CENTERS FOR MEDICARE & MEDICAID SERVICES

PERM Recoveries Exception Template Review

Contact Info/Date/CMS Response

State populates yellow highlighted areas with the contact info of the staff member most familiar with the exception request.

Populated by CMS after receipt from state

	PERM Recoveries Exception Template	
	State:	*Date Request Received by CMS:
	State POC Name:	Cycle/RY:
	State POC Email:	Date CMS Response to State:
	State POC Phone Number:	

Populated by CMS once final decision provided to state

Claim & Error Details

State populates yellow highlighted areas with error details (*columns A-H). Use additional forms if needed.*

Claims must have all necessary documentation to make a decision or the request will be returned to the state.

Instructions:

Col A, Claim Reference Number: This column denotes how to refer back to a claim quickly throughout the document. Claims with similar summaries should be listed on the same form. Additional forms should be used for other claims as needed. If 4 claims are all claims that were fixed after the 60-day window, then all of these claims should be listed in a row, i.e., 1-4. In the sections below where CMS asks for a summary, all 4 claims can be explained in the same summary.

Col A1, State Page # State: Input the page number where the State's request summary begins on this document.

Col D, DP/MR Error Code: Input the error code related to the claim. e.g., if the original error was cited because of no medical record documentation from the state the error code should be MR1.

Col F, Date of FEFR: Input the initial date that the claim was reported on the annual FEFR. States have one year after a claim is reported on the FEFR to initiate a request for exception. Requests received after this deadline will not be accepted.

Col G, Error Amount: Enter the amount in dollars that was cited as an overpayment on the claim.

Col H, Recovery Exception Reason (See App. A): Enter the corresponding number from the Appendix that is applicable to the claim. If a claim does not fall under one of those three reasons, CMS will not accept it.

A	A1	B	C	D	E	F	G	H	I
Claim Reference Number	State Page # Start	PERM ID	Claim Category	DP/MR Error Code	Date of Service	Date of FEFR	Error Amount	Recovery Exception Reason (See App. A)	CMS Decision
1	Pg. 2	XXM2003F116	13	MR2	01/31/2020 to 01/31/2020	11/15/2021	$100.00	3	Approved
2	Pg. 4	XXC1901F058	2	MR6	10/08/19 to 10/08/19	11/15/2021	$723.21	2	Denied
3									
4									
5									

CMS populates column I with final decision

Request Details

State populates yellow highlighted areas for each claim in which a recoveries exception is requested. Please be as descriptive as possible.

Reason for Original Error Findings	**Claim Ref 1** - The provider was working to obtain the missing documentation to support the payment of services provided but was unable to do so prior to the cycle cutoff. **Claim Ref 2** – The number of units billed by the provider were not supported in the record documentation.
Explanation of Exception Request	**Claim Ref 1** - ABC vendor provided the state with the signed and approved support plan in place on the date of service. The support plan we received post cycle cutoff complies with our state policy requirements and supports payment for the services provided. We request an exception to the requirement to return the federal share of this payment. **Claim Ref 2** – The 120 units billed for code W5993 by ABC provider was corrected last week.
Relevant Documents	**Claim Ref 1** - Individual Support Plan dated 12/01/2019 **Claim Ref 2 –** Please see attached screen shot

Relevant Citations	**Claim Ref 1** - State Code XX (Developmental Disabilities Support Services Manual) Chapter 5 para A1 – an approved support plan must be developed that contains the signatures of the individual and all participants **Claim Ref 2 –** N/A

CMS Evaluation & Response

CMS populates with analysis & decision for each claim.

----------**FOR CMS USE ONLY**----------

Claim Reference Number	CMS Decision Explanation (Includes Response to State by date & Applicable Regulation Citations as indicated.)
1	The CMS Recoveries Panel agrees with the additional documents provided by the state and the Medicaid Federal Financial Participation (FFP) for this claim does not need to be returned. The documentation submitted was sufficient to modify the error finding.
2	The CMS Recoveries Panel denies the recovery exception request for this claim. CMS upholds the original MR6 error finding because the referenced claim received a decision by the CMS Appeal panel on 01/15/20 and is not eligible for a Recoveries Exception Request. .
3	
4	
5	
Response to State (include Date):	
Applicable Regulation Citations:	

Acceptable Exceptions Reasons

Any request for recoveries exceptions must be based on one of the below reasons. Please submit to CMS within three months of publication of the FEFR for CMS to consider the information.

1. The state collects the overpayment from the provider – If the state receives recovery of the overpayment from the provider, the one-year rule no longer applies. When the state collects the overpayment from the provider, the state must return the federal share on the next quarter ending CMS-64 and/or CMS-21 expenditure report.

2. The state adjusts the claim to the correct amount – The PERM program reviews claims paid or denied in each quarter of the RY, including adjustments made to the claims within 60 days of the original paid date. Thus, the RC could identify overpayments for claims where the state waited more than 60 days from the original paid date to adjust to the correct paid amount. In such instances, the state is not required to return the federal share. The state should notify the PERM State Liaison and CMS DFO contact and provide documentation (e.g., screenshots, etc.) of the adjustment.

Acceptable Exceptions Reasons, continued

Any request for recoveries exceptions must be based on one of the below reasons. Please submit to CMS within three months of publication of the FEFR for CMS to consider the information.

3. Provider successfully appeals to the state – If a provider successfully appeals the error to an Administrative Law Judge (ALJ), the state can submit proof of the ALJ decision to the PERM State Liaison and will not need to return the federal share of the overpayment. Many states have an informal appeal process in place that is preferable and less time - consuming than a formal ALJ appeal. If an error is overturned through an informal appeal process, the state should submit documentation to the PERM State Liaison and CMS DFO contact. CMS reviews the documentation to determine whether the federal share needs to be returned.

4. Provider or state submits documentation after the cycle has ended – After the cycle is over, when states send out recovery demand letters to providers, providers sometimes submit the outstanding medical record to the state [mostly for No Reviewable Documentation Received (MR1) and Document(s) Absent from Record (MR2) errors]. Since this occurs after the cycle cutoff date and the allowable timeframe for documentation submission (i.e., 75 days for initial MRRs and 14 days for additional documentation requests), the claim remains an error for PERM purposes, but CMS cannot request in good faith that states return the federal share if there is sufficient proof that demonstrates the state paid the claim correctly. The state should send the documentation to the CMS PERM State Liaison through the PERM Review Contractor (RC) Secure File Transfer Protocol (SFTP). As a reminder, please do not send PII nor PHI information through email. CMS' PERM appeals panel reviews the documentation to determine if it demonstrates the state correctly paid the claim. After a decision is made, the CMS PERM State Liaison will notify the CMS DFO contact and the state of the determination.

Acceptable Exceptions Reasons, continued 2

Any request for recoveries exceptions must be based on one of the below reasons. Please submit to CMS within three months of publication of the FEFR for CMS to consider the information.

5. The state is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with 42 CFR § 433.318 Overpayments involving providers who are bankrupt or out of business. For bankrupt or out of business providers, the state must comply with the documentation requirements outlined in § 433.318.

CMS
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Any Questions?