| CMS Manual System | Department of Health & Human Services (DHHS) |
| --- | --- |
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 13595** | **Date: January 26, 2026** |
| | **Change Request 14362** |

**SUBJECT: Updates of Chapters 3, 4, and Exhibits in Publication (Pub.) 100-08, Including Updates to the Provider Notification Process and Vetting with the CMS Process**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to revise various sections within Chapters 3, 4, and Exhibits in Pub. 100-08. The revisions include updates to the Provider Notification process and Vetting with CMS process, in addition to inclusion of guidance regarding Unified Program Integrity Contractor (UPIC) Escalation of Inquiries.

These updates do not affect the provider and/or beneficiary populations. Rather, these updates are solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

**EFFECTIVE DATE: February 26, 2026**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: February 26, 2026**

***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 | 3/3.2/3.2.3/3.2.3.1/Additional Documentation Requests (ADR) |
| R | 3/3.2/3.2.3/3.2.3.2/Time - Frames for Submission |
| R | 3/3.2/3.2.3/3.2.3.5/Acceptable Submission Methods for Responses to ADRs |
| R | 3/3.6/3.6.4/Notifying the Provider |
| R | 4/Table of Contents |
| R | 4/4.2/4.2.2/4.2.2.7/Program Integrity Security Requirements |
| R | 4/4.5/4.5.1/UPIC and I-MEDIC Responsibilities |
| R | 4/4.6/Vetting with CMS |
| R | 4/4.7/4.7.4/4.7.4.1/Production of Medical Records and Documentation for an Appeals Case File |
| R | 4/4.8/4.8.3/Initial and Routine Communications with Providers, Suppliers and Authorized Representatives |
| N | 4/4.8/4.8.4/Escalation of Inquiries |
| N | 4/4.8/4.8.4/4.8.4.1/Congressional Inquiries |
| N | 4/4.8/4.8.4/4.8.4.2/Escalated Inquiries Involving Investigative Outcomes and Administrative Actions (non-payment suspension escalations) |
| N | 4/4.8/4.8.4/4.8.4.3/Escalated Inquiries Involving Payment Suspensions |
| N | 4/4.8/4.8.4/4.8.4.4/Providers on Zone Restrictions |
| R | Exhibits/Table of Contents |
| N | Exhibits/Exhibit 49/CERT Unified Post-Payment ADR Sample Letter |
| N | Exhibits/Exhibit 49.1/OMHA e-Appeal Portal - How to Access the Portal |
| N | Exhibits/Exhibit 49.2/How to Upload Documents via the OMHA e-Appeal Portal |
| N | Exhibits/Exhibit 50/UPIC and I-MEDIC Fax Cover Sheet |

**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: 13595 | Date: January 26, 2026 | Change Request: 14362 |
|---|---|---|---|

**SUBJECT: Updates of Chapters 3, 4, and Exhibits in Publication (Pub.) 100-08, Including Updates to the Provider Notification Process and Vetting with the CMS Process**

**EFFECTIVE DATE: February 26, 2026**
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These updates do not affect the provider and/or beneficiary populations. Rather, these updates are solely related to contractor technical processes and procedures. All updates ensure our contractors have the most recent guidance. This CR does not require Provider Education.

## II. GENERAL INFORMATION

**A. Background:** The purpose of this CR is to update sections in Chapters 3, 4, and Exhibits in Pub. 100-08. Specifically, guidance in Chapter 3 is being updated to instruct contractors of the use of Kiteworks and the Provider Notification process. Also, guidance in Chapter 4 is being added to instruct contractors of the Vetting with CMS process and procedures.

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

## III. 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 | |
| 14362.1 | The Investigations Medicare Drug Integrity Contractor (I-MEDIC) shall be advised that section 3.2.3.1 in chapter 3 of Publication (Pub) 100-08 in the Internet Only Manual (IOM) applies to their workload, as indicated. | | | | | | | | | UPICs |
| 14362.2 | The UPIC and I-MEDIC shall be advised that they | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | are authorized by the CMS to use Kiteworks for purposes of facilitating the secure exchange of records and information with providers and suppliers. | | | | | | | | | |
| 14362.3 | When requesting additional documentation for medical review using Kiteworks, if, after no more than two attempts of sending the Additional Documentation Request (ADR) request via Kiteworks (to include atleast 3 calendar days between attempts for a response), there is no response (i.e., no acknowledgment/download/receipt email is received from Kiteworks), the request shall be sent via certified mail, FedEx, UPS, fax etc. | | | | | | | | | UPICs |
| 14362.4 | The I-MEDIC shall be advised that section 3.2.3.5 in chapter 3 of Pub 100-08 in the IOM applies to their workload, as indicated. | | | | | | | | | UPICs |
| 14362.5 | The UPICs and I-MEDIC shall be advised that they may accept medical documentation submitted via Kiteworks. | | | | | | | | | UPICs |
| 14362.6 | The UPICs and the I-MEDIC shall be advised that they may use Kiteworks to facilitate the secure exchange of records and information between contractors, providers/suppliers, and | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | MACs. | | | | | | | | | |
| 14362.6.1 | The UPICs and the I-MEDIC shall be advised that Kiteworks is authorized in the Federal Risk and Authorization Management Program (FedRAMP) for secure file transfer and sharing functions. | | | | | | | | | UPICs |
| 14362.6.2 | The UPICs and I-MEDIC shall continue to ensure Federal Information Security Management Act/FedRAMP compliance in accordance with the CMS Office of Information Technology's security requirements. | | | | | | | | | UPICs |
| 14362.6.3 | The UPICs and the I-MEDIC shall be advised that the exchange of records and information may include, but is not limited to:<br>• ADRs,<br>• Overpayment/education letters,<br>• Post-payment medical review outcomes documentation,<br>• Administrative actions notices, and<br>• Statistical sample spreadsheets and methodologies. | | | | | | | | | UPICs |
| 14362.7 | Each UPIC and I-MEDIC shall develop and utilize a fax cover sheet with standardized elements to ensure consistency in messaging and to facilitate | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | sender validation. | | | | | | | | | |
| 14362.7.1 | The UPICs and the I-MEDIC shall be advised that a standardized fax cover sheet shall include several key elements to verify the legitimacy of the fax sent by the UPIC and/or I-MEDIC. | | | | | | | | | UPICs |
| 14362.7.2 | The UPICs and the I-MEDIC shall be advised that these elements shall include:<br>• Official logo and address of the program integrity contractor sending the fax,<br>• CMS logo,<br>• Case number reference, and<br>• Verification of UPIC and I-MEDIC contact information. | | | | | | | | | UPICs |
| 14362.7.3 | The UPICs and the I-MEDIC shall see example at Exhibit 50 – UPIC and I-MEDIC Fax Cover Sheet in the Exhibits chapter of Pub 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.8 | The UPICs shall be advised that section 4.5.1 in chapter 4 of Pub 100-08 in the IOM applies to UPICs who receive identified potential user abuse of Medicare Beneficiary Identifier (MBI) Lookup Tools in Medicare Administrative Contractor (MAC) portals. | | | | | | | | | UPICs |
| 14362.8.1 | The UPICs shall be advised that when the | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | Center for Program Integrity (CPI) identifies potential user abuse in the MBI Lookup tool, CPI will enter a case in the Unified Case Management system, screen and vet as needed, and tag the case as an MBI Lookup violation. | | | | | | | | | |
| 14362.8.2 | The UPICs shall be advised that CPI will advise the applicable UPICs of the details of the case and request an investigation into inappropriate claim submissions, if applicable. | | | | | | | | | UPICs |
| 14362.9 | The UPICs and I-MEDIC shall be advised of the Vetting with CMS guidance per section 4.6 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.10 | The UPICs and I-MEDIC shall be advised of the Production of Medical Records and Documentation for an Appeals Case File guidance per section 4.7.4.1 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.11 | The UPICs and I-MEDIC shall be advised of the Initial and Routine Communications with Providers, Suppliers and Authorized Representatives guidance per section 4.8.3 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.12 | The UPICs and I-MEDIC shall be advised of the Escalation of Inquiries | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | guidance per section 4.8.4 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | |
| 14362.13 | The UPICs and I-MEDIC shall be advised of the Congressional Inquiries guidance per section 4.8.4.1 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.14 | The UPICs and I-MEDIC shall be advised of the Escalated Inquiries Involving Investigative Outcomes and Administrative Actions (non-payment suspension escalations) guidance per section 4.8.4.2 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.15 | The UPICs shall be advised of the Escalated Inquiries Involving Payment Suspensions guidance per section 4.8.4.3 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.16 | The UPICs and I-MEDIC shall be advised of the Providers on Zone Restrictions guidance per section 4.8.4.4 in chapter 4 of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.17 | The UPICs and I-MEDIC shall be advised of the CERT Unified Post-Payment ADR Sample Letter per Exhibit 49 in the Exhibits chapter of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.18 | The UPICs and I-MEDIC shall be advised of the Office of Medicare | | | | | | | | | UPICs |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | Hearings and Appeals (OMHA) e-Appeal Portal - How to Access the Portal guidance per Exhibit 49.1 in the Exhibits chapter of Pub. 100-08 in the IOM. | | | | | | | | | |
| 14362.19 | The UPICs and I-MEDIC shall be advised of the How to Upload Documents via the OMHA e-Appeal Portal guidance per Exhibit 49.2 in the Exhibits chapter of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |
| 14362.20 | The UPICs and I-MEDIC shall be advised of the UPIC and I-MEDIC Fax Cover Sheet per Exhibit 50 in the Exhibits chapter of Pub. 100-08 in the IOM. | | | | | | | | | UPICs |

## IV. PROVIDER EDUCATION

None

**Impacted Contractors:** None

## V. 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**

## VI. CONTACTS

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VII. 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 3 - Verifying Potential Errors and Taking Corrective Actions

**Table of Contents**
*(Rev. 13595; Issued: 01-26-26)*

**Transmittals for Chapter 3**

### 3.2.3.1 - Additional Documentation Requests (ADR)

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

This section applies to MACs, *RACs, SMRC,* CERT, UPICs, *and the Investigations Medicare Drug Integrity Contractor (I-MEDIC)* as indicated.

In most reviews, the MACs, CERT, RACs, SMRC, and UPICs are unable to make a determination on prepayment or post-payment claims they have chosen for review based upon the information on the claim, its attachments, or the billing history found in claims processing system (if applicable) or the Common Working File (CWF). In those instances, the reviewer shall solicit documentation from the provider or supplier by issuing an ADR.

The MACs, CERT, RACs, SMRC, and UPICs shall specify in the ADR only those individual pieces of documentation needed to make a determination. When reviewing documentation, the reviewer shall give appropriate consideration to all documentation that is provided in accordance with other sections of this manual.

The MACs, RACs, and SMRC shall also support soliciting documentation from the provider or supplier via Electronic Submission of Medical Documentation (esMD). The contractors shall send an Electronic Medical Documentation Request (eMDR) via esMD to those providers/suppliers that have registered to receive the request electronically. The contractors are encouraged to explore other ways to send eMDRs electronically (e.g.,, using direct exchange, clearinghouses, state Health Information Exchange (HIEs)).

Providers interested in submitting documentation via esMD can find information on the CMS esMD website at http://www.cms.gov/esMD.

*The UPICs and I-MEDIC are authorized by CMS to use Kiteworks for purposes of facilitating the secure exchange of records and information with providers and suppliers (see Subsection 3.6.4 – Notifying the Provider for additional information).*

### 3.2.3.2 - Time - Frames for Submission

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

**A. Prepayment Review Time Frames**

When requesting documentation for prepayment review, the MACs and UPICs shall notify providers when they expect documentation to be received. Per 42 CFR § 405.903, providers and suppliers have 45 calendar days to submit additional documentation in response to a MAC, RAC, or SMRC request. Providers and suppliers have 30 calendar days to respond to a UPIC request.

Contractors may accept documentation received after the 45 and 30-calendar day (for UPICs) time frames for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation. Per 42 CFR § 405.930, reviewers shall deny claims when the requested documentation to support payment is not received by the expected time frame.

**B. Post-payment Review Time Frames**

When requesting documentation for post-payment review, the MACs, CERT, SMRC, UPICs and RACs shall notify providers when they expect documentation to be received. Per 42 CFR § 405.929, providers and suppliers have 45 calendar days to submit additional documentation in response to a MAC, RAC, SMRC or CERT request. Providers and suppliers have 30 calendar days to respond to a UPIC request. Contractors may accept documentation received

after the 45 and 30-calendar day (for UPICs) time frames for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation.

Per 42 CFR § 405.930, contractors shall deny claims when the requested documentation to support payment is not received by the expected time frame (including any applicable extensions).

**C. For esMD submissions**

The esMD review contractor shall use the esMD Cloud system receipt date as the date the documentation was received. If the esMD Cloud receipt date is outside of the contractors normal business hours, the following business day shall be used as the receipt date. Contractors shall pull for esMD files and latest transaction status at least every 4 hours (business hours) daily; including a mandatory pulling between the hours of 6-7pm EST daily. If unforeseeable circumstances occur, in which contractors are not technically capable of retrieving documentation in a timely manner due to issues outside of their control, contractors are to notify the esMD Team and can use the date documentation was available to be retrieved once issues have been resolved in the esMD Cloud system.

***D. Kiteworks Submissions***

*This section applies to the UPICs and the I-MEDIC. When requesting additional documentation for medical review using Kiteworks, if, after no more than two attempts of sending the ADR request via Kiteworks (to include atleast 3 calendar days between attempts for a response), there is no response (i.e., no acknowledgment/download/receipt email is received from Kiteworks), the request shall be sent via certified mail, FedEx, UPS, fax etc.*

## 3.2.3.5 - Acceptable Submission Methods for Responses to ADRs

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

This section applies to MACs, RACs, CERT, SMRC, UPICs, *and I-MEDIC,* as indicated.

Reviewers shall be clear in their ADR letters about what documentation submission methods they will accept from a provider or Health Information Handler (HIH). The MACs, CERT, SMRC and RACs shall accept documents via paper, fax, CD/DVD, electronic submission of medical documentation (esMD), and contractor website portal.

A. Paper

The MACs, CERT, SMRC, and RACs are encouraged to state in the ADRs that paper medical documentation can be mailed by any means including US Postal Service, FedEx, UPS, or certified mail. To facilitate delivery of documentation, MACs, CERT, SMRC, and RACs should provide a physical mailing address instead of a P.O. Box.

B. Fax

If the MACs, CERT, SMRC, or RACs have the capability to offer fax confirmation, they are encouraged to send such confirmations with every successfully received fax.

C. Imaged Medical Documentation File(s) Sent on CD/DVD

The MACs, CERT and SMRC shall state in the ADR that imaged medical documentation files on CD/DVD may be mailed by any means. RAC ADRs shall provide a website link or phone number that provides information regarding the requirements for submitting imaged documentation on CD or DVD.

D. Medical Documentation Sent via Electronic Submission of Medical Documentation (esMD) Transmission

Electronic Submission of Medical Documentation (esMD) is a system that allows providers/HIHs to submit medical documentation over secure electronic means. Information about the esMD system can be found at www.cms.gov/esMD.

MACs, SMRC, and CERT are encouraged to state in their ADRs how providers can get more information about submitting medical documentation via the esMD mechanism.

Any time a new esMD service or document type is being offered, and any contractor wants to publish a public announcement (website, list serve, tweet, etc.) the contractor must clear the announcement with CMS

E. Contractor Website Portal

The MACs are encouraged to state in the ADRs that medical documentation can be submitted by this route.

*F. Kiteworks*

*The UPICs and I-MEDIC may accept medical documentation submitted via this route.*

## 3.6.4 - Notifying the Provider

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

This section applies to the MACs, RACs, UPICs, *and I-MEDIC,* as indicated.

**A. General**

*UPICs and the I-MEDIC may use Kiteworks to facilitate the secure exchange of records and information between contractors, providers/suppliers, and MACs. Kiteworks is authorized in the Federal Risk and Authorization Management Program (FedRAMP) for secure file transfer and sharing functions. The UPICs and I-MEDIC, including all approved subcontractors, shall continue to ensure Federal Information Security Management Act (FISMA)/FedRAMP compliance in accordance with the CMS Office of Information Technology's (OIT) security requirements.*

*The exchange of records and information may include, but is not limited to:*

- *Additional Documentation Request (ADR),*
- *Overpayment/education letters,*
- *Post-payment medical review outcomes documentation,*
- *Administrative actions notices, and*
- *Statistical sample spreadsheets and methodologies.*

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider even if no overpayment determination is made. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the RACs shall issue a Review Results Letter for all audits as outlined in their SOW requirements.

UPICs shall comply with the requirements listed below when issuing Review Results Letters. Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;

- Reason for conducting the review or good cause for reopening;
- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;
- The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded and if others were payable;
- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;
- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;
- Total underpayment amounts;
- Total overpayment amounts that the provider or supplier is responsible for;
- Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault;
- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days (not applicable to RACs or UPICs);
- The provider's or supplier's right to request an extended repayment schedule (not applicable to RACs or UPICs);
- The MACs and UPICs shall include limitation of liability and appeals information in the provider notices;
- The MACs shall include appeals information in the provider notices;
- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and
- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re-review in 6 months).

If a claim is denied through prepayment review, the MACs and UPICs are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and RAC shall notify the provider by issuing a notification letter to meet this requirement. The UPIC shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

## B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for medical record review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

## C. RACs

For overpayments detected through medical record review, the RAC shall send a review results letter as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For underpayments, the RAC shall notify the provider as indicated in the RAC SOW. In addition, the RAC shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and pay back the underpayment.

## D. UPICs

For overpayments detected through medical record review, and after coordination between the UPIC and OIG, the UPIC shall send a review results letter (the MAC sends the demand letter). In addition, the UPIC shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The UPIC shall use discretion on whether to send the review results letter.

## E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC or UPIC had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, that the denial was made without reviewing the documentation because the requested documentation was not received or was not received within the allowable time frame (§1862(a) (1) of the Act). This information will be useful to the provider in deciding whether to appeal the decision. When denying the claims, contractors shall use Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service.

For claims where the reviewer makes a denial following medical record review, the reviewer has the discretion to indicate in the denial notice, using Group Code: CO - Contractual Obligation and Claim Adjustment Reason Code (CARC) 50 - these are non- covered services because this is not deemed a “medical necessity” by the payer that the denial was made after review of submitted documentation. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.

# Medicare Program Integrity Manual
## Chapter 4 - Program Integrity

**Table of Contents**
***(Rev. 13595; Issued: 01-26-26)***

## Transmittals for Chapter 4


4.6 - *Vetting with CMS*

4.8.3 – *Initial and Routine Communication with Providers, Suppliers and Authorized Representatives*

*4.8.4 – Escalation of Inquiries*

*4.8.4.1 – Congressional Inquiries*

*4.8.4.2 – Escalated Inquiries Involving Investigative Outcomes and Administrative Actions*

*4.8.4.3 – Escalated Inquiries Involving Payment Suspensions*

*4.8.4.4 – Providers on Zone Restrictions*

## 4.2.2.7 – Program Integrity Security Requirements

***(Rev. 13595; Issued:01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

This section applies to UPICs.

To ensure a high level of security for the UPIC functions, the UPIC shall develop, implement, operate, and maintain security policies and procedures that meet and conform to the requirements of the Business Partners System Security Manual (BPSSM) and the CMS Informational Security Acceptable Risk Safeguards (ISARS). Further, the UPIC shall adequately inform and train all UPIC employees to follow UPIC security policies and procedures so that the information the UPIC obtain is confidential.

**Note:** The data UPICs collect in administering UPIC contracts belong to CMS. Thus, the UPICs collect and use individually identifiable information on behalf of the Medicare program to routinely perform the business functions necessary for administering the Medicare program, such as MR and program integrity activities to prevent fraud, waste, and abuse. Consequently, any disclosure of individually identifiable information without prior consent from the individual to whom the information pertains, or without statutory or contract authority, requires CMS' prior approval.

This section discusses broad security requirements that UPICs shall follow. The requirements listed below are in the BPSSM or ARS. There are several exceptions. The first is requirement A (concerning UPIC operations), which addresses several broad requirements; CMS has included requirement A here for emphasis and clarification. Two others are in requirement B (concerning sensitive information) and requirement G (concerning telephone security). Requirements B and G relate to security issues that are not systems related and are not in the BPSSM.

### A. Unified Program Integrity Contractor Operations

- The UPIC shall conduct their activities in areas not accessible to the general public.

- The UPIC shall completely segregate itself from all other operations. Segregation shall include floor-to-ceiling walls and/or other measures described in ARS Appendix B PE-3 and CMS-2 that prevent unauthorized persons access to or inadvertent observation of sensitive and investigative information.

- Other requirements regarding UPIC operations shall include sections 3.1, 3.1.2, 4.2, 4.2.5, and 4.2.6 of the BPSSM.

### B. Handling and Physical Security of Sensitive and Investigative Material

Refer to ARS Appendix B PE-3 and CMS-1 for definitions of sensitive and investigative material.

In addition, the UPIC shall follow the requirements provided below:

- Establish a policy that employees shall discuss specific allegations of fraud only within the context of their professional duties and only with those who have a valid need to know, which includes (this is not an exhaustive list):

  - Appropriate CMS personnel
  - UPIC staff

  - MAC MR staff

  - UPIC or MAC audit staff

- UPIC or MAC data analysis staff

- UPIC or MAC senior management

- UPIC or MAC corporate counsel

- The ARSs require that:

  - The following workstation security requirements are specified and implemented: (1) what workstation functions can be performed, (2) the manner in which those functions are to be performed, and (3) the physical attributes of the surroundings of a specific workstation or class of workstation that can access sensitive CMS information. CMS requires that for UPICs all local workstations as well as workstations used at home by UPICs comply with these requirements.

  - If UPIC employees are authorized to work at home on sensitive data, they shall observe the same security practices that they observe at the office. These shall address such items as viruses, virtual private networks, and protection of sensitive data, including printed documents.

  - Users are prohibited from installing desktop modems.

  - The connection of portable computing or portable network devices on the CMS claims processing network is restricted to approved devices only. Removable hard drives and/or a Federal Information Processing Standards (FIPS)-approved method of cryptography shall be employed to protect information residing on portable and mobile information systems.

  - Alternate work sites are those areas where employees, subcontractors, consultants, auditors, etc. perform work associated duties. The most common alternate work site is an employee's home. However, there may be other alternate work sites such as training centers, specialized work areas, processing centers, etc. For alternate work site equipment controls, (1) only CMS Business Partner-owned computers and software are used to process, access, and store sensitive information; (2) a specific room or area that has the appropriate space and facilities is used; (3) means are available to facilitate communication with the managers or other members of the Business Partner Security staff in case of security problems; (4) locking file cabinets or desk drawers; (5) "locking hardware" to secure IT equipment to larger objects such as desks or tables; and (6) smaller Business Partner-owned equipment is locked in a storage cabinet or desk when not in use. If wireless networks are used at alternate work sites, wireless base stations are placed away from outside walls to minimize transmission of data outside of the building.

The UPIC shall also adhere to the following:

- Ensure the mailroom, general correspondence, and telephone inquiries procedures maintain confidentiality whenever the UPIC receives correspondence, telephone calls, or other communication alleging fraud. Further, all internal written operating procedures shall clearly state security procedures.

- Direct mailroom staff not to open UPIC mail in the mailroom unless the UPIC has requested the mailroom do so for safety and health precautions. Alternately, if mailroom staff opens UPIC mail, mailroom staff shall not read the contents.

- For mail processing sites separate from the UPIC, the UPIC shall minimize the handling of UPIC mail by multiple parties before delivery to the UPIC.

- The UPIC shall mark mail to CMS Central Office or to another UPIC "personal and confidential" and address it to a specific person.

- Where more specialized instructions do not prohibit UPIC employees, they may retain sensitive and investigative materials at their desks, in office work baskets, and at other points in the office during the course of the normal work day. Regardless of other requirements, the employees shall restrict access to sensitive and investigative materials, and UPIC staff shall not leave such material unattended.

- The UPIC staff shall safeguard all sensitive or investigative material when the materials are being transported or sent by UPIC staff.

- The UPIC shall maintain a controlled filing system (refer to section 4.2.2.6.1).

**C. Designation of a Security Officer**

The security officer shall take such action as is necessary to correct breaches of the security standards and to prevent recurrence of the breaches. In addition, the security officer shall document the action taken and maintain that documentation for at least seven (7) years.

Actions shall include:

- Within one (1) hour of discovering a security incident, clearly and accurately report the incident following BPSSM requirements for reporting of security incidents. For purposes of this requirement, a security incident is the same as the definition in section 3.6 of the BPSSM, Incident Reporting and Response.

- Specifically, the report shall address the following where appropriate:

  - Types of information about beneficiaries shall at a minimum address whether the compromised information includes name, address, HICNs, and date of birth;

  - Types of information about providers/suppliers shall at a minimum address if the compromised information includes name, address, and provider/supplier ID;

  - Whether LE is investigating any of the providers/suppliers with compromised information; and

  - Police reports.

- Provide additional information that CMS requests within 72 hours of the request.

- If CMS requests, issue a Fraud Alert to all CMS Medicare contractors within 72 hours of the discovery that the data was compromised, listing the HICNs and provider/supplier IDs that were compromised.

- Within 72 hours of discovery of a security incident, when feasible, review all security measures and revise them if necessary so they are adequate to protect data against physical or electronic theft.

Refer to section 3.1 of the BPSSM and Attachment 1 of this manual section (letter from Director, Office of Financial Management, concerning security and confidentiality of UPIC data) for additional requirements.

**D. Staffing of the Unified Program Integrity Contractor and Security Training**

The UPIC shall perform thorough background and character reference checks, including at a minimum credit checks, for potential employees to verify their suitability for employment. Specifically, background checks shall at least be at level 2- moderate risk. (People with access to sensitive data at CMS have a level 5 risk). The UPIC may require investigations above a level 2 if the UPIC believes the higher level is required to protect sensitive information.

At the point the UPIC makes a hiring decision for a UPIC position, and prior to the selected person's starting work, the UPIC shall require the proposed candidate to fill out a conflict of interest declaration, as well as a confidentiality statement.

Annually, the UPICs shall require existing employees to complete a conflict of interest declaration, as well as a confidentiality statement.

At least once a year, the UPICs shall thoroughly explain to and discuss with employees the special security considerations under which the UPIC operates. Further, this training shall emphasize that in no instance shall employees disclose sensitive or investigative information, even in casual conversation. The UPIC shall ensure that employees understand the training provided.

Refer to section 2.0 of the BPSSM and ARS Appendix B AT-2, AT-3, AT-4, SA-6, MA-5.0, PE-5.CMS.1, IR2-2.2, CP 3.1, CP 3.2, CP 3.3, and SA 3.CMS.1 for additional training requirements.

## E. Access to Unified Program Integrity Contractor Information

Refer to section 2.3.4 of the BPSSM for requirements regarding access to UPIC information. The UPIC shall notify the OIG if parties without a need to know are asking inappropriate questions regarding any investigations. The UPICs shall refer all requests from the press related to the Medicare Integrity Program to the CMS contracting officer with a copy to the CORs and BFLs for approval prior to release. This includes, but is not limited to, contractor initiated press releases, media questions, media interviews, and Internet postings.

## F. Computer Security

Refer to section 4.1.1 of the BPSSM for the computer security requirements.

## G. Telephone and Fax Security

The UPICs shall implement phone security practices. The UPICs shall discuss investigations only with those individuals who need to know the information and shall not divulge information to individuals not known to the UPIC involved in the investigation of the related issue.

Additionally, the UPICs shall only use CMS, the OIG, the DOJ, and the FBI phone numbers that they can verify. To assist with this requirement, UPIC management shall provide UPIC staff with a list of the names and telephone numbers of the individuals of the authorized agencies that the UPICs deal with and shall ensure that this list is properly maintained and periodically updated.

Employees shall be polite and brief in responding to phone calls but shall not volunteer any information or confirm or deny that an investigation is in process. However, UPICs shall not respond to questions concerning any case the OIG, the FBI, or any other LE agency is investigating. The UPICs shall refer such questions to the OIG, the FBI, etc., as appropriate.

Finally, the UPICs shall transmit sensitive and investigative information via facsimile (fax) lines only after the UPIC has verified that the receiving fax machine is secure.
Unless the fax machine is secure, UPICs shall make arrangements with the addressee to have someone waiting at the receiving machine while the fax is transmitting. The UPICs shall not transmit sensitive and investigative information via fax if the sender must delay a feature, such as entering the information into the machine's memory.

*Each UPIC and I-MEDIC shall develop and utilize a fax cover sheet with standardized elements to ensure consistency in messaging and to facilitate sender validation.*

*A standardized fax cover sheet shall include several key elements to verify the legitimacy of the fax sent by the UPIC and/or I-MEDIC. These elements shall include:*

- *Official logo and address of the program integrity contractor sending the fax,*
- *CMS logo,*
- *Case number reference, and*
- *Verification of UPIC and I-MEDIC contact information.*

*See example at Exhibit 50 – UPIC and I-MEDIC Fax Cover Sheet.*

## 4.5.1 - UPIC and I-MEDIC Responsibilities

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

This section applies to the UPICs and the MACs.

When a complaint is received from the MAC screening staff, the UPIC shall further screen the complaint, resolve the complaint, or make referrals, as needed, to the appropriate entity.

The MAC shall screen and forward the complaints within 45 business days from the date of receipt by the screening staff, or within 30 business days of receiving medical records and/or other documentation, whichever is later, to the UPIC. The UPIC shall send the acknowledgement letter within 15 calendar days of receipt of the complaint referral from the MAC screening staff, unless it can be resolved sooner. The letter shall be sent on UPIC letterhead and shall contain the telephone number of the UPIC analyst handling the case.

If the MAC refers a DME provider/supplier that was previously referred to the UPIC, is under active investigation, is on an active Payment Suspension, has been referred to law enforcement and is under active law enforcement investigation, or is under an active zone restriction, the UPIC shall not send the following letters to the beneficiary/complainant.

- **Acknowledgement** within 15 calendar days of receipt of the complaint referral from the MAC screening staff unless it can be resolved sooner;
- **Acknowledgement** to the complainant, indicating that a referral is being made, if applicable, to the appropriate MAC unit for further action;
- **Complaint resolution** within seven (7) calendar days of resolving the complaint investigation.

The UPIC shall document the MAC referral/complaint in the active investigation file (CSE) in UCM as well as upload the referral/complaint in the Documents section of the active CSE. Should the UPIC need additional beneficiary interviews, the UPIC should consider interviewing beneficiaries that have filed a complaint.

If the UPIC staff determines, after screening the complaint, that it is not a potential fraud, waste, and/or abuse issue, but involves other issues (e.g., MR, enrollment, claims processing), the complaint shall be referred back to the MAC area responsible for screening. The MAC screening staff shall track the complaints returned by the UPIC. However, the UPIC shall send an acknowledgement to the complainant, indicating that a referral is being

made, if applicable, to the appropriate MAC unit for further action. The UPIC shall track complaints referred by the MAC screening area in the UPIC's internal tracking system. The UPIC shall send the complainant a resolution letter within seven (7) calendar days of resolving the complaint investigation.

*This section applies to UPICs who receive identified potential user abuse of MBI Lookup Tools in MAC portals.*

*When CPI identifies potential user abuse in the MBI Lookup tool, CPI will enter a case in the UCM, screen and vet as needed, and tag the case as an MBI Lookup violation. CPI will advise the applicable UPIC(s) of the details of the case and request an investigation into inappropriate claim submissions, if applicable.*

This section applies to the I-MEDIC.

When a complaint is received by the I-MEDIC complaint screening staff, an acknowledgement letter shall be sent to the complainant within five (5) calendar days. The I-MEDIC complaint screening staff shall screen, resolve, or if warranted, escalate the complaint to the screening team at the I-MEDIC within 30 calendar days from the date of receipt.

Once a complaint has been escalated to lead screening, the I-MEDIC shall further screen the lead, open an investigation, or make referrals, as needed, to the appropriate entity within 45 days.

The I-MEDIC shall track all complaints received by its complaint screening staff in an internal tracking system. All complaints that have escalated to a lead status shall be tracked in the UCM.

The I-MEDIC complaint screening staff shall send the complainant a resolution letter within five (5) calendar days of resolving the complaint investigation.

## 4.6 - *Vetting with CMS*

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*All leads and any new subjects that the UPIC determines warrant further investigation shall be vetted through CMS for approval before advancing to an investigation. The UPIC shall vet all applicable National Provider Identifiers (NPIs) and Provider Identifiers associated with the provider or supplier's tax identification number when initially vetting the lead with CMS. The UPIC shall submit the lead on each subject to CMS via UCM within two (2) business days of the UPIC determining that the lead should be transitioned into an investigation.*

For the submission to CMS, *the UPIC shall submit subjects to the UCM queue for CMS vetting, ensuring that each subject includes: NPI and the provider/supplier name*.

*The UPIC shall only open investigations into leads that have been approved by CMS. Once CMS approves the lead, the subject will be marked with the vetting determination date and determination type in UCM. If CMS instructs the UPIC to close the lead without further action, the UPIC shall do so within two (2) business days. These subjects will be marked with the HHS/OIG Vetting Determination Date in UCM with a red system 'chip'.*

*If the screening results in a new investigation or becomes part of an existing investigation, that screening information shall be included in the investigation file. If, during a UPIC investigation, it is determined that additional subject(s) should be incorporated into the ongoing investigation, the UPIC shall vet each additional subject with CMS, using the approved CMS process described above, before implementing any investigative actions*

*related to the additional subject(s). For any new investigations, the UPIC shall complete the appropriate updates in the UCM within seven (7) calendar days*.

### 4.7.4.1 - Production of Medical Records and Documentation for an Appeals Case File

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

When the UPIC denies a claim and the provider, supplier, physician or beneficiary appeals the denial, the MAC shall request the medical records and documentation that the UPIC used in making its determination. The UPIC shall assemble the case file and send it to the MAC within five (5) business days. If the MAC request is received outside of normal business hours or on an observed holiday that the UPIC is closed for business, the first business day will not be counted until the first business day after receipt of the request (i.e., if received on Saturday, the following Monday will be counted as the first business day). If the 5th business day falls on an observed holiday where either the UPIC or MAC is closed for business, documentation shall be sent on the next business day.

The UPIC shall include any position papers or rationale and support for its decision so that the appeals adjudicator can consider it during the appeals process. However, UPICs shall be aware that an appeals case file is discoverable by the appellant. This means that the appellant can receive a complete copy of the case file. Since the provider may receive the case file, the UPIC shall consult with law enforcement before including any sensitive information relative to a case.

*When submitting documents to Office of Medicare Hearing and Appeals, UPICs shall use (OMHA's) e-Appeal Portal (Portal) for electronic submission of documents related to a Level 3 appeal. Submitting documents through the Portal is generally faster and more reliable than sending them via mail, fax, or email. Additionally, OMHA cannot accept documents containing Personally Identifiable Information (PII) and Protected Health Information (PHI) via email, so utilizing the Portal will resolve any concern about accidental, unsecure transmission of PII or PHI via email. Therefore, all UPICs shall use the Portal for electronic document submission.*

*Examples of Level 3 Appeal related documents that UPICs shall upload to the Portal, as applicable, may include, but are not limited to Position Papers, Curricula Vitae (CVs), Evidence, Written Testimony, etc. Once uploaded to the Portal, these documents are automatically attached to the appeal in OMHA's Electronic Case Adjudication and Processing Environment (ECAPE). The Portal provides immediate confirmation (on the website and via email) that submissions are received, and the ALJ team assigned to an appeal receives an alert whenever a document is uploaded to that appeal via the Portal. While the Portal shall be the primary method of document submission by the UPICs, circumstances may arise when the Portal is not available or practical. For example, on rare occasions, the Portal may be unavailable due to maintenance. In these circumstances, the UPICs may submit Level 3 Appeal related documents via email, fax, or mail, if all PII and PHI have been redacted or removed.*

*The Portal is available at hhs-ecape-portal.entellitrak.com. To enter the Portal, UPIC representatives must first create an account. Refer to Exhibit 49.1 for instructions on How to Access the Portal. Once an account is created, the UPIC representative may upload relevant Level 3 Appeal documents. Refer to Exhibit 49.2 for instructions on How to Upload Documents Via the Portal.*

*Note: Contractors and appellants may also use the Portal to check the status of an existing ECAPE appeal.*

If the UPIC would like to be notified of an Administrative Law Judge (ALJ) hearing on a particular case, the UPIC shall put a cover sheet in the case file before sending it to the

MAC. The cover sheet shall state that the UPIC would like to be notified of an ALJ hearing and list a contact name with a phone and fax number where the contact can be reached. The cover sheet shall also include language stating, "PLEASE DO NOT REMOVE" to ensure it stays on the case file should the file be sent to the Quality Improvement Contractor. If the UPIC receives a notice of hearing, the UPIC shall contact the Qualified Independent Contractor (QIC) immediately.

The QICs are tasked with participating in ALJ hearings; therefore, they are the primary Medicare contractor responsible for this function. UPICs may participate in an ALJ hearing, but they shall work with the QIC to ensure that duplicative work is not being performed by both the UPIC and the QIC in preparation for the hearing. UPICs shall never invoke party status. If the UPIC participates in a hearing, it shall be as a non-party. An ALJ cannot require participation in a hearing, whether it is party or non-party. If a UPIC receives a notice that appears contrary to this instruction, the UPIC shall contact the QIC and their BFL, with a copy to the COR, immediately.

### 4.8.3 – *Initial and Routine Communications with Providers, Suppliers and Authorized Representatives*

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*This section applies to UPICs and the I-MEDIC.*

*UPICs and the I-MEDIC shall use a central, non-specific contractor mailbox for standard communications with providers, suppliers, and/or their authorized representatives. In addition, routine written communication related to investigative activities and administrative actions, including Medical Record Request letters, Notice of Payment Suspension letters, and Final Findings Letters from the UPIC, should contain a point of contact, contractor e-mail/mailbox information, and/or phone numbers for the point of contact should a provider or supplier have questions.*

### *4.8.4 – Escalation of Inquiries*

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*This section applies to UPICs and the I-MEDIC, outlining the protocol to be followed when a provider, supplier, or their authorized representative requests to speak with the UPIC or I-MEDIC management or has escalated a matter related to an investigation or administrative action through direct outreach to CMS, Congressional Offices or other external entities.*

#### *4.8.4.1 – Congressional Inquiries*

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*If a UPIC directly receives a Congressional Inquiry from any external requestor and/or CMS components other than CPI, they shall immediately submit the Congressional Inquiry for processing to the appropriate CMS BFL or designated staff person (dependent upon the nature of the Congressional Inquiry; i.e. investigation related, payment suspension related, etc.). The UPIC shall also send a copy of the communication to their COR.*

*Once the Congressional Inquiry is received by CMS, it will be logged, reviewed, and assigned to the appropriate UPIC(s), as needed. Upon UPIC receipt of a Congressional Inquiry assignment, the UPIC shall prepare all relevant information as requested in the Congressional Inquiry, and submit the information to the appropriate CMS BFL or designated staff person, with a copy to their COR, by an agreed upon date and delivery method. The UPIC shall not respond directly to the Congressional Office. Upon CMS receipt of the UPIC's relevant information, CMS will coordinate internally and respond to the inquiry as needed*

### *4.8.4.2 – Escalated Inquiries Involving Investigative Outcomes and Administrative Actions (non-payment suspension escalations)*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*If a matter is escalated, such as when a provider, supplier, and/or their authorized representative requests to speak with UPIC or I-MEDIC management through verbal or written communication, the contractor shall contact the inquiring party in a manner which they deem most appropriate to acknowledge the inquiry or concern and provide a response within 3 business days unless circumstances prevent this, and/or CMS has already advised on the same topic. This ensures transparency and responsiveness once a matter reaches a heightened level of concern. The contractor representative shall ensure all mailboxes and phone messages are checked at least twice each business day for incoming communication. Escalated inquiries referred to CMS directly by the provider, supplier, or their authorized representative will be responded to by the designated Business Function Lead(s) (BFLs) in the Division of Provider Investigations (DPI) after clearance through the Fraud Investigations Group Front Office (FIG FO) in accordance with current guidelines.*

### *4.8.4.3 – Escalated Inquiries Involving Payment Suspensions*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*This section only applies to UPICs. For payment suspension matters that have been escalated:*

- *The UPIC shall prepare a draft email response to the provider, supplier, or authorized representative.*

- *The draft must be submitted to the UPIC's designated BFL in the Division of Investigative Support (DIS) with a copy (cc) to the Contract Officer's Representative (COR) and Division of Provider Investigations (DPI) BFL for CMS clearance prior to release.*

- *Upon clearance, the UPIC must blind copy (bcc) or forward the final communication to the above CMS staff (in DIS, CMG and DPI) for awareness and documentation.*

### *4.8.4.4 – Providers on Zone Restrictions*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*To maintain the integrity of the investigation, UPICs generally, unless otherwise advised, do not respond to provider and supplier inquiries when the provider or supplier is placed on full zone restriction by law enforcement (LE). However, UPICs are encouraged to communicate with the LE contact in such situations to determine the best and appropriate course of action. For partial zone restrictions, UPICs may conduct certain investigative activities in accordance with directives by LE; however, communication and responses to inquiries regarding the case or status by the provider or supplier should not be conducted unless otherwise directed by LE.*

*All communication between the UPICs/I-MEDIC and a provider, supplier, or their authorized representative, including receipt of inquiry, coordination with CMS, and response to the inquirer, shall be documented in the appropriate UCM CSE(s).*

# Medicare Program Integrity Manual
## Exhibits

**Table of Contents**
***(Rev. 13595; Issued: 01-26-26)***

## Transmittals for Exhibits

*Exhibit 49 – CERT Unified Post-Payment ADR Sample Letter*
*49.1 – OMHA e-Appeal Portal - How to Access the Portal*
*49.2 – How to Upload Documents via the OMHA e-Appeal Portal*
*Exhibit 50 – UPIC and I-MEDIC Fax Cover Sheet*

## *Exhibit 49 – CERT Unified Post-Payment ADR Sample Letter*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*The OMHA e-Appeal Portal is a secure, web-based system that allows parties to electronically manage Medicare appeals before OMHA, including submitting case information and documents online instead of relying on paper and mail. The following exhibits are designed to help users effectively utilize this system: one provides step-by-step instructions for creating and accessing a portal account, and the other explains how to upload appeal documents within the portal so that information is properly associated with the correct case.*

## *Exhibit 49.1 – OMHA e-Appeal Portal - How to Access the Portal*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*The OMHA e-Appeal Portal is available at <hhs-ecape-portal.entellitrak.com>.*

***Portal Account Creation:***

*To create a new portal account, navigate to the website at <hhs-ecape-portal.entellitrak.com>. Then select the green button labeled "Sign in with ID.me." You will be redirected to ID.me and prompted to sign in or create an ID.me account.*

*The portal utilizes ID.me to provide identity verification for new accounts and multi-factor authentication for secure sign-in to existing accounts. Creating an ID.me account requires a picture ID (such as a driver's license or passport) and an email address or phone number for verification. It usually takes about 15-20 minutes. In some situations, a live video call may be required to verify a new user's identity.*

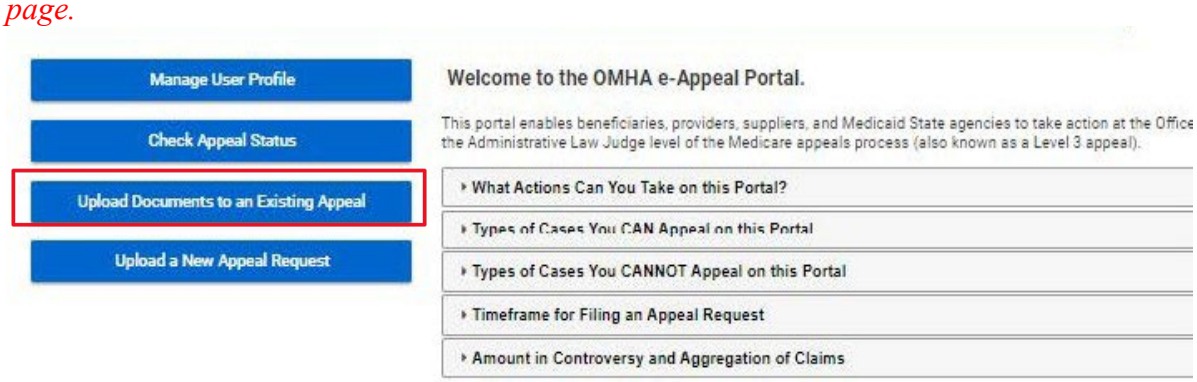
*Once you finish signing in to or creating an account with ID.me, you will be redirected back to the portal's user registration page and prompted to enter some profile information. Once you've entered the required information, click "Register" and you will be directed to your portal account's home page.*

***Portal Account Sign-in:***

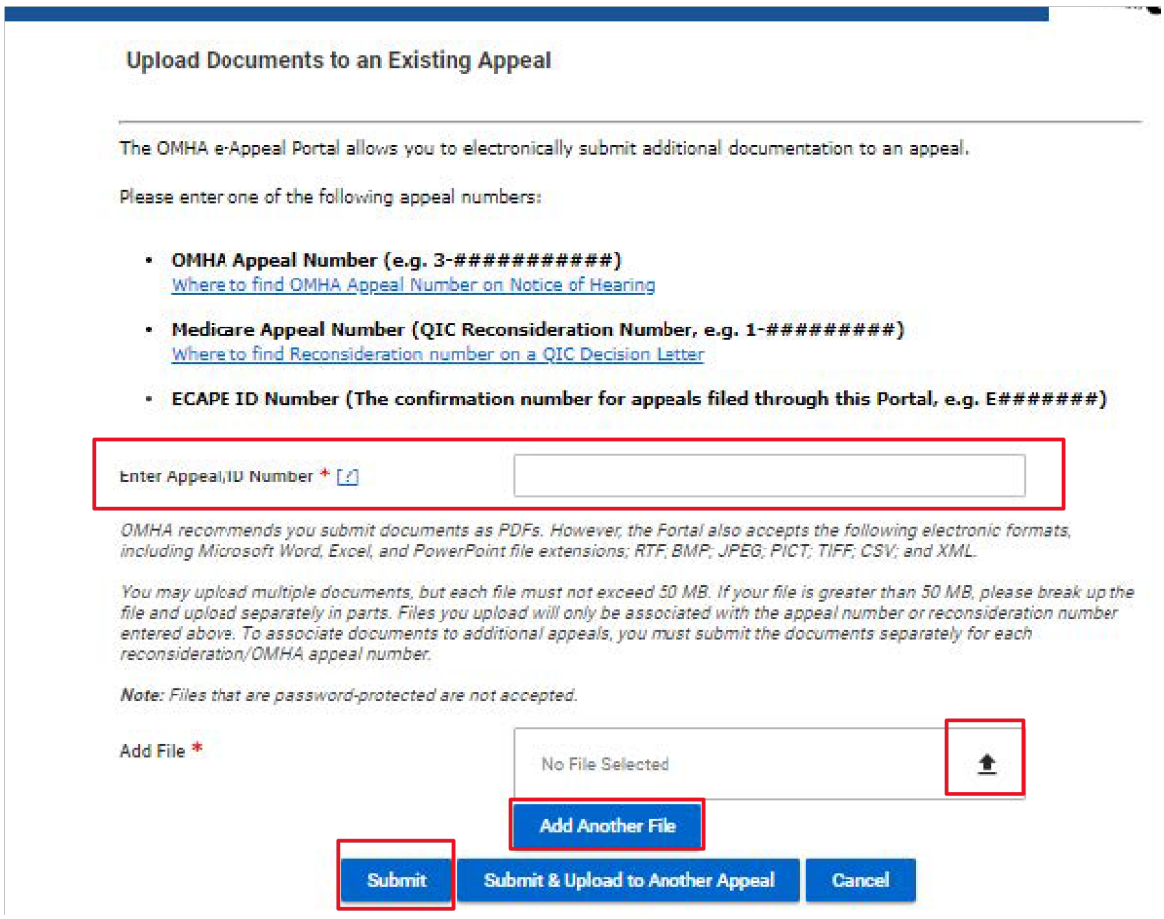
*To sign-in to an existing portal account, navigate to the website at <hhs-ecape-portal.entellitrak.com>. Then select the green button labeled "Sign in with ID.me." You will be redirected to ID.me and prompted to sign in with multi-factor authentication to your ID.me account. Once you have signed into ID.me, you will be transferred to your portal account's home page.*

## *Exhibit 49.2 – How to Upload Documents via the OMHA e-Appeal Portal*
***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

*To upload documents to an existing Level 3 appeal, sign-in to the portal. From the main page, select the "Upload Additional Documents to an Appeal tab" on the left side of the page.*



*Enter the OMHA appeal number and then select the file(s) you wish to upload to the appeal by clicking the "Add Another File" button.*




*Once the OMHA appeal number is entered and the desired files are added, click "Submit."*

*A confirmation pop-up question will appear, asking "Are you sure you would like to submit the Attachment?" Click "OK."*

*After you select "OK," a screen will appear to confirm the files were uploaded. The appeal number and the file name(s) uploaded will be listed. You will also receive an e-mail confirmation.*

***Note:*** *Use caution when entering the appeal number to avoid adding files to the wrong appeal. Avoid using any spaces before or after the appeal number. The Administrative Law Judge and team assigned to the appeal will receive an alert that a document was uploaded to the appeal. You may upload multiple documents, but each file is restricted to 50MB. If the file is larger than 50MB, it will need to be broken down into smaller files and then uploaded. The following file types can be uploaded: PDF, RTF, Word, Excel, PowerPoint, BMP, JPEG, PICT, TIFF, CSV, and XML.*

## *Exhibit 50 – UPIC and I-MEDIC Fax Cover Sheet*

***(Rev. 13595; Issued: 01-26-26; Effective: 02-26-26; Implementation: 02-26-26)***

Fax Cover Sheet

TO: _____

FAX NUMBER: _____

FROM: _____

UPIC JURISDICTION: _____

PHONE NUMBER: _____

DATE: _____

NUMBER OF PAGES (INCLUDING COVER): _____

CASE NUMBER: _____

## CONFIDENTIALITY NOTICE

This fax and any documents accompanying it may contain confidential, proprietary, or legally privileged information intended solely for the use of the individual or entity to whom it is addressed. If you have received this fax in error, please notify the sender immediately and destroy all copies. Any unauthorized review, use, disclosure, distribution, or duplication of this communication is strictly prohibited.

## VALIDATION OF UPIC COMMUNICATIONS

To confirm the legitimacy of this communication and validate UPIC contact information, please refer to the online contractor directory to verify the address and phone number. When contacting CMS or the UPIC regarding this matter, please reference your assigned case number listed above.

EXAMPLE