
CMS Manual System

Pub. 100-08 Medicare Program Integrity

Transmittal 80

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Date: JULY 16, 2004

CHANGE REQUEST 3341

I. SUMMARY OF CHANGES: This transmittal changes the fraud and abuse complaint screening instructions to allow 45 days to send acknowledgements and resolutions either by phone or written correspondence for written complaints.

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 16, 2004

***IMPLEMENTATION DATE: August 16, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/4.6.2/Complaint Screening

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment – Business Requirements

Pub. 100-08	Transmittal: 80	Date: July 16, 2004	Change Request 3341
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SUBJECT: PIM Fraud and Abuse Complaint Screening Revisions

I. GENERAL INFORMATION

A. Background: The timeframes have been changed for the initial and second level screening staff to send acknowledgements and resolutions to the complainant. Also, the screeners have been given the option to provide these either by written correspondence or telephone.

B. Policy: N/A

C. Provider Education: N/A

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement #	Requirements	Responsibility
3341.1	CSRs at the initial screening staff level shall send an acknowledgement or resolution letter for written requests within 45 calendar days of the receipt date stamped in the mailroom, unless the written request can be acknowledged or resolved over the telephone.	ACs and Medicare contractors
3341.2	If the second level screening staff is able to resolve the inquiry without referral, they shall send a resolution letter, unless it can be resolved by telephone, within 45 calendar days of receipt from the initial screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later.	ACs and Medicare contractors
3341.3	If the AC or Medicare contractor second-level screening staff determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or Medicare contractor BI unit for further development within 45 calendar days of the date of	ACs and Medicare contractors

	receipt from the initial screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later.	
3341.4	If after conducting second level screening of Harkin Grantee complaints or OIG Hotline complaints, the AC or Medicare contractor staff determines that the complaint is a potential fraud and abuse situation, the complaint shall be sent to the PSC or Medicare contractor BI unit within 45 calendar days of the date of receipt from the initial screening staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later.	ACs and Medicare contractors

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirements #	Instructions

B. Design Considerations: N/A

X-Ref Requirements #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting/Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: August 16, 2004	These instructions shall be implemented within your current operating budget.
Implementation Date: August 16, 2004	

<p>Pre-Implementation Contact(s): Kimberly Downin kdownin@cms.hhs.gov 410-786-0188</p> <p>Post-Implementation Contact(s): Kimberly Downin kdownin@cms.hhs.gov 410-786-0188</p>	
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4.6.2 - Complaint Screening

(Rev. 80, Issued 07-16-04, Effective/Implementation: 08-16-04)

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

A - Medicare Contractor and Affiliated Contractor Responsibilities

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

Initial Screening

Customer service representatives (CSRs) shall try to resolve as many inquiries as possible in the Initial Screening with data available in their desktop system. *The CSRs shall send an acknowledgement or resolution letter for written requests within 45 calendar days of the receipt date stamped in the mailroom, unless the written request can be acknowledged or resolved over the telephone.* The following are some scenarios that a CSR may receive and resolve in the initial phone call rather than refer to second-level screening (this is not an all-inclusive list):

- Lab Tests – CSRs shall ask the caller if they recognize the referring physician. If they do, remind the caller that the referring physician may have ordered some lab work for them. The beneficiary usually does not have contact with the lab because specimens are sent to the lab by the referring physician office. (Tip: ask if they remember the doctor withdrawing blood or obtaining a tissue sample on their last visit.)
- Anesthesia Services - CSRs shall check the beneficiary claims history for existing surgery or assistant surgeon services on the same date. If a surgery charge is on file, explain to the caller that anesthesia service is part of the surgery rendered on that day.
- Injections - CSRs shall check the beneficiary claim history for the injectable (name of medication) and the administration. Most of the time, administration is not payable (bundled service) (Part B only). There are very few exceptions to pay for the administration.
- Services for Spouse - If the beneficiary states that services were rendered to his/her spouse and the Health Insurance Claim Numbers (HICNs) are the same, with a different suffix, the CSR shall initiate the adjustment and the overpayment process.
- Billing Errors - If the beneficiary states that he/she already contacted his/her provider and the provider admitted there was a billing error, and the check is still

outstanding, the CSR shall follow the normal procedures for resolving this type of billing error.

- Services Performed on a Different Date - The beneficiary states that service was rendered, but on a different date. This is not a fraud issue. An adjustment to the claim may be required to record the proper date on the beneficiary's file.
- Incident to Services - Services may be performed by a nurse in a doctor's office as "incident to." These services are usually billed under the physician's provider identification number (PIN) (e.g., blood pressure check, injections, etc.). These services may be billed under the minimal Evaluation and Management codes.
- Billing Address vs. Practice Location Address - The CSR shall check the practice location address, which is where services were rendered. Many times the Medicare Summary Notice will show the billing address and this causes the beneficiary to think it is fraud.
- X-rays with Modifier 26 - The CSRs shall ask the caller if he/she recognizes the referring physician. If so, the CSR shall explain to the caller that whenever modifier 26 is used, the patient has no contact with the doctor. The CSR shall further explain that the provider billing with modifier 26 is the one interpreting the test for the referring physician.

Initial Screening activities shall be charged to Activity Code 13002 (Beneficiary and Provider Written Inquiries), Activity Code 13003 (Beneficiary and Provider Walk-in Inquiries), Activity Code 13005 (Beneficiary Telephone Inquiries), or Activity Code 33001 (Provider Telephone Inquiries), whichever is the most applicable. In fiscal year 2004, there is a separate Activity Code for Provider Written Inquiries (33002) and Provider Walk-in inquiries (33003). The current Beneficiary Inquiries Manual Instructions will be revised and the FY2004 Budget and Performance Requirements will be developed to reflect the following Performance Priorities: 1) Telephones, 2) Second Level Screening, 3) Written, and 4) Walk-in, and 5) Customer Service Plan Activities.

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

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

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

The initial screening staff shall maintain a log of all potential fraud and abuse inquiries. At a minimum, the log shall contain the following information:

- Beneficiary name
- Provider Name
- Beneficiary HIC#
- Nature of the Inquiry
- Date of the Inquiry
- Internal Tracking Number
- Date Referred to the Second Level Screening Staff
- Date Closed

Second-Level Screening

When the complaint/inquiry cannot be resolved by the CSR, the issue shall be referred for more detailed screening, resolution, or referral, as appropriate, within the AC or Medicare contractor. If the second level screening staff is able to resolve the inquiry without referral, they shall send a resolution letter, *unless it can be resolved by telephone, within 45 calendar days of receipt from the initial screening staff, or within 30 calendar of receiving medical records and/or other documentation, whichever is later.* The second-level screening staff shall maintain a log of all potential fraud and abuse inquiries received from the initial screening staff. At a minimum, the log shall include the following information:

- Beneficiary name
- Provider name
- Beneficiary HIC#
- Nature of the Inquiry
- Date received from the initial screening staff
- Date referral is forwarded to the Medicare contractor BI unit or the date it is sent to the PSC
- Destination of the referral (i.e., name of PSC or Medicare contractor BI unit)

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

The AC or Medicare contractor staff shall call the beneficiary or the provider, check claims history, and check provider correspondence files for educational/warning letters or contact reports that relate to similar complaints, to help determine whether or not there is a pattern of potential fraud and abuse. The AC or Medicare contractor shall request and review certain documents, as appropriate, from the provider, such as itemized billing statements and other pertinent information. If the AC or Medicare contractor is unable to make a determination on the nature of the complaint (e.g., fraud and abuse, billing errors) based on the aforementioned contacts and documents, the AC or Medicare contractor shall order medical records and limit the number of medical records ordered to only those required to make a determination. If the medical records are not received within 45 calendar days, the claim(s) shall be denied *and referred to the PSC or Medicare contractor BI unit for investigation*. The second-level screening staff shall only perform a billing and document review on medical records to verify and validate that services were rendered. If fraud and abuse is suspected after performing the billing and document review, the medical record shall be forwarded to the PSC (if BI work was transitioned to a PSC) or Medicare contractor BI unit for clinician review. If the AC or Medicare contractor staff determines that the complaint is not a fraud and/or abuse issue, and if the staff discovers that the complaint has other issues (e.g., medical review, enrollment, claims processing), it shall be referred to the appropriate department. In these instances, the AC or Medicare contractor shall also be responsible for acknowledging these complaints, and sending appropriate resolution letters to the beneficiary or complainant. If the AC or Medicare contractor second-level screening staff determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or Medicare contractor BI unit for further development within *45* calendar days *of the date of receipt from the initial screening staff*, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later. The AC or Medicare contractor shall refer immediate advisements received by beneficiaries or providers and potential fraud or abuse complaints received by current or former provider employees immediately to the PSC or Medicare contractor BI unit for further development.

The AC or Medicare contractor shall be responsible for screening all Harkin Grantee complaints for fraud. If after conducting second level screening, the AC or Medicare contractor staff determines that the complaint is a potential fraud and abuse situation, the complaint shall be sent to the PSC or Medicare contractor BI unit within *45* calendar days *of the date of receipt from the initial screening staff*, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later. The complainant shall be clearly identified to the PSC or Medicare contractor BI unit as a Harkin Grantee complaint. The AC or Medicare contractor shall be responsible for

entering all initial referrals identified in the second-level screening area and any updates received from the PSC or Medicare contractor BI unit into the Harkin Grantee Tracking System (HGTS).

The AC or Medicare contractor shall be responsible for downloading and screening complaints from the OIG Hotline Database, and for updating the database with the status of all complaints. If the AC or Medicare contractor determines that the complaint is a potential fraud and abuse situation, the second-level screening staff shall forward it to the PSC or Medicare contractor BI unit for further development within 45 calendar days of receipt, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later, just like all other complaints. The PSC or Medicare contractor BI unit shall be responsible for updating the valid cases that have been referred. PSCs and Medicare contractors shall control all OIG Hotline referrals by the OIG Hotline number (the “H” or “L” number) as well as by any numbers used in the tracking system. PSCs and Medicare contractors shall refer to this number in all correspondence to the RO.

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

- Claims forms may have been altered or upcoded to obtain a higher reimbursement amount.
- It appears that the provider may have attempted to obtain duplicate reimbursement (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to be paid twice). This does not include routine assignment violations. An example for referral might be that a provider has submitted a claim to Medicare, and then in two days resubmits the same claim in an attempt to bypass the duplicate edits and gain double payment. If the provider does this repeatedly and the AC or Medicare contractor determines this is a pattern, then it shall be referred.
- Potential misrepresentation with respect to the nature of the services rendered, charges for the services rendered, identity of the person receiving the services, identity of persons or doctor providing the services, dates of the services, etc.
- Alleged submission of claims for non-covered services are misrepresented as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs).
- Claims involving potential collusion between a provider and a beneficiary resulting in higher costs or charges to the Medicare program.
- Alleged use of another person’s Medicare number to obtain medical care.

- Alleged alteration of claim history records to generate inappropriate payments.
- Alleged use of the adjustment payment process to generate inappropriate payments.
- Any other instance that is likely to indicate a potential fraud and abuse situation.

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

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

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

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

- Provider name and address.
- Type of provider involved in the allegation and the perpetrator, if an employee of a provider.
- Type of service involved in the allegation.
- Relationship to the provider (e.g., employee or another provider).
- Place of service.
- Nature of the allegation(s).
- Timeframe of the allegation(s).
- Date of service, procedure code(s).
- Name and telephone number of the AC or Medicare contractor employee who received the complaint.

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

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

B – Program Safeguard Contractor and Medicare Contractor Benefit Integrity Unit Responsibilities

At the point the complaint is received from the AC or Medicare contractor screening staff, it shall be the responsibility of the PSC or Medicare contractor BI unit to further investigate the complaint, resolve the complaint investigation, or make referrals as needed to appropriate law enforcement entities or other outside entities.

It shall be the responsibility of the PSC or the Medicare contractor BI unit to send out acknowledgement letters for complaints received from the AC or Medicare contractor. The AC or Medicare contractor shall be responsible for screening and forwarding the complaints within *45* calendar days *from the date of* receipt *by the second level screening*

staff, or within 30 calendar days of receiving medical records and/or other documentation, whichever is later, to the PSC or Medicare contractor BI unit. The PSC or Medicare contractor BI unit shall send the acknowledgement letter within 15 calendar days of receipt of the complaint referral from the AC or Medicare contractor second-level screening staff, unless it can be resolved sooner. The letter shall be sent out on PSC or Medicare contractor BI unit letterhead and shall contain the telephone number of the PSC or Medicare contractor BI unit analyst handling the case.

If the PSC or Medicare contractor BI unit staff determines, after investigation of the complaint, that it is not a fraud and/or abuse issue, but has other issues (e.g., medical review, enrollment, claims processing, etc.), it shall be referred to the AC or Medicare contractor area responsible for second-level screening, or if applicable, the appropriate PSC unit for further action. This shall allow the AC or Medicare contractor screening area to track the complaints returned by the PSC or Medicare contractor BI unit. However, the PSC or Medicare contractor BI unit shall send an acknowledgement to the complainant, but indicate that a referral is being made, if applicable, to the appropriate PSC, or to the appropriate AC or Medicare contractor unit for further action.

The PSC or Medicare contractor BI unit shall be responsible for communicating any updates as a result of their investigation on Harkin Grantee complaints to the AC or Medicare contractor second-level screening staff, who shall update the database accordingly.

The PSC or Medicare contractor BI unit shall be responsible for updating valid cases that have been referred from the OIG Hotline Database by the AC or Medicare contractor second-level screening area.

The PSC or Medicare contractor BI unit shall be responsible for sending the complainant a resolution within 7 calendar days of the resolution on the complaint investigation and/or case in accordance with PIM Chapter 4, §4.8.