Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2719

SUBJECT: Screening of Complaints Alleging Fraud and Abuse

This Program Memorandum (PM) supersedes PM AB-02-179 released on December 27, 2002, and supersedes any language within Joint Operating Agreements (JOAs) for those contractors whose benefit integrity work has been transitioned to a Program Safeguard Contractor (PSC).

The purpose of this PM is to clearly delineate the responsibility of Medicare fee-for-service contractors and PSCs with regard to screening complaints alleging potential fraud and abuse. Therefore, this PM applies to all Medicare fee-for-service contractors and PSCs.

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.

Medicare Fee-for-Service Contractor Responsibilities

The Medicare fee-for-service contractor will be responsible for screening all complaints of potential fraud and abuse. For both Medicare fee-for-service contractors who have and have not transitioned their benefit integrity (BI) work to a PSC, this screening will occur in the two phases described below:

Initial Screening

Customer Service Representatives (CSRs) should try to resolve as many inquiries as possible in the initial screening with data available in their desktop system. 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 may 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. Again, the beneficiary 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 must check the beneficiary claim 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 must 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 their spouse and the Health Insurance Claim (HIC) numbers are the same with a different suffix, the CSR should initiate the adjustment and the overpayment process.

Billing Errors

If the beneficiary states that he/she already contacted their provider and they admitted it was a billing error, the CSR must follow the normal procedures for resolving this type of billing error.

Services Performed on a Different Date

The beneficiary states that the 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 the doctor's office as "incident to." These services are 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 must check practice location address where services were rendered. Many times the Medicare Summary Notice (MSN) will show the billing address and this causes the beneficiary to think it is fraud.

X-Rays with Modifier 26

The CSRs may ask the caller if they recognize the referring physician. If they do, the CSR is to explain to the caller that whenever modifier 26 is used, the patient has no contact with the doctor. They are to further explain that the provider billing with modifier 26 is the one interpreting the test for the referring physician.

In fiscal year 2003, initial screening activities are to 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 (FY) 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 FY 2004 Budget and Performance Requirements will be developed to reflect the following Performance Priorities: 1) Telephones; 2) second level screening; 3) Written; 4) Walk-in; and 5) Customer Service Plan Activities.

CSRs are to use proper probing questions and 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 must be forwarded immediately to the second level screening staff for handling.

Second Level Screening

When the complaint/inquiry cannot be resolved by the CSR, the issue must be referred for more detailed screening, resolution, or referral, as appropriate, within the Medicare fee-for-service contractor.

The Medicare fee-for-service contractor staff calls the beneficiary or the provider, checks claims history, and 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 of potential fraud and abuse. The Medicare fee-for-service contractor must request and review certain documents, as appropriate, from the provider such as itemized billing statements and other pertinent information. If the Medicare fee-for-service 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 Medicare fee-for-service contractor may order medical records and must limit the number of medical records ordered to only those required to make a determination. The second level screening staff should 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 must be forwarded to the PSC for clinician review, if BI work was transitioned to a PSC. If the Medicare fee-for-service 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, etc.), it should be referred to the appropriate department. In these instances, the Medicare fee-for-service contractor is also responsible for acknowledging these complaints.

If the Medicare fee-for-service contractor second level screening staff determines that the complaint is a potential fraud and abuse situation, the Medicare fee-for-service contractor must forward it to the Medicare fee-for-service contractor benefit integrity unit (BIU) or PSC for further development within 30 calendar days of receipt in the AC mailroom, or within 30 calendar days of receiving medical records.

The Medicare fee-for-service contractor must refer fraud or abuse complaints received by current or former provider employees immediately to the Medicare fee-for service contractor BIU or PSC for further development.

The Medicare fee-for-service contractor second level screening staff is responsible for screening all Harkin Grantee complaints for fraud. If after conducting screening, the Medicare fee-for-service contractor staff determines that the complaint is a potential fraud and abuse situation, the complaint must be sent to the Medicare fee-for-service contractor BIU or PSC within 30 calendar days of receipt in the AC mailroom, or within 30 calendar days of receiving medical records, and identified to the Medicare fee-for-service contractor BIU or PSC as a Harkin Grantee complaint. The Medicare fee-for-service contractor second level screening staff is responsible for entering all initial referrals into the Harkin Grantee Tracking System (HGTS). The Medicare fee-for-service contractor BIU or PSC is responsible for updating the valid cases that have been referred.

The Medicare fee-for-service contractor second level screening staff is responsible for downloading and screening complaints from the OIG Hotline Database, and updating the database with the status of all complaints. If the Medicare fee-for-service contractor determines that the complaint is a potential fraud and abuse situation, the Medicare fee-for-service contractor second level screening staff must forward it to the Medicare fee-for-service contractor BIU or PSC for further development within 30 calendar days of receipt in the AC mailroom, or within 30 calendar days of receiving medical records just like all other complaints. The Medicare fee-for-service contractor BIU or PSC will be responsible for updating the valid cases that have been referred.

Complaints are forwarded to the Medicare fee-for-service contractor BIU 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 Medicare fee-for-service contractor determines this is a pattern, then it should 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 the person or doctor providing the services, dates of the services, etc.;
- Alleged submission of claims for non-covered services as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs);
- Claims involving 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 Medicare fee-for-service contractor BIU or PSC Benefit Integrity (BI) unit for further development, the Medicare fee-for-service contractor second level screening area 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 Medicare fee-for-service 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; and

- Name and telephone number of the Medicare fee-for-service contractor employee who received the complaint.

NOTE: Since this is not an all-inclusive list, the Medicare fee-for-service contractor BIU or 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).

When a provider inquiry or complaint of potential fraud and abuse is received, the second level screening staff will not perform any screening, but prepare a referral package and send it immediately to the PSC or Medicare fee-for-service BIU. The referral package will 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 Medicare fee-for-service contractor employee who received the complaint.

The Medicare fee-for-service contractor reports 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 in workload column 1; report the total number of medical records ordered for beneficiary inquiries in workload column 2; and report the total number of potential fraud and abuse beneficiary complaints identified and referred to the PSC in workload column 3. The Medicare fee-for-service contractor must keep a record of the cost and workload for all provider inquires of potential fraud and abuse that are referred to the PSC or Medicare fee-for-service contractor BIU in Activity Code 13201/01.

Medicare Fee-For-Service Contractor BIU and PSC Responsibilities

At the point the complaint is received from the Medicare fee-for-service contractor, it will be the responsibility of the Medicare fee-for-service contractor BIU or PSC to further develop the complaint, resolve the complaint, or make referrals as needed to appropriate law enforcement entities or other outside entities.

It is the Medicare fee-for-service contractor BIU's or PSC's responsibility to send out acknowledgement letters for complaints received from the Medicare fee-for-service contractor second level screening area. The Medicare fee-for-service contractor is responsible for screening and forwarding the complaints, within 30 calendar days of receipt in the AC mailroom, or within 30 calendar days of receiving medical records, to the Medicare fee-for-service contractor BIU or PSC so that the Medicare fee-for-service contractor BIU or PSC can send the acknowledgement within 15 calendar days of the letter's receipt from the Medicare fee-for-service contractor second level screening area, unless it can be resolved sooner. The letter will be sent out on Medicare fee-for-service contractor BIU or PSC letterhead and will contain the telephone number of the Medicare fee-for-service contractor BIU or PSC BI analyst handling the case.

If the Medicare fee-for-service contractor BIU or 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 Medicare fee-for-service contractor area responsible for the second level screening, or if applicable, the PSC unit for further action. This will allow the Medicare fee-for-service contractor screening area to track the complaints returned by the Medicare fee-for-service contractor BIU or PSC. However, the Medicare fee-for-service contractor BIU or PSC must still acknowledge the complaint, but indicate that the complaint is being referred to the appropriate Medicare fee-for-service contractor unit, or if applicable, to the appropriate PSC unit for further action.

The Medicare fee-for service contractor BIU or PSC will be responsible for updating the Harkin Grantee Tracking System (HGTS) for the valid cases that have been referred by the Medicare fee-for-service contractor second level screening area.

The Medicare fee-for-service contractor BIU or PSC will be responsible for updating valid cases that have been referred from the OIG Hotline Database by the Medicare fee-for-service contractor second level screening area.

The *effective date* for this PM is June 13, 2003.

The *implementation date* for this PM is June 13, 2003.

Contractors need to submit Supplemental Budget Requests for these activities for FY 2003, and the justification must include their current backlog of complaints and a plan to become current.

This PM may be discarded after June 13, 2004.

If you have any questions, contact Michelle Albert for PSC related questions at malbert@cms.hhs.gov or 410-786-5658; contact Kimberly Downin for second level screening questions at kdownin@cms.hhs.gov or 410-786-0188; or contact Tom Hessenauer for initial screening questions at jhessenauer@cms.hhs.gov or 410-786-7542.