CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 135

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JANUARY 6, 2006

CHANGE REQUEST 4228

SUBJECT: Changes to the GTL Titles

I. SUMMARY OF CHANGES: In chapter 3 of the PIM, GTL was changed to Primary GTL and Co-GTL was changed to Associate GTL.

NEW/REVISED MATERIAL
EFFECTIVE DATE: February 6, 2006
IMPLEMENTATION DATE: February 6, 2006

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:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/3.5.1.1/Prepayment Edits
R	3/3.6.2/Location of Postpayment Reviews
R	3/3.6.5/Notification of Provider(s)or Supplier(s) and Beneficiaries of the Postpayment Review Results
R	3/3.6.8/Evaluation of the Effectiveness of Postpayment Review and Next Steps
R	3/3.6.9/Postpayment Files
R	3/3.8/Overpayment Procedures
R	3/3.9.1.1/Fraud or Willful Misrepresentation Exists - Fraud Suspensions
R	3/3.9.1.2/Overpayment Exists But the Amount is Not Determined - General Suspensions

R	3/3.9.1.3/Payments to be Made May Not be Correct - General Suspensions
R	3/3.9.1.4/Provider Fails to Furnish Records and Other Requested Information - General Suspensions
R	3/3.9.2.1/CMS Approval
R	3/3.9.2.2.1/Prior Notice Versus Concurrent Notice
R	3/3.9.2.2.2/Content of Notice
R	3/3.9.2.2.3/Shortening the Notice Period for Cause
R	3/3.9.2.2.4/Mailing the Notice to the Provider
R	3/3.9.2.2.5/Opportunity for Rebuttal
R	3/3.9.2.3.1/Claims Review
R	3/3.9.2.4/Duration of Suspension of Payment
R	3/3.9.2.5/Removing the Suspension
R	3/3.9.3.1/DMERCs and DMERC PSCs
R	3/3.9.3.2/Other Multi-Regional Contractors
R	3/3.10.4.5/Informational Copies to Primary GTL, Associate GTL, SME, or CMS RO
R	3/3.10.6.1/Notification of Provider or Supplier of the Review and Selection of the Review Site
R	3/3.10.7.2/Informational Copy to Primary GTL, Associate GTL, SME, or CMS RO
R	3/310.9.1/Sampling Methodology Overturned

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 135	Date: January 6, 2006	Change Request 4228

SUBJECT: Changes to the GTL Titles

I. GENERAL INFORMATION

A. Background: In chapter 3 of the PIM, GTL was changed to Primary GTL and Co-GTL was changed to Associate GTL.

B. Policy: N/A

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
		PSC	FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
							FISS	MCS	VMS	CWF	
4228.1	For PSCs, GTL shall be referred to as Primary GTL and Co-GTL shall be referred to as Associate GTL	X									
4228.2	In chapter 3, §3.10.6.1, when not giving advance notice, the PSC BI or MR unit shall obtain the advance approval of the Primary GTL; and the Medicare contractor BI or MR unit shall obtain the advance approval of the CMS RO. The PSC shall not obtain advance approval from the RO.	X				X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHH	Car	DME	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 6, 2006 **Implementation Date:** February 6, 2006 **Pre-Implementation Contact(s):** Kimberly Downin, Kimberly.Downin@cms.hhs.gov **Post-Implementation Contact(s):** Kimberly Downin, Kimberly.Downin@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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Table of Contents
(Rev.135, 01-06-06)

3.5.1.1 - Prepayment Edits

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services and to select targeted claims for review prior to payment. Medical review (MR) edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

Contractors may not install edits that result in the automatic denial of services based solely on the diagnosis of a progressively debilitating disease where treatment may be reasonable and necessary. The appearance of a progressively debilitating disease on a claim or history does not permit automated prepay denials that presume a stage of that disease that negates the effectiveness of treatment. Additionally, when a beneficiary with a progressively debilitating disease experiences an illness or injury unrelated to their progressively debilitating disease, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 Code V54.81 (aftercare following joint replacement) as the primary diagnosis, not ICD-9 Code 331.0 (Alzheimer's Disease). Automated denials may only be used when the service, in that circumstance, is never reasonable and necessary. For example, an electromyography (EMG) for Alzheimer's may be auto denied because it will never be reasonable and necessary for that ICD code; but EMG may not be auto denied when the claim shows "focal muscular weakness" -- even though that claim also shows Alzheimer's. Physical therapy may not be auto denied solely because multiple sclerosis appears on the claim, but may be if there is no other justification for the service listed. There are stages of the disease at which, for example, physical therapy for gait training will not be effective, but MR must look into the claims history or examine records to make that determination**.**

A. Ability to Target

Contractors must focus edits to suspend only claims with a high probability of being denied on MR. Focused edits reduce provider burdens and increases the efficiency of MR activities. Edits should be specific enough to identify only the services that the contractor determines to be questionable based on data analysis. Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Carrier systems must be able to select claims for prepayment review using different types of comparisons. By January 2001 (unless otherwise specified), fiscal intermediary (FI) systems must be able to perform these comparisons as well. At a minimum, those comparisons must include:

- Procedure-to-Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history. FIs on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Procedure to Provider – For a given provider, this permits selective screening of services that need review.

- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period. FIs on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin Bl2 injection is related to pernicious anemia, absence of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.

- Procedure to Specialty Code (Carrier) or TOB (FI) – This permits contractors to screen services provided by a certain specialty or TOB.

- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;

- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);

- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over $500);

- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and

- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

B. Evaluation of Prepayment Edits

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits as follows:

Automated edits must be evaluated annually.

- All routine or complex review edits must be evaluated quarterly.

These evaluations are to determine their effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too brief a time to observe a change. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ESTABLISHED AUTOMATED** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to the RO (for (PSCs, the *Primary* GTL, *Associate* GTL, and SME) and central office (CO) staff documentation demonstrating that they consider appeals in their edit evaluation process; and

- Specificity of edits in relation to identified problem(s).

- Contractors should note that even an automated edit that results in no denials may be effective so long as the presence of the edit is not preventing the installation of other automated edits.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ALL OTHER** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to RO and CO staff

documentation demonstrating that they consider appeals in their edit evaluation process.

- Specificity of edits in relation to identified problem(s);

- Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;

- Impact of educational or deterrent effect in relation to review costs; and

- The presence of more costly problems identified in data analysis that needs higher priority than existing edits considering the number of claims/days/charges reviewed in comparison to claims/days/charges denied.

Contractors must test each edit before implementation and determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

C. Adding Local Medical Review Policy (LMRP)/Local Coverage Determination (LCD) and National Coverage Determination (NCD) ID Numbers to Edits

By January 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD or NCD ID number(s) associated with the denial.

By April 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on a lab negotiated NCD includes the NCD ID number(s) associated with the denial.

By October 4, 2004, VMS carriers and PSCs must ensure the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

By October 4, 2004, MCS carriers must ensure that the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

By July 5, 2005, VMS carriers and PSCs must ensure the testing and documentation is completed for any edit that may result in a denial based on an LMRP/LCD or NCD and includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial. All Medicare Summary Notices (MSNs) printed on or after July 5, 2005 must contain the new MSN message for denials based on an LMRP, LCD, or NCD.

By July 5, 2005, MCS carriers must ensure that the testing and documentation is completed for any edit that may result in a denial based on an LMRP/LCD or NCD

includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial. All MSNS printed on or after July 5, 2005, must contain the new MSN message for denials based on an LMRP or LCD.

D. Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

Under section 1862 of the Social Security Act, as amended by section 944 of the Medicare Modernization Act, in the case of an item or service provided by a hospital or critical access hospital pursuant to section 1867of the Social Security Act (EMTALA) on or after January 1, 2004, FIs must make determinations of whether the item or service is reasonable and necessary on the basis of information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not only on the patient's principal diagnosis). The frequency with which an item or service is provided to the patient before or after the time of the service shall not be a consideration.

The National Uniform Billing Committee designated Form Locator 76 of the UB-92 claim form (837i 2300 HI segment, HI02-2. HI02-1 (the qualifier for HI02-2) must = ZZ. This HI02 is used only once per claim.) to be used for the ICD-9-CM code that represents the patient's reason for the visit in 1999. Recently CMS added edit criteria to require this on an outpatient claim Types of Bill (TOBs) 13X, 14X, 23X, 71X, 73X, 83X, and 85X. Only one diagnosis code may be shown on a claim as the reason for the visit, and that is recorded in Form Locator 76. At the provider's discretion, additional signs and symptoms codes not inherent in the principal diagnosis may be reported in Form Locators 68 through 75 (837i 2300 HI segment, HI01-2. HI01-1 (the qualifier for HI01-2) must = BF. Additional codes may be added in HI02 through HI12). The FIs shall instruct providers that they may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 045X, 0516, or 0526 to assure appropriate payment. The system must scan these fields as well for payable diagnosis codes. For LCDs with frequency edits, you must turn off those frequency edits for these services.

The FIs may target medical review for potentially aberrant ED billing, but decisions must be based on the information available to the treating physician or practitioner, including the patient's presenting conditions. FIs will continue to perform their data analysis on EDs to ensure that there are no aberrant patterns of outliers.

The FIs shall reopen claims for ED services provided on or after January 1, 2004 that were previously denied prior to the issuance of this instruction if the provider so requests.

3.6.2 - Location of Postpayment Reviews

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

Contractors must decide whether to conduct the postpay review at the provider or supplier site or at the contractor site. Considerations in determining whether to conduct a provider or supplier site review are:

- The extent of aberrant patterns identified in their focused review program; (See PIM chapter 3, section 3.2);
- The past failure of a provider or supplier to submit appropriate and timely medical records; and
- Contractor resources.

A. Contractor Site Reviews

The contractor notifies the provider(s) or supplier(s) that they have 30 calendar days from the date of the letter to provide the medical record or other requested documentation. (See PIM Exhibit 7.2 for a sample letter.) Contractors have the discretion to grant an extension of the timeframes upon request.

If the information requested is not received within 45 days, the contractor shall review the claims with the information on hand. Contractors must complete the review and notify the provider or supplier in writing of their findings within 60 calendar days from the start of the review, or receipt of medical records, whichever is later. If the contractor needs more than 60 calendar days, they must request an extension from the RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME).

B. Provider or Supplier Site Reviews

Contractors determine what, if any, advance notification of a scheduled review is given to a provider or supplier. The contractor may give advance notice when a provider or supplier has satellite offices from which medical records will have to be retrieved. When giving advance notice, the contractor must include an explanation of why the review is being conducted.
The list of claims requiring medical records may be included with the advance notice or at the time of the visit at the discretion of the contractor.

Contractors may conduct team reviews when potential problems exist in multiple areas. The team may consist of MR, audit, BI, State surveyors, provider enrollment or Medicaid staff depending on the issues identified. As a minimum, before conducting provider or supplier site reviews, consult and share information with other internal and external staff

as appropriate to determine if there are issues that the reviewers should be aware of or if a team review is needed.

Annually, contractors must instruct providers or suppliers (via bulletin article, Web article, etc.) that any Medicare contractor staff person who visits the provider site must show a photo identification indicating their affiliation with the Medicare contractor. Contractors must provide to all reviewers who participate in provider site reviews a photo identification card indicating the reviewer's affiliation with the Medicare contractor. To perform provider or supplier site reviews, all reviewers must present photo identification cards indicating their affiliation with the Medicare contractor to the provider staff and other reviewers on site.

During provider site reviews, reviewers shall photocopy pertinent medical records when services are denied, when a physician or other medical consultation is needed, or when it appears that records have been altered. Contractors shall retain these records for appeals or BI purposes.

Reviewers shall hold entrance and exit interviews with appropriate provider or supplier staff. A provider or supplier representative can also be present while claims are reviewed. Reviewers must answer any questions the provider or supplier staff may have.

During entrance interviews, reviewers explain the following:

- Scope and purpose of the review;
- Why postpayment review is being conducted;
- The list of claims that require medical records;
- How recumbent of overpayment is made if claims are denied;
- Answer any questions related to the review; and
- Notify the provider or supplier of their rebuttal rights. (See PIM, Chapter 3, Section 3.6.6.)

During exit conferences, the contractor shall discuss the findings of the review. The provider or supplier must be allowed an opportunity to discuss or comment on the claims decisions.

3.6.5 – Notification of Provider(s) or Supplier(s) and Beneficiaries of the Postpayment Review Results

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

A. Provider or Supplier Notification

Contractor MR staff must prepare a letter to notify each provider or supplier of the results of the postpayment review. These letters may (but are not required to) contain a demand for repayment of any overpayments they may have made. Some contractors may wish to have another department issue the actual demand letter. Contractors must notify the provider(s) that the postpayment review has been completed even in those instances where no corrective actions or overpayments are involved.

Contractors must send the Notification of Postpayment Review Results to each provider or supplier within 60 days of the exit conference (for provider or supplier site reviews) or receipt of medical records (for contractor site reviews). If the contractors need more than 60 days, they are to contact their RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) for an extension. Each letter must include:

- Identification of the provider(s) or supplier(s)--name, address, and provider or supplier number;
- The reason for conducting the review;
- A narrative description of the overpayment situation: state the specific issues involved which created the overpayment and any pertinent issues as well as any recommended corrective actions the provider should consider taking;
- The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded; A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied, the amounts which will not be recovered from the provider or supplier, under/overpayment amounts and the §§1879 and 1870 determinations made for each specific claim;
- For statistical sampling for overpayment estimation reviews, any information required by PIM, chapter 3, section 3.10.4.4;
- Total underpayment amounts;
- Total overpayment amounts for which the provider or supplier is responsible;

- Total overpayment amounts for which the provider or supplier is not responsible because the provider or supplier was found to be without fault;

- Intermediaries must include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;

- An explanation of the provider's or supplier's right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6);

- 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, and the provider's or supplier's right to request an extended repayment schedule;

- The provider or supplier appeal rights; and

- A discussion of any additional corrective actions or follow-up activity the contractor is planning (i.e., prepayment review, re-review in 6 months).

Contractors may send the final notification letter by certified mail and return receipt requested.

Sample letters are in PIM Exhibit 7.3 with attachment Exhibit 7.3.1 and the Part B sample letter is Exhibit 7.4 with attachment Exhibit 7.4.1. Contractors may adapt the language used under each heading to the particular situation they are addressing.

B. Beneficiary Notification

Contractors must also notify each beneficiary when re-adjudication of the claim results in a change to the initial determination. This can be done via an MSN or individual letter. In the case where a sample of claims is extrapolated to the universe, only those beneficiaries in the sample need to be notified.

3.6.8 – Evaluation of the Effectiveness of Postpayment Review and Next Steps

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews). Contractors must determine if any other corrective actions are necessary such as:

- In cases where the MR unit uncovers potential fraud in the course of its postpayment review activities, the MR unit shall refer these cases to the Medicare contractor BI unit or the PSC. If it is believed that the overpayment has been caused by fraud, do not request a refund until the fraud issue is resolved (see PIM, chapter 3, section 3.8).

- Initiate provider or supplier specific edit to focus prepayment review on the problem provider or supplier or group of providers or suppliers (see PIM, chapter 3, section 3.5.1) if appropriate;

- Work with the RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) to suspend payment to the provider or group of providers (see PIM, chapter 3, section 3.9);

- Refer provider certification issues to the State survey agency through the RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) staff.

- Refer quality issues involving inpatient hospital services, if any, to the QIO;

- Coordinate with the QIO and carrier/intermediary on interrelated billing problems;

Contractors perform a follow-up analysis of the provider(s) or supplier(s) periodically for as long as necessary to determine if further corrective actions are required. In some cases, it may be feasible and timely to perform the follow-up analysis of the provider or supplier after the 3 month time period. Contractors must continue monitoring the provider or supplier or group of providers or suppliers until there is a referral to the Medicare contractor BI unit or the PSC, there is evidence that the utilization problem is corrected, or data analysis indicates resources would be better utilized elsewhere.

3.6.9 - Postpayment Files

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Contractors must establish an audit trail that identifies:

- Claims and beneficiaries selected;

- The period of review;
- The reason for the review (aberrancy validation, high provider error rate, wide-spread service-specific problem.); and
- Findings to show why the original claim determination was changed. The documentation must be clear and concise, and include the basis for revision.

Contractors must complete a Summary Report for each postpayment review case. Include in the report:

- The reason(s) the provider or group of providers was selected for review;
- A chronological record of all review events and actions;
- The information used to perform the review (e.g., relevant LMRP)
- A record of all decisions made and all actions taken to deal with the provider's MR problem, including who made the decisions and the reasons for taking the actions;
- Documentation of statistical methods used if overpayment is projected;
- Whenever possible, postpayment savings in terms of actual overpayment, settlement based, or statistically extrapolated;
- A record of all contacts with providers or beneficiaries; and
- Documentation of §§1879, 1870, or 1842(1) determinations. (See PIM Exhibit 14.)

Retain the Summary Report and all postpay files for 36 months following the conclusion of a postpay case unless the RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) requires a longer period or unless the case is referred to the PSC or Medicare contractor BI unit (and in this case, retain the files for the longer of 36 months or the completion of the investigation). A sample summary report is found in Exhibit 13. Contractors have the option of using an alternate format for the postpay summary report with RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) approval.

3.8 – Overpayment Procedures

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The PSCs shall refer all identified overpayments to the AC who shall send the demand letter and recoup the overpayment.

Contractors should initiate recovery of overpayments whenever it is determined that Medicare has erroneously paid. In any case involving an overpayment, even where there is a strong likelihood of fraud, request recovery of the overpayment. PSCs and Medicare contractor BI units notify law enforcement of their intention to collect outstanding overpayments in cases in which they are aware of a pending investigation. There may be situations where OIG/OI or other law enforcement agencies might recommend that overpayments are postponed or not collected; however, this must be made on a case-by-case basis, and only when recovery of the overpayment would undermine the specific law enforcement actions planned or currently taking place. Medicare contractor BI units refer such requests to the RO (for PSCs, such requests are referred to the *Primary* GTL, *Associate* GTL, and SME). If delaying recoupment minimizes eventual recovery, delay may not be appropriate. Medicare contractor BI units must forward any correspondence received from law enforcement requesting the overpayment not be recovered to the RO (PSCs forward this to the *Primary* GTL, *Associate* GTL, and SME). The RO (for PSCs, the *Primary* GTL, *Associate* GTL, and SME) will decide whether or not to recover.

If a large number of claims are involved, contractors consider using statistical sampling for overpayment estimation to calculate the amount of the overpayment. (See PIM, chapter 3, §3.10.)

Contractors have the option to request the periodic production of records or supporting documentation for a limited sample of submitted claims from providers or suppliers to which amounts were previously overpaid to ensure that the practice leading to the overpayment is not continuing. The contractor may take any appropriate remedial action described in this chapter if a provider or supplier continues to have a high level of payment error.

3.9.1.1 – Fraud or Willful Misrepresentation Exists - Fraud Suspensions

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Suspension of payment may be used when the contractor or CMS possesses reliable information that fraud or willful misrepresentation exists. For the purposes of this section, these types of suspensions will be called "fraud suspensions."

Fraud suspensions may also be imposed for reasons not typically viewed within the context of false claims. An intermediary example is that the QIO has reviewed inpatient claims and determined that the diagnosis related groups (DRGs) have been upcoded. An example carriers may find is that suspected violation of the physician self referral ban is cause for suspension since claims submitted in violation of this statutory provision must be denied and any payment made would constitute an overpayment. Forged signatures on Certificates of Medical Necessity (CMN), treatment plans, and other misrepresentations on Medicare claims and claim forms to obtain payment result in overpayments. Credible allegations of such practices are cause for suspension pending further development.

Whether or not the contractor or PSC recommends suspension action to CMS is a case-by-case decision requiring review and analysis of the allegation and/or facts. The following information is provided to assist the contractor and PSC in deciding when to recommend suspension action.

A. Complaints

There is considerable latitude with regard to complaints alleging fraud and abuse. The history, or newness of the provider, the volume and frequency of complaints concerning the provider, and the nature of the complaints all contribute to whether suspension of payment should be recommended. If there is a credible allegation(s) that a provider is submitting or may have submitted false claims, the contractor shall recommend suspension of payment to the RO and PSCs shall recommend suspension of payment to the *Primary* GTL, *Associate* GTL, and SME.

B. Provider Identified in CMS Fraud Alert

Contractors shall recommend suspension to the RO and PSCs shall recommend suspension to the *Primary* GTL, *Associate* GTL, SME if a provider in their jurisdiction is the subject of a CMS national fraud alert and the provider is billing the identical items/services cited in the alert or if payment for other claims must be suspended to protect the interests of the government.

C. Requests from Outside Agencies

Contractors and PSCs shall follow the suspension of payment actions for each agency request indicated below.

- CMS -- Initiate suspension as requested.

- OIG/FBI – Contractors shall forward the written request to the CMS RO and PSCs shall forward the request to the *Primary* GTL, *Associate* GTL, and SME for its review and determination. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will decide.

- AUSA/DOJ – Contractors shall forward the written request to the CMS RO and for PSCs, the *Primary* GTL, *Associate* GTL, and SME for review and determination.

- Other – Other situations the contractor or PSC may consider recommending suspension of payment to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME are:

    - Provider has pled guilty to, or been convicted of, Medicare, Medicaid, CHAMPUS, or private health care fraud and is still billing Medicare for services;

    - Federal/State law enforcement has subpoenaed the records of, or executed a search warrant at, a health care provider billing Medicare;
    - Provider has been indicted by a Federal Grand Jury for fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct related to a health care program;

    - Provider presents a pattern of evidence of known false documentation or statements sent to the contractor; e.g., false treatment plans, false statements on provider application forms.

3.9.1.2 – Overpayment Exists But the Amount is Not Determined - General Suspensions

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Suspension of payment may be used when the contractor or CMS possesses reliable information that an overpayment exists but has not yet determined the amount of the overpayment. In this situation, the contractor shall recommend suspension to the RO and the PSC shall recommend suspension to the *Primary* GTL, *Associate* GTL, and SME. For the purposes of this section, these types of suspensions will be called “general suspensions.”

EXAMPLE: Several claims identified on post-pay review were determined to be non-covered or miscoded. The provider has billed this service many times before and it is suspected that there may be a number of additional non-covered or miscoded claims that have been paid.

3.9.1.3 – Payments to be Made May Not be Correct - General Suspensions

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Suspension of payment may be used when the contractor or CMS possesses reliable information that the payments to be made may not be correct. In this situation, the contractor shall recommend suspension to the RO and the PSC shall recommend suspension to the *Primary* GTL, *Associate* GTL, and SME. For the purposes of this section, these types of suspensions will be called "general suspensions".

3.9.1.4 –Provider Fails to Furnish Records and Other Requested Information - General Suspensions

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Suspension of payment may be used when the contractor or CMS possesses reliable information that the provider has failed to furnish records and other information requested or that is due, and which is needed to determine the amounts due the provider. In this situation, the contractor shall recommend suspension to the RO and the PSC shall recommend suspension to the *Primary* GTL, *Associate* GTL, and SME. For the purposes of this section, these types of suspensions will be called "general suspensions".

EXAMPLE: During a postpayment review, medical records and other supporting documentation are solicited from the provider to support payment. The provider fails to submit the requested records. The contractor determines that the provider is continuing to submit claims for services in question.

3.9.2.1 – CMS Approval

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The initiation (including whether or not to give advance notice), modification, or removal of any type of suspension requires the explicit prior approval of the CMS RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME. The designated approving authority in the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will seek the advice of the Regional Chief Counsel's Office (RCCO) and coordinate suspension action with its law enforcement partners as it deems appropriate.

The contractor or PSC shall forward a draft of the proposed notice of suspension and a brief summary of the evidence upon which the recommendation is based to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME. The contractor shall not take suspension action without the explicit approval of the resident RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME. In most cases, the RO or if a PSC, the *Primary* GTL, *Associate* GTL, and SME will notify OIG and other law enforcement partners of its decision and will keep law enforcement apprised of any future decisions to modify the suspension. However, if a contractor, a PSC, or CMS has been working with law enforcement on the case, immediately notify them of the recommendation to the RO or

for PSCs, the *Primary* GTL, *Associate* GTL, and SME. Notice may consist of a telephone call or a fax if there is a need to expedite suspension. If law enforcement wants more time to study or discuss the suspension, contractors shall discuss their request with the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME. If law enforcement requests that suspension action should, or should not, be taken, contractors shall contact the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME. Contractors and PSCs shall also advise law enforcement that the request must be in writing and must provide a detailed rationale justifying why payment should, or should not, be suspended.

3.9.2.2.1 – Prior Notice Versus Concurrent Notice

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Contractors and PSCs shall inform the provider of the suspension action being taken. When prior notice is appropriate, give at least 15 calendar days prior notice. Day one begins the day after the notice is mailed.

A. Medicare Trust Fund would be harmed by giving prior notice: Contractors and PSCs shall recommend to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME, not to give prior notice if in the contractor's or PSC's opinion, any of the following apply:

1. Delay in suspension will cause the overpayment to rise at an accelerated rate (i.e., dumping of claims);

2. There is reason to believe that the provider may flee the contractor's jurisdiction before the overpayment can be recovered; or

3. The contractor or PSC has first hand knowledge of a risk that the provider will cease or severely curtail operations or otherwise seriously jeopardize its ability to repay its debts.

If the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME waives the advance notice requirement, contractors and PSCs send the provider notice concurrent with implementation of the suspension, but no later than 15 days, after suspension is imposed.

B. Suspension imposed for failure to furnish requested information: Contractors and PSCs shall recommend that the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME waive prior notice requirements for failure to furnish information requested by the contractor or PSC that is needed to determine the amounts due the provider.

If the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME waives the prior notice requirement, contractors and PSCs shall send the provider notice concurrent with implementation of the suspension, but no later than 15 days after the suspension is imposed.

C. Fraud suspension: With respect to fraud suspensions, contractors and PSCs shall recommend to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME that prior notice not be given. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will decide whether to waive the notice. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will also direct the content of the notice.

If the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME waives the advance notice requirement, the contractor or PSC shall send the provider notice concurrent with implementation of the suspension, but no later than 15 days, after suspension is imposed.

3.9.2.2.2 – Content of Notice

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Contractors and PSCs shall prepare a "draft notice" and send it, along with the recommendation, to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME for approval. The draft notice shall include, at a minimum:

- That suspension action will be imposed;
- The extent of the suspension (i.e., all claims, certain types of claims, 100% suspension or partial suspension);
- That suspension action is not appealable;
- That CMS has approved implementation of the suspension;
- When suspension will begin;
- The items or services affected;
- How long the suspension is expected to be in effect;
- The reason for suspending payment;
- That the provider has the opportunity to submit a rebuttal statement within 15 days of notification; and
- Where to mail the rebuttal.

In the notice, contractors and PSCs shall also state why the suspension action is being taken.

For fraud suspensions, the contractor or PSC shall do so in a way that does not disclose information that would undermine a potential fraud case. The rationale must be specific enough to justify the action being taken and allow the provider an opportunity to identify the problem. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will direct the content of the notice. The notice does not need to specify that the provider

is suspected of fraud or willful misrepresentation. It can identify the claims involved and state, for example, that the claims paid or to be paid should not have been.

3.9.2.2.3 – Shortening the Notice Period for Cause

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

At any time, the contractor or PSC may recommend to the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME that the advance notice be shortened during the notice period. Such a recommendation would be appropriate if the contractor or PSC believes that the provider is intentionally submitting additional claims in anticipation of the effective date of the suspension. If suspension is imposed earlier than indicated in the notice, the contractor or PSC shall notify the provider in writing of the change and the reason.

3.9.2.2.4 – Mailing the Notice to the Provider

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

After consultation with and approval from the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME, contractors and PSCs shall send the notice of suspension to the provider. In the case of fraud suspensions, they send a copy to the OIG, FBI, or AUSA if they have been previously involved.

3.9.2.2.5 – Opportunity for Rebuttal

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The suspension notice gives the provider an opportunity to submit to the contractor or PSC a statement within 15 days indicating why suspension action should not be, or should not have been, imposed. However, this may be shortened or lengthened for cause (see 42 CFR 405.374(b)). A provider's reaction to suspension may include threats of court action to restore payment or to stop the proposed action. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will consult with OGC and will advise the contractor or PSC before the contractor or PSC responds to any rebuttal statements.

Contractors and PSCs shall ensure the following:

- CMS Review – Contractors and PSCs shall immediately forward provider responses to the CMS RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME.

- Timing – Implementation of suspension actions is not delayed by the receipt and/or review of the rebuttal statement. The suspension goes into effect as indicated in the notice.

- Review of Rebuttal – Because suspension actions are not appealable, the rebuttal is the provider's only opportunity to present information as to why suspension action should be non-initiated or terminated. Contractors and PSCs shall also carefully review the provider's rebuttal statement and consider all facts and issues

raised by the provider. If the contractor or PSC is convinced that the suspension action should be non-initiated or terminated, they shall consult immediately with the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME.

- Response – Respond to the provider's rebuttal within 15 days from the date the statement is received, following consultation with the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME.

3.9.2.3.1 – Claims Review

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

A. Claims Review of Suspended Claims:

Once suspension has been imposed, contractors and PSCs shall follow normal claims processing and MR procedures. Contractors shall make every attempt within the MR budget to determine if suspended claims are payable. Contractors and PSCs shall ensure that the provider is not substituting a new category of improper billing to counteract the effect of the payment suspension. If the claim is determined to be not payable, it shall be denied. For claims that are not denied, the contractor shall send a remittance advice to the provider showing that payment was approved but not sent. Contractors and PSCs are not required to perform 100% pre-pay medical review of suspended claims. Contractors and PSCs shall consult with their RO or for PSCs, with their *Primary* GTL, *Associate* GTL, and SME when resources would be better utilized by determining what percentage of claims in a universe of suspended claims are payable through use of statistical sampling procedures. Contractors and PSCs shall use the principles of statistical sampling found in the PIM, Chapter 3, §3.10, to determine what percentage of claims in a given universe of suspended claims are payable.

B. Review of Suspected Fraudulent or Overpaid Claims:

Contractors and PSCs shall follow procedures in the PIM Chapter 3, §3.8 in establishing an overpayment. The overpayment consists of all claims in a specific time period determined to have been paid incorrectly. Contractors and PSCs shall make all reasonable efforts to expedite the determination of the overpayment amount.

NOTE: Claims selected for postpayment review may be reopened within 1 year for any reason or within 4 years for good cause. Cost report determinations may be reopened within 3 years after the Notice of Program Reimbursement has been issued. Good cause is defined as new and material evidence, error on the face of the record, or clerical error. The regulations have open-ended potential for fraud or similar fault. The exception to the 1-year rule is for adjustments to DRG claims. A provider has 60 days to request a change in an assignment of a DRG. (See 42 CFR 412.60(d).)

3.9.2.4 – Duration of Suspension of Payment

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

A. Time Limits

The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will initially approve suspension for a period up to 180 days. The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME may extend the period of suspension for up to an additional 180 days upon the written request of the contractor or PSC, OIG, or other law enforcement agency. The request shall provide:

- Name and address of the provider under suspension;
- Amount of additional time needed (not to exceed the 180 days); and
- Rationale explaining why the additional time is necessary.

B. Exceptions to Time Limits

The following exceptions may apply:

- Department of Justice (including U.S. Attorneys). The RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME may grant an additional extension to the Department of Justice if it submits a written request. Requests must include: 1) the identity of the person or entity under suspension, 2) the amount of time needed for continued suspension in order to implement an ongoing or anticipated criminal and/or civil proceeding, and 3) a statement of why and/or how criminal and/or civil actions may be affected if the suspension is not extended. This extension may be granted based on a request received by the RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME at any time before or during the period of suspension.

- OIG. The time limits in subsection A above do not apply if the case has been referred to and is being considered by OIG for administrative sanctions (e.g., CMPs). However, this exception does not apply to pending criminal investigations by OIG.

C. Provider Notice of the Extension

The contractor or PSC shall notify the provider of the requested extension.

The contractor or PSC shall obtain the RO or if a PSC, *Primary* GTL, *Associate* GTL, and SME decision about the extension request, and shall notify the provider if the suspension action has been extended.

3.9.2.5 – Removing the Suspension

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Contractors shall recommend to the RO and PSCs shall recommend to the *Primary* GTL, *Associate* GTL, and SME that suspension of payments be terminated at such time as the time limit expires.

The contractor or PSC may recommend on a case by case basis to the RO or for the PSC, the *Primary* GTL, *Associate* GTL, and SME that it be terminated earlier if any of the following apply:

A. If the basis for the suspension action was that an overpayment existed but the amount of the suspected overpayment is not yet determined, and:

- No overpayment was identified;
- The amount of suspected overpayment has been determined and it is no longer accruing; or
- The amount of the suspended monies exceeds the estimated amount of the suspected overpayment.

B. If the basis for the suspension action was that fraud or willful misrepresentation existed, there is satisfactory evidence that the fraud activity has ceased, and the amount of suspended monies exceeds the estimated amount of the suspected overpayment.

C. If the basis for the suspension action was that payments to be made may not be correct, and the contractor or PSC has determined that payments to be made are correct.

D. If the basis for the suspension action was that the provider failed to furnish records, the provider has submitted all previously requested records, and the contractor or PSC believes the provider will comply with future requests for records.

When the suspension expires or is lifted early, the disposition of the suspension shall be achieved within a reasonable time period.

3.9.3.1 – DMERCs and DMERC PSCs

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The DMERCs and DMERC PSCs shall initiate suspension action when one of the criteria listed above is identified. (See PIM Chapter 3 §3.9.1,When Suspension of Payment May Be Used.) The following details the process that shall be followed when one DMERC or DMERC PSC suspends payments.

A. The initiating DMERC or DMERC PSC shall get the approval of its lead RO or for PSCs, the *Primary* GTL, *Associate* GTL and SME. CMS' ROs have agreed to support the decision of another RO.

B. The initiating DMERC or DMERC PSC shall share the suspension of payment information with all of the other DMERCs and DMERC PSCs. Reliable information that payments should be suspended in one region is sufficient reason for suspension decisions to apply to the other regions.

C. The lead RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME shall issue one suspension letter on CMS letterhead advising that payments will be held by all DMERCs and DMERC PSCs. This letter shall advise the supplier to contact the initiating DMERC or DMERC PSC should the supplier have any questions.

D. Should the suspension action require an extension of time, the lead RO or for PSCs, the *Primary* GTL, *Associate* GTL, and SME will send an extension letter to the supplier.

3.9.3.2 – Other Multi-Regional Contractors

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

In some situations, more than one CMS RO may be involved. For example, both the Seattle (resident RO) and Kansas City (RHHI RO) have jurisdiction in Idaho. Where there are multiple ROs, it is incumbent on the ROs (not the contractors or PSCs) to reach consensus on suspension action and to provide a single point of contact at the resident RO for the contractor or PSCs. In other words, it is usually the RO that services the geographic State or area where the beneficiary and providers are located that would be responsible for coordinating CMS's decision and contacts with interested law enforcement agencies. The PSC shall contact their *Primary* GTL, *Associate* GTL, and SME for the correct RO contact on payment suspensions.

Model Suspension of Payment Letters can be found in Exhibit 16.

3.10.4.5 - Informational Copies to *Primary* GTL, *Associate* GTL, SME or CMS RO

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The PSC or Medicare contractor BI or MR unit shall send informational copies of the statistician-approved sampling methodology to their *Primary* GTL, *Associate* GTL, SME or CMS RO. The *Primary* GTL, *Associate* GTL, SME or CMS RO will keep the methodology on file and will forward to CO upon request. If this sampling methodology is applied routinely and repeatedly, the PSC or Medicare contractor BI or MR unit shall not repeatedly send the methodology to the *Primary* GTL, *Associate* GTL, SME or CMS RO.

3.10.6.1 – Notification of Provider or Supplier of the Review and Selection of the Review Site

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

The PSC or Medicare contractor BI or MR unit shall first determine whether it will be giving advance notification to the provider or supplier of the review. Although in most cases the PSC or Medicare contractor BI or MR unit shall give prior notification, the provider or supplier is not always notified before the start of the review. When not giving advance notice, the PSC *BI or MR unit shall obtain the advance approval of the Primary GTL; and the* Medicare contractor BI or MR unit shall obtain *the advance approval of the* CMS RO. When giving advance notice, provide written notification by certified mail with return receipt requested (retain all receipts).

Second, regardless of whether you give advance notice or not, you shall determine where to conduct the review of the medical and other records: either at the provider or supplier's site(s) or at your office (PSC or Medicare contractor BI or MR unit).

3.10.7.2 - Informational Copy to *Primary* GTL, *Associate* GTL, SME or CMS RO

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

Send an informational copy of the demand letter to the *Primary* GTL, *Associate* GTL, SME or CMS RO. They will maintain copies of demand letters and will forward to CO upon request. If the demand letter is used routinely and repeatedly, you shall not repeatedly send it to the *Primary* GTL, *Associate* GTL, SME or CMS RO.

3.10.9.1 - Sampling Methodology Overturned

(Rev. 135, Issued: 01-06-06, Effective: 02-06-06, Implementation: 02-06-06)

If the decision issued on appeal contains a finding that the sampling methodology was not valid, there are several options for revising the estimated overpayment based upon the appellate decision:

A. If the decision issued on appeal permits correction of errors in the sampling methodology, you shall revise the overpayment determination after making the corrections. Consult with your *Primary* GTL, *Associate* GTL, SME or CMS RO to confirm that this course of action is consistent with the decision of the hearing officer (HO), administrative law judge (ALJ) or Departmental Appeals Board (DAB), or with the court order.

B. You may elect to recover the actual overpayments related to the sampled claims and then initiate a new review of the provider or supplier. If the actual overpayments related to the sampling units in the original review have been recovered, then these individual sampling units shall be eliminated from the sampling frame used for any new review. Consult with your *Primary* GTL, *Associate* GTL, SME or CMS RO to confirm that this course of action is consistent with the decision of the HO, ALJ or DAB, or with the court order.

C. You may conduct a new review (using a new, valid methodology) for the same time period as was covered by the previous review. If this option is chosen, you shall not recover the actual overpayments on any of the sample claims found to be in error in the original sample. Before employing this option, consult with your *Primary* GTL, *Associate* GTL, SME or CMS RO to verify that this course of action is consistent with the decision of the HO, ALJ or DAB, or with the court order.