Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-02-179 **Date: DECEMBER 27, 2002**

CHANGE REQUEST 2406

SUBJECT: Complaint Screening

The purpose of this Program Memorandum (PM) is to clearly delineate the responsibility for Affiliated Contractors (AC) and Program Safeguard Contractors (PSC) with regard to complaint screening. Therefore, this PM applies to intermediaries and carriers whose benefit integrity functions have been transitioned to a PSC. This PM supersedes any language within Joint Operating Agreements (JOAs).

A fraud or abuse complaint is a statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

AC Responsibilities:

The AC is responsible for screening all complaints of potential fraud and abuse. In the case of a beneficiary complaint, the AC may contact the beneficiary in an effort to determine if the complaint was a misunderstanding. When the complaint cannot be resolved as a billing error or misunderstanding, the AC staff also checks 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. The AC may also request certain documents from the provider such as itemized billing statements, and other pertinent information; however, this excludes medical records.

If the AC staff determines that the complaint is not a fraud and/or abuse issue, they must fully document why. If it is determined that this complaint is not a fraud and abuse issue, but has other issues (e.g., medical review, enrollment, claims processing, etc.), it must be referred to the appropriate department. In these instances, the AC is also responsible for acknowledging these complaints.

If the AC complaint staff determines that the complaint is a potential fraud and abuse situation, the AC must forward it to the PSC for further development within 30 days of receipt.

The AC must refer fraud or abuse complaints received by current or former provider employees immediately to the PSC for further development.

The AC is responsible for screening all Harkin Grantee complaints for fraud. If after conducting the initial screening, the AC staff determines that the complaint is a potential fraud and abuse situation, the complaint must be sent to the PSC and identified to the PSC as a Harkin Grantee complaint. The AC is responsible for entering all initial referrals into the Harkin Grantee Tracking System (HGTS). The PSC is responsible for updating the valid cases that have been referred.

The AC is responsible for downloading and screening complaints from the OIG Hotline Database. If the AC determines that the complaint is a potential fraud and abuse situation, the AC must forward it to the PSC for further development within 30 days of receipt just like all other complaints.

Complaints are forwarded to the PSC for further investigation under the following circumstances (this is not intended to be an all inclusive list):

- Review of medical records is required to determine whether the complaint is a fraud and/or abuse issue;
- 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 determines this is a pattern it must 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 ABNs;
- Claims involving a potential collusion between a provider and 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 claims history records to generate inappropriate payments;
- Alleged use of the adjustment payment process to generate inappropriate payments; or
- Any other instances that are 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 Benefit Integrity (BI) unit for further development, the AC prepares a referral package that includes, at a minimum, the following:

- Provider name, provider number and address information;
- 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 complaint 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; and
- Name and telephone number of the AC employee who received the complaint.

NOTE: Since this is not an all-inclusive list, the PSC reserves 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).

The AC charges the screening for potential fraud complaints to CAFM II (Contractor Administrative-Budget and Financial Management System) Activity Code (AC) 13002 for written inquiries, AC 13003 for walk-in inquiries, and AC 13005 for beneficiary telephone inquiries. The AC charges the referral package to Activity Code 23201 for PSC support services on fraud complaint development.

PSC Responsibilities:

At the point the complaint is received from the AC, it is the responsibility of the PSC to further develop the complaint, order medical records, resolve the complaint, or make referrals as needed to appropriate law enforcement entities or other outside entities.

It is the PSC's responsibility to send out acknowledgement letters for complaints received from the AC. The AC is responsible for screening and forwarding the complaints, within 30 days of receipt, to the PSC so that the PSC can send the acknowledgement within 45 days of the letter's receipt in the AC's mailroom, unless it can be resolved sooner. The letter is sent out on PSC letterhead and contains the telephone number of the PSC BI analyst handling the case.

If the PSC staff determines, after further development, that the complaint is not a fraud and/or abuse issue, but has other issues (e.g., medical review, enrollment, claims processing, etc.) it must be referred to the AC for further action. These complaints must be returned to the AC area responsible for the initial screening. This will allow the AC to track the complaints returned by the PSC. However, the PSC must still acknowledge the complaint, but indicate that the complaint is being referred to the AC for further action.

The PSC is responsible for updating the Harkin Grantee Tracking System (HGTS) for the valid cases that have been referred by the AC.

The *effective date* for this PM is December 27, 2002.

The *implementation date* for this PM is immediately December 27, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after September 30, 2003.

If you have any PSC related questions, contact Michelle Albert at 410-786-5658 or Kim Downin at 410-786-0188. For complaint screening questions contact Tom Hessenauer at 410-786-7542.