Program Memorandum Intermediaries/Carriers

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

Transmittal AB-03-105 **Date: JULY 25, 2003**

CHANGE REQUEST 2787

SUBJECT: Harkin Grantees: Complaint Tracking System and Aggregate Reports

This Program Memorandum (PM) provides instructions for implementing the Harkin Grantee Tracking System (HGTS) on the Metaframe server. This PM delineates the responsibilities for all Medicare Fiscal Intermediaries (FIs) and Carriers, including those personnel who the contractors designate for maintaining the HGTS tracking system.

Harkin Grantee Project Description

The Harkin Grantees (named after Senator Tom Harkin) are part of a broad anti-fraud and abuse initiative to combat waste, fraud, and abuse within the Medicare program. The anti-fraud and abuse initiative is supported by the partnership between the Department of Health & Human Services, Office of Inspector General, and the Administration on Aging (AOA).

The Harkin Grantees are senior volunteers who focus on detecting and reporting fraudulent or improper Medicare activities primarily in home health care, nursing facilities, hospice and among durable medical equipment suppliers.

Harkin Grantee Tracking System Instructions

As described in transmittal AB-03-083 (CR 2719) dated June 6, 2003, regarding complaint screening, the Medicare FIs and Carriers are responsible for collecting, tracking, and reporting the administrative and monetary results of potential fraud and abuse complaints generated by the Harkin Grantee state projects. These contractors are responsible for developing aggregate reports and making the reports available to the Harkin Grantee state project coordinators every 6 months.

Access the Harkin Grantee State/Local Contact information at www.aoa.gov/smp/index.asp

System Access to Metaframe

The Harkin Grantee Tracking System migrated from the Winframe server to the Metaframe server. Access the Metaframe system as follows:

> Download the new Citrix Client and upgrade. Download the Client software:
> **http://download2.citrix.com/files/en/products/client/ica/current/ica32.exe**

Data Collection

Each Medicare FI and Carrier must designate a person to input the complaint information into the HGTS database located on the Metaframe system. These designees will enter data on a continuous basis related to complaints generated by the Harkin Grantee state projects.

The Harkin Grantees will report their complaints according to their usual procedure using the model complaint form. (See Model Complaint Form).

Upon the Harkin Grantee complaints, the Medicare contractors will enter the following information into the Metaframe database fields.

Project number	Medicare contractor number
Date of report	Overpayment Identified
Provider Number	Overpayment Recovered
Provider Name	Action Taken
Provider City	Further Explanation
Provider State	

Data Dissemination/Aggregate Reports

The contractors will compile information in the database into an aggregate report. The contractors will distribute the aggregate reports to the Harkin Grantee state project coordinators every six months. Aggregate reports should be distributed by the second week of July (covering data between January – June) and the second week of January (covering data between July – December).

The January through June, and July through December report cycle will be continuous until further instruction.

The contractors will forward copies of the aggregate reports to Kimberly R. Pugh at Kpugh@cms.hhs.gov

The *effective date* for this PM is July 28, 2003.

The *implementation date* for this PM is August 8, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 28, 2004.

Any question regarding these instructions should be directed to Kimberly R. Pugh at (410) 786-9212. Questions regarding the operation and/or access of the Metaframe database should be directed to Binh Nguyen at (410) 786-3682 or Scott Wakefield at (410) 786-4301.

Attachment

Model Form Attachment

HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM

DATE:

From: (Your Name)_____ Organization: _____

Address:_____ City:_____ State:_____

Zip:_____

Phone: (With Area Code) Fax # E-Mail (If Applicable)

Beneficiary Name: Medicare #: Medicaid #:
Date of Birth:

Address: Phone #: (With Area Code)

City: State: Zip:

Name of Complainant (If Different From Beneficiary):

Address: Phone #: (With Area Code)

City: State: Zip:

Complaint Against: (Name of facility, provider, physician, lab, supplier, etc.)
Claim # (If appropriate)

Date(s) of Service:

Business Address: Phone: (With Area Code)

Provider Number:

City: State: Zip:

Please describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page if you need more room. If you feel you were billed for services or supplies that were not provided, continue on with the non-rendered service section below.

Description of Complaint:

_____

_____

_____

_____

Non-rendered Services Section:

Did you see any provider that day? _____ If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)

Was the service(s) provided on another day? _____ If yes, when? _____

Have you ever seen the provider listed? _____ If yes, when? _____

Have you contacted the provider/supplier regarding this billing? _____ Yes _____ No

If yes, to whom did you speak and what was the result of the conversation?

I authorize _____ and *(insert name of project)* **to discuss my complaint for the purpose of investigating possible fraud or abuse.**

I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.

_____ _____

Signature **Date**

If receiving a telephone complaint write "telephone complaint" on the signature line

Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: *(insert name of project)*