CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13879	**Date: July 23, 2026**
	Change Request 14549

SUBJECT: Updates to Chapters 4 and Exhibit 16 in Publication (Pub.) 100-08, Including Updates to the Provider Identity Theft Investigations, and Victimized Provider Waiver of Liability Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise various sections within chapter 4 and Exhibit 16 in Pub. 100-08. The revisions include updates to the "Provider Identity Theft Investigations, Victimized Provider Waiver of Liability Process, and Identifying and Reporting Compromised Medicare Beneficiary Identifiers" process and the Model Payment Suspension Letters exhibit.

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: August 24, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 24, 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	4/Table of Contents
R	4/4.2/4.2.2/4.2.2.8/4.2.2.8.1/4.2.2.8.1.4/Contractor Coordination and Suppression and Exclusion Upload Requirements Related to the RAC Data Warehouse
R	4/4.3/4.3.2/4.3.2.3/MAC Complaint Screening
R	4/4.5/Screening Leads
R	4/4.7/4.7.1/4.7.1.2/Case Coordination with UPICs
R	4/4.7/4.7.2/Provider Identity Theft Investigations, Victimized Provider Waiver of Liability Process, and Identifying and Reporting Compromised Medicare Beneficiary Identifiers
N	4/4.7/4.7.2/4.7.2.1/Provider Identity Theft Investigations and Victimized Provider Waiver of Liability Process
N	4/4.7/4.7.2/4.7.2.2/Identifying and Reporting Compromised Medicare Beneficiary Identifiers (MBIs)
R	4/4.9/4.9.1/Immediate Advisements to the OIG/OI
R	Exhibits/Exhibit 16/ Model Payment Suspension Letters

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The MAC 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: 13879	Date: July 23, 2026	Change Request: 14549

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update sections in chapter 4 and Exhibit 16 in Pub. 100-08. Specifically, guidance in chapter 4 is being updated to instruct contractors of the updated process associated with Provider Identity Theft Investigations, Victimized Provider Waiver of Liability Process, and Identifying and Reporting Compromised Medicare Beneficiary Identifiers. Additionally, updates have been applied to the Model Payment Suspension Letters exhibit.

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	
14549.1	The contractor shall forward the Immediate Advisement (IA) to Law Enforcement and continue to screen the lead, if deemed appropriate except for leads initiated by an Office									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of the Inspector General (OIG) Hotline referral that has already been reviewed by OIG/Office of Investigations (OI), unless new allegations, new information, or program vulnerabilities are identified if criteria for an IA are met during evaluation of the lead.									
14549.2	The contractor shall be advised that the Center for Program Integrity identified Group Determinations of Compromised Medicare Beneficiary Identifiers (MBIs) as a type of investigation that shall be discussed during the case coordination meetings.									UPICs
14549.3	The contractor shall be advised of the Provider Identity Theft Investigations and Victimized Provider Waiver of Liability Process as outlined in Chapter 4, section 4.7.2.1 of Pub. 100-08.									UPICs
14549.4	The contractor shall be advised of the Identifying and Reporting									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Compromised MBIs as outlined in Chapter 4, section 4.7.2.2 of Pub. 100-08.									
14549.5	The contractor shall be advised that they are not required to submit an IA for leads or investigations initiated from an OIG Hotline referral that has already been reviewed by OIG/OI, unless new allegations, new information, or program vulnerabilities are identified that warrant re-notification to OIG/OI.									UPICs
14549.6	The contractor shall refer IAs to the OIG/OI only when the applicable criteria are met, unless prior approval is given by the business function lead, with the exception of OIG hotline referrals, unless new information is identified.									UPICs
14549.7	The contractor shall be advised of the updated Model Payment Suspension Letters as referenced in Exhibit 16.									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 MAC 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

Table of Contents
(Rev. 13879; Issued: 07-23-26)

Transmittals for Chapter 4

4.2.2.8.1.4 – Contractor Coordination and Suppression and Exclusion Upload Requirements Related to the RAC Data Warehouse

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

This section applies to all medical review contractors (UPIC, RAC, MAC, SMRC) uploading suppression and exclusions into the RACDW unless otherwise noted.

The CMS utilizes the RAC Data Warehouse (RACDW) to track review contractor activity. The RACDW allows contractors that perform medical reviews to prevent duplicative claim reviews by using the Suppressions and Exclusions process.

For assistance with file errors, contact the system administrators at helpdesk.RACDW@koniag-gs.com. Current suppression/exclusion file layouts are available by download from the RACDW itself.

Suppressions:

Suppressions are used by Non-RAC entities to identify a set of claims as temporarily off-limits for selection by other review entities. The set of claims are identified by using the current suppression file layout, which utilizes parameters to narrow the universe of suppressed claims.

Suppression Requirements:

Suppressions shall be entered using the most current suppression file layout found in the RACDW. All required fields shall be submitted upon initial upload. The Suppression file layout does not allow the suppression of claims with a paid date older than 3 years. Individual NPIs or legacy numbers shall be entered for each suppression. If a provider has multiple NPIs or legacy numbers, the RACDW will only suppress uploaded NPIs or legacy numbers. Any error codes generated from the system shall be corrected by the uploading entity before successful upload can be completed. Unless other parameters have been included on the initial upload, all suppressions will automatically expire within 12 months of the date they were entered into the RACDW. If a suppression is required for longer than 12 months, the contractor shall re-new the suppression prior to the expiration date. The individual user that uploaded a suppression file shall be responsible for releasing any suppressions in that file that are no longer valid within 2 business days. Data entered in the situational fields in the suppression file layout shall require an additional narrative in the comments field for final approval. The contractor shall be responsible for correcting and re-uploading any disapproved suppressions within 2 business days of the disapproval.

Exclusions:

Exclusions are claims that have been previously reviewed by a medical review entity (or that are part of an extrapolated settlement universe). They are identified by specific claim number uploaded into the RACDW utilizing the current exclusion file layout and are permanently flagged as unavailable for additional review by a review contractor.

Exclusion Requirements:

Exclusions shall be entered using the most current version of the exclusion file layout found in the RACDW. All required fields shall be submitted upon initial upload. Any error codes generated from the system shall be corrected before successful upload can be completed.

UPIC-Specific Requirements for Suppressions and Exclusions:

The UPIC shall enter suppressions in the RACDW as soon as the investigation begins, no later than 2 business days after the investigation is opened. UPICs can renew any active suppressions that are within 30 days of their expiration date. To do so, the UPIC shall provide a new date, add 'Renewal' in the justification space, and resubmit the entry for approval in the RACDW. The UPIC shall release suppressions within 2 business days of the underlying investigations/cases being closed.

Statistically Valid Random Sampling (SVRS):

In the event that the UPIC is unable to determine at the time of review whether any overpayments that are identified will be extrapolated to the parent claim universe, the UPIC shall enter a suppression utilizing the current file layout. If the UPIC does ultimately assess an extrapolated overpayment, the UPIC shall release the suppression and exclude the entire universe. If the overpayment is computed based only on the sampled claims (i.e., the overpayment is not projected to the entire universe), the UPIC shall release the suppression and exclude only the sample claims that were actually reviewed.

If a provider is under review by another contractor (RAC, MAC, SMRC), the UPIC shall contact that contractor to determine which entity should continue to review that provider and how to proceed with the current medical review, such as closing it out or completing the medical review and then referring it to the UPIC.

4.3.2.3 – MAC Complaint Screening

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

A. MAC Screening of CCO Referrals

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

Prior to proceeding with the adjustment of a claim as the result of a second-level screening, the MAC shall check the Recovery Audit Contractor (RAC) Data Warehouse (RACDW) for suppressions and/or exclusions. If a suppression and/or exclusion is present, the MAC shall not adjust the claim and the complaint or inquiry shall be closed. However, if the MAC determines that the complaint or inquiry indicates potential fraud, and a suppression and/or exclusion is not present, the MAC shall make a referral to the UPIC, using the referral guidelines established in 4.3.2.4 – Referrals to the UPIC.

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

- Beneficiary name;
- Provider/supplier name;
- Beneficiary HICN;

- Nature of the inquiry;

- Date received from the initial screening staff (i.e. date the initial screening staff receives the lead from the CCO);

- If applicable, date RACDW was checked to confirm the absence of a suppression and/or exclusion.

- Date referral was sent to the UPIC;

- Destination of the referral (i.e., name of the UPIC);

- Documentation that a complaint or inquiry received from the initial screening staff was not forwarded to the UPIC and an explanation why (e.g., inquiry was misrouted or inquiry was a billing error that should not have been referred to the screening staff); and

- Date complaint or inquiry was closed.

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

When a complaint meeting the criteria of an IA or potential fraud, waste or abuse is received, the MAC shall not perform any screening but shall prepare a referral package within ten (10) business days of when the inquiry or IA was received, except for instances of potential patient harm, of which a referral package shall be prepared by the end of the next business day after the inquiry or IA was received, and send it to the UPIC during the same timeframe using the guidelines established in section 4.3.2.4 – Referrals to the UPIC. Once the complaint has been referred to the UPIC, the MAC shall close the complaint in its internal tracking system.

B. Screening of OIG Hotline Referrals

The MAC shall screen every OIG Hotline complaint received from CMS to determine if the complaint can be closed, resolved, other appropriate action taken by the MAC, or referred to either another contractor, a State Medicaid Agency, or Marketplace Integrity. If the MAC determines that a referral shall be made, the MAC shall adhere to the referral guidelines established below and in 4.3.2.4 – Referrals to the UPIC.

All OIG Hotline complaints sent to the MAC by CMS shall be reviewed, determinations shall be made, and final action shall be taken within 45 business days from the date the complaint is received, unless medical records have been requested and the MAC is pending

receipt of the records. The MAC shall use the date contained in the e-mail from CMS as the start of the 45 business day timeframe.

If, the MAC requests medical records and those records are not received within 45 business days, the MAC shall deny the claim(s) or keep the request open beyond the 45 business day timeframe to allow for receipt of the requested records, whichever is appropriate.

If fraud is suspected when medical records are not received or the MAC determines otherwise that the complaint or inquiry indicates potential fraud, waste, and abuse, the MAC shall forward it to the UPIC for further development within 45 business days of the date of receipt from CMS or within 30 business days of the date of receipt of medical records and/or other documentation, whichever is later. If a referral shall be made, the MAC shall adhere to the referral guidelines established below and in 4.3.2.4 – Referrals to the UPIC.

If the MAC determines that the complaint or inquiry is not a fraud and/or abuse issue, and if the MAC discovers that the complaint or inquiry has other issues (e.g., MR, enrollment, claims processing), it shall be referred to the appropriate department and then closed.

If the MAC receives a complaint from CMS that has been erroneously assigned to the MAC, the contractor shall transfer the erroneously assigned complaint to the appropriate MAC within 10 business days from the date it determined that the complaint was erroneously assigned.

MACs may receive complaints alleging fraud, waste or abuse in the Medicaid program. Upon receipt, the MAC shall refer the complaints to the appropriate Program Integrity Unit (PIU) within the State Medicaid Agency (SMA) noted in Exhibit 47.

The MAC shall identify and refer complaints alleging fraud, waste, or abuse in the Medicare Part C or Part D programs to the MEDIC. This includes complaints that do not have a credible allegation of fraud.

The MAC shall identify and refer complaints alleging fraud, waste, or abuse involving the Federal Marketplace and State-Based Exchanges, insurance agents/brokers marketing Marketplace plans, and Marketplace consumers to the following email address: marketplaceintegrity@cms.hhs.gov, with a copy to the MAC CORs. The MAC shall close the complaint in its internal tracking system. These referrals shall be done in accordance with the timeframes established above.

The MAC shall only be required to close a complaint from the OIG Hotline in its internal tracking system and will no longer refer complaints that do not allege fraud, waste, or abuse involving CMS programs to the OIG.

If the MAC receives duplicate complaints, the second duplicate complaint shall be closed and cross-referenced to the original complaint. Subsequent complaints will be thoroughly reviewed to ensure that any new information is added to the original complaint. This will ensure all items in question related to the complaint are addressed. When the complaint is closed, monetary actions (if involved) shall only be claimed on the primary complaint.

4.5 - Screening Leads

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

This section applies to UPICs.

Screening is the initial step in the review of a lead (described in section 4.2.2.1 of this chapter) to determine the need to perform further investigation based on the potential for fraud, waste, or abuse. Screening shall be completed within 45 calendar days after receipt of the lead.

The receipt date of the lead is generally determined by the date the UPIC receives a complaint. If the lead resulted from data analysis conducted by the UPIC, the receipt of the lead shall be the date the lead was referred from the UPIC data analysis department to its investigation or screening unit. For a new lead that is identified from an active or current UPIC investigation, the receipt of the lead shall be the date the new lead was identified by the UPIC investigator.

Note: If criteria for an IA are met during evaluation of the lead, the UPIC shall forward the IA to LE and continue to screen the lead, if deemed appropriate *except for leads initiated from an OIG Hotline referral that has already been reviewed by OIG/OI, unless new allegations, new information, or program vulnerabilities are identified.*

Activities that the UPIC may perform in relation to the screening process include, but are not limited to:

- Verification of provider's enrollment status;
- Coordination with the MAC on prior activities (i.e., prior medical reviews, education, appeals information, etc.);
- Data analysis;
- Policy / regulation analysis;
- Contact with the complainant, when the lead source is a complaint;
- Beneficiary interviews; and
- Site verification to validate the provider's/supplier's practice location. Note: While there is no requirement to check locked doors during a site verification, UPICs are authorized to check the doors. As such, the UPIC shall assess the environment and use sound judgement to determine when it is appropriate to check locked doors.

Any screening activities shall not involve contact with the subject provider/supplier or implementation of any administrative actions (i.e., post-payment reviews, prepayment reviews/edits, payment suspension, and revocation). However, if the lead is based solely on a potential assignment violation issue, the UPIC may contact the provider directly to resolve only the assignment violation issue. If the lead involves potential patient harm, the UPIC shall immediately notify CMS within two (2) business days.

As it relates to the UPIC's handling of potential assignment violations, if the UPIC is unable to make contact with the provider at least five (5) attempts, the UPIC shall refer the assignment violation issue to the appropriate CMS Regional Office for resolution.

After completing its screening, the UPIC shall close the lead if it does not appear to be related to fraud, waste, or abuse. Prior to closing the lead, the UPIC shall take any appropriate actions (i.e., referrals to the MAC, RA, state, or QIO). For example, if a lead does not appear to be related to potential fraud, waste, or abuse but the lead needs to be referred to the MAC, the date that the UPIC refers the information to the MAC is the last day of the screening.

At a minimum, the UPIC shall document the following information in its case file:

- The date the lead was received and closed;
- Lead source (e.g., beneficiary, MAC, provider/supplier);
- Record the name and telephone number of the individual (or organization), if applicable, that provided the information concerning the alleged fraud or abuse;
- Indicate the provider's/supplier's name, address, and ID number;
- Start and end date of the screening;
- Description of the actions/activities performed;
- Start and end date of each action/activity;
- A brief description of the action taken to close the lead (e.g., reviewed records and substantiated amounts billed). Ensure that sufficient information is provided to understand the reason for the closeout;
- The number of leads received to date regarding this provider/supplier, including the present lead. This information is useful in identifying providers/suppliers that are involved in an undue number of complaints; and
- Any documentation associated with the UPIC's activities (i.e., referrals to other entities).

Additionally, if the screening process exceeds 45 calendar days, the UPIC shall document the reasons, circumstances, dates, and actions associated with the delay in the UCM and its monthly reporting in CMS ARTS.

If the UPIC identifies specific concerns while screening a lead that warrants contact with a specific provider/supplier, the UPIC shall contact the BFL, with a copy to the COR, for further guidance (e.g., UPIC determines that provider/supplier contact is needed in order to determine if the case warrants further investigation).

4.7.1.2 - Case Coordination with UPICs

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

UPICs shall discuss their top investigations with CMS during regularly scheduled case coordination meetings.

The purpose of these meetings is to ensure that the contractor's top investigations are shared with all relevant stakeholders to ensure the appropriate parties handle a specific case as expeditiously as possible. In addition, CPI identified the following types of investigations that shall be discussed during the case coordination meetings:

- Immediate Advisements (IA);
- Extrapolated Overpayment Requests (not associated with a Payment Suspension);
- 100% Prepayment Review Requests;
- UPIC Payment Suspension Recommendations;
- Revocation Requests;

- Potential Referrals to Law Enforcement;
- *Group Determinations of Compromised MBIs.*

4.7.2 - *Provider* Identity Theft Investigations, Victimized Provider Waiver of Liability Process*, and Identifying and Reporting Compromised Medicare Beneficiary Identifiers*

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

This section applies to UPICs.

4.7.2.1 – Provider Identity Theft Investigations and Victimized Provider Waiver of Liability Process

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

For purposes of this chapter, a "compromised NPI" is a provider/supplier number that has been used by unauthorized entities or individuals to submit claims to, i.e., bill, the Medicare program.

The UPICs shall investigate the alleged theft of provider identities, and report validated compromised NPIs into the UCM Compromised Number Records module, in accordance with the applicable instruction and guidance documents (Of note, the instruction and guidance documents are located in the "Job Aids" and "Release Notes" section of the UCM Documentation Storage site. These documents are updated each time updates/enhancements occur.). An example of provider identity theft may include a provider's identity having been stolen and used to establish a new Medicare enrollment or a new billing number (reassignment) under an existing Medicare enrollment, or updating a current Medicare provider identification number with a different electronic funds transfer (EFT) payment account causing inappropriate Medicare payments to unknown person(s) and potential Medicare overpayment and eventually, U.S. Department of Treasury (UST) debt issued to the victimized provider.

The UPICs shall discuss the identity theft case with the BFL. If claims are still being submitted and Medicare payments are being made, the UPIC should pursue strategies to prevent likely overpayments from being disbursed, such as prepayment reviews, auto-denial edits, Do Not Forward (DNF) requests, or immediate payment suspensions. The purpose of these administrative actions is to stop the payments. The UPICs are not authorized to request the MAC to write-off any overpayments related to the ID theft. Prior to any enrollment actions, the UPIC should be aware of the suspected victim's reassignments and consider the effect of Medicare enrollment enforcement actions on the alleged ID theft victim's current employments.

If an actual financial harm exists as a result of the ID theft (i.e., existence of Medicare debt or overpayment determination), the UPIC will follow the Victimized Provider Project (VPP) procedures, which include the following:

- *At the point in which a UPIC begins to investigate provider ID theft complaints and incurred debt, it sends a letter acknowledging receipt of the complaint, informing the provider that CMS is investigating the complaint and reviewing materials submitted, and designating a VPP point of contact at the UPIC (IOM Pub. #100-08; Exhibit 8 – Letter 1);*
- *The next steps in this process include, but may not be limited to, the following:*
    - *Check if the case in question is in the UCM system. Vet the provider(s) with the DHHS - OIG or other appropriate LE agency to ensure that the*

contractor's investigative process will not interfere with prosecution;

- *A VPP case package must then be completed by the UPIC using the templates provided in the VPP information packet;*
- *Describe the case and how the provider's ID was stolen or compromised. List all overpayment(s) for which the provider is being held liable. Clearly indicate those paid amounts that are in DNF and/or on payment suspension status, and the amounts that were paid with an actual check or electronic transfer to the fraudulent bank account;*
- *Provide legitimate and compromised/stolen 855 forms with provider enrollment and reassignment of benefits information in order to verify legitimate PTAN(s)/NPI(s) and identify the fraudulent ones;*
- *Get signed provider victim attestation statement(s) about the ID theft from the provider(s)/supplier(s).*
- *Provide a police report from the alleged victim provider or any law enforcement documentation;*
- *Provide financial background information, such as*
  - *IRS Form 1099 or W-2; and*
  - *Overpayment requests/debt collection notices.*
- *Include any trial, DOJ and OIG documents like OIG proffers, indictment, judgments and sentencing documents; and*
- *Based on the information gathered and the investigation conducted, the UPICs will state their recommendation as part of the package and provide the reason for the recommendation. Two recommendations are possible:*
  - *Hold provider harmless and rescind provider of federal ID theft case-related debt; OR*
  - *Hold provider liable for debt.*

The UPIC will submit the complete VPP packet to the CMS CPI VPP team. In ID theft cases in which the victimized providers are located in multiple states and served by different UPICs, the UPIC jurisdiction in which the perpetrator's trial was located will be the lead UPIC that will coordinate with the other UPICs and submit a completed VPP packet to the CMS CPI VPP team.

The VPP team will validate and remediate all facts and information submitted by the UPIC. Part of the VPP team review may involve consultation with the HHS Office of General Counsel. This consultation may include, but may not be limited to, consideration of supporting documentation or lack thereof to support a decision that the provider is an actual victim of ID theft as well as compliance with federal statutes and regulations related to ID theft policies, debt collection and recall of overpayments.

The VPP team will make a final determination if the alleged ID theft victim is a true victim and approve a rescindment of Medicare overpayments reported in the name of the confirmed ID theft victim.

When calculating the actual overpayments related to the fraudulent claims under each provider victim, there may be situations in which discrepancies exist between LE and contractor loss calculation data. In these situations, the final figures used in making overpayment determinations should come from MAC data on amounts paid out in the name of the victimized providers using the cleared payments transmitted to the fraudulent bank accounts established in the DOJ case.

Once a final decision is made by the VPP team, the UPIC or Lead UPIC, as appropriate, will be informed.

If the provider victim is determined to be a true victim of ID theft, the UPIC will send out a letter using the template in the IOM Pub. #100-08 Exhibits chapter informing the provider of the favorable decision and that the assessed overpayment against the victim will be rescinded ((IOM Pub. #100-08; Exhibit 8 – Letter 2). This decision shall then flow through

the UPIC to the MAC for a recall of the associated debt. (NOTE: The MAC's instructions for processing providers' debts that have been confirmed as identity theft are found in the Medicare Financial Management Manual Chapter 4, Section 110 – Confirmed Identity Theft). The MAC shall follow the process for making adjustments to the claims system and recall the debt registered under the victimized provider from the US Department of Treasury.

If the decision is not positive (i.e. ID theft is not confirmed), the UPIC shall correspond directly with the provider to inform him/her that CMS did not have sufficient information to confirm that identity theft has occurred. The UPIC shall send Letter 3 from the IOM Pub. #100-08 Exhibits chapter to the provider with a copy to the MAC.

4.7.2.2 – Identifying and Reporting Compromised Medicare Beneficiary Identifiers (MBIs)

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

For purposes of this chapter, a "compromised MBI" is an MBI that a UPIC determines has likely been stolen by unauthorized entities or individuals.

UPICs may determine an MBI is compromised in one of two ways:

- *Individual determination*
- *Group determination*

Compromised MBIs – Individual Determination

UPICs shall make an individual determination of a compromised MBI when they determine that the beneficiary does not have a verifiable relationship with a provider that billed, referred, or ordered an item or service on their behalf and a group determination is not appropriate.

Compromised MBIs – Group Determination

As UCM functionality allows, UPICs may request a group determination of compromised MBIs when they establish a pattern of beneficiaries not having a verifiable relationship with a provider that billed, ordered, or referred claims for them. In these cases, groups of MBIs associated with these providers may be deemed compromised based on evidence gathered by the UPIC.

To request a group determination of compromised MBIs, UPICs shall document their rationale for the determination and take appropriate vetting/deconfliction actions in UCM.

4.9.1 - Immediate Advisements to the OIG/OI

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

The UPIC shall notify the OIG/OI of an immediate advisement as quickly as possible, but not more than four (4) business days after identifying a lead or investigation that meets the following criteria. *UPICs are not required to submit an IA for leads or investigations initiated from an OIG Hotline referral that has already been reviewed by OIG/OI, unless new allegations, new information, or program vulnerabilities are identified that warrant re-notification to OIG/OI.* The UPIC shall maintain internal documentation on these advisements when it receives allegations with one or more of the following characteristics:

- Indications of UPIC or MAC employee fraud

- Allegations of kickbacks or bribes, discounts, rebates, and other reductions in price
- Allegations of a crime committed by a federal or state employee in the execution of their duties
- Indications of fraud by a third-party insurer that is primary to Medicare
- Confirmation of forged documentation during the course of an investigation, include, but is not limited to:
    - identification of forged documents through medical review; and/or
    - attestation from provider confirming forged documentation.
- Allegations and subsequent verification of services not rendered as a result of any of the following:
    - *M*edical review findings;
    - *I*nterviews or attestations from a minimum of three (3) beneficiaries indicating that they did not receive services; and/or
    - *A*ttestations from referring/ordering providers indicating they did not refer/order a service (e.g., confirmation of no relationship with the beneficiary prior to service, or confirmed impossible day billings).
- Confirmed complaints from current or former employees that indicate the provider in question inappropriately billed Medicare for all or a majority of its services. Confirmation would be required though one of the following:
    - *M*inimum of three (3) beneficiary interviews confirming the inappropriate billing;
    - *P*rovider attestation(s) confirming the inappropriate billing; or o medical review findings.
- Confirmation of beneficiary recruitment into potentially fraudulent schemes and/or provider participation (e.g., telemarketing or solicitation schemes);
- Substantiated identity theft of a provider's Medicare number, a beneficiary's Medicare number, or selling or sharing of beneficiary lists;
- Confirmed indication of patient harm (e.g., through medical review findings or confirmation of issues identified during an onsite visit or interviews with providers or beneficiaries).
- Indication of provider/supplier fraud related to national emergency, pandemic, etc.
    - Should an IA of this nature be identified, the UPIC shall notify their BFL to determine if the IA should be forwarded to a specific OIG/OI point-of- contact.

IAs should be referred to the OIG/OI only when the above criteria are met, unless prior approval is given by the BFL, *with the exception of OIG hotline referrals, unless new information is identified.*

Should local LE have specific parameters or thresholds in place that do not allow them to accept certain IAs, the UPIC shall notify its BFL, with a copy to the COR, and request exemption from the applicable IA criteria in that particular jurisdiction.

When IA criteria are met, the UPICs shall perform an initial assessment to identify and document dollars currently pending payment to the provider. Should high dollar amounts be identified with either scenario, the UPIC shall notify CMS immediately, but not to exceed two (2) business days from date of identification.

Once the criteria for an IA are met, the UPIC shall notify the OIG/OI via phone or email to determine if a formal IA referral should be sent to the OIG/OI. If the IA is related to a provider/supplier that spans multiple jurisdictions, the UPIC shall notify any impacted UPIC and/or I-MEDIC Program Directors of the potential IA, allegation, and IA criteria.

The UPIC shall document this communication in UCM. The UPIC shall also send notification to its appropriate BFL, with a copy to the COR, of the potential IA. If the UPIC does not receive a response from the OIG/OI within two (2) business days (5 business days for the I- MEDIC), it shall notify its appropriate BFL, with a copy to the COR, and await further instructions. If the OIG/OI confirms that a formal IA should be sent, the UPIC shall provide all available documentation, including billed/paid amounts for the YTD and the previous year, to the OIG/OI within four (4) business days of receiving the response from OIG/OI. Upon submission of the IA to the OIG/OI, the UPIC shall request written and/or email confirmation from the OIG/OI acknowledging receipt of the IA. Simultaneously, the UPIC shall notify the CMS identified Strike Force points of contacts, if the notification includes providers/suppliers located within a Strike Force jurisdiction. Additionally, the UPIC shall notify and send a copy of the IA to its COR/BFL and the case coordination team, at CPIMCCNotifications@cms.hhs.gov, the same day the advisement is made to OIG/OI. In this notification to CMS, the UPIC shall advise if it has any other potential administrative actions it may want to pursue related to the provider(s)/supplier(s). The provider(s)/supplier(s) identified in an accepted IA shall be added to the UPIC's next scheduled case coordination meeting.

If the OIG/OI determines that a formal IA is not needed, the UPIC shall advise its appropriate BFL, with a copy to the COR, and immediately continue its investigation. In instances where an IA is related to a Plan employee whistleblower, the I-MEDIC does not have to notify the case coordination team of the IA nor does the IA have to be discussed at a case coordination meeting. Rather, the I-MEDIC shall close the complaint upon acceptance and/or declination of the IA due to these complaint types being outside of the I-MEDIC's SOW.

If the IA is related to a provider/supplier that spans multiple jurisdictions, the UPIC shall send a notification to the other UPIC and/or I-MEDIC Program Directors on the same date the formal IA is sent to OIG/OI. The UPIC shall copy its COR/BFL on such communication. Upon receipt of the notification from the primary UPIC, the other UPICs and/or I-MEDIC shall provide confirmation to the primary UPIC and its COR/BFL that the notification has been received, and it is ceasing activity as instructed below. Upon receipt of acceptance or declination of the IA from the OIG/OI, the primary UPIC shall notify the other UPIC and/or I-MEDIC Program Directors of the outcome.

Upon identification and submission of an IA to the OIG/OI, unless otherwise directed, all impacted UPICs and/or I-MEDIC shall cease all investigative and administrative activities, with the exception of screening activities, data analysis, etc., until the OIG/OI responds with its acceptance or declination of the IA. If the UPIC does not receive an immediate response from the OIG/OI, the UPIC shall contact OIG/OI after two (2) business days from the date of the IA notification and document the communication in the UCM system. If the UPIC does not receive a response from the OIG/OI within five (5) business days from the date of the IA notification, the UPIC shall contact its appropriate BFL, with a copy to the COR, for further guidance.

If the OIG/OI declines or accepts the IA, the UPIC shall document the decision in UCM and follow the processes described in Chapter 4, § 4.5, 4.6, and 4.7 of the PIM, unless otherwise directed by CMS.

Additionally, until the necessary updates are made in the UCM, if the UPIC submits an

IA based on the updated criteria, it shall select all six (6) IA options on the “External Stakeholders” page of the UCM, and notate the justification of the IA in the Record Summary section of the UCM.

During the case coordination meeting, the UPIC may receive additional guidance from CMS related to subsequent actions related to the IA. If the UPIC has questions following the case coordination meeting, the UPIC shall coordinate with its appropriate BFL, with a copy to the COR.

Medicare Program Integrity Manual
Exhibits

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(Rev. 13879; Issued: 07-23-26)

Exhibit 16 - Model Payment Suspension Letters

(Rev. 13879; Issued: 07-23-26; Effective: 08-24-26; Implementation: 08-24-26)

A. Payment Suspension Initial Notice *of Suspension* Based on Fraud

[UPIC Information Header]

***Confidentiality Notice**: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original message.*

***To**:*
[Provider Name]
Attn: [Point of Contact]
[Provider Street Address]
[Provider City, State Zip code]

***From**:*
[UPIC Name - UPIC Region]
[Street Address]
[City, State, Zip Code]

The remainder of this page is intentionally blank.

Delivery Method: [INSERT]

[Date]

***To**:*
[Provider Name]
Attn: [Point of Contact]
[Provider Street Address]
[Provider City, State Zip Code]

***Reference Number**: [INSERT HERE]*
***Provider Name:** [INSERT HERE]*
***Provider NPI:** [INSERT HERE]*
***Provider PTAN:** [INSERT HERE]*

***Subject**: Notice of Suspension of Medicare Payments*

Dear [Point of Contact]:

[Use the following template to construct a Notice of Suspension (NOS) for a credible allegation of fraud payment suspension. All NOS shall retain the formatting established in this template. The body of the NOS shall be formatted to "justified" text alignment.]

*The purpose of this letter is to notify you that the Centers for Medicare & Medicaid Services (CMS), after consulting with the Department of Health and Human Services Office of Inspector General, has decided to **[SELECT FULL OR PARTIAL SUSPENSION LANGUAGE:** fully suspend Medicare payments to Click here to enter Provider/Supplier Name, (Click here to enter abbreviated Provider/Supplier Name), pursuant to 42 C.F.R. § 405.371(a)(2) and 42 C.F.R. § 405.372(a)(4). **OR** partially suspend Medicare payments to Click here to enter abbreviated Provider/Supplier Name at a rate of **[X]**%, pursuant to 42 C.F.R. § 405.371(a)(2) and 42 C.F.R. § 405.372(a)(4).] [**SELECT NO PRIOR NOTICE OR PRIOR NOTICE LANGUAGE:** The suspension of Medicare payments took effect on **[Month Day, Year]**. Prior notice of this suspension was not provided because giving prior notice would place additional Medicare funds at risk and hinder CMS' ability to recover any determined overpayment. See 42 C.F.R. §§ 405.372(a)(3). **OR** The suspension of Medicare payments will take effect on **[Month Day, Year].]***

The decision to suspend Medicare payments is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as allegations from any source including, but not limited to, fraud hotline complaints verified by further evidence, claims data mining, and patterns identified through audits, civil false claims cases, and law enforcement investigations. 42 C.F.R. § 405.370(a). Allegations are considered to be credible when they have indicia of reliability. Id. This suspension will last until resolution of the ongoing investigation, as defined under 42 C.F.R. § 405.370(a).1

Allegation(s)

The suspension of Medicare payments to Click here to enter abbreviated Provider/Supplier Name is based on, but not limited to, information that Click here to enter abbreviated Provider/Supplier Name misrepresented services billed to the Medicare program. Specifically, the suspension of Medicare payments is based on the following allegation(s) as

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1 The Office of Inspector General, and the Department of Justice as appropriate, are consulted in all cases of suspected fraud as required by 42 C.F.R. § 405.371(a)(2).

well as the example claims below, which we have included to provide evidence of the findings.

***Allegation #** (Rename this "Allegation 1" if there is more than one allegation.): [Refer to Attachment A – Notice of Suspension Language Guide, Step 1 to **identify and insert the approved language reflective of the primary allegation. Insert the appropriate approved language HERE.**]*

1. *[See Attachment A, Step 2 to identify and insert the approved language reflective of the subparagraph detail associated with the primary allegation.]*

   [Insert claim examples relevant to the subparagraph detail. Add rows if necessary. If one claim box is used for multiple subparagraph details of an allegation, the below statement should be inserted after the last subparagraph detail, before the claim box: "The below claim control numbers (CCNs) are examples of the allegations listed above."]

Claim Control Number (CCN)	Date(s) of Service
	MM/DD/YYYY

2. *[If necessary, add additional subparagraph detail associated with the primary allegation. Use Attachment A, Step 2 to identify the approved language reflective of the necessary subparagraph detail.]*

   [If additional subparagraph detail is added above, insert claim examples relevant to the subparagraph detail. Add rows if necessary.]

CCN	Date(s) of Service
	MM/DD/YYYY

***Allegation 2:** (If another primary allegation needs to be added, repeat all steps listed above. Continue repeating these steps to add allegations (e.g., Allegation 2, Allegation 3, etc.) as necessary. If a secondary allegation is identified, use Attachment A, Step 3 to insert the applicable approved language. If no additional allegations are needed after the primary allegation, delete this section and move on.)*

Investigation Process

The investigation into this matter is ongoing, and the claims listed above represent only a sample of the problematic claims identified. The summary of allegations and the claims listed above provide notice of the reasons for the payment suspension. As the investigation continues, you may be asked to provide information. Click here to enter abbreviated Provider/Supplier Name must be responsive to requests for documentation and information to prevent claim denials and other administrative actions.

Right to Rebut

Pursuant to 42 C.F.R. § 405.372(b), you have the right to submit a written rebuttal statement, including evidence supporting your rebuttal statement. Evidence provided in your rebuttal should be specific to each allegation on which the suspension was based, including but not

limited to the claim examples provided.2 Merely providing general assertions or denials typically will be insufficient to overcome the allegation(s). Your rebuttal statement should be received within 15 business days of receipt of this notice. Requests for additional time to submit a rebuttal statement will be considered on a case-by-case basis.

If you choose to submit a rebuttal statement, your rebuttal statement should be sent to:

[UPIC Region] Unified Program Integrity Contractor
[Street Address]
[City, State, Zip Code]

Notice of Rebuttal Response

The suspension of Medicare payments will continue while your rebuttal statement is being reviewed. See 42 C.F.R. § 405.375(a). You will be notified in writing of the response. The response notice will include the findings regarding each allegation or condition upon which the suspension is based and an explanation as to why the suspension of Medicare payments will continue or be terminated. See 42 C.F.R. § 405.375(b)(2).

The response following your rebuttal is not an initial determination and is not appealable. See 42 C.F.R. § 405.375(c).

Disposition of Suspended Funds

The suspension of Medicare payments is based upon credible allegations of fraud, and, as such, a determination will be made regarding an overpayment. A final decision regarding any overpayment may be delayed until the resolution of the investigation. See 42 C.F.R. § 405.372(c)(2). An investigation is resolved when "legal action is terminated by settlement, judgment, or dismissal, or when the case is closed or dropped because of insufficient evidence to support the allegations of fraud." 42 C.F.R. § 405.370. If an overpayment is determined, you will receive a separate written notice from the Medicare Administrative Contractor that processes the Medicare claims you submit, Click here to enter Name of MAC, advising you of the reasons for the overpayment determination. 42 C.F.R. § 405.921(b).

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 overpayment, 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 balance be paid to another entity, the excess will be released to Click here to enter abbreviated Provider/Supplier Name.

Processing of Claims During the Suspension

Claims will continue to be processed during the suspension period. 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.

[INSERT the following paragraph IF the provider is going to be placed on prepayment review as part of the payment suspension.]
*Also, CMS **[SELECT ONE: is continuing OR has implemented]** the process of reviewing your Medicare claims and supporting documentation prior to payment. The purpose of the*

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2 References in this letter to "rebuttal statement" include references to "evidence" submitted unless otherwise indicated.

prepayment process is to ensure that all payments made by the Medicare program are appropriate and consistent with Medicare rules, regulations and policy. Notification is hereby given that you are expected to comply with the prepayment process for claims for all dates and services.

Statutory Obligation to Return Overpayments

As a Medicare provider, you are responsible for monitoring compliance with Medicare requirements. Upon discovering that payments were received in error, you are statutorily required to return the overpayments within 60 days. See § 1128J(d)(2) of the Social Security Act and 42 C.F.R. § 401.305.

If you have any questions regarding the status of the suspension, please direct your inquiry to Click here to enter UPIC email address. Any request to remove the suspension must be submitted through the written rebuttal process described above.

Sincerely,

[UPIC Company Name] – A CMS Unified Program Integrity Contractor

cc: Centers for Medicare & Medicaid Services

B. 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).

The 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

C. 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

D. 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

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

Date

To:
Attn: [Point of Contact]
[Provider Name]
[Provider Street Address]
[Provider City, State Zip code]

Reference Number:
Provider Name:
Provider Medicare ID Number (s):
Provider NPI:

Subject: Payment Suspension Extension Notice

Dear [Point of Contact]:

As previously advised in the Notice of Payment Suspension dated [date], the Centers for Medicare & Medicaid Services (CMS) suspended payments to [Provider/Supplier Name ("Shortened Name")] based upon credible allegations of fraud under 42 C.F.R. § 405.371(a)(2). CMS regulations authorize payment suspensions based upon credible allegations of fraud to continue until resolution of the investigation including termination of any civil or criminal proceedings. See 42 C.F.R. § 405.370 (defining "resolution of an investigation") and § 405.372(d)(3)(ii).

Consistent with 42 C.F.R. § 405.371(b), CMS has (1) evaluated whether there is good cause to not continue the payment suspension and (2) received a certification from the Office of Inspector General (OIG) or other law enforcement agency that the matter continues to be under investigation warranting continuation of the suspension. We are writing to inform you that the payment suspension remains in place.

The maintenance of your payment suspension applies to claims in process. 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 [UPIC Email address].

Sincerely,

[UPIC PoC]

Program Integrity Manager
[Region] Unified Program Integrity Contractor
[Name of UPIC]
[Telephone]

F. 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 overpayments 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

G. 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 overpayments 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