CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11009	**Date: September 17, 2021**
	Change Request 12100

Transmittal 10893, dated August 6, 2021, is being rescinded and replaced by Transmittal 11009, dated September 17, 2021, to make additional revisions to section 4.6.2.3 that removes a MAC requirement and include clarifying additional language. This correction also revises business requirement 12100.1.1. and adds business requirement 12100.2. All other information remains the same.

SUBJECT: Revision to Medicare Administrative Contractor (MAC) Complaint Screening Process - Checking the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) Prior to Claim Adjustment

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to require the MAC to check the RACDW for suppressions and/or exclusions, prior to claim adjustment as the result of a second-level screening. If a suppression and/or exclusion is present, the MAC shall not adjust the claim, and the complaint or inquiry shall be closed. However, if the MAC determines that the complaint or inquiry indicates potential fraud, and a suppression/exclusion is not present, the MAC shall make a referral to the Unified Program Integrity Contractor (UPIC), using the referral guidelines established in section 4.6.2.4 – (Referrals to the UPIC) in chapter 4 of Publication (Pub.) 100-08.

EFFECTIVE DATE: September 5, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2021

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	4/4.6/4.6.2.3/Complaint Screening Process

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: 11009	Date: September 17, 2021	Change Request: 12100

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SUBJECT: Revision to Medicare Administrative Contractor (MAC) Complaint Screening Process - Checking the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) Prior to Claim Adjustment

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I. GENERAL INFORMATION

A. Background: This will require the MAC to check the RACDW for suppressions and/or exclusions prior to adjusting a claim as the result of a second-level screening. If a suppression and/or exclusion is present, the MAC shall not adjust the claim and the complaint or inquiry shall be closed. However, if the MAC determines that the complaint or inquiry indicates potential fraud, and a suppression and/or exclusion is not present, the MAC shall make a referral to the UPIC, using the referral guidelines established in section 4.6.2.4 – (Referrals to the UPIC) in chapter 4 of Pub. 100-08.

B. Policy: Section 302 of the Tax Relief Act and Health Care Act of 2006.

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	
12100.1	The contractor shall follow all guidance in section 4.6.2.3 of chapter 4 in Pub. 100-08, check the RACDW for suppressions and/or exclusions prior to claim adjustment following a second-level screening.	X	X	X	X					
12100.1.1	The MAC shall not adjust the claim, if	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	a suppression and/or exclusion is present.									
12100.1.2	The contractor shall make a referral to the UPIC, using the referral guidelines established in section 4.6.2.4 – (Referrals to the UPIC),) in chapter 4 of Pub. 100-08, if the MAC determines that the complaint or inquiry indicates potential fraud and a suppression/exclusion is not already present.	X	X	X	X					
12100.2	The MAC shall contact the review contractor that originated the suppression or exclusion to coordinate next steps (e.g. how the complaint or inquiry shall be closed), for claims where a suppression or exclusion is present.	X	X	X	X					

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): Tony Olivis, Tony.Olivis@cms.hhs.gov , Ashley Badami, 410-786-0828 or Ashley.Badami@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

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(Rev. 11009; Issued: 09-17-21)

4.6.2.3 - MAC Complaint Screening

(Rev. 11009; Issued: 09-17-21; Effective: 10-19-21; Implementation:10-19-21)

A. MAC Screening of CCO Referrals

The MAC shall only screen potential fraud, waste, and abuse complaints, inquiries referred by the CCO with a paid amount of $100 or greater (including the deductible as payment), or three (3) or more beneficiary complaints or inquiries, regardless of dollar amount, about the same provider/supplier. Complaints or inquiries that do not meet the above threshold for screening shall be closed.

Prior to proceeding with the adjustment of a claim as the result of a second-level screening, the MAC shall check the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) for suppressions and/or exclusions. If a suppression and/or exclusion is present, the MAC shall not adjust the claim and the complaint or inquiry shall be closed. However, if the MAC determines that the complaint or inquiry indicates potential fraud, and a suppression and/or exclusion is not present, the MAC shall make a referral to the UPIC, using the referral guidelines established in 4.6.2.4 – Referrals to the UPIC.

Each complaint or inquiry shall be tracked and retained for one (1) year. Beneficiaries inquiring about complaints should be advised that they are being tracked and reviewed. The MAC shall perform a more in-depth review if additional complaints or inquiries are received. The MAC shall enter all potential fraud, waste, and abuse complaints or inquiries received from beneficiaries into their internal tracking system. The MAC shall maintain a log of all potential fraud, waste, and abuse complaints or inquiries received from the CCO. At a minimum, the log shall include the following information:

- Beneficiary name;
- Provider/supplier name;
- Beneficiary HICN;
- Nature of the inquiry;
- Date received from the initial screening staff (i.e. date the initial screening staff receives the lead from the CCO);
- *If applicable, date RACDW was checked to confirm the absence of a suppression and/or exclusion.*
- Date referral was sent to the UPIC;
- Destination of the referral (i.e., name of the UPIC);
- Documentation that a complaint or inquiry received from the initial screening staff was not forwarded to the UPIC and an explanation why (e.g., inquiry was misrouted or inquiry was a billing error that should not have been referred to the screening staff); and
- Date complaint or inquiry was closed.

The MAC staff may call the beneficiary or the provider/supplier, check claims history, and check provider/supplier correspondence files for educational or warning letters or contact reports that relate to similar complaints or inquiries, to help determine whether or not there is a pattern of potential fraud, waste, and abuse. The MAC shall request and review certain documents, such as itemized billing statements and other pertinent information, as appropriate, from the provider/supplier. If the MAC is unable to make a determination on the nature of the complaint or inquiry (e.g., fraud, waste, and abuse, billing errors) based on the aforementioned contacts and documents, the MAC shall order medical records and limit the number of medical records ordered to only those required to make a determination. The MAC shall only perform a billing and document review on medical records to verify that services were rendered. If fraud, waste, and abuse are suspected after performing the billing and

document review, the medical records shall be forwarded to the UPIC for review in accordance with the referral timeframe identified below.

When a complaint meeting the criteria of an IA or potential fraud, waste or abuse is received, the MAC shall not perform any screening but shall prepare a referral package within ten (10) business days of when the inquiry or IA was received, except for instances of potential patient harm, of which a referral package shall be prepared by the end of the next business day after the inquiry or IA was received, and send it to the UPIC during the same timeframe using the guidelines established in section 4.6.2.4 – Referrals to the UPIC. Once the complaint has been referred to the UPIC, the MAC shall close the complaint in its internal tracking system.