CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 498	**Date: December 27, 2013**
	Change Request 8541

SUBJECT: Notifying the Provider of Postpayment Review Results

I. SUMMARY OF CHANGES: This CR instructs contractors to provide review results letters to providers at the conclusion of postpayment reviews, even if no overpayment determination is made.

EFFECTIVE DATE: January 28, 2014
IMPLEMENTATION DATE: January 28, 2014

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	3.6.4/Notifying the Provider

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 obliged 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

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

Business Requirements

Pub. 100-08	Transmittal: 498	Date: December 27, 2013	Change Request: 8541

SUBJECT: Notifying the Provider of Postpayment Review Results

EFFECTIVE DATE: January 28, 2014
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I. GENERAL INFORMATION

A. Background: Contractors currently send a review results letter to the provider when an overpayment determination is made. The instructions are being changed so that a review results letter shall be sent to the providers even if no overpayment determination has been made.

B. Policy: Contractors currently send a review results letter to the provider when an overpayment determination is made.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8541.1	MACs shall send a review results letter to the provider at the conclusion of postpayment review even if no overpayment determination is made.	X	X	X	X					
8541.2	Review results letters shall include the review determination for each claim in the sample, including a specific explanation of why some services were determined to be non-covered, or incorrectly coded and if others were payable.	X	X	X	X					ZPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, 410-786-7480 or debbie.skinner@cms.hhs.gov , Marissa malcolm, 410-786-0119 or marissa.malcolm@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. 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 do 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.

3.6.4 - Notifying the Provider

(Rev.498, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

This section applies to, MACs, Recovery Auditors, and ZPICs, as indicated.

A. General

At the conclusion of postpayment review, the MACs shall send a Review Results Letter to the provider *even if no overpayment determination is made*. If the MACs choose to send a Review Results Letter separately from the demand letter they shall do so within the timeframes listed in PIM chapter 3, §3.3.1.1F. Likewise, the Recovery Auditors shall issue a Review Results Letter for complex audits as outlined in their SOW requirements. ZPICs shall comply with the requirements listed below when issuing Review Results Letters.

Each Review Results Letter shall include:

- Identification of the provider or supplier—name, address, and NPI;
- Reason for conducting the review or good cause for reopening;
- A narrative description of the overpayment situation that states the specific issues involved in the overpayment as well as any recommended corrective actions;
- The *review determination* for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded *and if others were payable*;
- A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, the §1879 and §1870 of the Act determinations made for each specific claim, along with the amounts that will and will not be recovered from the provider or supplier;
- Any information required by PIM chapter 8, §8.4 for statistical sampling for overpayment estimation reviews;
- Total underpayment amounts;
- Total overpayment amounts that the provider or supplier is responsible for;
- Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault;
- MACs shall include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- 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 (not applicable to Recovery Auditors or ZPICs);
- The provider's or supplier's right to request an extended repayment schedule (not applicable to Recovery Auditors or ZPICs);
- The MACs and ZPICs shall include limitation of liability and appeals information in the provider notices;

- The MACs shall include appeals information in the provider notices;

- The MACs shall include the provider or supplier financial rebuttal rights under PIM chapter 3, §3.6.5; and,

- For MAC Review Results Letter only, a description of any additional corrective actions or follow-up activity the MAC is planning (i.e., prepayment review, re-review in 6 months).

If a claim is denied through prepayment review, the MACs and ZPICs are encouraged to issue a notification letter to the provider but may use a remittance notice to meet this requirement. However, if a claim is denied through postpayment review, the MAC and Recovery Auditor shall notify the provider by issuing a notification letter to meet this requirement. The ZPIC shall use discretion on whether to issue a notification letter.

The CERT contractor is NOT required to issue provider notices for claims they deny. Instead, the CERT contractor shall communicate sufficient information to the MAC to allow the MAC to develop an appropriate provider notice.

B. MACs

The MACs need provide only high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared system remittance advice messages are sufficient notices to the provider. However, for complex review, the provider should be notified through the shared system, but the MAC shall retain more detailed information in an accessible location so that upon written or verbal request from the provider, the MAC can explain the specific reason the claim was denied as incorrectly coded or otherwise inappropriate.

C. Recovery Auditors

For overpayments detected through **complex** review, the Recovery Auditor shall send a review results letter as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send a remittance advice to the provider and collect the overpayment.

For overpayments detected through **non-complex** review, the Recovery Auditor shall notify the provider as indicated in the Recovery auditor SOW and will communicate sufficient information to the MAC so that the MAC can send a Remittance Advice to the provider.

For underpayments, the Recovery Auditor shall notify the provider as indicated in the Recovery Auditor SOW. In addition, the Recovery Auditor shall communicate sufficient information to the MAC so that the MAC can send Remittance Advice to the provider and pay back the underpayment.

D. ZPICs

For overpayments detected through **complex** review, and after coordination between the ZPIC and OIG, the ZPIC shall send a review results letter (the MAC sends the demand letter). In addition, the ZPIC shall communicate sufficient information to the MAC so that the MAC can send a demand letter to the provider and collect the overpayment. The ZPIC shall use discretion on whether to send the review results letter.

E. Indicate in the Denial Notice Whether Records Were Reviewed

For claims where the MAC or ZPIC had sent an ADR letter and no timely response was received, they shall issue a denial and indicate in the provider denial notice, using remittance advice code N102/56900, that the denial was made without reviewing the documentation because the requested documentation was not

received or was not received within the allowable time frame (§1862(a) (1) of the Act). This information will be useful to the provider in deciding whether to appeal the decision.

For claims where the reviewer makes a denial following complex review, the reviewer has the discretion to indicate in the denial notice, using remittance advice code N109 that the denial was made after review of submitted documentation. This includes those claims where the provider submits documentation along with the claim and the reviewer selects that claim for review.