CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11218	**Date: January 27, 2022**
	Change Request 12595

SUBJECT: Updates to Chapter 4 in Publication (Pub.) 100-08, Including Removal of Requests for Anticipated Payment (RAP) Suppressions and Updates to Exhibit 16 - Model Payment Suspension Letters in Pub. 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections within Chapter 4 in Pub. 100-08. The primary updates in this CR include the removal of references to RAP suppressions. Additionally, Exhibit 16 (Model Payment Suspension Letters) in the Exhibits Chapter of Pub. 100-08 has been revised.

EFFECTIVE DATE: February 28, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 28, 2022

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/4.4/Home Health Agency Billing and Notice of Admission (NOA)
R	4/4.4/4.4.1/Education and Additional Monitoring
R	4/4.4/4.4.2/Corrective Action Plans
N	4/4.4/4.4.2/4.4.2.1/Notification to the HHA
N	4/4.4/4.4.2/4.4.2.2/CAP Submission
N	4/4.4/4.4.2/4.4.2.3/CAP Acceptance and Monitoring
N	4/4.4/4.4.2/4.4.2.4/CAP Closeout
R	4/4.4/4.4.3/Coordination and Referral to the UPIC
D	4/4.4/4.4.3/4.4.3.1/Notification to the HHA
D	4/4.4/4.4.3/4.4.3.2/CAP Submission
D	4/4.4/4.4.3/4.4.3.3/CAP Acceptance and Monitoring
D	4/4.4/4.4.3/4.4.3.4/CAP Closeout
D	4/4.4/4.4.4/RAP Suppression
D	4/4.4/4.4.4/4.4.4.1/Notice of RAP Suppression
D	4/4.4/4.4.4/4.4.4.2/Monitoring During RAP Suppression
D	4/4.4/4.4.4/4.4.4.3/Result of Initial RAP Suppression Monitoring Period
D	4/4.4/4.4.4/4.4.4.3/4.4.4.3.1/Reinstatement of RAP Authorization
D	4/4.4/4.4.4/4.4.4.3/4.4.4.3.2/Continuation of RAP Suppression
D	4/4.4/4.4.5/Coordination and Referral to the UPIC
R	4/4.5/Screening Leads
R	4/4.5/4.5.1/UPIC and I-MEDIC Responsibilities
R	4/4.7/4.7.1/Conducting Investigations
R	4/4.7/4.7.1/4.7.1.2/Case Coordination with UPICs
R	4/4.7/4.7.4/4.7.4.1/Production of Medical Records and Documentation for an Appeals Case File
R	4/4.9/4.9.1/Immediate Advisements to the OIG/OI
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: 11218	Date: January 27, 2022	Change Request: 12595

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EFFECTIVE DATE: February 28, 2022
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I. GENERAL INFORMATION

A. Background: The CMS will make revisions to various sections in Chapter 4 and Exhibit 16 in Pub. 100-08 based on updates to the Unified Program Integrity Contractor (UPIC) and Investigations Medicare Drug Integrity Contractor processes.

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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12595.1	Contractors shall follow the guidance in section 4.4 Home Health Agency Billing and Notice of Admission (NOA) in Chapter 4 of Pub. 100-08.			X						UPICs
12595.2	Contractors shall follow the guidance in section 4.4.1 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.2 in Chapter 4.			X						UPICs
12595.3	Contractors shall follow the			X						UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	guidance in section 4.4.2 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.3 in Chapter 4.									
12595.4	Contractors shall follow the guidance in section 4.4.2.1 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.3.1 in Chapter 4.			X						UPICs
12595.5	Contractors shall follow the guidance in section 4.4.2.2 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.3.2 in Chapter 4.			X						UPICs
12595.6	Contractors shall follow the guidance in section 4.4.2.3 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.3.3 in Chapter 4.			X						UPICs
12595.7	Contractors shall follow the guidance in section 4.4.2.4 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.3.4 in Chapter 4.			X						UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12595.8	Contractors shall follow the guidance in section 4.4.3 in Chapter 4 of Pub. 100-08 which was originally referenced in section 4.4.5 in Chapter 4.			X						UPICs
12595.9	Contractors shall assess the environment and use sound judgement to determine when it is appropriate to check locked doors when performing site verifications.									UPICs
12595.10	The MACs shall follow the guidance in section 4.5.1 in Chapter 4 of Pub. 100-08 and screen and forward complaints within 45 business days from the date of receipt by the screening staff, or within 30 business days of receiving medical records and/or other documentation, whichever is later, to the UPIC.	X	X	X	X					
12595.11	The Contractor shall submit requests through its current processes (i.e., via Unified Case Management System) and									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	coordinate subsequent actions with the appropriate points of contact within CMS for any investigative activities that require approval by CMS.									
12595.12	The Contractor shall assemble the case file and send it to the MAC within five (5) business days upon request from the MAC for an appeal of a claim denial determination.	X	X	X	X					UPICs
12595.13	Contractors shall refer to the updated Exhibit 16 - Model Payment Suspension Letters in the Exhibits Chapter of Pub. 100-08 when sending payment suspension notices to providers/suppliers.									UPICs

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 4 - Program Integrity

Table of Contents
(Rev. 11218; Issued: 01-27-2022)

Transmittals for Chapter 4

4.4 - Home Health Agency *Billing and Notice of Admission (NOA)*

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

This section applies to MACs who process Home Health claims.

*Prior to January 1, 2022, u*nder the Prospective Payment System (PPS) Medicare *made* a split percentage payment for most Home Health PPS episode periods. The first payment *was* for a Request for Anticipated Payment (RAP), and the last *was* for a claim. *As of January 01, 2022, Home Health Agencies (HHA) shall no longer submit RAPs for any Home Health period of care with a "from" date on or after January 1, 2022. Instead, for each admission to home health, the HHA notifies the Medicare systems via submission of an NOA.* See Pub 100-04, Medicare Claims Processing Manual, Chapter 10, Home Health Agency Billing, for more detailed information regarding the processing of *NOAs*.

MACs may identify instances where *an HHA's* use of *NOAs* indicates potential fraud, waste or abuse. Upon identifying misuse of *NOAs*, the MAC shall initiate corrective action. Corrective action includes, but is not limited to, education, warnings, Corrective Action Plans, and referrals to the UPIC.

4.4.1 - *Education and Additional Monitoring*

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

In monitoring the use of NOAs and Home Health claims, a MAC may identify potential misuse that is not significant enough to warrant immediate implementation of a Corrective Action Plan, but may indicate the need for additional education and monitoring. The MAC shall educate the HHA on the appropriate use of NOAs. Appropriate steps include calling the HHA to discuss the concerns identified, distributing educational materials to the HHA, and/or sending correspondence to the HHA. At a minimum, the MAC shall make clear to the HHA that:

- *the HHA's billing practices are inconsistent with Medicare policy guidelines;*
- *the HHA's billing practices are being subjected to increased monitoring;*
- *if improvement is not demonstrated upon completion of a reasonable monitoring period (e.g., 30 days), there is potential for additional future action, including Corrective Action Plans and/or referral to the UPIC; and*
- *the MAC will convey next steps, if any, upon completion of the monitoring period.*

Once the monitoring period has ended, the MAC shall inform the HHA of the outcome. This may include no additional action being taken, the monitoring period being extended or the implementation of additional corrective action, including but not limited to a Corrective Action Plan as detailed in Section 4.4.3.

4.4.2 - *Corrective Action Plans*

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

In monitoring an HHA's activities, a MAC may identify misuse of NOAs that warrants immediate implementation of a Corrective Action Plan (CAP). The purpose of the CAP is to ensure adherence to CMS regulations and that an HHA is implementing processes/internal controls to improve billing practices.

4.4.2.1 - Notification to the HHA

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

A MAC shall notify the HHA in writing that a CAP is required based on non-compliant billing practices; detail the misuse the MAC identified; indicate the anticipated length of the CAP.

4.4.2.2 - CAP Submission
(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

The HHA must submit the CAP within 14 calendar days from the date of the MAC's letter. In the CAP, the HHA must address the following:

- *A statement of the problem(s) or weakness(es) that caused the misuse of NOA identified by the MAC.*
- *The proposed solution(s) along with other pertinent information including time frames for resolving the problem(s).*
- *The individual responsible for monitoring the CAP who will coordinate with the MAC.*
- *Other relevant information.*

If an HHA fails or refuses to submit a CAP, the MAC shall take immediate action to refer the HHA to the UPIC in accordance with Section 4.4.5.

The MAC shall provide the UPICs a list of HHAs with pending or accepted CAPs on a regular basis, i.e., at least monthly. The submission or acceptance of a CAP does not preclude the UPIC from opening an investigation for potential fraud.

4.4.2.3 - CAP Acceptance and Monitoring
(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

The MAC shall notify the HHA once the CAP has been reviewed and accepted. The MAC shall convey the length of time the CAP will be in place. Normally, CAPs will be implemented for a minimum of 30 calendar days, but the MAC may require a longer implementation period based on the specific problems/weaknesses. The MAC shall periodically monitor the HHA's progress toward the proposed solutions prior to the end of the implementation period.

If the MAC is unable to accept the CAP, the MAC has discretion to allow the HHA an additional period not to exceed 14 calendar days to resubmit. If the HHA is unable to resolve the issues with the CAP, the MAC shall consider additional corrective action, including referral to the UPIC.

4.4.2.4 - CAP Closeout
(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

Once the monitoring period has ended, the MAC shall formally inform the HHA of the outcome. This includes no additional action being taken, the monitoring period being extended or the implementation of additional corrective action, including but not limited to a Corrective Action Plan as detailed in Section 4.4.3, based on other misuse identified.

Upon request by a UPIC, the MAC shall provide information regarding a CAP.

4.4.3 - *Coordination and Referral to the UPIC*
(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

Throughout the monitoring of Home Health claims, the MAC shall coordinate with the UPIC to determine if there is an open investigation concerning the HHA and appropriate next steps. If there is an open investigation on the HHA, the MAC shall immediately refer their findings to the UPIC and take no further action unless otherwise agreed upon.

A MAC may determine that an HHA's misuse of NOAs and/or other conduct, such as an HHA's failure to respond to requests/queries during periods of increased monitoring, CAPs, etc., warrants immediate referral to the appropriate UPIC. MACs and UPICs shall coordinate in accordance with Pub 100-08, Medicare Program Integrity Manual, Chapter 4, Program Integrity and their Joint Operating Agreements.

4.5 - Screening Leads

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

This section applies to UPICs.

Screening is the initial step in the review of a lead (described in section 4.2.2.1 of this chapter) to determine the need to perform further investigation based on the potential for fraud, waste, or abuse. Screening shall be completed within 45 calendar days after receipt of the lead.

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

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

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

- Verification of provider's enrollment status;
- Coordination with the MAC on prior activities (i.e., prior medical reviews, education, appeals information, etc.);
- Data analysis;
- Policy / regulation analysis;
- Contact with the complainant, when the lead source is a complaint;
- Beneficiary interviews; and
- Site verification to validate the provider's/supplier's practice location. *Note: While there is no requirement to check locked doors during a site verification, UPICs are authorized to check the doors. As such, the UPIC shall assess the environment and use sound judgement to determine when it is appropriate to check locked doors.*

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

the lead involves potential patient harm, the UPIC shall immediately notify CMS within two (2) business days.

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

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

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

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

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

4.5.1 - UPIC and I-MEDIC Responsibilities

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

This section applies to the UPICs *and the MACs*.

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

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

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

This section applies to the I-MEDIC.

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

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

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

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

4.7.1 – Conducting Investigations

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

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

- Screening activities as referenced in Section 4.5;
- Contact with the subject provider or ordering/referring providers via telephone or on-site visit;
- Medical record requests and reviews (as defined in PIM, chapter 3);
- Prepayment medical reviews associated with a limited claim count (i.e., 25- 50 claims) or targeted review (i.e., specific CPT codes) (as defined in PIM, chapter 3);
- Implementation of auto-denial edits; and
- Recommendation of other administrative actions (as defined in PIM chapters 3, 8, and 10) to CMS. These items will include any administrative actions identified below to be discussed during the case coordination meetings.

Additionally, the UPICs shall coordinate with LE partners prior to making contact with any provider/supplier, when it knows there is or was a LE case on the provider/supplier.

The UPIC shall review the Unified Case Management (UCM) system prior to contacting any provider/supplier to verify the following:

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

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

For any investigative activities that require approval by CMS (i.e., Payment Suspension or revocation/deactivation requests), the UPIC shall submit those requests through its current processes (i.e., via UCM) and coordinate subsequent actions with the appropriate points of contact within *CMS*.

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

4.7.1.2 - Case Coordination with UPICs

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

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

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

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

4.7.4.1 - Production of Medical Records and Documentation for an Appeals Case File

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

When the UPIC denies a claim and the provider, supplier, physician or beneficiary appeals the denial, the MAC shall request the medical records and documentation that the UPIC used in making its determination. The UPIC shall assemble the case file and send it to the MAC within five (5) *business* days. If the MAC request is received outside of normal business hours or on an observed holiday that the UPIC is closed for business, the first *business* day will not be counted until the first business day after receipt of the request (i.e., if received on Saturday, the following Monday will be counted as the first *business* day).

The UPIC shall include any position papers or rationale and support for its decision so that the appeals adjudicator can consider it during the appeals process. However, UPICs shall be aware that an appeals case file is discoverable by the appellant. This means that the appellant can receive a complete copy of the case file. Since the provider may receive the case file, the UPIC shall consult with law enforcement before including any sensitive information relative to a case.

If the UPIC would like to be notified of an *Administrative Law Judge (*ALJ*)* hearing on a particular case, the UPIC shall put a cover sheet in the case file before sending it to the MAC. The cover sheet shall state that the UPIC would like to be notified of an ALJ hearing and list a contact name with a phone and fax number where the contact can be reached. The cover sheet shall also include language stating, "PLEASE DO NOT REMOVE" to ensure it stays on the case file should the file be sent to the *Quality Improvement Contractor (*QIC*)*. If the UPIC receives a notice of hearing, the UPIC shall contact the QIC immediately.

The QICs are tasked with participating in ALJ hearings; therefore, they are the primary Medicare contractor responsible for this function. UPICs may participate in an ALJ hearing, but they shall work with the QIC to ensure that duplicative work is not being performed by both the UPIC and the QIC in preparation for the hearing. UPICs shall never invoke party status. If the UPIC participates in a hearing, it shall be as a non-party. An ALJ cannot require participation in a hearing, whether it is party or non-party. If a UPIC receives a notice that appears contrary to this instruction, the UPIC shall contact the QIC and their primary COR and BFL immediately.

4.9.1 - Immediate Advisements to the OIG/OI

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

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

- Indications of UPIC or MAC employee fraud
- Allegations of kickbacks or bribes, discounts, rebates, and other reductions in price
- Allegations of a crime committed by a federal or state employee in the execution of their duties
- Indications of fraud by a third-party insurer that is primary to Medicare
- Confirmation of forged documentation during the course of an investigation, include, but is not limited to:
    - o identification of forged documents through medical review; and/or
    - o attestation from provider confirming forged documentation.

- Allegations and subsequent verification of services not rendered as a result of any of the following:
    - o medical review findings;
    - o interviews or attestations from a minimum of three (3) beneficiaries indicating that they did not receive services; and/or
    - o attestations from referring/ordering providers indicating they did not refer/order a service (e.g., confirmation of no relationship with the beneficiary prior to service, or confirmed impossible day billings).
- Confirmed complaints from current or former employees that indicate the provider in question inappropriately billed Medicare for all or a majority of its services. Confirmation would be required though one of the following:
    - o minimum of three (3) beneficiary interviews confirming the inappropriate billing;
    - o provider attestation(s) confirming the inappropriate billing; or
    - o medical review findings.
- Confirmation of beneficiary recruitment into potentially fraudulent schemes and/or provider participation (e.g., telemarketing or solicitation schemes);
- Substantiated identity theft of a provider's Medicare number, a beneficiary's Medicare number, or selling or sharing of beneficiary lists;
- Confirmed indication of patient harm (e.g., through medical review findings or confirmation of issues identified during an onsite visit or interviews with providers or beneficiaries).
- Indication of provider/supplier fraud related to national emergency, pandemic, etc.
    - o Should an IA of this nature be identified, the UPIC shall notify their BFL to determine if the IA should be forwarded to a specific OIG/OI point-of-contact.

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

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

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

Once the criteria for an IA are met, the UPIC shall notify the OIG/OI via phone or email to determine if a formal IA referral should be sent to the OIG/OI. If the IA is related to a provider/supplier that spans multiple jurisdictions, the UPIC shall notify any impacted UPIC and/or I-MEDIC Program Directors of the potential IA, allegation, and IA criteria.

The UPIC shall document this communication in UCM. The UPIC shall also send notification to its COR and BFL of the potential IA. If the UPIC does not receive a response from the OIG/OI within two (2) business days (5 business days for the I- MEDIC), it shall notify its COR and BFL team and await further instructions. If the OIG/OI confirms that a formal IA should be sent, the UPIC shall provide all available documentation, including billed/paid amounts for the YTD and the previous year, to the OIG/OI within four (4) business days of receiving the response from OIG/OI. Upon submission of the IA to the OIG/OI, the UPIC shall request written and/or email confirmation from the OIG/OI acknowledging receipt of the IA. Simultaneously, the UPIC shall notify the CMS identified Strike Force points of contacts, if the notification includes providers/suppliers located within a Strike Force jurisdiction. Additionally, the UPIC shall notify and send a copy of the IA to

its COR/BFL and the case coordination team, at CPIMCCNotifications@cms.hhs.gov, the same day the advisement is made to OIG/OI. In this notification to CMS, the UPIC shall advise if it has any other potential administrative actions it may want to pursue related to the provider(s)/supplier(s). The provider(s)/supplier(s) identified in an accepted IA shall be added to the UPIC's next scheduled case coordination meeting.

If the OIG/OI determines that a formal IA is not needed, the UPIC shall advise its COR/BFL and immediately continue its investigation. In instances where an IA is related to a Plan employee whistleblower, the I-MEDIC does not have to notify the case coordination team of the IA nor does the IA have to be discussed at a case coordination meeting. Rather, the I-MEDIC shall close the complaint upon acceptance and/or declination of the IA due to these complaint types being outside of the I-MEDIC's SOW.

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

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

If the OIG/OI declines or accepts the IA, the UPIC shall document the decision in UCM and follow the processes described in Chapter 4, § 4.5, 4.6, and 4.7 of the PIM, unless otherwise directed by CMS.

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

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

Medicare Program Integrity Manual

Exhibits

(Rev. 11218; Issued: 01-27-2022)

Exhibit 16 - Model Payment Suspension Letters

(Rev. 11218; Issued: 01-27-2022; Effective: 02-28-2022; Implementation: 02-28-2022)

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:
PSP Number:

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 *the Centers for Medicare & Medicaid Services' (CMS)* ability to recover any determined overpayment. *See* 42 C.F.R. § 405.372(a)(3) and (4).

The CMS through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. *See* 42 C.F.R. § 405.371(a)(2). 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. *See* 42 C.F.R. § 405.370(a). Allegations are considered 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).

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, *d*ate of *s*ervice, amount paid *and basis for selected claim* 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 serve as a basis for the determination to suspend your Medicare payments:

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

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 this payment suspension.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. If you opt to do so, we request that you submit this rebuttal statement to us within 15 days of receipt of this notice, and you may include with this statement any evidence you believe supports your reasons why the suspension should be removed. If you choose to submit a rebuttal statement, 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, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. *See* 42 C.F.R. § 405.375(a). 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 an initial determination and 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(s). 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 also applies to claims in process.

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. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}*, CMS' Medicare Administrative Contractor (MAC)*. When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, 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 UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or *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* 42 U.S.C. §

1395y(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 regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

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:
PSP Number:

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 Centers for Medicare & Medicaid Services (CMS) through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. *See* 42 C.F.R. § 405.371(a)(2). 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 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).

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, *d*ate of *s*ervice, amount paid *and basis for selected claim* 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 serve as a basis for the determination to suspend your Medicare payments:

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

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 this payment suspension.

Pursuant to 42 C.F.R. §§ 405.372(b)(2) and 405.374, you have the right to submit a rebuttal statement in writing to us within the next 15 days of receipt of this notice indicating why you believe the suspension should not be implemented or should be removed. If you opt to do so, you may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be implemented or should be removed. If you choose to submit a rebuttal statement, your rebuttal statement and supporting 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 implemented, removed, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. Thereafter, we will notify you in writing of our determination to implement, continue, or remove the suspension and provide specific findings on the conditions upon which the suspension may be implemented, 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 an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is implemented or 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 claims in process.

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. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, *CMS' Medicare Administrative Contractor (MAC).* When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, 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 UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or *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* 42 U.S.C. § 1395y(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 regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

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:
PSP Number:

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). Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder *the Centers for Medicare & Medicaid Services' (CMS)* ability to recover any determined overpayment. *See* 42 C.F.R. § 405.372(a)(3) and (4).

CMS through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). 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 UPIC or MAC}. More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, *d*ate of *s*ervice, amount paid *and basis for selected claim* 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 serve as a basis for the determination to suspend your Medicare payments:

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

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 this payment suspension.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. If you opt to do so, we request that you submit this rebuttal statement to us within 15 days and you may include with this statement any evidence supporting your reasons why the suspension should be removed. If you choose to submit a rebuttal statement, 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 or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. *See* 42 C.F.R. § 405.375(a). 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 an initial determination and 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. We will continue to process claims 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 also applies to claims in process.

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. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, *CMS' Medicare Administrative Contractor (MAC)*. When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, 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 UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or *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* 42 U.S.C. § 1395y(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 regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

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:
PSP Number:

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).

The Centers for Medicare & Medicaid Services (CMS) through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). 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 UPIC 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 serve as a basis for the determination to suspend your Medicare payments:

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

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 this payment suspension.

Pursuant to 42 C.F.R. §§ 405.372(b)(2) and 405.374, you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should not be implemented or should be removed. If you opt to do so, you may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be implemented or should be removed. If you choose to submit a rebuttal statement, 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 implemented, removed, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. Thereafter, we will notify you in writing of our determination to implement, continue, or remove the suspension and provide specific findings on the conditions upon which the suspension may be implemented, 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 an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is implemented or 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. We will inform you of developments and will promptly notify you of any overpayment determination(s). 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 also applies to claims in process.

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. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, *CMS' Medicare Administrative Contractor (MAC)*. When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, 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 UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or *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* 42 U.S.C. § 1395y(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 regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

Sincerely,

Name

E. Reliable Information that an Overpayment Exists (RIO) 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:
PSP Number:

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 UPIC NAME}, *CMS' Unified Program Integrity Contractor*, 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 claims in process. 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 the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378, and then to reduce any other obligation to 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 remainder will be released to you.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox].

Sincerely,

Name

F. Credible Allegation of Fraud (CAF) 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:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.371(b), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER UPIC NAME}, *CMS' Unified Program Integrity Contractor*, to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The continuation of your payment suspension applies to claims in process. We will continue to suspend your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(c)(2). When the payment suspension is terminated, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to 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 regarding the status of the suspension, please direct your inquiry to [shared mailbox].

Sincerely,

Name

G. Payment Suspension Termination Notice

USE THIS LETTER IF SENDING PAYMENT SUSPENSION TERMINATION NOTICE TO THE PROVIDER'S/SUPPLIER'S ATTORNEY

Date

Name of Attorney
Address

City, State Zip

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

Dear {Medicare Provider/Supplier Attorney's Name}:

The Centers for Medicare & Medicaid Services (CMS) has directed us to terminate the payment suspension in effect for Medicare payments to [provider] pursuant to 42 C.F.R. § 405.372(c). The provider was notified of the results of our review and the overpayment(s) we determined on [INSERT DATE]. The overpayment information was forwarded to [INSERT MAC], *CMS' Medicare Administrative Contractor (MAC)* for further action. [insert MAC name] will issue the overpayment demand letter(s), along with information regarding the provider's appeal rights. Once the payment suspension is removed, any funds withheld as a result of the payment suspension shall be applied first to reduce or eliminate any overpayment by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378 and then to reduce any other obligation to CMS or the 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 the provider.

Please be advised that this action to terminate the payment suspension should not be construed as any positive determination regarding the provider's Medicare billing and is not an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve the provider of any civil or criminal liability, and it does not offer a defense to any further administrative, civil or criminal actions against the provider.

Sincerely,

Name

H. Payment Suspension Termination Notice

USE THIS LETTER IF SENDING PAYMENT SUSPENSION TERMINATION NOTICE TO THE PROVIDER/SUPPLIER

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:
Record Identifier(s):

Dear {Medicare Provider/Supplier's Name}:

The Centers for Medicare & Medicaid Services (CMS) has directed us to terminate the payment suspension in effect for Medicare payments to [provider] pursuant to 42 C.F.R. § 405.372(c). You were notified of the results of our review and the overpayment(s) we

determined on [INSERT DATE]. The overpayment information was forwarded to [INSERT MAC], *CMS' Medicare Administrative Contractor (MAC),* for further action. [Insert MAC name] will issue the overpayment demand letter(s), along with information regarding your appeal rights. Once the payment suspension is removed, any funds withheld as a result of the payment suspension shall be applied first to reduce or eliminate any overpayment by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378 and then to reduce any obligation to CMS or the 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 the payment suspension should not be construed as any positive determination regarding your Medicare billing and is not an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve you of any civil or criminal liability, and it does not offer a defense to any further administrative, civil or criminal actions against you.

Sincerely,

Name