CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 943	**Date: February 21, 2020**
	Change Request 11629

SUBJECT: Updates to Chapter 4 and Exhibit 8 in Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections within Chapter 4 and Exhibit 8 in Pub. 100-08.

EFFECTIVE DATE: March 24, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 24, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/4.7/Investigations
R	4/4.7/4.7.1/Conducting Investigations
R	4/4.8/Disposition of Cases Referred to Law Enforcement
N	4/4.12/4.12.10/UCM Outages
R	4/4.17/UPIC Hospice Cap Liability Process – Coordination with the MAC
R	4/4.18/4.18.1/4.18.1.2/Immediate Advisements to the OIG/OI
R	4/4.23/Identity Theft Investigations and Victimized Provider Process
R	Exhibits/Exhibits 8/Victimized Provider Process Letter Templates

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: 943	Date: February 21, 2020	Change Request: 11629

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EFFECTIVE DATE: March 24, 2020
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I. GENERAL INFORMATION

A. Background: The CMS is revising Chapter 4 and Exhibit 8 in Pub. 100-08 based on updates to Unified Program Integrity Contractor (UPIC) and Investigations Medicare Drug Integrity Contractor (I-MEDIC) processes and procedures.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11629.1	The UPIC shall submit requests to the CMS for approval with a copy to its Contracting Officer's Representative (COR) and Business Function Leads (BFL) for approval when initiating investigative activities that require preapproval by CMS (i.e., activities referenced in section 4.15).									UPICs
11629.2	The UPIC shall ensure that all									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	investigations originating from an Accountable Care Organization (ACO) referral or involving ACOs, ACO participants or ACO providers/suppliers are provided a heightened level of priority and are promptly reviewed and investigated to ensure the appropriate administrative or other action(s) are taken in an expeditious manner.									
11629.3	The UPIC shall perform screening activities as referenced in section 4.6.3 in chapter 4 of Pub. 100-08.									UPICs
11629.4	The UPIC shall follow the direction as outlined in section 4.18.1)Referral of Cases to the Office of Inspector General (OIG) / Office of Investigations (OI)) of Chapter 4 in Pub. 100-08.									UPICs
11629.5	The UPIC shall complete Unified									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Case Management System (UCM) entries within five business days of UCM being restored when there are system outages, scheduled or unscheduled, resulting in UCM being unavailable for two or less business days.									
11629.5.1	The UPIC shall complete UCM entries within ten business days of UCM being restored when there are system outages, scheduled or unscheduled, resulting in UCM being unavailable for greater than two business days.									UPICs
11629.6	The UPIC shall follow UPIC Hospice Cap Liability Process, as described in section 4.17 in Chapter 4 of Pub. 100-08.									UPICs
11629.7	The UPIC shall notify any impacted UPIC and/or Investigations Medicare Drug Integrity Contractor									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Program Directors of a potential Immediate Advisement (IA), allegation, and IA criteria if the IA is related to a provider/supplier that spans multiple jurisdictions.									
11629.8	The UPIC shall document OIG declined or accepted IAs in the UCM and follow the processes described in sections 4.6.3, 4.6.4, and 4.7 in Chapter 4 of Pub. 100-08, unless otherwise directed by CMS.									UPICs
11629.9	The UPIC shall follow the Identity Theft Investigations and Victimized Provider Process, as described in section 4.23 in Chapter 4 of Pub. 100-08.									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.943; Issued: 02-21-20)

Transmittals for Chapter 4

4.7 - Investigations

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

This section applies to UPICs.

An investigation is the expanded analysis performed on leads once such lead is vetted and approved by CMS to be opened as an investigation. The UPIC shall focus its investigation in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicare Trust Fund dollars within 180 calendar days, unless otherwise specified by CMS.

For any investigative activities that require preapproval by CMS (i.e., *activities referenced in Section 4.15*), the UPIC shall submit those requests to CMS for approval with a copy to its COR and BFLs for approval when initiating those actions.

Prioritization of the investigation workload is critical to ensure that the resources available are devoted primarily to high-priority investigations. *The UPIC shall ensure that all investigations originating from an Accountable Care Organization (ACO) referral or involving ACOs, ACO participants or ACO providers/suppliers are provided a heightened level of priority and are promptly reviewed and investigated to ensure the appropriate administrative or other action(s) are taken in an expeditious manner.*

The UPIC shall maintain files on all investigations. The files shall be organized by provider or supplier and shall contain all pertinent documents including, but not limited to, the original referral or complaint, investigative findings, reports of telephone contacts, warning letters, documented discussions, documented results of any investigative activities, any data analysis or analytical work involving the potential subject or target of the investigation, and decision memoranda regarding final disposition of the investigation (refer to section 4.2.2.4.2 of this chapter for information concerning the retention of these documents).

Under the terms of their contract, the UPICs shall investigate potential fraud, waste, or abuse on the part of providers, suppliers, and other entities that receive reimbursement under the Medicare program for services rendered to beneficiaries. The UPICs shall refer potential fraud cases to LE, as appropriate, and provide support for these cases. In addition, the UPICs may provide data and other information related to potential fraud cases initiated by LE when the cases involve entities or individuals that receive reimbursement under the Medicare program for services rendered to beneficiaries.

For investigations that the providers/suppliers are subject to prior authorization by the MAC, the UPIC may request the MAC to release the prior authorization requirement prior to pursuing the investigation further.

For those investigations that are national in scope, CMS will designate a lead UPIC, if appropriate, to facilitate activities across the zones.

4.7.1 – Conducting Investigations

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

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 4.6.3*;

- Contact with the subject provider or ordering/referring providers via telephone or on-site visit;
- Medical record requests and reviews (as defined in PIM, chapter 3);
- Prepayment medical reviews associated with a limited claim count (i.e., 25-50 claims) or targeted review (i.e., specific CPT codes) (as defined in PIM, chapter 3);
- Implementation of auto-denial edits; and
- Recommendation of other administrative actions (as defined in PIM chapters 3, 8, and 15) to CMS. These items will include any administrative actions identified below to be discussed during the case coordination meetings.

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

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

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

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

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

4.8 - Disposition of Cases Referred to Law Enforcement

(Rev. 943, Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

The UPIC shall refer investigations to law enforcement when it has substantiated allegations of fraud including, but not limited to, documented allegations that a provider, beneficiary, supplier, or other subject: (a) engaged in a pattern of improper billing, (b) submitted

improper claims with suspected knowledge of their falsity, or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. Prior to making such referrals, the UPIC shall *follow the direction as outlined in § 4.18.1 Referral of Cases to the OIG/OI*, unless otherwise instructed by CMS.

4.12.10 - UCM Outages
(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

If there are system outages, scheduled or unscheduled, resulting in UCM being unavailable for two or less business days, the expectation is that the contractors shall complete UCM entries within five business days of UCM being restored.

If there are system outages, scheduled or unscheduled, resulting in UCM being unavailable for greater than two business days, the expectation is that the contractors shall complete UCM entries within ten business days of UCM being restored.

4.17 - *UPIC Hospice Cap Liability Process – Coordination with the MAC*
(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

This section applies to UPICs.

Medicare Part A includes a hospice benefit for terminally ill patients. Congress has established a retrospective "cap" on the aggregate amount that Medicare will reimburse hospice providers each year. Historically, PI contractor reviews of hospices have overlapped with the MAC review of the benefit cap liability for those same hospices; resulting in a potential double recovery for the government. Therefore, the following communication and process between the UPICs and MACs shall be followed, in order to minimize the occurrence of these double recoveries, and check the RAC Data Warehouse to ensure the provider is not under suppression.

- *UPIC Initiated Reviews:*

    - *When using statistical sampling that may result in an actual and/or extrapolated overpayment, upon the initiation of a hospice review, the UPIC shall reach out to the MAC to determine whether the hospice is subject to any finalized or ongoing cap liability reviews (self-reported, final, and/or re-opening) for the applicable period of the UPIC's audit.*

      If there are no ongoing/finalized cap liability determinations, the UPIC shall proceed with its review. Prior to the issuance of its final overpayment, the UPIC again shall reach out to the MAC to ascertain whether, in the intervening period, the hospice has become subject to an ongoing/finalized cap liability determination. If the hospice has not become subject to such determination, the UPIC shall finalize its review and issue the findings to the hospice and refer any overpayment to the MAC for collection.

      If it's determined that the hospice is subject to any finalized or ongoing cap liability reviews (self-reported, final, and/or re-opening) for the applicable period of the UPIC's audit, whether at the onset of the UPIC's review or prior to issuance of the final review findings, the UPIC shall only design an SSOE for those years that are not subject to the cap determinations / settlement period. For the period that is subject to the cap determinations / settlement period, the UPIC shall not design a SSOE until for that period until the review has been completed. The UPIC shall review the cap liability determination and determine whether the UPIC's proposed findings would constitute a

double recovery against the hospice. If the UPIC determines that there is no potential for double recovery against the hospice, the UPIC shall finalize its review and issue the findings to the hospice and refer any overpayment to the MAC for collection. If, however, the UPIC believes that a double recovery may/will occur, the UPIC shall note the amount of the double recovery in its report and deduct that amount from the overpayment determination that it refers to the MAC for collection. This process ensures that a provider is not penalized for the same beneficiary twice.

The UPIC shall contact its COR and IAG BFL if it has any questions or concerns about the hospice review and/or overpayment.

4.18.1.2 - Immediate Advisements to the OIG/OI

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

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:
    - identification of forged documents through medical review; and/or
    - attestation from provider confirming forged documentation.
- Allegations and subsequent verification of services not rendered as a result of any of the following:
    - medical review findings;
    - interviews or attestations from a minimum of three (3) beneficiaries indicating that they did not receive services; and/or
    - attestations from referring/ordering providers indicating they did not refer/order a service (e.g., confirmation of no relationship with the beneficiary prior to service, or confirmed impossible day billings).
- Confirmed complaints from current or former employees that indicate the provider in question inappropriately billed Medicare for all or a majority of its services. Confirmation would be required though one of the following:
    - minimum of three (3) beneficiary interviews confirming the inappropriate billing;
    - provider attestation(s) confirming the inappropriate billing; or
    - medical review findings.
- Confirmation of beneficiary recruitment into potentially fraudulent schemes (e.g., telemarketing or solicitation schemes);
- Substantiated identity theft of a provider's Medicare number, a beneficiary's Medicare number, or selling or sharing of beneficiary lists;
- Confirmed indication of patient harm (e.g., through medical review findings or confirmation of issues identified during an onsite visit or interviews with providers or beneficiaries).

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

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

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

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

In this notification to CMS, the UPIC shall advise if it has any other potential administrative actions it may want to pursue related to the provider(s)/supplier(s). *The* provider(s)/supplier(s) identified in an accepted IA shall be added to the UPIC's next scheduled case coordination meeting.

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

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

If the OIG/OI declines or accepts the IA, the UPIC shall document the decision in UCM and follow the processes described in Chapter 4, § *4.6.3,* 4.6.4, and 4.7 of the PIM, unless otherwise directed by CMS.

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

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

4.23 – Identity Theft Investigations and Victimized Provider Process

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

This section applies to the UPICs.

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

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

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

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

- At the point in which a UPIC begins to investigate provider ID theft complaints and incurred debt, it sends a letter acknowledging receipt of the complaint, informing the provider that CMS is investigating the complaint and reviewing materials submitted, and designating a VPP point of contact at the UPIC *(IOM Pub. #100-08; Exhibit 8 – Letter 1)*;

- The next steps in this process include, but may not be limited to, the following:
    - Check if the case in question is in the UCM system. Vet the provider(s) with the DHHS - OIG or other appropriate LE agency to ensure that the contractor's investigative process will not interfere with prosecution;

- A VPP case package must then be completed by the UPIC using the templates provided in the VPP information packet;
- Describe the case and how the provider's ID was stolen or compromised. List all overpayment(s) for which the provider is being held liable. Clearly indicate those paid amounts that are in DNF and/or on payment suspension status, and the amounts that were paid with an actual check or *electronic transfer* to the fraudulent bank account;
- Provide legitimate and compromised/stolen 855 forms with provider enrollment and reassignment of benefits information in order to verify legitimate PTAN(s)/NPI(s) and identify the fraudulent ones;
- Get signed provider victim attestation statement(s) about the ID theft from the provider(s)/supplier(s).
- Provide a police report from the alleged victim provider *or any law enforcement documentation*;
- Provide financial background information, such as
  - IRS Form 1099 or W-2; and
  - Overpayment requests/debt collection notices.
- Include any trial, DOJ and OIG documents like OIG proffers, indictment, judgments and sentencing documents; and
- Based on the information gathered and the investigation conducted, the *UPICs* will state *their* recommendation as part of the package and provide the reason for the recommendation. Two recommendations are possible:
  - Hold provider harmless and *rescind* provider of federal *ID theft case-related* debt; OR
  - Hold provider liable for debt.

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

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

The VPP team will make a final determination if the alleged ID theft victim is a true victim and approve a *rescindment* of Medicare *overpayments* reported *in* the *name of the confirmed* ID theft victim.

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

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

If the provider victim is determined to be a true victim of ID theft, the UPIC will send out a letter using the template in the *IOM Pub. #100-08 Exhibits chapter* informing the provider of

the favorable decision and that the *assessed* overpayment *against the victim* will be *rescinded ((IOM Pub. #100-08; Exhibit 8 – Letter 2)*. *This decision shall then flow through the UPIC to the MAC for a recall of the associated debt. (NOTE: The MAC's instructions for processing providers' debts that have been confirmed as identity theft are found in the Medicare Financial Management Manual Chapter 4, Section 110 – Confirmed Identity Theft).* The MAC will follow the process for making adjustments to the claims system and recall the debt registered under the victimized provider from the *US Department of Treasury*.

If *the decision is not positive (i.e. ID theft is not confirmed), the UPIC shall correspond directly with the provider to inform him/her that CMS did not have sufficient information to confirm that identity theft has occurred. The* UPIC *shall* send *Letter* 3 *from* the *IOM Pub. #100-08 Exhibits chapter to the provider with a copy to the MAC*.

Medicare Program Integrity Manual
Exhibits

Table of Contents
(Rev.943; Issued: 02-21-20)

Transmittals for Exhibits

Exhibit 8 - *Victimized Provider Process Letter Templates*

(Rev. 943; Issued: 02-21-20; Effective: 03-24-20; Implementation: 03-24- 20)

Letter 1: Send to the Medicare Provider/Supplier when you begin your evaluation of the potential identity theft.

[Date]

Dear [Name of Medicare Provider/Supplier]:

VPP Case #

This letter serves notice that CMS has received your complaint alleging that your identity has been stolen or compromised and that you have suffered unwarranted Medicare related financial liabilities as a result.

The Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). CMS, in coordination with its Program Integrity Contractors, conducts an extensive investigation of the allegation; reviews any documentation submitted by the provider regarding the theft (including actions taken to report the theft and to prevent additional loss); evaluates any associated financial liabilities or overpayments; and then makes a final decision regarding the case.

Where evidence compellingly demonstrates that the Medicare provider/supplier is a victim of identity theft, the Medicare provider/supplier shall be released from financial liability specifically associated with specific overpayment(s) associated with the fraudulent claims at issue. Where insufficient evidence exists to release a Medicare provider/supplier from financial liability, the Medicare provider/supplier shall still have the right to appeal any overpayments and any related claim determinations through Medicare's established appeals process, and/or to provide any additional evidence, as appropriate, to seek a new VPP decision.

CMS is in the process of investigating your complaint and reviewing the materials you have submitted. CMS or its Program Integrity Contractors may be contacting you for further information, and you may be asked to sign an attestation, under penalty of perjury, regarding the circumstances of the identity theft. CMS will strive to make a decision no later than 60 days from the date of receipt of your complete attestation and documentation package.

[Name of UPIC] is the Program Integrity Contractor that will be gathering evidence related to your case. Your Point of Contact (POC) is:

[Name and Contact Information]

If you have any additional information that you believe will be helpful to your case, please provide it to the POC. Please note that CMS and the Program Integrity Contractors are assisted best in these investigations and decisions if Medicare providers/suppliers supply the most comprehensive evidence up-front in order to make the investigative and review process as efficient, effective, and informed as possible. The Program Integrity Contractor will conduct an investigation based on evidence received, as well as through other evidence known to it or otherwise obtained, and will present its findings to CMS for a final decision. The Program Integrity Contractor will notify you of CMS's decision in writing.

Please note that the potential release from financial liability for fraudulent claims submitted in your name is restricted solely to those claims, and that the release from financial liability shall not attach to claims that are not the subject of this investigation. Further, the VPP is only for providers who have suffered actual financial harm as a result of identity theft; it is not for Medicare providers/suppliers whose identities may have been stolen, but who have incurred no Medicare financial liability. If you believe that you have been a victim of identity theft, but you have not suffered consequent financial liability, please contact [Name of Contractor] to report the theft and provide as much information as possible to assist CMS to prevent further misuse.

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]

Letter 2: Send to the Medicare Provider/Supplier if CMS decided that identity theft has likely occurred and overpayment collection should stop.

[Insert Date]

[Insert identifying information regarding specific overpayment(s) and affected claims]

Dear [Name of Medicare Provider/Supplier]:

VPP Case #

As we previously informed you, the Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). This letter serves notice that CMS has completed its VPP investigation of your identity theft complaint and has decided that sufficient information exists to confirm identity theft and to relieve you of certain debt(s). CMS has made a decision that you should not be held liable for the following overpayment(s) (describe dollar amount(s) and timeframe(s) of claims at issue). Therefore, pursuant to Chapter 4 of the Medicare Financial Management Manual (IOM Publication 100-06), the Medicare Administrative Contractor (MAC) shall stop its collection efforts upon receipt of CMS' notification. Specifically, the MAC shall:

1. *Update its systems, as appropriate, to reflect rescission of the overpayment;*
2. *Refund any recoupment made against you on the specified overpayment(s) and/or affected claims;*
3. *Stop the recoupment against you on the specified overpayment(s) and/or affected claims;*
4. *Discontinue sending demand letters to you on the specified overpayment(s) and/or affected claims;*
5. *Not refer any specified overpayment(s) and/or affected claims to the Department of Treasury for collection;*
6. *Recall all specified overpayment(s) and/or affected claims on the debt/s referred to the Department of Treasury.*

Please note that the foregoing is solely limited to the specified overpayment(s) and/or affected claims, and shall not apply to claims or overpayments that were not the subject of this case. If you have any questions, please contact:

[Point of Contact at UPIC and Contact Information]

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]

Letter 3: Send to the Medicare Provider/Supplier if CMS informs you that it is unable to determine that identity theft has occurred and overpayment notice with appeal rights has already been issued.

[Insert Date]

[Identifying Information Regarding Overpayment(s) and Affected Claims]

Dear [Name of Medicare Provider/Suppliers]:

VPP Case # _____

As we previously informed you, the Victimized Provider Project (VPP) was established by the Centers for Medicare & Medicaid Services (CMS) for the purpose of assisting Medicare providers/suppliers who have been victims of identity theft, and who have consequently suffered liabilities in the form of unwarranted Medicare related financial obligations to the Federal government (e.g., overpayment determinations). This letter serves notice that CMS has completed its VPP investigation of your identity theft allegation with regard to the identified overpayment(s) and/or affected claims, and has decided that insufficient information exists at this time to support a finding of identity theft.

Please be advised that this decision does not affect your appeal rights. You were previously afforded appeal rights in your notice of overpayment, and we refer you to your previously issued overpayment determination notice for guidance on such appeal rights.

Sincerely,

[Program Integrity Contractor Manager Name and Title]
[Office/Organization]