Article 11 Section 04 Investigation & Overpayment Procedures

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11.04.01 Investigation Procedures

11.04.01A Before Certification

When conducting an investigation **before** CMS benefits are approved, the Fraud worker will:

Step	Action
1	Review the application.
2	Contact individuals who can verify the facts given by the applicant/beneficiary.
3	Review records, e.g., medical records, which can verify facts given.
4	Access available computer information systems.
5	After verifying the facts, recommend action to either certify or deny.
6	Note in case comments the recommendation.
7	Notify the case worker via email.

If the worker disagrees with the recommendation of the Fraud worker, the worker will:

Step	Action
1	Discuss the difference of opinion with his/her supervisor and the Fraud worker.
2	If an agreement is not reached, the case will be referred to the HCA Manager who will resolve the difference of opinion through discussion with all parties involved.

11.04.01B After Certification

When conducting an investigation **after** CMS benefits have been are approved, the Fraud worker will:

Step	Action
1	Review the case record.
2	<table><tr><th>**If a determination can be made at the initial review that…**</th><th>**Then the Fraud worker will…**</th></tr><tr><td>there is no overpayment,</td><td>document the results of the investigation in the CMS IT System.</td></tr><tr><td>an overpayment has occurred or additional information is needed to make a determination,</td><td>complete and send form CMS-30 to the beneficiary. The CMS-30 informs the beneficiary of the: • information received; • request for additional information needed; • expiration date of the current certification period; and • continued use of the CMS program might result in an increase in the overpayment amount.</td></tr></table>
3	If the beneficiary does not respond or responds and the information provided results in a determination of ineligibility, CMS benefits are to be discontinued (Refer to 08.02).

11.04.02 Overpayment Procedures

11.04.02A Overpayment

When an overpayment has occurred, the Fraud worker will:

Step	Action
1	Send a request for claim payment (CMS-53) from the ASO.
2	Compute the amount of the overpayment and sends the overpayment notice (CMS-31) to the beneficiary.
3	Recompute the overpayment amount upon the expiration of the certification period after allowing time for providers to submit claims for payment.

4	Document the case with the results of the investigation. If the fraud was reported via a MC 609 referral form, the Fraud worker completes the “Action Taken” section of the form and files an electronic copy in the case record.
5	Forward a copy of the overpayment notice to the CMS Fraud Program Specialist.