CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12515	**Date: February 22, 2024**
	Change Request 13508

SUBJECT: Updates of Chapter 4, Chapter 8, and Exhibits in Publication (Pub.) 100-08, Including Prioritization and Payment Suspension Language Guidance

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update sections within Chapter 4, Chapter 8, and Exhibits in Pub. 100-08. The updates in this CR include, but are not limited to, Unified Program Integrity Contractor (UPIC) guidance regarding how to prioritize Accountable Care Organization (ACO) referrals, payment suspension language guidance, and updates to model payment suspension letters.

EFFECTIVE DATE: March 25, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 25, 2024

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	4/4.7/Investigations
R	8/8.3/8.3.2.1/CMS Approval
R	8/8.3/8.3.2.5/Terminating the Payment Suspension
R	8/8.3/8.3.3.1/DME Payment Suspensions (MACs and UPICs)
R	8/8.3/8.3.3.2/Non-DME National Payment Suspensions (MACs and UPICs)
R	Exhibits/Exhibit 16/Model Payment Suspension Letters

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: 12515	Date: February 22, 2024	Change Request: 13508

SUBJECT: Updates of Chapter 4, Chapter 8, and Exhibits in Publication (Pub.) 100-08, Including Prioritization and Payment Suspension Language Guidance

EFFECTIVE DATE: March 25, 2024
**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: This CR will update sections in Chapters 4 and 8 and the Exhibits in Pub. 100-08. Specifically, guidance in Chapter 4 is being revised to instruct the UPICs on how to prioritize ACO referrals. The guidance in Chapter 8 is being revised to instruct the UPICs on payment suspension language. The guidance in Exhibits is being revised to provide necessary updates to the model payment suspension letters.

B. Policy: This CR does not involve any legislative or regulatory policies.

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	
13508.1	The UPIC shall ensure that all investigations originating from an ACO referral or involving ACOs, ACO participants or ACO providers/suppliers (if known) are provided a heightened priority score.									UPICs
13508.2	The UPIC shall request the MAC implement a "payment suspension" or "partial payment suspension" for all payment suspensions, when									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	applicable.									
13508.2.1	The MAC shall no longer use "F_Fraud and Abuse", “F_CMS Request” or “P_CMS Request” Healthcare Integrated General Ledger Accounting System (HIGLAS) hold reason codes for UPIC requested payment suspension activities for all payment suspensions and emergency payment suspensions.	X	X	X	X					UPICs
13508.2.2	MACs shall only use "F_PSC Request" (Full Hold) or “P_PSC Request”(Partial Hold) HIGLAS hold reason codes going forward for all UPIC requested payment suspension and emergency payment suspension activities.	X	X	X	X					UPICs
13508.2.3	UPICs shall not request that MACs create placeholder debts or “escrow amounts” based on anticipated provider settlements.									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13508.2.4	The MAC shall no longer create these debts in HIGLAS.	X	X	X	X					UPICs
13508.2.5	The MAC shall reach out to the Office of Financial Management for guidance before any action is taken if a UPIC requests a MAC to create a placeholder debt.	X	X	X	X					UPICs
13508.3	The UPIC shall be advised that when the payment suspension is terminated, the disposition of the withheld funds shall be achieved in accordance with 42 Code of Federal Regulations §405.372(e) and the payment suspension edit withholding the provider's funds is removed in the MAC system accordingly, within 60 days.									UPICs
13508.4	The Lead UPIC shall be responsible for coordinating and reporting to its Business Function Lead, with a copy to their Contracting Officer's Representative, whether the non-									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	lead UPICs are compliant with the payment suspension timeframe and activities.									
13508.5	Non-lead UPICs shall not create a separate Payment Suspension Record (PSP) and is responsible for timely updating the lead UPIC's PSP with monthly suspended amounts within their jurisdictions, as well as adding any pertinent comments and/or documentation.									UPICs
13508.6	The UPIC shall use the updated Payment Suspension template when sending a payment suspension termination notice to the provider's/supplier s' attorney.									UPICs
13508.7	The UPIC shall use the updated Payment Suspension template when sending a payment suspension termination notice to the provider/suppliers.									UPICs

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

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.12515; Issued:02-22-24)

4.7 – Investigations

(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

This section applies to UPICs.

An investigation is the expanded analysis performed on leads once such lead is vetted and approved by CMS to be opened as an investigation. The UPIC shall focus its investigation in an effort to establish the facts and the magnitude of the alleged fraud, waste, or abuse and take any appropriate action to protect Medicare Trust Fund dollars within 210 calendar days, unless otherwise specified by CMS.

For any investigative activities that require preapproval by CMS (i.e., activities referenced in Section 4.7.1.2), the UPIC shall submit those requests to CMS for approval with a copy to its COR and BFLs for approval when initiating those actions.

Prioritization of the investigation workload is critical to ensure that the resources available are devoted primarily to high-priority investigations. The UPIC shall ensure that all investigations originating from an Accountable Care Organization (ACO) referral or involving ACOs, ACO participants or ACO providers/suppliers *(if known)* are provided a heightened priority *score.*

The UPIC shall maintain files on all investigations. The files shall be organized by provider or supplier and shall contain all pertinent documents including, but not limited to, the original referral or complaint, investigative findings, reports of telephone contacts, warning letters, documented discussions, documented results of any investigative activities, any data analysis or analytical work involving the potential subject or target of the investigation, and decision memoranda regarding final disposition of the investigation (refer to section 4.2.2.6.2 of this chapter for information concerning the retention of these documents).

Under the terms of their contract, the UPICs shall investigate potential fraud, waste, or abuse on the part of providers, suppliers, and other entities that receive reimbursement under the Medicare program for services rendered to beneficiaries. The UPICs shall refer potential fraud cases to LE, as appropriate, and provide support for these cases. In addition, the UPICs may provide data and other information related to potential fraud cases initiated by LE when the cases involve entities or individuals that receive reimbursement under the Medicare program for services rendered to beneficiaries.
For investigations that the providers/suppliers are subject to prior authorization by the MAC, the UPIC may request the MAC to release the prior authorization requirement prior to pursuing the investigation further.

For those investigations that are national in scope, CMS will designate a lead UPIC, if appropriate, to facilitate activities across the zones.

Medicare Program Integrity Manual

Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation

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(Rev.12515; Issued:02-22-24)

8.3.2.1 – CMS Approval

(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

If the UPIC believes that a UPIC-initiated Payment Suspension is a viable option for an investigation, they shall update UCM appropriately to ensure the case is included on the next case coordination meeting agenda for discussion. For national or multi-regional suspensions, only the lead UPIC shall discuss the suspension at the case coordination meeting.

During the case coordination meeting, if CMS agrees that the criteria for Payment Suspension is met, CMS will instruct the UPIC to submit the Payment Suspension request(s) with the completed Administrative Action Review (AAR) form to CPI through the UCM. The Payment Suspension team member will review the submissions and make a formal determination as to whether a Payment Suspension is a viable option.

During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to these investigations. If the UPIC has questions following the case coordination meeting, the UPIC shall coordinate with its COR, BFL, and/or suspension team member, as needed.

When a payment suspension is approved by CPI, the UPIC shall inform the respective MAC of this action and the MAC shall effectuate the suspension of payments to the provider unless prior notice of the payment suspension is necessary. When prior notice is necessary, the MAC shall effectuate the suspension of payment in concert with the established date from the payment suspension notice.

For all payment suspensions, the UPIC shall request the MAC implement a "payment suspension" or "partial payment suspension" when applicable. For all payment suspensions and emergency payment suspensions, the MAC shall no longer use "F_Fraud and Abuse", "F_CMS Request" or "P_CMS Request" HIGLAS hold reason codes for UPIC requested payment suspension activities. MACs shall only use "F_PSC Request" (Full Hold) or "P_PSC Request"(Partial Hold) HIGLAS hold reason codes going forward for all UPIC requested payment suspension and emergency payment suspension activities.

UPICs shall not request that MACs create placeholder debts or "escrow amounts" based on anticipated provider settlements. The MAC shall no longer create these debts in HIGLAS. If a UPIC requests a MAC to create a placeholder debt, the MAC shall reach out to OFM for guidance before any action is taken.

The MACs shall ensure that all money on the payment floor is not released to the provider after the effective date of the suspension and the money is withheld in accordance with the payment suspension rules and regulations. MACs shall provide an accounting of the money withheld on day one of the payment suspension to the UPIC. The UPIC shall enter this amount in the UCM as the first monetary entry.

Unless otherwise specified, when a payment suspension is imposed, no payments are to be released to the provider as of the effective date of the payment suspension. This includes payments for new claims processed, payments for adjustments to claims previously paid, interim PIPs. If it is discovered that money is released to the provider after the effective date of the payment suspension, the MAC or UPIC shall contact CPI for guidance.

8.3.2.5 – Terminating the Payment Suspension

(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

The UPIC shall recommend to CPI that the payment suspension be terminated prior to the payment suspension expiring. The UPIC shall provide this request via the UCM at least 14 calendar days prior to the anticipated payment suspension expiration date. No action associated with the termination shall be taken without the explicit approval of CPI. The UPIC shall prepare a "draft termination notice" (in accordance with section 8.3.2.2 of this chapter) and send it, along with a draft overpayment notice(s) and any other supportive information, to CPI for approval.

The UPIC shall recommend to CPI that a suspension be terminated when any of the following occur:

- The basis for the payment suspension action was that an overpayment may exist or money to be paid may be incorrect, and the UPIC has determined the amount of the overpayment, if any.

- The basis for the payment suspension action was that a credible allegation of fraud exists against the provider, and the amount of the overpayment has been determined.

- The basis for the payment suspension action was that payments to be made may not be correct, and the UPIC has determined that current payments to be made are now correct, and any associated overpayments have been determined.

- The basis for the payment suspension action was that the provider failed to furnish records, and the provider has now submitted all appropriate requested records.

When the payment suspension is terminated, the disposition of the withheld funds shall be achieved in accordance with 42 CFR §405.372(e) and the payment suspension edit withholding the provider's funds is removed in the MAC system accordingly*, within 60 days*. Upon approval of the termination notice by CPI, the UPIC shall provide a copy of the signed notice via the UCM to CPI.

8.3.3.1 – DME Payment Suspensions (MACs and UPICs)

(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

For national payment suspensions involving durable medical equipment (DME) suppliers that are enrolled in multiple jurisdictions, the following is applicable for DME MACs and UPICs:

- When CMS suspends payments to a DME supplier, all payments to the supplier are suspended in all DME jurisdictions if the same Tax Identification Number is used. The information (whether based on fraud or non-fraud) that payments should be suspended in one DME jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.

- The UPIC that requests the national payment suspension to CPI shall become the "Lead" UPIC for the payment suspension if the payment suspension is approved. The Lead UPIC is responsible for informing the other UPICs (non-lead UPICs) of the payment suspension being initiated and for the coordination of the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities of the national suspension by each of the contractors.

- The Lead UPIC is responsible for coordinating and reporting to its BFL, with a copy to *their* COR, whether the non-lead UPICs are compliant with the payment

suspension timeframe and activities.

- All non-lead UPICs are responsible for determining an overpayment(s) for its jurisdiction. Non-lead UPICs shall take into account the findings of the Lead UPIC and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.

For UPIC-initiated DME payment suspensions:

- Each UPIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective DME MAC jurisdiction and has communicated this to the lead UPIC. If non-lead UPIC determines that medical review would not be appropriate in their jurisdiction for subject provider, non-lead UPIC shall notify and request permission from their BFL to opt out of the medical review.

- The Lead UPIC shall create both a CSE record, if not already created, to track the investigative activities and a PSP record to track the activities specific to the payment suspension in UCM. The lead UPIC shall check the "lead" checkbox. Non-lead UPICs shall not create a separate PSP and is responsible for timely updating the lead UPIC's PSP with monthly *suspended* amounts within their jurisdictions, as well as adding any pertinent comments and/or documentation.

  Non-lead UPICs shall create a CSE and the appropriate administrative action records to track their activities.

8.3.3.2 – Non-DME National Payment Suspensions (MACs and UPICs)
(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

For national payment suspensions involving national providers (such as chain hospitals, chain Skilled Nursing Facilities, franchised clinics, laboratories, etc.) that are enrolled in multiple jurisdictions, the following may be applicable for MACs and UPICs:

- When CMS suspends payments to a national provider, all payments to the national provider are suspended in all jurisdictions if they share the same Tax Identification Number. The information (whether based on fraud or non-fraud) that payments should be suspended in one jurisdiction is sufficient reason for payment suspension decisions to apply to the other locations.

- The UPIC that requests the national payment suspension to CPI shall become the "Lead" UPIC for the payment suspension. The Lead UPIC is responsible for informing the other UPICs (non-lead UPICs) of the payment suspension being initiated and for the coordination regarding the payment suspension activities. CMS suggests that monthly contractor calls be held to communicate the current activities by each of the contractors.

- The Lead UPIC is responsible for coordinating and reporting to its BFL, with a copy to the COR, whether the non-lead UPICs are compliant with the payment suspension timeframe and activities.

- All non-lead UPICs are responsible for determining an overpayment(s) for its jurisdiction. Non-lead UPICs shall take into account the findings of the Lead UPIC and take appropriate measures (prepayment review, etc.) to protect and safeguard Medicare Trust Fund dollars from being inappropriately paid.

For UPIC-initiated non-DME national payment suspensions:

- Each UPIC shall be responsible for ensuring that the payment suspension edit has been initiated in its respective MAC jurisdiction and has communicated this to the Lead UPIC. If non-lead UPIC determines that medical review would not be appropriate in their jurisdiction for subject provider, non-lead UPIC shall notify and request permission from their BFL to opt out of the medical review.

- The Lead UPIC shall create both a CSE record to track the investigative activities and a PSP record to track the activities specific to the payment suspension in UCM. The lead UPIC shall check the "lead" checkbox. Non-lead UPICs shall not create a separate PSP and is responsible for timely updating the lead UPIC's PSP with monthly *suspended* amounts within their jurisdictions, as well as adding any pertinent comments and/or documentation.

  Non-lead UPICs shall create a CSE and the appropriate administrative action records to track their activities.

Medicare Program Integrity Manual
Exhibits

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Transmittals for Exhibits

Exhibit 16 - Model Payment Suspension Letters

(Rev.12515; Issued:02-22-24; Effective: 03-25-24; Implementation:03-25-24)

A. Payment Suspension Initial Notice Based on Fraud (No Prior Notice Given)

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments Provider/Supplier
Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments took effect on {ENTER DATE}. Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder the Centers for Medicare & Medicaid Services' (CMS) ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3) and (4).

The CMS through its Central Office made the decision to suspend your Medicare payments. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. *See* 42 C.F.R. § 405.371(a)(2). CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. *See* 42 C.F.R. § 405.370(a). Allegations are considered credible when they have indicia of reliability. *See* 42 C.F.R. § 405.370. This suspension may last until resolution of the investigation as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. *See* 42 C.F.R. § 405.372(d)(3).

Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, date of service, amount paid and basis for selected claim when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}.

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid	Basis for Selected Claim

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for this payment suspension.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. If you opt to do so, we request that you submit this rebuttal statement to us within 15 days of receipt of this notice, and you may include with this statement any evidence you believe supports your reasons why the suspension should be removed. If you choose to submit a rebuttal statement, your rebuttal statement and any pertinent evidence should be sent to:

{YOUR NAME}, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. *See* 42 C.F.R. § 405.375(a). Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. *See* 42 C.F.R. § 405.375(b)(2). This determination is not an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. *See* 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination(s). Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension also applies to claims in process.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, CMS' Medicare Administrative Contractor (MAC). When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated} Finally, {Name of UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or MAC}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *See* 42 U.S.C. §

1395y(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

Sincerely,

Name

B. Payment Suspension Initial Notice Based on Fraud (Prior Notice Given)

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments will take effect on {ENTER DATE}.

The Centers for Medicare & Medicaid Services (CMS) through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. *See* 42 C.F.R. § 405.371(a)(2). CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered credible when they have indicia of reliability. *See* 42 C.F.R. § 405.370. This suspension may last until resolution of the investigation as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. *See* 42 C.F.R. § 405.372(d)(3).

Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, {Continue with further supportive information and specific examples (no less than five). Only use claim numbers, date of service, amount paid and basis for selected claim when referencing the specific claim examples. Do Not use beneficiary names or HIC#s in the notice.}.

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid	Basis for Selected Claim

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for this payment suspension.

Pursuant to 42 C.F.R. §§ 405.372(b)(2) and 405.374, you have the right to submit a rebuttal statement in writing to us within the next 15 days of receipt of this notice indicating why you believe the suspension should not be implemented or should be removed. If you opt to do so, you may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be implemented or should be removed. If you choose to submit a rebuttal statement, your rebuttal statement and supporting evidence should be sent to:

{YOUR NAME}, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be implemented, removed, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. Thereafter, we will notify you in writing of our determination to implement, continue, or remove the suspension and provide specific findings on the conditions upon which the suspension may be implemented, continued, or removed, as well as an explanatory statement of the determination. *See* 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is implemented or continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. *See* 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to claims in process.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, CMS' Medicare Administrative Contractor (MAC). When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated} Finally, {Name of UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or MAC}, has initiated a process to review your Medicare claims and supporting documentation prior to

payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *See* 42 U.S.C. § 1395y(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

Sincerely,

Name

C. Payment Suspension Initial Notice Based on Reliable Information (No Prior Notice Given)

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments took effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d). Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder the Centers for Medicare & Medicaid Services' (CMS) ability to recover any determined overpayment. See 42 C.F.R. § 405.372(a)(3) and (4).

CMS through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF UPIC or MAC}. More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, date of service, amount paid and basis for selected claim when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}.

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid	Basis for Selected Claim

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for this payment suspension.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. If you opt to do so, we request that you submit this rebuttal statement to us within 15 days and you may include with this statement any evidence supporting your reasons why the suspension should be removed. If you choose to submit a rebuttal statement, your rebuttal statement and any pertinent evidence should be sent to:

{YOUR NAME}, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. *See* 42 C.F.R. § 405.375(a). Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. *See* 42 C.F.R. § 405.375(b)(2). This determination is not an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. *See* 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. We will continue to process claims during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension also applies to claims in process.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, CMS' Medicare Administrative Contractor (MAC). When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated} Finally, {Name of UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or MAC}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *See* 42 U.S.C. § 1395y(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

Sincerely,

Name

D. Payment Suspension Initial Notice Based on Reliable Information (Prior Notice Given)

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments {INSERT THE FOLLOWING IF THIS IS A NATIONAL PAYMENT SUSPENSION: in all jurisdictions} pursuant to 42 C.F.R. § 405.371(a)(1). The suspension of your Medicare payments will take effect on {ENTER DATE}. This payment suspension may last for up to 180 days from the effective date and may be extended under certain circumstances. *See* 42 C.F.R. § 405.372(d).

The Centers for Medicare & Medicaid Services (CMS) through its Central Office made the decision to suspend your Medicare payments. *See* 42 C.F.R. § 405.372(a)(4)(iii). The suspension of your Medicare payments is based on reliable information that an overpayment exists or that the payments to be made may not be correct. Specifically, the suspension of your Medicare payments is based on, but not limited to, information from claims data analysis and medical review completed by {NAME OF UPIC or MAC}. More particularly, {Continue with further supportive information and specific claim examples (no less than five). Only use claim numbers, Date of Service and amount paid when referencing the claim examples. Do Not use beneficiary names or HIC#s in the notice.}.

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number	Date(s) of Service	$$ Amount Paid	Basis for Selected Claim

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for this payment suspension.

Pursuant to 42 C.F.R. §§ 405.372(b)(2) and 405.374, you have the right to submit a rebuttal statement in writing to us within the next 15 days indicating why you believe the suspension should not be implemented or should be removed. If you opt to do so, you may include with this statement any evidence you believe is pertinent to your reasons why the suspension should not be implemented or should be removed. If you choose to submit a rebuttal statement, your rebuttal statement and any pertinent evidence should be sent to:

{YOUR NAME}, Program Integrity Analyst
{ADDRESS}

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be implemented, removed, or should remain in effect within 15 days of receipt of the complete rebuttal package, consistent with 42 C.F.R. § 405.375. Thereafter, we will notify you in writing of our determination to implement, continue, or remove the suspension and provide specific findings on the conditions upon which the suspension may be implemented, continued, or removed, as well as an explanatory statement of the determination. *See* 42 C.F.R. § 405.375(b)(2). However, if by the end of this period no rebuttal has been received, the payment suspension will go into effect automatically. This determination is not an initial determination and is not appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is implemented or continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. *See* 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. We will inform you of developments and will promptly notify you of any overpayment determination(s). Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension also applies to claims in process.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. Please be advised that CMS may charge interest on the amount of the overpayment, consistent with 42 C.F.R. § 405.378. In the written notice alerting you to the overpayment, you will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from {MAC name}, CMS' Medicare Administrative Contractor (MAC). When the payment suspension has been removed, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

{Insert the following paragraph if prepayment review is being initiated} Finally, {Name of UPIC or MAC}, a CMS {Unified Program Integrity Contractor (UPIC) or MAC}, has initiated a process to review your Medicare claims and supporting documentation prior to payment. The purpose of implementing this prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. The prepayment process is often applied to safeguard Medicare from unnecessary expenditures and to ensure that Medicare payments are made for items and services which are "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *See* 42 U.S.C. § 1395y(a)(1)(A). Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox]. Any request to remove the suspension must be submitted through the rebuttal process described above.

Sincerely,

Name

E. Reliable Information that an Overpayment Exists (RIO) Payment Suspension Extension Notice

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.372(d), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER UPIC NAME}, CMS' Unified Program Integrity Contractor, to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The extension of your payment suspension applies to claims in process. We will continue to withhold your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(d). When the payment suspension is terminated, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. *See* 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the remainder will be released to you.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox].

Sincerely,

Name

F. Credible Allegation of Fraud (CAF) Payment Suspension Extension Notice

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of Extension of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
PSP Number:

Dear {Medicare Provider/Supplier's Name}:

Please be advised that pursuant to 42 C.F.R. § 405.371(b), the Centers for Medicare & Medicaid Services (CMS) has directed {ENTER UPIC NAME}, CMS' Unified Program Integrity Contractor, to continue the suspension of your Medicare payments for an additional 180 days effective {Enter Date that the payment suspension was to expire}.

The continuation of your payment suspension applies to claims in process. We will continue to suspend your Medicare payments until an investigation of the circumstances has been completed in accordance with 42 C.F.R. § 405.372(c)(2). When the payment suspension is terminated, any money withheld as a result of the payment suspension shall be applied first to reduce or eliminate any determined overpayment by CMS including any interest assessed under 42 C.F.R. § 405.378, and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services. *See* 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Should you have any questions regarding the status of the suspension, please direct your inquiry to [shared mailbox].

Sincerely,

Name

G. Payment Suspension Termination Notice

USE THIS LETTER IF SENDING PAYMENT SUSPENSION TERMINATION NOTICE TO THE PROVIDER'S/SUPPLIER'S ATTORNEY

Date

Name of Attorney
Address

City, State Zip

Re: Notice of *Commencement of Process for* Termination of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
Record Identifier(s):

Dear {Medicare Provider/Supplier Attorney's Name}:

The Centers for Medicare & Medicaid Services (CMS) has directed us to *commence the process to* terminate the payment suspension in effect for Medicare payments to [provider] pursuant to 42 C.F.R. § 405.372(c). The provider was notified of the results of our review and the overpayment(s) we determined on [INSERT DATE]. The overpayment information was forwarded to [INSERT MAC], CMS' Medicare Administrative Contractor (MAC) for further action. *As part of that process, the MAC will review our findings and* will issue the overpayment demand letter(s), along with information regarding the provider's appeal rights. *The MAC typically will complete the process to terminate the suspension within approximately 60 days.* Once the payment suspension is *terminated*, any funds withheld as a result of the payment suspension shall be applied first to reduce or eliminate any overpayment*s determined* by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378 and then to reduce any other obligation to CMS or the U.S. Department of Health and Human Services per 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to the provider.

Please be advised that *the termination of* the payment suspension should not be construed as *a* positive determination regarding the provider's Medicare billing and is not an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve the provider of any civil or criminal liability, and it does not offer a defense to any further administrative, civil or criminal actions against the provider.

Sincerely,

Name

H. Payment Suspension Termination Notice

USE THIS LETTER IF SENDING PAYMENT SUSPENSION TERMINATION NOTICE TO THE PROVIDER/SUPPLIER

Date

Name of Addressee (if known)
Name of Medicare Provider/Supplier
Address
City, State Zip

Re: Notice of *Commencement of Process for* Termination of Suspension of Medicare Payments
Provider/Supplier Medicare ID Number(s):
Provider/Supplier NPI:
Record Identifier(s):

Dear {Medicare Provider/Supplier's Name}:

The Centers for Medicare & Medicaid Services (CMS) has directed us to *commence the process to* terminate the payment suspension in effect for Medicare payments to [provider] pursuant to 42 C.F.R. § 405.372(c). You were notified of the results of our review and the overpayment(s) we determined on [INSERT DATE]. The overpayment information was forwarded to [INSERT MAC], CMS' Medicare Administrative Contractor (MAC), for further action. *As part of that process, the MAC will review our findings and* issue the overpayment demand letter(s), along with information regarding your appeal rights. *Typically, the MAC will complete the process to terminate the suspension within approximately 60 days.* Once the payment suspension is removed, any funds withheld as a result of the payment suspension shall be applied first to reduce or eliminate any overpayment*s determined* by CMS including any associated interest accrued pursuant to 42 C.F.R. § 405.378 and then to reduce any obligation to CMS or the U.S. Department of Health and Human Services per 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Please be advised that *the termination of a* payment suspension should not be construed as any positive determination regarding your Medicare billing and is not an indication of government approval of or acquiescence regarding the claims submitted. It does not relieve you of any civil or criminal liability, and it does not offer a defense to any further administrative, civil or criminal actions against you.

Sincerely,

Name