CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-15 Medicaid Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13945	**Date: September 3, 2026**
	Change Request 14548

SUBJECT: Updates to Chapter 3, Chapter 4, and Chapter 5 in Publication (Pub.) 100-15, Including Updates to the Vetting Process and the Creating Overpayment Records Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise various sections in chapter 3, chapter 4 and chapter 5 in Pub. 100-15. The revisions include updates to the vetting process and various minor edits throughout.

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: October 5, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 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	3/3.4/Vetting Process
R	4/4.1/Documentation of Investigations/Audits and Medical Review Findings
R	4/4.3/Overpayment Resolution Process
R	4/4.3/4.3.1/Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure
R	4/4.4/State Appeal Process
R	4/4.5/Close-Out Letters
R	5/5.2/Entry Requirements for Investigations
R	5/5.3 - Creating Overpayment (OPT) Records
R	5/5.4/Mandatory Fields in UCM for Medicaid

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor 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. 100-15	Transmittal: 13945	Date: September 3, 2026	Change Request: 14548

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to update sections in chapter 3, chapter 4 and chapter 5 of Pub. 100-15. Specifically, guidance regarding the vetting process and various other minor updates are being made to the manual chapters.

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	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14548.1	The contractor shall simultaneously upload the initial referral form (Appendix L), or state vetting form, and the Investigative Plan (IP) to the Unified Case Management (UCM) system when submitting the proposed lead to the Medicaid Business Function Lead (BFL).									UPICs
14548.2	The contractor shall be advised that the state will be given two weeks (14 calendar									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	days) to respond to the vetting request.									
14548.2.1	The contractor shall proceed with opening the investigation if no response is received in two weeks.									UPICs
14548.2.2	The contractor shall be advised that if requested by the State, ahead of the response due date, the UPIC may grant the State a response time extension with BFL approval.									UPICs
14548.3	The contractor shall be advised that adequate documentation consists of documents obtained by the investigator during the course of the investigation/audit or medical review and should be part of the investigation/audit working file.									UPICs
14548.3.1	The contractor shall upload all documents relevant to investigative/audit findings to the UCM.									UPICs
14548.4	The contractor shall review the provider's responses, if any, to determine if adjustments to the findings are necessary.									UPICs
14548.5	The contractor shall be advised that the Medicaid BFL, the contract, and, if necessary, the state will reconcile any issues with the Revised Initiate Findings Report (RIFR), after which, the contractor produces a Final Findings Report (FFR) and completes the FFR – State Transmittal Letter and submits both to the CMS for approval within 13 months of the Medicaid Investigation									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Start Date.									
14548.6	The contractor shall be advised that versions of the FFR – State Transmittal Letter are available for fee for service and/or managed care investigations/audits, where the managed care overpayments can be recouped.									UPICs
14548.7	The contractor shall comply with the applicable directions when preparing FFRs for all assigned Medicaid investigations/audits.									UPICs
14548.8	The contractor shall review each State Medicaid Agency's (SMA) appeal process during the onset of any proposed investigation/audit, so they understand the level of support needed and can plan appropriately should the SMA require support during the appellate process.									UPICs
14548.9	The contractor shall complete a summary of the investigation/audit that is submitted to the SMA along with the letter to the provider, and a copy is uploaded to UCM.									UPICs
14548.10	The contractor shall be advised that investigative activities, such as on-site visits, interviews, etc. shall be captured in the "Activity Log" section of UCM, which can be accessed within the system.									UPICs
14548.11	The contractor shall spawn an overpayment record in the UCM when there is an									UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	identified overpayment.									
14548.12	The contractor shall include any activities planned for the investigation in the "Activity Log" section of UCM, which can be accessed within the system.									UPICs
14548.13	The contractor shall be advised that the State Agency field within the General Tab of the UCM is a mandatory field for investigations/audits that have a "Program Type" of 'Medicaid.'									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 Medicare Administrative Contractor 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

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 3 – Medicaid Investigations & Audits

(Rev. 13945; Issued: 09-03-2026)

3.4 - Vetting Process

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

All leads and any new providers that the UPIC determines warrant further investigation shall be vetted concurrently through the SMA and CMS for approval before transitioning to an investigation. Prior to submitting to CMS and SMA for vetting, with the exception of managed care plan leads, the UPIC will submit the proposed lead to the Medicaid BFL for review and approval. *When submitting the proposed lead to the Medicaid BFL, the UPIC shall simultaneously upload the initial referral form (Appendix L), or state vetting form, and the Investigative Plan (IP) to the UCM.* This is to ensure that projects of the highest priority are being addressed by the UPIC, and resources are being properly allocated.

When vetting with CMS, the UPICs shall follow the Medicare PIM 4.6 - Vetting Leads with CMS.

When vetting with the SMA, the UPIC will submit an initial referral form to the SMA (Appendix L). The SMA's acceptance or declination of the proposed investigation shall be clearly documented on such form and shall be uploaded into the Document section of UCM by the UPIC. In addition, the UPIC shall indicate in the "State Involvement" tab the date vetting was sent to the SMA, the date the response was received, and the state's response. *The state will be given two weeks (14 calendar days) to respond to the vetting request. If no response is received in two weeks the UPIC shall proceed with opening the investigation. If requested by the State, ahead of the response due date, the UPIC may grant the State a response time extension with BFL approval.*

If the SMA declines pursuing the provider/scheme (for example, the SMA has already investigated the provider or scheme and had no findings), then the proposed investigation shall be closed. However, leads should not be closed due to delays in the state's response to vetting. Instead, the UPIC shall document any delays in the vetting process in UCM. If the SMA declines a potential investigation that the UPIC believes is a major risk to the applicable state Medicaid program, the UPIC will communicate this to the CMS COR/BFL team.

Medicaid Program Integrity Manual
Chapter 4 - Reporting Investigational Findings and Making Referrals

(Rev. 13945; Issued: 09-03-2026)

4.1 - Documentation of Investigations/Audits and Medical Review Findings

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

All investigations/audits and medical review findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the investigator during the course of the investigation*/audit* or medical review and should be part of the investigation/audit working file. The working paper file contains evidence accumulated throughout the investigation/audit to support the work performed, the results of the investigation/audit, including adjustments made, and all findings made by the reviewer. All documents *relevant to investigative/audit findings* shall be uploaded to UCM.

Examples of documents are:

1. Copies of federal and/or state policies and regulations.
2. Copies of medical/financial records to support the finding.
3. Copies of state generated remittance advices which support the claim payment or credit adjustment.
4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists.
5. Investigator's notes regarding the investigation.
6. Miscellaneous memoranda that pertain to the investigation.

4.3 - Overpayment Resolution Process

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

Upon identification of an overpayment based on a Medicaid investigation/audit, an Initial Findings Reports (IFR) is sent to the Medicaid BFL for review and approval. Once the BFL has approved the IFR, the UPIC will send the IFR to the SMA within 180 days of the Medicaid Investigation Start Date for review and comments for 30 calendar days. The 180-day time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the Unified Case Management (UCM) system. If the state disagrees with the findings of the UPIC, which results in monetary changes to the Appendix A, the UPIC will revise the IFR and incorporate any other grammatical or narrative corrections identified by the state and document the changes in the UCM, the document will remain an IFR. If there are monetary changes, the UPIC shall inform the BFL to determine the next step. If the state's comments speak to the body of the report and are primarily grammatical or corrections to cited regulations, terminology, etc., the document will remain an IFR, and the UPIC will make any necessary corrections.

The IFR may then be transmitted by the UPIC to the provider for review and comments for 30 calendar days, if required by the SMA. *The* UPIC will review the provider's responses, if any, to determine if adjustments to the findings are necessary. If no adjustments are made to the findings, resulting in no monetary changes to the Appendix A, the UPIC will produce an FFR. If adjustments to the findings, which result in monetary changes to the Appendix A, are necessary, the UPIC will make the revisions in a revised IFR (RIFR) and the RIFR is sent to CMS and the state, this time with a 15-day review and comment period. *The Medicaid BFL*, the UPIC, and, if necessary, the state will reconcile any issues with the RIFR, after which the UPIC produces an FFR and completes the FFR – State Transmittal Letter and submits both to CMS for approval within 13 months of the Medicaid Investigation Start Date. The 13-month time frame is based on normal progression of the investigation/audit with no cause for delay or circumstances outside UPIC control, unless otherwise specified by CMS. All delays shall be documented in the UCM system. CMS, upon approving the FFR, sends the FFR and State Transmittal Letter to the state. The FFR – State Transmittal Letter (Appendix E) can be found in the Appendices. Versions of the *FFR –* State Transmittal Letter are available for FFS and/or managed care investigations/audits, where the managed care overpayments can be recouped (Appendix E); FFS and managed care investigations/ audits when the managed care overpayments are not recoupable, but the FFS are (Appendix F); and managed care-only investigations/audits when there are only managed care overpayments that are not recoupable (Appendix G).

The FFR identifies the total overpayment amount paid to the provider and specifies the amount of Federal Financial Participation (FFP) that the state must return to CMS. It is the state's responsibility to adjudicate the review findings with the provider. The state has one year from the date the overpayment is identified to recover or attempt to recover the overpayment from the provider before the federal share must be refunded to CMS. Under CMS's regulations, the date of discovery of overpayments begins on the date that CMS first notifies the SMA in writing of the overpayment and specifies a dollar amount subject to recovery. (See 42 C.F.R. § 433.316).

Sometimes a 100% overpayment is identified because the provider or supplier does not provide the contractor with the required medical record documentation to conduct a post-payment medical review. A 100% overpayment means that all the claims in the contractor's selected sample are considered to be improperly billed and paid based on the documentation received (or lack thereof). Therefore, they are fully denied through post-payment review. In these instances, the UPIC shall consult with its BFL and SMA on any potential 100% overpayment determinations prior to initiation of state overpayment reporting actions or notice to the provider/supplier. If approved, the UPIC shall coordinate the overpayment reporting actions with the SMA. If denied, the UPIC shall follow the instructions provided by its Medicaid BFL.

In certain instances, the SMA may require an update to the FFR, based on updated analysis by the state, resulting in a downward adjustment in the amount of an overpayment due to an appeal decision from an administrative law judge, informal hearing decision, issues identified within the referenced policy, etc. In these instances, the UPIC shall notify CMS of the discrepancies and discuss a proposed resolution. If it is determined that an update to the FFR is necessary, CMS and the UPIC shall collaborate to draft a Revised FFR (RFFR), along with the FFR Addendum – State Transmittal Letter (Appendix H), which CMS shall submit to the SMA upon completion. The UPIC will edit the OPT financial information in UCM on the original OPT record, upload the RFFR and FFR Addendum – State Transmittal Letter, and notify the BFL via email.

4.3.1 - Calculation of Federal Financial Participation (FFP) Based on State's Date of Expenditure

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

The UPIC shall calculate the FFP amount for each discrepant claim line identified based on the Federal Medical Assistance Percentage (FMAP) in place at the time of the state Medicaid agency's date of expenditure (i.e., the date the state Medicaid agency paid the applicable claim). The total overpayment amount shall be entered into Appendix A of the FFR. The UPIC shall comply with the following directions when preparing FFRs for all assigned Medicaid investigations*/audits*.

- The UPIC shall add columns to Appendix A identifying the "Federal Share Percentage" and "Federal Share Amount" for each Fiscal Year (FY) and FY Quarter identified per discrepant claim.
- The UPIC shall add a column to Appendix A identifying the date of expenditure, in addition to the date of service.
- The UPIC shall use the appropriate "Federal Share Percentage" for FY and Quarter.
- The UPIC shall add a column to Appendix A identifying the "Federal Share Total."
- The UPIC shall sum total the "Federal Share Total" column at the bottom of the Appendix A.

(Example)

Federal Share % (FY15)	Federal Share % (FY16)	Federal Share Amount (FY15)	Federal Share Amount (FY16)	Federal Share Total
%	%	$	$	$

			Total	$

In calculation of the FFP, the UPIC shall consult the Federal Register for the applicable FMAP rate and shall monitor any changes to the FMAP as published in the Federal Register on an ongoing basis. The relevant FMAP table can be found quickly and directly by searching the internet for "Federal Register FMAP rates for FY [year]." The Federal Register displays adjustments to the FMAP for states and territories periodically based on legislation, (i.e., the American Recovery and Reinvestment Act (2009) increased the FMAP for certain claims for services on or after October 1, 2008. The UPIC may also contact the SMA for the applicable FMAP rate. In addition, The Patient Protection and Affordable Care Act (2010) allowed states to file a State Plan Amendment (SPA) to expand Medicaid to cover additional populations. The federal government financed the costs of these newly eligible beneficiaries at a different rate than those who were previously eligible.).

The UPIC shall ensure that the calculations for each claim/claim line and financial payments are accurate for each FY. If, as a result of an appeal, the overpayment needs to be recalculated, the UPIC shall follow the methodology used in the original overpayment calculation.

4.4 - State Appeal Process

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

The CMS does not dictate the process by which UPIC Medicaid review findings are appealed. Rather, appeal processes are determined by each state and are subject to the state's Medicaid program requirements.

It is the responsibility of the SMAs to defend review findings in an administrative appeal or judicial proceeding, although the UPIC may provide testimonial support and other assistance to the state to defend the review findings throughout administrative or judicial proceedings.

It is recommended that the UPIC review each SMA's appeal process during the onset of any proposed investigation*/audit*, so they understand the level of support needed and can plan appropriately should the SMA require support during the appellate process.

The UPIC should alert the Medicaid BFL/COR to any situation where a state indicates a reluctance to defend FFR findings in an appeal.

The UPIC will notify CMS of any changes to the overpayment amounts resulting from hearing decisions.

4.5 - Close-Out Letters

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

If the provider has been notified of the initiation of an investigation/audit and the Medicaid investigation/audit is later discontinued, or if the findings are insufficient to pursue, a close out letter will be issued to the provider. The close-out letter provides notification to the provider that the review has concluded and no further action on the part of the provider is necessary. The UPIC is responsible for obtaining approval from CMS prior to issuing a close-out letter. Upon approval, the UPIC sends the close-out letter to the provider in question, sends a copy to the state, and uploads a copy to UCM. A sample of the "Close-Out Letter" can be found at Appendix A.

In addition, the UPIC will complete a summary of the investigation*/audit* that is submitted to the SMA along with the letter to the provider, and a copy is uploaded to UCM. This summary is not sent to the provider. The "Closing Summary" template can be found at Appendix B.

Medicaid Program Integrity Manual
Chapter 5 - Unified Case Management System

(Rev. 13945; Issued: 09-03-2026)

5.2 - Entry Requirements for Investigations

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

For most of this information, please defer to section 4.12.2 of the Medicare PIM titled, "Initial Entry and Update Requirements for UPIC Leads and Investigations."

Guidance unique to Medicaid:

Investigative activities, such as on-site visits, interviews, etc. shall be captured in the "*Activity Log*" section of UCM.

The UPIC shall take all appropriate administrative actions in accordance with this manual and in conjunction with the SMA.

5.3 - Creating Overpayment (OPT) Records

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

The UPIC shall spawn an OPT record in the UCM when there is an identified overpayment.

For investigations/audits of managed care network providers, where the provider is enrolled in multiple managed care organizations (MCOs), one OPT record will be opened. The UPIC will break down the overpayments of each MCO payor within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each payor.

In circumstances where the provider is being investigated/audited for both fee-for-service (FFS) claims and is enrolled in managed care, one OPT record will be opened. The UPIC will break down the overpayments for the FFS portion and the MCO within the UCM "Overpayment Financials" section and in the FFR with a separate appendix/attachment for each.

For the "Overpayment Financials" section of the OPT record, the 'Original Overpayment Amount' will be the amount in the IFR that goes to the SMA and may include any revisions in the overpayment amount based on the CMS review. Whenever the overpayment is revised—either due to the state's review or the provider's review—the UPIC shall update the financial section of the OPT record with the revised amounts in the 'Original Overpayment Amount' column and include the date of the revision in the 'Determination Date' column. The 'Original Overpayment Amount' column should reflect the overpayment amount identified in the FFR submitted to CMS.

For the 'Federal Share Amount' of the "Overpayment Financials" section, the federal share will only be calculated for the FFR and will be entered prior to submitting the FFR to CMS. The amount will be the calculated federal share of the overpayment amount identified in the FFR. If the FFR is revised after it has been issued to the SMA, and the overpayment changes, the 'Revised Overpayment Amount' will be revised to reflect the new overpayment amount, and the federal share will be recalculated, and the amount will be entered in the 'Revised Federal Share' column.

For a Revised FFR (RFFR), that has occurred after the FFR is issued to the SMA, the UPIC will update the financial amount by editing the original OPT record. The UPIC shall create a folder in the UCM and upload all RFFR documents and notify the BFL of the RFFR via email.

5.4 - Mandatory Fields in UCM for Medicaid

(Rev.13945; Issued: 09-03-2026; Effective: 10-05-2026; Implementation: 10-05-2026)

There are some fields in UCM which are mandatory for investigations/audits that have a "Program Type" of

'Medicaid.' Currently, these include the fields listed below, although this list may change as needs arise. Please refer to the UCM User Manual and Release Notes for all changes and updates.

Mandatory Fields for the Case (CSE) Record:

1) Fraud Case Summary Section
   a) Case Close Reason (if closed as a lead)
   b) Medicaid/Medi-Medi Case Close Reasons (when closed as an investigation)

2) *Activity Log* Section
   a) Any activities planned for the investigation shall be captured here. This may or may not include interviews with beneficiaries, providers, employees, etc.; on-site reviews; medical reviews, etc.

3) General Tab
   a) Program Type
   b) Data Source of Lead
   c) *State* Agency

4) Allegations Tab
   a) Provider Type (formerly Service Type)
   b) Medicaid Dollars at Risk:
      i. FFS
      ii. MCO

5) State Involvement Tab
   a) Date Lead Vetted with State
   b) State Response Date
   c) State Response Status