned claim in the sample (refer to Exhibit 14.2 *of this manual*); and
- The amount of overpayment (after allowance for deductible and coinsurance).

B. Step 2

Notify the provider*/supplier* of the preliminary overpayment findings and preliminary review findings.

C. Step 3

If the provider*/supplier* submits additional documentation, review the material and adjust the preliminary overpayment findings, accordingly.

D. Step 4

Calculate the final overpayment.

E. Step 5

Refer to the overpayment recoupment staff.

8.2.3.2 – Conduct of Expanded Review Based on Statistical Sampling for Overpayment Estimation and Recoupment of Projected Overpayment by Contractors

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The MACs shall perform the actual recoupment identified by the ZPICs.

A. If an expanded review of claims is conducted, contractors shall follow the sampling instructions found in *section* 8.4 *of this chapter,* obtain and review claims and medical records, and document for each claim reviewed:

- The amount of the original claim;
- The allowed amount;
- The rationale for denial;
- The §1879 determination for each assigned claim in the sample denied because the service was not medically reasonable and necessary (or the §1842(1) provider*/supplier* refund determination on non-assigned provider*/supplier* claims denied on the basis of §1862(a)(1)(A)) (refer to Exhibit 14.1 *of this manual*);
- The §1870 determination for the provider*/supplier* for each overpaid assigned claim in the sample (refer to Exhibit 14.2 *of this manual*); and
- The amount of overpayment (after allowance for deductible and coinsurance).

B. Contractors calculate the projected overpayment by extrapolating from the actual overpayment to the universe that excludes those claims determined that the provider*/supplier* did not have knowledge that the service was not medically necessary;

C. Notify the provider*/supplier* of the preliminary projected overpayment findings and review findings;

D. If the provider*/supplier* submits additional documentation, review the material and adjust the preliminary projected overpayment findings, accordingly;

E. Calculate the final overpayment; and

F. Refer to the overpayment recoupment staff.

8.2.3.3 - *Reserved for Future Use*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

8.2.4 - Coordination with Audit and Reimbursement Staff

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

MAC MR staff must work closely with their Audit/Reimbursement staff from the beginning of the postpay*ment* process to ensure that the universe selected is appropriate and that overpayments and underpayments are accurately determined and reflected on the provider's cost report. They furnish the Audit/Reimbursement staff the following information upon completion of the postpayment review:

- The sample documentation contained in *Pub. 100-08, chapter 3, section 3.5.2*;
- The identification of incorrectly paid or incorrectly denied services; and
- All other information required by the Cost Report Worksheets in *Pub. 100-08, chapter 3, section 3.5.2* and applicable Exhibits.

They also furnish the above information if adjustments are made as a result of appeals.

In most instances, the Audit/Reimbursement staff will:

- Determine the overpayment to be recovered based on MR findings and pursue the recovery of the overpayment; and

- Use the information MR provides on their postpayment review findings to ensure an accurate settlement of the cost report and/or any adjustments to interim rates that may be necessary as a result of the MR findings. To preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, the same data must be used when the projection is made as was used when the sample was selected. Individual claims will not be adjusted. In the event that a cost report has been settled, Audit/Reimbursement staff will determine the impact on the settled cost report and the actions to be taken.

Projections on denied services must be made for each discipline and revenue center when PPS is not the payment method.

When notifying the provider of the review results for cost reimbursed services, MR must explain that the stated overpayment amount represents an interim payment adjustment. Indicate that subsequent adjustments may be made at cost report settlement to reflect final settled costs.

Information from the completed Worksheets 1 - 7 must be routed to the Audit and Reimbursement staff. In addition to the actual and projected overpayment amounts, the information must provide the number of denied services (actual denied services plus projected denied services) for each discipline and the amounts of denied charges (actual denied amounts plus projected denied amounts) for supplies and drugs.

Upon completion of the review, furnish the Audit and Reimbursement staff with the information listed in the PIM.

8.3 – Suspension of Payment

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

This section applies to Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs). Hereinafter, Program Safeguard Contractors (PSCs) shall be included in the term ZPICs.

Hereinafter, suspension of payment may be referenced as "payment suspension."

Requests for Suspension of Payment ("Payment Suspension") may be approved when there is reliable information that an overpayment exists, when payments to be made may not be correct, or when there is a credible allegation of fraud existing against a provider. The process by which the *ZPIC* notifies and coordinates with the MAC *to implement a* CMS-approved suspension of payment shall be documented in the *Joint Operating Agreement (JOA) between the MAC and the ZPIC. The* ZPICs shall advise and coordinate *the imposition of a payment suspension* with the *appropriate* MAC when *a* payment suspension has been approved by CMS. The ZPIC shall perform the necessary medical review *and development of overpayments for payment suspensions that have* received CMS approval, *when appropriate.*

Medicare authority to withhold payment in whole or in part for claims otherwise determined to be payable is found in federal regulations at 42 CFR *§* 405.370-375, which provide for the suspension of payments.

All payment suspensions shall be referred to the CMS/Center for Program Integrity (CPI) via the Fraud Investigation Database (FID) for approval. ZPICs shall notify their appropriate CPI Contracting Officer's Representative (COR)/Business Function Lead (BFL) of the submission by providing the FID number via email.

8.3.1 – When Suspension of Payment May Be Used

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A payment suspension may be used when there is:

- *Reliable information that* an overpayment exists, but the amount of the overpayment is not yet determined;
- *Reliable information that* the payments to be made may not be correct;
- *Reliable information that* the provider fails to furnish records and other *essential* information *necessary* to determine the amounts due to the provider;
- *In cases of suspected fraud, a payment suspension may be used when there is a credible allegation of fraud.*

These *above* reasons for implementing a *payment* suspension are described more fully below.

***NOTE:** If a payment suspension is approved, this edit of withholding of Medicare funds takes precedent over any other edits withholding money in the MAC systems. When it is time to terminate the payment suspension, the withheld funds must first be applied to the Medicare overpayment(s) and any excess is then applied to any other outstanding overpayments or debts owed to CMS or HHS in accordance with 42 CFR §405.372(e), unless otherwise directed by CMS.*

NOTE: For providers that file cost reports, *a payment* suspension may have little impact. If the provider is receiving periodic interim payments (PIP), *the* interim payments may be suspended. If the provider is not *receiving* PIP*s*, *a payment* suspension will affect the settlement of the cost report. When an overpayment is determined, the amount is not included in any settlement amount on the cost report. For example, if the *A/B*

MAC (A) has *withheld (*suspended*)* $100,000 when the cost report is settled, the *A/B MAC (A)* would continue to hold the $100,000. This means *that* if the cost report shows *the Medicare program* owing the provider $150,000, the provider would only receive $50,000 until the *payment* suspension action has been *terminated*. If the provider owes *the Medicare program* money at settlement, the amount of the suspended payment would increase the amount owed by the provider. In most instances, *A/B MACs (A)* should adjust interim payments to reflect projected cost reductions. *The contractors are to l*imit the adjustment to the percentage of potential fraud or the total payable amount for any other reasons. For example, if the potential fraud involved *five* percent of the *periodic* interim rate, the reduction in payment is not to exceed *five* percent. Occasionally, suspension of all interim payments may be appropriate.

NOTE: *If a payment suspension is approved for a home health agency, all Requests for Anticipated Payments (RAPs) are to be suppressed (disapproved) in accordance with 42 C.F.R. §409.43(c)(2). The ZPIC shall make this request to CPI as part of its request for a payment suspension.*

In addition, CMS may suppress RAP payments for program integrity concerns absent a payment suspension. If the ZPIC determines that a RAP suppression is appropriate they shall submit the following information to CMS:

- *Are final bills being submitted by the HHA? Yes or No*
- *Indicate the volume (dollar and number of claims) of RAPs for the past 12 months.*
- *A brief summary supporting the request for RAP suppression.*

8.3.1.1 – *Credible Allegation of* Fraud Exists *Against a Provider* - Fraud Suspensions

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A payment *suspension* may be used when the ZPIC*, law enforcement, or* CMS *determines that a credible allegation of fraud exists against a provider or supplier (hereinafter referred to as provider).* For purposes of *section 8.3 et seq.,* these types of *payment* suspensions will be called "fraud suspensions."

Fraud suspensions may also be imposed for reasons not typically viewed within the context of false claims. *For example:*

- The Quality Improvement Organization *(QIO)* has reviewed inpatient claims and determined that the diagnosis related groups (DRGs) have been upcoded.
- *The ZPIC* or MAC may *suspect a* violation of the physician self-referral ban. *For this reason, the violation may be considered the cause for a payment suspension* since claims submitted in violation of this statutory provision must be denied and any *payments* made would constitute an overpayment.
- *Even though services are rendered and may be determined as medically necessary and reasonable by the Medicare contractor, law enforcement has credible allegations of kickbacks.*
- Forged signatures on *medical record documentation (e.g.,* Certificates of Medical Necessity (CMN), treatment plans, *etc.) and/or* other misrepresentations on Medicare claims *or associated* forms to obtain payment *that would* result in *an* overpayment *determination.*

Whether or not the ZPIC recommends *a payment* suspension to CMS*, the final determination is determined on a* case-by-case *basis and requires* review and analysis of the *allegation and* facts. The following information is provided to assist the ZPIC in deciding when to recommend *a payment* suspension *to CPI.*

A. Complaints

There is considerable latitude with regard to complaints alleging fraud, *waste,* and abuse. The *provider's Medicare* history, *including* the volume and frequency of complaints concerning the provider, and the nature of the complaints all contribute to whether *a payment* suspension should be *referred to CPI.* If there is a credible allegation(s) that a provider is submitting or may have submitted false claims, the ZPIC *may* recommend *a fraud* suspension *to CPI only after the ZPIC has vetted the provider in accordance with Pub.*

100-08, chapter 4, section 4.6.4. (If the MAC identifies the potential fraud issue from a complaint, the MAC shall refer its information to the respective ZPIC for development).

B. *Requests for Suspension of Payment*

For initial ZPIC requests to suspend payments, the ZPIC shall inform its assigned BFL of the potential suspension. The BFL will discuss all findings with the ZPIC. After informing the BFL about the suspension, the contractor shall submit the payment suspension request via the FID if the contractor determines such action is warranted. The Payment Suspension Administrative Action Request (AAR), draft suspension notice, and all other relevant documentation that supports the suspension request shall be uploaded by the contractor as part of the FID submission.

The ZPIC shall *also prepare and submit, if appropriate, a payment suspension referral package to CPI via the FID for all requests received from (but not limited to):*

- CMS
- *Office of Inspector General* (OIG)
- *Federal Bureau of Investigation* (FBI)
- *Assistant United States Attorney* (AUSA)
- *Other law enforcement agencies*

C. *Other Situations*

Other situations *that* may *be* consider*ed when* recommending *a fraud* suspension to CPI *include, but are not limited to:*

- Provider has pled guilty to, or been convicted of, Medicare, Medicaid, *TRICARE,* or private health care fraud and is still billing Medicare for services*;*
- Federal/State law enforcement has subpoenaed the records of, or executed a search warrant *upon,* a health care provider billing Medicare;
- Provider has been indicted by a Federal Grand Jury for fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct related to a health care program;
- Provider presents a pattern of evidence of known false documentation or statements sent to the *ZPIC* or the MAC; e.g., false treatment plans, false statements on provider application forms.

D. Good Cause Exceptions

Reference is made in 42 CFR §405.371(b)(1) that allows for good cause exceptions to not suspend payments or continue a payment suspension when there are credible allegations of fraud. These exceptions may be considered for approval by CMS if any apply:

- *Law enforcement has requested that a payment suspension not be imposed because such action may compromise or jeopardize its investigation;*
- *CMS/CPI has determined that a beneficiary access to care issue may exist and potentially cause a danger to life or health in whole or part;*

- *CMS/CPI has been determined that other administrative remedies may be implemented that would be more effective in protecting Medicare funds (such as revocation, prepayment review); or*

- *CMS determines that the imposition or the continuation of a payment suspension is not in the best interest of the Medicare program.*

Every 180 calendar days after the initiation of a payment suspension based on credible allegations of fraud, CMS is required to evaluate whether there is good cause to terminate the payment suspension. Good cause to terminate a payment suspension is deemed to exist if the payment suspension has been in effect for 18 months. However, there are two exceptions. The first exception is that the case has been referred to and is being considered by the OIG for an administrative action such as a civil monetary penalty or permissive exclusion, or such administrative action is pending, and the OIG has made its request to not terminate the payment suspension in writing. The second exception is that the Department of Justice has submitted a written request to extend the payment suspension based on the ongoing investigation and its anticipation of filing a criminal or civil action or both, or based on a pending criminal or civil action or both. (See 42 CFR §405.371(b)(2) and §405.371(b)(3).)

CMS/CPI makes the final decision on whether good cause to terminate exists, based on the totality of the circumstances. For all fraud suspensions, the ZPICs shall submit requests to CPI via the FID within 14 calendar days before the suspension expires. CPI will evaluate the request to consider whether good cause to terminate the payment suspension exists.

8.3.1.2 – *Reliable Information that an* Overpayment Exists - General Suspensions

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A payment suspension *may be implemented* when the MAC, ZPIC*,* or CMS possesses reliable information that an overpayment exists. In this situation, the MAC *shall refer its information to the respective ZPIC for development of a potential suspension. The* ZPIC shall *refer a payment* suspension to *CPI via the FID for consideration.* For the purposes of this section, these types of payment *suspensions* will be called "general suspensions."

EXAMPLE *(including but not limited to):* Several claimed services identified *from either a prepayment or* post-payment review were determined to be non-covered or miscoded. *It has been determined that there is a pattern of noncompliant billings (*the provider has billed this service many times before*)* and it is suspected that there may be a *substantial* number of additional non-covered or miscoded claims paid *in the past.*

8.3.1.3 – *Reliable Information that the* Payments to Be Made May Not Be Correct - General Suspensions

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A payment *suspension* may be *implemented* when the MAC or ZPIC or CMS possesses reliable information that the payments to be made may not be correct. In this situation, the MAC *shall refer its information to the respective ZPIC for development of a potential suspension. The* ZPIC shall *refer a payment* suspension to *CPI for consideration.* For the purposes of this section, these types of *payment* suspensions will be called "general suspensions."

EXAMPLE (including but not limited to): *Several claimed services identified from a post-payment review were determined to be non-covered or miscoded. It has been determined that the provider has not changed its billing behavior and it is suspected that there may be a continuance of non-covered or miscoded claimed services to be billed in the future.*

8.3.1.4 – Provider Fails to Furnish Records and Other Requested Information - General Suspensions

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

*A payment s*uspension may be used when the MAC, ZPIC, or CMS possesses reliable information that the provider has failed to furnish records and other information requested or that is due, and which is needed to determine the amounts due the provider. In this situation, the MAC *shall refer its information to the respective ZPIC for development of a potential suspension. The* ZPIC shall *refer a payment* suspension to the *CPI for consideration*. For the purposes of this section, these types of *payment* suspensions will be called "general suspensions."

EXAMPLE *(including but not limited to):* During a post-payment review, medical records and other supporting documentation are solicited from the provider to support payment. The provider fails to submit the requested records *after two attempts*. *The ZPIC may request a payment suspension due to non-response from the provider.*
*In lieu of imposing a payment suspension, the MAC or ZPIC may deny the paid claims because the provider failed to provide the requested documentation after two attempts. In either case, t*he *MAC or ZPIC should* determine *if* the provider is continuing to submit claims for *the* services in question *and take appropriate action(s) to correct the behavior.*

***NOTE**: In the above example, if the only reason for the payment suspension is the failure by the provider to furnish the requested records, and if the provider does eventually provide the requested information, the ZPIC shall discuss this matter with CPI for guidance.*

***EXAMPLE (including but not limited to)**: The provider fails to timely file an acceptable cost report. Refer to 42 CFR §405.371(d). (NOTE: Such requests regarding the timely filing of an acceptable cost report shall be submitted only to and approved by the CMS, Office of Financial Management and not CPI.)*

8.3.2 – Procedures for Implementing *a Payment* Suspension

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

8.3.2.1 – CMS Approval

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The initiation (including whether or not to give advance notice), modification, *extension,* or removal of any type of suspension requires the explicit prior approval of *CPI*. The ZPIC will discuss *requests for payment* suspension *and other proposed administrative actions with CPI. Where applicable, MACs should consult with the respective ZPIC about any potential payment suspension it believes should be considered. At which point, the MAC shall refer its information to the respective ZPIC for development of a potential suspension.*

A meeting may be held between the ZPIC and CPI prior to the approval of a payment suspension action involving an initial request, rebuttal, extension or termination.

The ZPIC shall request all initial payment suspensions via FID and provide all required information in the respective fields and upload all required attachments. Information uploaded to the FID shall include:

1. *The AAR – Payment Suspension form*
2. *A draft of the proposed payment suspension initial notice following the format noted in section 8.3.2.2 of this chapter (in a word document format);*
3. *Any other supporting documentation.*

For general suspensions, the ZPIC shall complete its statistical sampling and have its medical records request letter prepared prior to the submission of the suspension request into the FID. A copy of the

medical record request letter shall be included as supporting documentation when the suspension request is submitted into the FID.

The ZPIC shall request all extensions to payment suspensions via the FID and provide all required information in the respective fields and upload all required attachments. The ZPIC shall make the request for an extension at least 14 calendar days before the anticipated expiration of the payment suspension. Information uploaded to the FID shall include:

1. *An updated AAR – Payment Suspension form*
2. *A draft of the proposed payment suspension extension notice following the format noted in section 8.3.2.2 of this chapter (in a word document format);*
3. *Any other supporting documentation.*

The ZPIC shall request all terminations to payment suspensions via the FID and provide all required information in the respective fields and upload all required attachments. The ZPIC shall make the request for a termination at least 14 calendar days before the anticipated expiration of the payment suspension. Information uploaded to the FID shall include:

1. *A draft of the proposed payment suspension termination notice following the format noted in section 8.3.2.2 (in a word document format);*
2. *A draft of the associated overpayment determination notice(s) (in a word document format).*

***NOTE:** All law enforcement-requested payment suspensions must be sent directly to CPI by law enforcement for consideration. If a ZPIC receives a law enforcement-requested payment suspension request, the ZPIC shall contact CPI for guidance.*

The ZPIC shall not take steps to implement any of the above suspension actions without the explicit approval of CPI. If approved, CPI shall make appropriate changes to the draft notice before approving the payment suspension notice and upload the approval and documents via the FID.

When a payment suspension is approved by CPI, the ZPIC 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 ZPIC. The ZPIC 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 ZPIC shall contact CPI for guidance.

8.3.2.2 – The Notice*s Involving Payment Suspensions*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The ZPICs shall use the following exhibits in this manual as the model notices when preparing the draft notices for CMS approval:

- *The Notice to Suspend Payments (Refer to Exhibits 16A to 16D)*
- *The Notice to Extend the Payment Suspension (Refer to Exhibit 16E)*

- *The Notice to Terminate the Payment Suspension (Refer to Exhibit 16F)*

8.3.2.2.1 – *Issuing a* Prior Notice versus *Issuing a* Concurrent Notice
(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

ZPICs shall inform the provider of the *payment* suspension action being taken. When prior notice is appropriate, *the ZPIC shall, in most instances,* give at least 15 calendar days*'* prior notice *before effectuating the payment suspension.* Day one begins the *calendar* day after the notice is mailed.

A. *If the* Medicare Trust Fund would be harmed by giving prior notice: *the* ZPIC shall recommend to *CPI* not to give prior notice if, in the ZPIC's opinion, any of the following apply:

1. *A* delay in *implementing the payment* suspension will cause the overpayment to rise at an accelerated rate (i.e., dumping of claims);

2. There is reason to believe that the *provider* may flee the MAC's jurisdiction before the overpayment can be recovered;

3. The MAC or ZPIC has first-hand knowledge of a risk that the provider will cease or severely curtail operations or otherwise seriously jeopardize its ability to repay its debts*; or*

4. *A delay may impact law enforcement's investigation.*

If *CPI approves* waiver *of* the *prior* notice requirement, *the* ZPIC shall send the provider notice concurrent with implementation of the payment suspension, but no later than *5 calendar* days after *the payment* suspension is imposed. *If additional time is needed to release the notice, the ZPIC shall confer with CPI for guidance.*

B. *If the reason for the payment s*uspension *request is because the provider* fail*ed* to furnish requested information*, the* ZPIC shall recommend that *CPI* waive *the* prior notice. If *CPI concurs to* waive the prior notice requirement, *the* ZPIC shall send the provider notice concurrent with implementation of the *payment* suspension, but no later than *5 calendar* days after the *payment* suspension is imposed. *If additional time is needed to release the notice, the ZPIC shall confer with CPI for guidance.*

C. *If the payment suspension request is a* fraud suspension*, the* ZPIC shall recommend to *CPI* that prior notice not be given. If *CPI concurs to* waive the prior notice requirement, the ZPIC shall send the provider notice concurrent with implementation of the *payment* suspension, but no later than *five calendar days* after *the payment* suspension is imposed. *If additional time is needed to release the notice, the ZPIC shall confer with CPI for guidance.*

8.3.2.2.2 – Content of *Payment Suspension* Notice
(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The ZPIC shall prepare a "draft notice" *(in accordance with section 8.3.2.2 of this chapter)* and send it, along with the recommendation and any other supportive information, to *CPI* for approval. The draft notice shall include, at a minimum:

- *The date the payment* suspension action will be *or has been* imposed*;*

- *How long the suspension is expected to be in effect (**NOTE**: All payment suspensions shall be established in 180 calendar day increments.);*

- The reason for suspending payment. *(For fraud suspensions, the ZPIC shall include the rationale to justify the action being taken.);*

- *In most notices, the ZPIC shall identify and describe at least five example claims that are associated with the reason for the payment suspension, if available. The example claims are to be current claims not more than 1 year old from the paid date. The notice shall only reference the example claim control number, the amount of payment, and the date of service;*

- The extent of the *payment* suspension (i.e., 100 percent *payment* suspension or partial *payment* suspension, *where less than 100 percent of payments are withheld);*

- *The payment* suspension action is not appealable;

- CMS/*CPI* has approved implementation of the *payment* suspension;

- *Documentation* that the provider has *been given* the opportunity to submit a rebuttal statement within 15 *calendar* days of notification; and

- *An address for the provider* to mail the rebuttal.

8.3.2.2.3 – Shortening the Notice Period for Cause
(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

At any time, the ZPIC may recommend to CPI that the *prior* notice be shortened during *a previously approved* notice period. Such a recommendation would be appropriate if the MAC or ZPIC believes that the provider *will* intentionally submit additional claims *prior to the* effective date of the *payment* suspension. *If CPI approves that the payment* suspension is to be imposed earlier than indicated in the *issued* notice, the ZPIC shall notify the provider in writing of the change and the reason. *The ZPIC shall draft a notice for CPI's approval before releasing the notice to the provider.*

8.3.2.2.4 – Mailing the Notice to the Provider
(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

After consultation with and approval from CPI, *the* ZPIC shall send the *approved payment suspension* notice *(initial, responses to rebuttals, extensions, and terminations)* to the provider. *All such notices shall be sent via USPS certified mail or utilizing other commercial mail carriers that allow the tracking of the correspondence to ensure receipt by the provider.* In the case of fraud suspensions, *the ZPIC shall* send *an informational* copy to the OIG, FBI, or the AUSA *for its file, if law enforcement has been previously involved and/or has an active investigation/case on the provider. The ZPIC shall also upload the signed copies of all notices released to the provider into the FID.*

8.3.2.2.5 – Opportunity for Rebuttal
(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

If the payment suspension is approved with prior notice, the provider is afforded an opportunity to submit to the ZPIC a statement within 15 *calendar* days indicating why *the payment* suspension action should not be imposed. However, this time may be shortened or lengthened for cause. (See 42 CFR *§*405.374(b).)

If the payment suspension is approved without prior notice, the provider is also afforded an opportunity to submit to the ZPIC a statement as to why the payment suspension action should not be imposed. (See 42 CFR §405.372(b)(2).) For purposes of consistency for both prior notice and no prior notice, CMS/CPI suggests that a 15 calendar day response time be established for the provider.

If a provider submits a rebuttal timely, a timely determination and written response by the ZPIC is required in accordance with 42 CFR §405.375. If a provider does not respond in a timely manner, the ZPIC shall submit a written response to the provider within 30 calendar days from the receipt date of the rebuttal.

ZPICs shall ensure the following:

- CMS Review – ZPICs shall forward *the* provider*'s rebuttal statement and any pertinent information* to CPI *via the FID within 1 business day of receipt. The ZPIC shall evaluate the information presented and then draft a response addressing each item mentioned in the rebuttal and submit it to CPI for approval via the FID no later than 10 calendar days from receipt. The ZPIC may contact CPI for guidance before drafting a response.*

- Timing –The *payment* suspension *shall* go into effect as indicated in the notice.

- Review of Rebuttal – Because *payment* suspension actions are not appealable, the rebuttal is the provider's only opportunity to present information as to why suspension action should *not* be initiated or *should be* terminated. ZPICs shall carefully review the provider's rebuttal statement and *pertinent information, and shall* consider all facts and issues raised by the *provider*. If the ZPIC is convinced that the *payment* suspension action should *not* be initiated or *should be* terminated, *it* shall consult with the *CPI for guidance*.

- Response – *CMS is obligated to consider the initial rebuttal and supportive information received from the provider and to make a determination within 15 calendar days from receipt of the rebuttal. (See 42 CFR §405.375(a).) If a full response cannot be drafted in the required timeframe, the ZPIC shall draft an interim response for release that is approved by CPI.*

8.3.2.3 – Claims Review During the *Payment* Suspension Period

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A payment suspension does not stop submitted claims from processing. A payment suspension only stops the claim payments from being released to the provider. These claim payments will be withheld in an account (which does not accrue any interest) for the purpose of applying the withheld funds to any potential overpayment(s) or other debts owed to CMS or HHS in accordance with 42 CFR §405.372(e). (This withholding of Medicare payments is for everything payable and releasable to the provider. It also includes adjustments to claims that would result in payments being released to the provider, RAPs, etc.) If a claim is submitted for payment and is partially or fully denied, the provider is afforded appeal rights to those denials.

8.3.2.3.1 – Claims Review

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

While a payment suspension does not stop claims processing, CMS prefers that all claims being processed during the payment suspension period be reviewed on a prepayment basis for reasonableness and necessity. If fraud-related, the review of claims should also address whether services were actually rendered as billed. This will ensure that the withheld payments only include payable claims to be used in the disposition of the funds when the final overpayment(s) are determined.

A. Claims Review

Once *a payment* suspension has been imposed, *the* MACs and ZPICs shall follow *the* claims processing *and review* procedures *in accordance with Pub. 100-08, chapter 3.* MACs *and ZPICs* shall ensure that the provider is not substituting a new category of improper billings to counteract the effect of the payment suspension. *(If such a situation arises, the ZPIC shall modify the payment suspension accordingly with CPI's approval.)* If the claim is determined to *not* be payable, it shall be denied *and the provider afforded its appeal rights.* For claims that are not denied, the MAC shall send a remittance advice to the provider showing that payment was approved but *the actual funds* not sent.

ZPICs are not required to perform 100 percent prepayment review of claims *processed during the payment suspension period.* If prepayment review is not conducted, a post-payment review shall be performed on *the*

universe of claims adjudicated *for payment* during the *payment* suspension, prior to the issuance of the overpayment determination. *In order to reduce the burden of resources, if only specific claim types (or certain codes) are the subject of noncompliance, the ZPIC may elect to only place such claims types on prepayment or post-payment review.* ZPICs shall consult with *CPI for guidance* when resources may be better utilized employing statistical sampling *for overpayment determination(s).* ZPICs shall use the principles of statistical sampling *for overpayment estimation* found in *section* 8.4 *of this chapter* to determine what percentage of claims in a given universe of *withheld* claims payments are payable. *In all cases involving a post-payment review, the ZPIC shall follow the rules of reopening as defined in 42 C.F.R. §405.980 and inform the provider that the claims are reopened in accordance with the regulations when requesting records and supportive information.*

B. Review of Suspected Fraudulent or Overpaid Claims:

The ZPIC shall follow procedures in the *Pub. 100-08,* chapter 3, *section* 3.*6* in establishing an overpayment. The overpayment consists of all claims in a specific time period*(s)* determined to have been paid incorrectly. *The* ZPIC shall make all reasonable efforts to expedite the determination of the overpayment amount. *The ZPIC shall account for binding revised determinations or binding reconsiderations in its overpayment determination in accordance with 42 CFR §405.984.*

NOTE: Claims selected for post-payment review may be reopened within *one* year for any reason or within *four* years for good cause. *(See 42 CFR §405.980.)* Cost report determinations may be reopened within *three* years after the Notice of Program Reimbursement has been issued. Good cause is defined as new and material evidence, error on the face of the record, or clerical error. The regulations have open-ended potential for fraud or similar fault. The exception to the *one* year rule is for adjustments to DRG claims. A provider has 60 *calendar* days to request a change in an assignment of a DRG. (See 42 C.F.R. *§*412.60(d).)

8.3.2.3.2 – Case Development – *Program* Integrity

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The ZPIC shall enter *all payment* suspensions into the FID. In the Suspension Narrative field, the ZPIC shall *include* the items/services affected (i.e., type of item/service and applicable HCPCS/CPT codes). *The first monetary entry of money withheld in the FID shall reflect the money withheld on Day One of the payment suspension.*

8.3.2.4 – Duration of *the Payment* Suspension

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A. Time Limits *for General Suspensions*

If CPI approves a general suspension, *it will be for a* 180 *calendar* day *period.*
The ZPIC shall complete its medical review and any subsequent activities (i.e., statistical sampling extrapolation, draft overpayment determination notice, etc.) during the initial 180 days of a general suspension. CMS expects the medical reviews to be completed and the calculation of any potential overpayments to be determined before the end of the initial suspension period. Only in rare instances will an extension be granted.

If an extension is required, the ZPIC shall request an extension of an additional 180 calendar days if time is needed to complete the overpayment determination. Only CPI may approve the request to extend the period of the payment suspension for up to an additional 180 calendar days upon the written request of the ZPIC. The request *to CPI to extend the payment suspension* shall provide *the following:*

- *The AAR – Payment Suspension form*
- *A draft of the proposed payment suspension extension notice following the format noted in section 8.3.2.2 of this chapter (in a word document format);*
- *A timeline of the completion of the medical review; and*

- *Any other supporting documentation.*

If approved for an extension, the period of time shall not exceed 180 calendar days. General suspensions shall not continue beyond 360 calendar days. However, there may be an occasion when the information gathered by the ZPIC during its review supports a change from a general suspension to a fraud suspension. Only with CPI approval may the category of the type of payment suspension be transitioned from a general payment suspension to a fraud suspension. If the transition from a general payment suspension to a fraud payment suspension is approved, the provider must be informed of the new development by the ZPIC with a CPI-approved notice. Additionally, the provider must be afforded the opportunity for rebuttal.

B. Exceptions to Time Limits *for Fraud Suspensions*

If a payment suspension is based on credible allegations of fraud, the payment suspension may continue beyond 360 days with a written request for an extension from law enforcement. An extension may be warranted if there has not been a resolution of law enforcement's investigation of the potential fraud. After 18 months, good cause not to continue a payment suspension is deemed to exist unless certain criteria are satisfied. (See 42 C.F.R. §405.371(b)(3).) To extend a fraud suspension beyond 18 months:

- *The* Department of Justice *must* submit a written request for an extension. Requests must include: 1) the identity of the person or entity under the *payment* suspension, 2) the amount of time needed for *continuation of the payment* suspension in order to *conclude the* criminal *or* civil *proceeding or both, and* 3) a statement of why and/or how criminal and/or civil actions may be affected if the *payment* suspension is not granted.

- *The OIG must submit a written request to extend the payment suspension because the case* is being considered by *the* OIG *for an* administrative *action (e.g., permissive exclusions, CMPs) or such action is pending.* However, this exception does not apply to pending criminal investigations by OIG.

C. Provider Notice of the Extension

The ZPIC shall obtain *CPI approval for* the extension request *and draft notice*, and shall notify the provider if the suspension action has been extended. *The ZPIC shall prepare a "draft extension notice" (in accordance with section 8.3.2.2 of this chapter) and submit it via the FID, along with any other supportive information, to CPI for approval at least 14 calendar days before the payment suspension is set to expire. The draft notice shall follow the model language provided in the exhibits and shall include, at a minimum:*

- *The date the payment suspension will be extended (**NOTE**: The date is to be the same date the payment suspension was to expire);*

- *The reason for extending the payment suspension; and*

- *That CMS has approved the extension of the payment suspension.*

Upon approval of the notice from CPI, the ZPIC shall provide a copy of the signed notice to CPI via the FID.

8.3.2.5 – *Terminating* the *Payment* Suspension

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The ZPIC shall recommend to CPI that *the payment suspension be* terminated *prior to the payment suspension expiring*. *The ZPIC shall provide this request via the FID at least 14 calendar days prior to the*

anticipated payment suspension expiration date. No action associated with the termination shall be taken without the explicit approval of CPI. The ZPIC shall prepare a "draft termination notice" (in accordance with section 8.3.2.2 of this chapter) and send it, along with a draft overpayment notice(s) and any other supportive information, to CPI for approval.

The ZPIC *shall* recommend to *CPI* that a suspension be terminated *when any of the following occur:*

- The basis for the *payment* suspension action was that an overpayment may exist *or money to be paid may be incorrect*, and the ZPIC has determined the amount of the overpayment, if any.

- The basis for the *payment* suspension action was that *a credible allegation of* fraud *exists against the provider*, and the amount of *the overpayment has been determined*.

- The basis for the *payment* suspension action was that payments to be made may not be correct, and the ZPIC has determined that *current* payments to be made are *now* correct*, and any associated overpayments have been determined*.

- The basis for the *payment* suspension action was that the provider failed to furnish records, *and* the provider has *now* submitted all *appropriate* requested records.

When the payment suspension is terminated, the disposition of the withheld funds shall be achieved in accordance with 42 CFR §405.372(e) and the payment suspension edit withholding the provider's funds is removed in the MAC system accordingly. Upon approval of the termination notice by CPI, the ZPIC shall provide a copy of the signed notice via the FID to CPI.

8.3.2.6 – Disposition of the *Withheld Funds*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

The MAC and ZPIC shall maintain an accurate, up-to-date record of the *dollar* amount withheld and the claims that comprise the *withheld* amount. *The* MAC and ZPIC shall keep a separate accounting of payment on all claims affected by the *payment* suspension. They shall keep track of how much money is uncontested and due the provider. The amount needs to be known as it represents assets that may be applied to reduce or eliminate any overpayment. (See *section 8.2 of this chapter.) The* MAC and ZPIC shall be able to provide, upon request, copies of the claims affected by the *payment* suspension. *The MAC shall coordinate the issuance of the demand for the overpayment(s) and termination of the payment suspension with respect to approved action by CPI. The MAC* shall apply the amount withheld first to the Medicare overpayment*(s)* and then *apply any excess money* to reduce any other obligation to CMS or to DHHS, *unless otherwise directed by CMS*. *The* MAC shall remit to the provider all monies held in excess of the amount the provider owes. If the provider owes more money than *what* was *with*held *as a result of the payment* suspension, the MAC shall initiate recoupment action, *unless otherwise directed by CMS*. *See 42 CFR §405.372(e).*

8.3.2.7 – Contractor Suspects Additional Improper Claims

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A. Present Time

If the *payment suspension is in the process of being terminated or has been terminated, and the* ZPIC believes that the provider will continue to submit noncovered, misrepresented, or potentially fraudulent claims, *the ZPIC* shall consider implementing or recommending other actions as appropriate (e.g., *education,* prepayment review, *revocation,* a new suspension of payment.)

B. Past Period of Time

If the payment suspension is in the process of being terminated or has been terminated, and the ZPIC believes there are past periods of *claims submissions* that may contain possible overpayments, *the* ZPIC shall consider recommending a new *payment* suspension covering those dates.

C. Additional Services

If, during the time that a provider is under *a partial payment* suspension for a particular service(s), *the ZPIC determines* there is reason to initiate *a payment* suspension action for a different service, a new *payment* suspension shall be initiated or *the new service(s) shall be* incorporated into the existing payment suspension depending on the circumstances. *The ZPIC shall discuss this action with CPI for a decision.*

Any time a new suspension action is initiated on a provider who is already under one or more *partial payment* suspension actions, *the* ZPIC shall, *if appropriate: (1)* obtain separate CMS approval, *(2)* issue an additional notice to the provider, *and (3)* offer a new rebuttal period *to the provider*.

8.3.3 – Suspension Process for Multi-Region Issues *(National Payment Suspensions)*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

8.3.3.1 – DME *Payment Suspensions (*MACs and ZPICs*)*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

For national payment suspensions involving durable medical equipment (DME) suppliers that are enrolled in multiple jurisdictions, the following is applicable for DME MACs and ZPICs:

- *When CMS suspends payments to a DME supplier, all payments to the supplier are suspended in all DME jurisdictions if the same Tax Identification Number is used. The information (whether based on fraud or non-fraud) that payments should be suspended in one DME jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.*

- *The ZPIC that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension if the payment suspension is approved. The lead contractor is responsible for informing the other respective contractors of the payment suspension being initiated and for the coordination of the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities of the national suspension by each of the contractors.*

- *The lead is responsible for coordinating and reporting to its CORs and BFLs whether the other contractors are compliant with the payment suspension timeframe and activities.*

- *All non-lead contractors are also responsible for determining an overpayment(s) for its jurisdiction. Non-lead contractors shall take into account the findings of the lead contractor and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.*

For ZPIC-initiated DME payment suspensions:

- *Each ZPIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective DME MAC jurisdiction and has communicated this to the lead ZPIC.*

- *Each ZPIC shall be responsible for providing timely updates on the withheld money in its corresponding DME MAC jurisdiction to the lead ZPIC for input in the FID payment suspension module, and in accordance with the FID requirements.*

8.3.3.2 – *Non-DME National Payment Suspensions (MACs and ZPICs)*

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

For national payment suspensions involving national providers (such as chain hospitals, chain Skilled Nursing Facilities, franchised clinics, laboratories, etc.) that are enrolled in multiple jurisdictions, the following may be applicable for MACs and ZPICs:

- *When CMS suspends payments to a national provider, all payments to the national provider are suspended in all jurisdictions if they share the same Tax Identification Number. The information (whether based on fraud or non-fraud) that payments should be suspended in one jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.*

- *The ZPIC that requests the national payment suspension to CPI shall become the "lead" contractor for the payment suspension. The lead contractor is responsible for informing the other respective contractors of the payment suspension being initiated and for the coordination regarding the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities by each of the contractors.*

- *The lead is responsible for coordinating and reporting to its CORs and BFLs whether the other contractors are compliant with the payment suspension timeframe and activities.*

- *All non-lead contractors shall be responsible for determining an overpayment(s) for its jurisdiction. Non-lead contractors shall take into account the findings of the lead contractor and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.*

For ZPIC-initiated non-DME national payment suspensions:

- *Each ZPIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective MAC jurisdiction and has communicated this to the lead ZPIC.*

- *Each ZPIC shall be responsible for providing timely updates on the withheld money in its respective zone to the Lead ZPIC, so it can update the FID payment suspension module in accordance with the FID requirements.*

Medicare Program Integrity Manual
Exhibits

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(Rev.670, Issued: 08-19-16)

Exhibit 16 - Model *Payment* Suspension Letters

(Rev. 670, Issued: 08-19-16, Effective: 11-23-16, Implementation: 11-23-16)

A. Payment Suspension Initial Notice Based on Fraud (No Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Suspension of Medicare Payments***
Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI: _____

Dear {Medicare Provider/Supplier's Name}

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. §405.371(a)(2). The suspension of your Medicare payments took effect on {ENTER DATE}. Prior notice of this suspension was not provided because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. §405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS), through its Central Office. See 42 C.F.R. §405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source, including but not limited to Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. §405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. §405.370, and may be extended under certain circumstances. See 42 C.F.R. §405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings, and which serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	*Date(s) of Service*	*$$ Amount Paid*

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example, in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. §405.372(b)(2), you have the right to submit a rebuttal statement in writing to us why the suspension should be removed. We request you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation), along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified or remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension, and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. §405.375(b)(2). This determination is not appealable. See 42 C.F.R. §405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. See 42 C.F.R. §405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both payments currently in process and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. §405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons therefore, and will be given an opportunity for rebuttal in accordance with 42 C.F.R. §405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services, in accordance with 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of ZPIC or MAC}, a CMS {Zone Program Integrity Contractor (ZPIC) or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures, and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. See Social Security Act, §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

B. Payment Suspension Initial Notice Based on Fraud (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Suspension of Medicare Payments***

Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI: _____

Dear {Medicare Provider/Supplier's Name}

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. §405.371(a)(2). The suspension of your Medicare payments will take effect on {ENTER DATE}.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS), through its Central Office. See 42 C.F.R. §405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source, including but not limited to Fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. See 42 C.F.R. §405.370. This suspension may last until "resolution of the investigation" as defined under 42 C.F.R. §405.370, and may be extended under certain circumstances. See 42 C.F.R. §405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings, and which serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	*Date(s) of Service*	*$$ Amount Paid*

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example, in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. §405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days as to why the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation), along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified or remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension, and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. §405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not appealable. See 42 C.F.R. §405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. See 42 C.F.R. §405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim

determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both payments in currently process and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. §405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons therefore, and will be given an opportunity for rebuttal in accordance with 42 C.F.R. §405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services, in accordance with 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of ZPIC or MAC}, a CMS {Zone Program Integrity Contractor (ZPIC) or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures, and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. See Social Security Act, §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

C. Payment Suspension Initial Notice Based on Reliable Information (No Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Suspension of Medicare Payments***
Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI:_____

Dear {Medicare Provider/Supplier's Name}

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. §405.371(a)(1). The suspension of your Medicare payments took effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. §405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days. Prior notice of this suspension was not provided because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. See 42 C.F.R. §405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS), through its Central Office. The suspension of your Medicare payments is based on reliable

information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF ZPIC or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings, and which serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	*Date(s) of Service*	*$$ Amount Paid*

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example, in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. §405.372(b)(2), you have the right to submit a rebuttal statement in writing to us why the suspension should be removed. We request you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation), along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified or remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension, and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. §405.375(b)(2). This determination is not appealable. See 42 C.F.R. §405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. See 42 C.F.R. §405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both payments currently in process and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. §405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons therefore, and will be given an opportunity for rebuttal in accordance with 42 C.F.R. §405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services, in accordance with 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of ZPIC or MAC}, a CMS {Zone Program Integrity Contractor (ZPIC) or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The

purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures, and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. See Social Security Act, §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

D. Payment Suspension Initial Notice Based on Reliable Information (Prior Notice Given)

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Suspension of Medicare Payments***
Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI: _____

Dear {Medicare Provider/Supplier's Name}

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. §405.371(a)(1). The suspension of your Medicare payments will take effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. §405.372(d). Any delays in producing medical records linked to the payment suspension request will likely extend this period beyond the 180 days.

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS), through its Central Office. The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF ZPIC or MAC.} More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}

The following list of sample claims provide evidence of our findings, and which serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number *Date(s) of Service* *$$ Amount Paid*

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example, in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. §405.372(b)(2), you have the right to submit a rebuttal statement in writing to us within the next 15 days as to why the suspension should be removed. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Your Name, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation), along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified or remain in effect within 15 days of receipt of the complete rebuttal package. Thereafter, we will notify you in writing of our determination to continue or remove the suspension, and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. See 42 C.F.R. §405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not appealable. See 42 C.F.R. §405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists, and if so, the amount of the overpayment. See 42 C.F.R. §405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both payments in currently process and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. §405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons therefore, and will be given an opportunity for rebuttal in accordance with 42 C.F.R. §405.374 from {MAC name.} When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services, in accordance with 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated:} Finally, {Name of ZPIC or MAC}, a CMS {Zone Program Integrity Contractor (ZPIC) or Medicare Administrative Contractor (MAC)}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures, and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. See Social Security Act, §1862(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

E. Payment Suspension Extension Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Extension of Suspension of Medicare Payments***
Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI:_____

Dear {Medicare Provider/Supplier's Name}

Please be advised that pursuant to 42 C.F.R. 405.372(d), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER ZPIC NAME} to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The extension of your payment suspension applies to both claims in process and future claims. We will continue to withhold your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. §405.372(d). When the payment suspension is terminated, any money withheld as a result of this action shall be first applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to the CMS or the U.S. Department of Health and Human Services. See 42 C.F.R. §405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name

F. Payment Suspension Termination Notice

Date
Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: ***Notice of Termination of Suspension of Medicare Payments***
Provider/Supplier Medicare ID Number(s): _____
Provider/Supplier NPI: _____

Dear {Medicare Provider/Supplier's Name}

Pursuant to C.F.R. §405.372(c), this is to notify you that the Centers for Medicare & Medicaid Services (CMS) has directed us to terminate the payment suspension in effect for your Medicare payments. You were notified of the results of our review and the overpayment(s) we determined on {Enter Date of letter}. This information has been forwarded to {MAC Name} for final action. In the near future, they will issue the overpayment demand letter, along with information regarding your appeal rights and process. When the payment suspension has been removed, any money withheld as a result of this action shall first be applied to reduce or eliminate any overpayment and then to reduce any obligation to CMS or U.S. Department of Health and Human Services per 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Please be advised that this action to terminate your payment suspension should not be construed as any positive determination regarding your Medicare billing, nor is it an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve you of any civil or criminal liability, nor does it offer a defense to any further administrative, civil or criminal actions against you.

Should you have any questions, please contact me in writing or via telephone at {phone number}.

Sincerely,

Name