CMS Guidance Document	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Executive Guidance Number 0255	**Date: February 6, 2008**
Planned Web Site Address http://www.cms.hhs.gov/manuals/	**Release planned:02/21/08**

PROGRAM AREA: Overpayments

SUBJECT: Redeterminations of Overpayments

APPLIES TO: Contractor specific

I. SUMMARY OF DOCUMENT: The purpose of this CR is to clarify the requirements for conducting a redetermination that is requested in response to a demand letter notifying the claimant of an overpayment.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER/SECTION/SUBSECTION/TITLE
R	29/310.4/The Redetermination

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Abby Block/202-260-1291/Director, Center for Beneficiary Choices
Agency POC	Lisa Childress/410-786-6956/CBC/MEAG/DAO

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	**Change Request**
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
	Other

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation is being interpreted. If not applicable, indicate N/A]

Attachment - Business Requirements

Pub. 100-04	Transmittal:	Date:	Change Request: 5859

SUBJECT: Redeterminations of Overpayments

Effective Date: 30 days from issuance
Implementation Date: 30 days from issuance

I. GENERAL INFORMATION

A. Background: The Medicare appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Overpayment determinations, when appealed, now go to the first level of appeal called redetermination. When a contractor is conducting a redetermination of an overpayment, it should consider the claim determinations as well as the sampling methodology used to project overpayments.

B. Policy:

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5859.1	The contractor shall consider the sampling methodology when conducting a redetermination of an overpayment determination, when that methodology is questioned in the redetermination request.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Lisa Childress (410) 786-6956
Post-Implementation Contact(s): Lisa Childress (410) 786-6956

VI. FUNDING

A. ***For Fiscal Intermediaries and Carriers*****:** No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:** The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

310.4 - The Redetermination

(Rev.)

The redetermination is an independent, critical examination of a Part A or B claim made by contractor personnel not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, contractor personnel must examine all issues in the claim.

A. Timely Processing Requirements

The carrier must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of (D)(4) below). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties.

2. For partial reversals and full reversals, when all of the following actions have been completed:

a. the decision letter is mailed to the parties, and
b. the actions to initiate the adjustment action in the claims processing system are taken.

When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.

3. For withdrawals and dismissals, the date dismissal notice is mailed to the parties.

B. Development of Appeal Case File

The reviewer must obtain and review all available, relevant information needed to make the determination. Other areas within the contractor may have information relevant to the claim(s) at issue. For example, the program integrity area (including medical review, overpayments, and fraud and abuse) may submit evidence to the reviewer for inclusion in the case file. Such evidence must be made available for inspection by an appellant upon request. Reviewers must exercise care in determining the weight to give fraud and abuse information where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed investigation

that supports denial of the claim(s). (See subsection D, below, for instructions on development of documentation.)

The development of the case file is important not only for the redetermination, but also to prepare for a potential appeal to the QIC. Proper development of the case file will assist the contractor in timely transmitting the case file to the QIC upon request. In cases of large overpayment cases involving many claims, this case file development is extremely important. When a reconsideration request is filed with the QIC, and the QIC requests a case file for a large overpayment case, it is critical the QIC obtain the case file timely so it can begin adjudication. Therefore, it should be a priority for the contractor to adequately develop case files.

C. Elements of the Redetermination

The following elements are essential to performing an adequate redetermination:

- The reviewer must not be the same person who made the initial determination.

- How the contractor conducts its redetermination depends on the appellant's request and what is at issue. There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the *amount paid*, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable.

- If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.

For appeals of a specific line item or service, the initial determination is the date of the first MSN or RA that states the decision. Adjustments to the claim that are included on later copies of the MSN or RA *(and do not revise the initial determination)* do not extend/change the appeal rights given under the initial determination. All other line items not yet reviewed may be reviewed within 120 days from the receipt of the initial determination, if requested.

Although the reviewer may not make a finding of criminal or civil fraud (see §280, "Fraud and Abuse"), the reviewer should review the claim to see if there is sufficient documentation and evidence supporting that the items or services were actually furnished or were furnished as billed.

If the appellant challenges the validity of the sampling methodology, the contractor reviews the claims in question as well as any statistical sampling used to extrapolate the

overpayment amount. For background on how PSCs use statistical sampling to estimate overpayments, see Pub. 100-08, chapter 3, section 10. If a reconsideration is subsequently requested, the entire case will be sent.

Per Pub. 100-06, chapter 3, sections 70 and 90, the contractor shall consider whether there was an overpayment, whether the amount of the overpayment was correctly calculated and extrapolated (if applicable), whether the appellant is liable for repayment, and whether recovery of the overpayment is waived.

Appellants must have the opportunity to submit written evidence and arguments relating to the claim at issue. This does not mean the reviewer must request such material, but he/she must accept and consider any relevant documentation submitted.

D. Requests for Documentation

1. Requesting documentation for State-Initiated Appeals

The reviewer should not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, the reviewer should request that the submitter of the appeal (i.e., the State or the party authorized to act on behalf of the Medicaid State agency) obtain and submit necessary documentation.

2. Requesting documentation for Provider, Physician, Supplier, or Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider, physician, or other supplier of the timeframe the provider or supplier has to submit the documentation. The reviewer documents his/her request in the redetermination case file. The requested documents may be submitted via facsimile, at the reviewer's discretion. In rare cases, a provider or supplier might inform the reviewer that he/she is having trouble obtaining the supporting documentation, such as hospital records. In this situation the contractor may provide the provider, physician or other supplier with assistance in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. See 4 below for information on extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting documentation for Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. For beneficiary-initiated appeals, the reviewer

notifies the beneficiary (either in writing or via a telephone call) when the reviewer has asked the beneficiary's provider, physician, or supplier for additional documentation. The beneficiary is advised (either in the letter or during a telephone call) that the provider, physician, or other supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, the reviewer will decide based on the evidence in the case file. If the reviewer sends the beneficiary a letter, it must include a description of the documentation that has been requested.

4. Extension for Receipt of Additional Documentation

When a party submits additional evidence after filing the request for redetermination, the contractor's 60-day decision-making timeframe is automatically extended for 14 calendar days for each submission. This additional 14 days is allowed for all documentation submitted by a party after the request, even when the documentation was requested by the contractor. Although this extension is granted to contractor for making decisions, it should not routinely be applied unless extra time is needed to consider the additional documentation.

5. General Information

The contractor routinely includes instructions on the appropriate information to submit with appeal requests in its provider newsletters and other educational literature. Providers, physicians and other suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.