



Medicare Physician Services Version

KEY CONCEPTS OUTLINE

Module 14: When the Medicare Payment is Not What You Expect: Audits and Appeals

I. Medicare Audit Programs

A. Comprehensive Error Rate Testing (or CERT)

1. Overview

- a. CERT is a Medicare audit program designed to determine national, contractor specific, and service-specific paid claim error rates. <Medicare Program Integrity Manual, Chapter 12 § 12.3>

2. CERT Administration

- a. There are two separate CERT contractors:

(i) The CERT Review Contractor

- (a) The CERT Review Contractor is responsible for reviewing all the records and comparing what was billed with what was documented to make a claim-by-claim decision if the claim was properly paid or not. <CERT Provider Website, “About Program” page>

- (1) The current CERT Review Contractor is Empower AI, Inc. located in Richmond, VA

(ii) The CERT Statistical Contractor

- (a) The CERT Statistical Contractor is responsible for the big picture analyses and may select further claims for review. <Medicare Program Integrity Manual, Chapter 12 § 12.3.2; CERT Provider Website, “About Program” page>

- (1) The current CERT Statistical Contractor is The Lewin Group located in Falls Church, VA. <CERT Provider Website, “About Program” page>

3. The Scope of the CERT Claims Review

a. Claims Selection Process

- (i) A random sample of claims is selected from each claims processing Contractor for inclusion in the CERT review. <Medicare Program Integrity Manual, Chapter 12 § 12.3.2>

b. Medicare Guidelines Applied to CERT Reviews

(i) In General

- (a) CMS requires the CERT Review Contractor to apply all national and local coverage, coding, and billing guidelines when performing CERT reviews. <Medicare Program Integrity Manual, Chapter 12 § 12.3.3.2>

4. Identified Overpayments and Underpayments

- a. If a CERT review identifies a claim that was either overpaid or underpaid, the claim is referred back to the Contractor for collection of the amount overpaid or payment of the underpaid amount. <Medicare Program Integrity Manual, Chapter 12 § 12.3.4>

5. CERT Appeals

- a. CERT decisions are appealable through the normal Medicare appeals process (as discussed below). <Medicare Program Integrity Manual, Chapter 12 § 12.3.5>

6. CERT Statistics

- a. The FY 2024 Medicare fee-for-service program projected improper payment rate is 7.66%, representing \$31.70 billion in improper payments, compared to the FY 2023 estimated improper payment rate of 7.38% representing \$31.2 billion in improper payments. <CMS web site page; Research-Statistics-Data.asp>
- b. Separate improper payment rates are calculated for Part A and Part B.
- c. Part B claims for professional services represent an improper payment rate of 10.35% which equates to \$11.45 billion in the yearly reporting period (July 1, 2023–June 30, 2024).

d. From the 2024 CERT report, the breakdown of improper payments made by all MACs were as follows. <Medicare Fee-For-Service 2024 Improper Payments Report>

- (a) No documentation – **8.2%** of total
- (b) Insufficient documentation – 59.8% of total
- (c) Medical necessity errors – **15.7%** of total
- (d) Incorrect coding – 10.0% of total
- Other – **6.3%** of total

B. Medicare Administrative Contractor – Target Probe and Educate

1. Newest initiative: Target Probe and Educate (TPE)
 - a. CMS has made the decision to adopt TPE performed at the MAC level based on favorable provider response to previous Probe and Educate (P&E) pilot programs
 - b. MAC specific based on data analytics
2. Effects providers and suppliers who have high denial rates or unusual billing practices
 - a. Those submitting compliant claims will NOT be included in TPE
3. TPE's purpose is to increase accuracy in specific areas through the identification of claim submission errors, and to assist physicians with correction and education.
<CMS Transmittal R1919OTN>
4. Notification:
 - a. Providers will be notified via letter of inclusion
 - b. May consist of three rounds of a prepayment probe review with education
 - (i) Review of 20–40 claims per “round”
 - (ii) At the end of each round, providers/suppliers will be sent a letter detailing the results of the reviews
 - (a) If claims errors are discovered, then:
 1. One-on-one education sessions will be provided

- (b) Education will also be provided throughout the TPE review process regarding easily resolved errors
- c. Discontinuation of review may occur at any time if appropriate improvement is achieved during the review process
- d. TPE does not amend or change the appeals process

C. The Recovery Audit Program

1. Recovery Audit Program Description

- a. As discussed in the first module, the Recovery Audit program is a congressionally mandated program resulting from a three-year Medicare demonstration program under which private companies called “recovery auditors” are paid on a contingency basis to identify Medicare underpayments and overpayments. <Medicare Financial Management Manual, Chapter 4 § 100.1 and MLN Matters Article SE0617>

2. Recovery Audit Program Appeals

- a. Overpayment determinations initiated through the Recovery Auditors are appealable through the normal Medicare appeals process (as discussed below). <Medicare Financial Management Manual, Chapter 4 §§ 100.7>

II. Medicare Appeals

A. The Initial Determination

- 1. The Contractor must process each clean claim submitted and make an “initial determination” on the claim within 30 days. <42 CFR §§ 405.904(a)(2), 405.922; Medicare Claims Processing Manual, Chapter 1 § 80.2.1.1>
 - a. A “clean claim” is one that can be processed by the Contractor without any investigation or development. <Medicare Claims Processing Manual, Chapter 1 § 80.2>
- 2. While all clean claims must be processed within 30 days, CMS has established a claims payment floor whereby claim payment must be held before payment is released. The claim payment floor is dependent upon if the claim was an electronic or a paper claim. <Medicare Claims Processing Manual, Chapter 1 § 80.2.1.2>
 - a. The claim payment floor for an electronic claim is 13 days.

- b. The claim payment floor for a paper claim is 26 days.

B. Reopening of a Claim Determination

1. Separate and Distinct from the Appeals Process

- a. The request for a telephone reopening of a claim is conducted at Contractor discretion and may result in changing of a claim determination. <Medicare Claims Processing Manual, Chapter 34 § 10>
- b. Requesting a reopening does not have an impact on initiating a first level of appeal (redetermination) within the required timeframe. A Contractor's decision not to reopen a claim is not appealable. <Medicare Claims Processing Manual, Chapter 34 § 10.2>
 - (i) If reopening a claim results in a revised determination, then new appeal rights will be offered on the revised determination. <Medicare Claims Processing Manual, Chapter 34 § 10>

2. Issues That Can Be Reopened

- a. MACs are required to offer a telephone reopening process to correct minor clerical errors or omissions. <Medicare Claims Processing Manual, Chapter 34 § 10.4>
- b. CMS defines clerical errors on the part of the Contractor or the provider to include:
 - (i) Mathematical or computational mistakes;
 - (ii) Transposed procedure or diagnostic codes;
 - (iii) Inaccurate data entry;
 - (iv) Misapplication of a fee schedule;
 - (v) Computer errors;
 - (vi) Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; and
 - (vii) Incorrect data items, such as provider number, use of a modifier or date of service. <Medicare Claims Processing Manual, Chapter 34 § 10.4>
- c. Reopening issues are limited to errors in form and content. Minor omissions that can be addressed as a reopening do not include failure to bill for certain items or

services that were not previously billed. <Medicare Claims Processing Manual, Chapter 34 § 10.4>

3. Issues That Cannot Be Reopened

- a. Issues that cannot usually be managed via the telephone reopening process and therefore must proceed through the appeals process include:
 - (i) Claims requiring the input of medical staff or entities outside of the reopening department;
 - (ii) Claims involving limitation on liability;
 - (iii) Medical necessity denials and reductions; or
 - (iv) Issues that require an analysis of documents such as operative reports and clinical summaries. <Medicare Claims Processing Manual, Chapter 34 § 10.5.2>

C. Medicare Claims Appeals Process – Five Levels

1. Contractor Redetermination – The First Level of Appeal

a. Overview

- (i) A physician/practitioner who disagrees with a Contractor’s initial determination on a claim may request a Contractor “redetermination.” <42 CFR §§ 405.940; Medicare Claims Processing Manual, Chapter 29 § 310>
 - (a) In order to provide some level of independence, the redetermination must be made by someone (typically a Contractor employee) who was not involved in making the initial determination. <42 CFR § 405.948; Medicare Claims Processing Manual, Chapter 29 § 310>

b. Time Frame for Requesting a Redetermination

- (i) In order to obtain a redetermination, the redetermination request must generally be received by the Contractor within 120 days of the date the physician/practitioner received the notice of the initial determination. <42 CFR § 405.946(a) Medicare Claims Processing Manual, Chapter 29 § 310.2>

- (a) In some cases, it may be possible to obtain an extension of the time limit for requesting a redetermination. <42 CFR § 405.946(b); Medicare Claims Processing Manual, Chapter 29 § 310.2>

c. The Redetermination Request

- (i) In order to be effective, a redetermination request must be made using a designated CMS redetermination request form (CMS 20027), or a letter of your own containing all of the following:
 - (a) the beneficiary's name,
 - (b) the Medicare health insurance claim number,
 - (c) the specific items or services for which the redetermination is being requested, including the specific dates of service,
 - (d) the name and signature of the party requesting the redetermination, and
 - (e) An explanation of why the party disagrees with the initial determination and any evidence that the physician/practitioner would like the MAC to consider in making the redetermination. <42 CFR §§ 405.944(b), 405.946; Medicare Claims Processing Manual, Chapter 29 § 310.1.B.2.b>

d. MAC Time Frame for Responding

- (i) Subject to certain limited exceptions, the MAC has 60 calendar days from the receipt of the redetermination request to issue its redetermination decision. <42 CFR § 405.950; Medicare Claims Processing Manual, Chapter 29 § 310.5.A>

2. QIC Reconsideration – The Second Level of Appeal

a. Overview

- (i) A physician/practitioner who disagrees with a Contractor redetermination decision may request “reconsideration” by a “Qualified Independent Contractor” (QIC). <42 CFR § 405.960; Medicare Claims Processing Manual, Chapter 29 § 320>

b. QIC Entities

- (i) The QICs are companies that contract with CMS to perform reconsiderations of Medicare claims as a part of the Medicare appeals process. <Medicare Claims Processing Manual, Chapter 29 § 110>

- (a) CMS must contract minimally with four QICs. <42 CFR § 405.902; Medicare Claims Processing Manual, Chapter 29 § 320>

c. Reconsideration Definition

- (i) A reconsideration is an independent review of the redetermination. The reconsideration is performed by a panel of individuals with specialized expertise (including, in some cases, physicians). <42 CFR § 405.968; Medicare Claims Processing Manual, Chapter 29 § 320>

d. Time Frame for Requesting a Reconsideration

- (i) In order to obtain a reconsideration, the reconsideration request must generally be received by the QIC within 180 days of the date the physician/practitioner received the notice of the redetermination. <42 CFR § 405.962(a); Medicare Claims Processing Manual, Chapter 29 § 320.2>
- (a) In some cases, it may be possible to obtain an extension of the time limit for requesting a reconsideration. <42 CFR § 405.962(b); Medicare Claims Processing Manual, Chapter 29 § 320.2>

e. The Reconsideration Request

(i) Information Required

- (a) In order to be effective, a reconsideration request must be made using a designated CMS reconsideration request form (CMS 20033), or contain all of the following:
 1. the beneficiary's name
 2. the Medicare health insurance claim number
 3. the specific items or services for which the reconsideration is being requested, including the specific dates of service,
 4. the name and signature of the party requesting the reconsideration,
 5. the name of the MAC that made the redetermination, and

6. an explanation of why the party disagrees with the redetermination and any evidence that the physician/practitioner would like the QIC to consider in performing the reconsideration. <42 CFR §§ 405.964, 405.966; Medicare Claims Processing Manual, Chapter 29 § 320.1>

(ii) Importance of Providing Complete Information

- (a) The failure to provide the QIC with all applicable evidence, including any missing documentation, may preclude subsequent consideration of that evidence. <42 CFR § 405.966>
 1. Once the QIC has made the Reconsideration decision, new evidence cannot be submitted to the ALJ without good cause for withholding the evidence from the QIC. <MLN Matters Article MM5554>
- (b) It is not necessary to duplicate information that was submitted in the first level Redetermination appeal. The documentation from the Redetermination is forwarded to the QIC. <Medicare Claims Processing Manual, Chapter 29 § 320.5; MLN Matters Article MM5554>

f. QIC Time Frame for Making the Reconsideration Decision

- (i) Subject to certain limited exceptions, the QIC has 60 calendar days from the receipt of a timely reconsideration request to issue its decision on the reconsideration. <42 CFR § 405.970; Medicare Claims Processing Manual, Chapter 29 § 320>
- (ii) If the QIC is not timely in rendering a decision, you may escalate your appeal to the ALJ level. <42 CFR § 405.970(c)(2); Medicare Claims Processing Manual, Chapter 29 § 330.1>

3. ALJ Appeal – Third Level of Appeal

a. Overview

- (i) A physician/practitioner who disagrees with a QIC's reconsideration decision may request a hearing before an administrative law judge (ALJ) if the amount at issue meets the requirement. <42 CFR §§ 405.1002, 405.1006 (b)>
 - (a) The amount in controversy (AIC) for 2025 must be at least \$190.
 1. The amount was \$180 in 2024.
 2. The amount was \$180 for 2023

b. How ALJ Hearings Are Conducted

- (i) At an ALJ hearing, the parties may submit evidence, examine witnesses, and present legal arguments. A representative of CMS, the Contractor, or the QIC may attend or join the hearing as a party. <42 CFR § 405.1000>

c. Time Frame for Requesting an ALJ Hearing

- (i) In order to obtain an ALJ hearing, the hearing request must be received by the appropriate entity (see below) within 60 days of receipt of the date that the physician/practitioner received notice of the QIC's reconsideration decision. <42 CFR § 405.1014(b); Medicare Claims Processing Manual, Chapter 29 § 330.2.B>
 - (a) The notice of the QIC reconsideration decision is supposed to specify where to send the request for an ALJ hearing. <42 CFR § 405.1014(b); Medicare Claims Processing Manual, Chapter 29 § 290.4>

d. The ALJ Hearing Request

- (i) In order to be effective, an ALJ hearing request must be made using a designated CMS ALJ request form (CMS 5011A/B) or contain all of the following:
 - (a) The beneficiary's name, address, and Medicare health insurance claim number,
 - (b) The name and address of the appellant,
 - (c) The name and address of any designated representative,
 - (d) The document control number assigned by the QIC,
 - (e) The dates of service,
 - (f) An explanation of why the party disagrees with the QIC's reconsideration decision, and
 - (g) A statement of any additional evidence that should be considered. <42 CFR § 405.1014(a); Medicare Claims Processing Manual, Chapter 29 § 330.2.C>

e. Time Frame for Issuance of the ALJ Decision

- (i) With some limited exceptions, the ALJ has 90 calendar days from the receipt of a timely ALJ hearing request to issue its decision. <42 CFR § 405.1016; Medicare Claims Processing Manual, Chapter 29 § 330.2.A>

4. Appeals Council Review – Fourth Level of Appeal

a. Overview

- (i) A physician/practitioner who is dissatisfied with the outcome of an ALJ hearing may request a review by the Appeals Council. <42 CFR § 405.1100; Medicare Claims Processing Manual, Chapter 29 § 340>
- (ii) The Appeals Council review is a “de novo” or fresh review of the issue. It looks at the issue anew, rather than simply considering whether the record will support the Contractor’s initial determination. <42 CFR § 1108>
- (a) A physician/practitioner requesting an Appeals Council review does not have an automatic right to a live hearing. In the absence of a live hearing, the Appeals Council makes its decision based on the written evidence submitted. <42 CFR § 1108>

b. Time Frame for Requesting an Appeals Council Review

- (i) A request for an Appeals Council Review must occur within 60 days of the ALJ’s decision. <Medicare Claims Processing Manual, Chapter 29 § 340>

c. Time Frame for Issuance of an Appeals Council Review Decision

- (i) Generally, the Medicare Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from the ALJ level. <CMS web site: <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/05AppealsCouncil.html>>

5. Judicial (i.e., Court) Review – Fifth Level of Appeal

a. Overview

- (i) A physician/practitioner who is dissatisfied with the outcome of an Appeals Council review may obtain a review by a federal district court if the amount in controversy requirement is met. <42 CFR §§ 405.1136, 405.1006 (c)>
- (ii) The amount remaining in controversy for requests made on or after January 1, 2025, is \$1900.00 < See 88 *Fed. Reg.* 67297>

(a) In 2024, the AIC was \$1850.

(b) In 2023, the AIC was \$1850.

b. Time Frame for Filing a Judicial Review

- (i) The time limit for filing for judicial review is 60 days from the date of the Appeals Council's decision. <Medicare Claims Processing Manual, Chapter 29 § 240.A>

D. Opportunities for Escalated Review During the Appeals Process

1. Because the appeals process is so lengthy, Congress requires that CMS provide appellants certain opportunities for expedited review of their claims. The appeals process provides the opportunity for physicians/practitioners to escalate their appeal request to a higher level in the following circumstances:

a. If the QIC fails to complete a reconsideration within the required time frame:

- (i) The QIC must notify the appellant and offer the appellant the opportunity to escalate the appeal to the ALJ.
- (ii) The appellant must notify the QIC in writing if it wishes to escalate the case to the ALJ.
- (iii) Unless the appellant makes a written request to escalate, the QIC will continue the reconsideration process. <42 CFR § 405.970(c)-(e)>

b. If the ALJ does not issue its decision within the required time frame, the appellant may request an Appeals Council review. <42 CFR § 405.1104

c. If the Appeals Council does not issue its decision within the required time frame, the appellant can request escalation to federal court. <42 CFR § 405.1132

E. Application of the Medicare Guidelines to the Reviewing Bodies

1. The QICs, ALJs and the Appeals Council <42 CFR §§ 405.968(b), 405.1060, 405.1062, 405.1063>
- a. All three reviewing bodies are bound to follow NCDs, CMS rulings and applicable laws.
- b. None of the three reviewing bodies are bound to follow LCDs, LMRPs or CMS program guidance (e.g., manuals, transmittals, etc.).

- (i) The choice to decline to follow a policy does not set a precedent.

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space available on a first-come, first-served basis. For security reasons, members of the public will be subject to security screening procedures and must present a valid photo identification to enter the building. Observers requiring auxiliary aids (e.g., sign language interpretation) for this meeting should email DisabilityProgram@fdic.gov to make necessary arrangements. This meeting of the Advisory Committee on Community Banking will also be Webcast live via the internet at <http://fdic.windrosemedia.com>. For optimal viewing, a high-speed internet connection is recommended. To view the recording, visit <http://fdic.windrosemedia.com/index.php?category=Community+Banking+Advisory+Committee>. Written statements may be filed with the Advisory Committee before or after the meeting.

Federal Deposit Insurance Corporation.

Dated at Washington, DC, on September 24, 2024.

James P. Sheesley,
Assistant Executive Secretary.

[FR Doc. 2024-22186 Filed 9-26-24; 8:45 am]

BILLING CODE 6714-01-P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (Act) (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the applications are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at <https://www.federalreserve.gov/foia/request.htm>. Interested persons may express their views in writing on the standards enumerated in paragraph 7 of the Act.

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business

information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington DC 20551-0001, not later than October 15, 2024.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690-1414. Comments can also be sent electronically to Comments.applications@chi.frb.org:

1. *The Michael Carl Martin BAA Irrevocable Trust, Michael Carl Martin, as trustee, both of Ann Arbor, Michigan, and Tye J. Klooster, as Trust Protector, Orland Park, Illinois; and the William Seth Martin BAA Irrevocable Trust, Ann Arbor, Michigan, William Seth Martin, as trustee, Wilmette, Illinois, and Tye J. Klooster, as Trust Protector, Orland Park, Illinois;* to join the Martin Family Control Group and acquire voting shares of Arbor Bancorp, Inc., and thereby indirectly acquire voting shares of Bank of Ann Arbor, both of Ann Arbor, Michigan.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,
Associate Secretary of the Board.

[FR Doc. 2024-22215 Filed 9-26-24; 8:45 am]

BILLING CODE 6210-01-P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at

the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at <https://www.federalreserve.gov/foia/request.htm>. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)).

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington DC 20551-0001, not later than October 28, 2024.

A. Federal Reserve Bank of Cleveland (Nadine M. Wallman, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101-2566. Comments can also be sent electronically to

Comments.applications@clev.frb.org:

1. *Wesbanco, Inc., Wheeling, West Virginia;* to acquire Premier Financial Corp., Defiance, Ohio, and thereby indirectly acquire Premier Bank, Youngstown, Ohio.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2024-22214 Filed 9-26-24; 8:45 am]

BILLING CODE 6210-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4206-N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2025

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in

controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2025. The calendar year 2025 AIC threshold amounts are \$190 for ALJ hearings and \$1,900 for judicial review.

DATES: This annual adjustment takes effect on January 1, 2025.

FOR FURTHER INFORMATION CONTACT: Liz Hosna, (410) 786-4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act) established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review at \$100 and \$1,000, respectively, for Medicare Part A and Part B appeals. Additionally, section 1869(b)(1)(E) of the Act provides that beginning in January 2005, the AIC threshold amounts are to be adjusted annually by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved and rounded to the nearest multiple of \$10. Sections 1852(g)(5) and 1876(c)(5)(B) of the Act apply the AIC adjustment requirement to Medicare Part C/Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement, pursuant to 42 CFR 417.840. Section 1860D-4(h)(1) of the Act, provides that a Medicare Part D plan sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) of the Act with respect to benefits, including appeals and the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations at § 405.1006(b)(2) require the Secretary of Health and Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register**. To be

entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at § 405.1006(b). Similarly, a party must meet the AIC requirements at § 405.1006(c) at the time judicial review is requested for the court to have jurisdiction over the appeal (§ 405.1136(a)).

B. Medicare Part C/MA Appeals

Section 1852(g)(5) of the Act applies the AIC adjustment requirement to Medicare Part C appeals. The implementing regulations for Medicare Part C appeals are found at 42 CFR 422, subpart M. Specifically, sections 422.600 and 422.612 discuss the AIC threshold amounts for ALJ hearings and judicial review. Section 422.600 grants any party to the reconsideration (except the MA organization) who is dissatisfied with the reconsideration determination a right to an ALJ hearing as long as the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary. Section 422.612 states, in part, that any party, including the MA organization, may request judicial review if the AIC meets the threshold requirement established annually by the Secretary.

C. Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

Section 1876(c)(5)(B) of the Act states that the annual adjustment to the AIC dollar amounts set forth in section 1869(b)(1)(E)(iii) of the Act applies to certain beneficiary appeals within the context of health maintenance organizations and competitive medical plans. The applicable implementing regulations for Medicare Part C appeals are set forth in 42 CFR 422, subpart M and apply to these appeals in accordance with 42 CFR 417.600(b). The Medicare Part C appeals rules also apply to health care prepayment plan appeals in accordance with 42 CFR 417.840.

D. Medicare Part D (Prescription Drug Plan) Appeals

The annually adjusted AIC threshold amounts for ALJ hearings and judicial review that apply to Medicare Parts A, B, and C appeals also apply to Medicare Part D appeals. Section 1860D-4(h)(1) of the Act regarding Part D appeals requires a prescription drug plan sponsor to meet the requirements set forth in sections 1852(g)(4) and (g)(5) of the Act, in a similar manner as MA organizations. The implementing regulations for Medicare Part D appeals can be found at 42 CFR 423, subparts M and U. More specifically, § 423.2006 of the Part D appeals rules discusses the

AIC threshold amounts for ALJ hearings and judicial review. Sections 423.2002 and 423.2006 grant a Part D enrollee who is dissatisfied with the independent review entity (IRE) reconsideration determination a right to an ALJ hearing if the amount remaining in controversy after the IRE reconsideration meets the threshold amount established annually by the Secretary, and other requirements set forth in § 423.2002. Sections 423.2006 and 423.2136 allow a Part D enrollee to request judicial review of an ALJ or Medicare Appeals Council decision if the AIC meets the threshold amount established annually by the Secretary, and other requirements are met as set forth in these provisions.

II. Provisions of the Notice—Annual AIC Adjustments

A. AIC Adjustment Formula and AIC Adjustments

Section 1869(b)(1)(E)(iii) of the Act requires that the AIC threshold amounts be adjusted annually, beginning in January 2005, by the percentage increase in the medical care component of the CPI for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of \$10.

B. Calendar Year 2025

The AIC threshold amount for ALJ hearings will rise from \$180 for CY 2024 to \$190 for CY 2025, and the AIC threshold amount for judicial review will increase from \$1,840 for CY 2024 to \$1,900 for CY 2025. These amounts are based on the 89.529 percent change in the medical care component of the CPI, which was at 297.600 in July 2003 and rose to 564.039 in July 2024. The AIC threshold amount for ALJ hearings changes to \$189.53 based on the 89.529 percent increase over the initial threshold amount of \$100 established in 2003. In accordance with section 1869(b)(1)(E)(iii) of the Act, the adjusted threshold amounts are rounded to the nearest multiple of \$10. Therefore, the CY 2025 AIC threshold amount for ALJ hearings is \$190.00. The AIC threshold amount for judicial review changes to \$1,895.21 based on the 89.529 percent increase over the initial threshold amount of \$1,000. This amount was rounded to the nearest multiple of \$10, resulting in the CY 2025 AIC threshold amount of \$1,900.00 for judicial review.

C. Summary Table of Adjustments in the AIC Threshold Amounts

In the following table we list the CYs 2021 through 2025 threshold amounts.

	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
ALJ Hearing	\$180	\$180	\$180	\$180	\$190
Judicial Review	1,760	1,760	1,850	1,840	1,900

III. Collection of Information Requirements

This document announces the annual adjustment in the AIC threshold amounts and does not impose any "collection of information" requirements as defined under 5 CFR 1320.3(c). Consequently, the notice is not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Evell Barco, who is the **Federal Register Liaison**, to electronically sign this document for purposes of publication in the **Federal Register**.

Chyana Woodyard,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2024-22142 Filed 9-26-24; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Diaper Distribution Demonstration and Research Pilot Beneficiary Survey

AGENCY: Office of Community Services, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Office of Community Services (OCS), Administration for Children and Families (ACF), U.S. Department of Health and Human Services, is proposing to continue to collect data to understand diaper need and outcomes for beneficiaries of the Diaper Distribution Demonstration and Research Pilot (DDDRP).

DATES: *Comments due* November 26, 2024. In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above.

ADDRESSES: You can obtain copies of the proposed collection of information and submit comments by emailing infocollection@acf.hhs.gov. Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The DDDR beneficiary survey was developed to examine diaper need and outcomes for beneficiaries served by DDDR. It was piloted under the Formative Data Collections for ACF Program Support information collection (Office of Management and Budget #0970-0531) with the first three cohorts of DDDR grant recipients. The survey includes an enrollment version, which collects demographic data on the children served and caregivers enrolling the program, along with information about employment, education, and income as well as indicators of diaper need. The follow-up version reduces the number of demographic items to focus on change over time in employment, education, income, and diaper need.

Respondents: Respondents are the caregivers enrolling their family members with diaper needs in DDDR services.

Annual Burden Estimates:

Instrument	Total number of respondents	Total number of responses per respondent	Average burden hours per response	Total burden hours	Annual burden hours
Beneficiary Survey—Enrollment Version	63,750	1	.083	5,291.25	1,763.75
Beneficiary Survey—Follow-Up Version	22,500	1	.067	1,507.5	502.5

Estimated Total Annual Burden Hours: 2,266.25.

Comments: The Department specifically requests comments on (a) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given

to comments and suggestions submitted within 60 days of this publication.

Authority: Section 1110, Social Security Act, 42 U.S.C. 1310.

Mary C. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2024-22132 Filed 9-26-24; 8:45 am]

BILLING CODE 4184-24-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; State Maternal Health Innovation Maternal Health Annual Report

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA submitted an Information

Targeted Probe and Educate (TPE) Q & A's



Q1. What is Targeted Probe and Educate?

A1. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers that bill a particular item or service rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers. TPE typically involves the review of 20-40 claims per provider/supplier, per item or service. This is considered a round, and the provider/supplier has a total of up to three rounds of review. After each round, providers/suppliers are offered individualized education based on the results of their reviews. Providers/suppliers are also offered individualized education during a round when errors that can be easily resolved are identified.

Q2. Why did CMS move to the TPE process for medical review?

A2. The results of previous Probe and Educate (P&E) programs have been well received by the provider/supplier community. Additionally, positive results of the TPE pilot program included a decrease in appeals as well as an increase in provider education which resulted in decreased denial rates for a vast majority of providers as they progressed through the P&E process. These initial P&E programs, however, included all providers/supplier that billed a particular service. In an effort to refine the P&E programs, CMS determined that efforts would be better directed toward those providers/suppliers who, based on data analysis, provide the most risk to the Medicare program, and not to all providers/suppliers billing a particular item/service.

Q3. How will a provider/supplier know if they have been selected for TPE review?

A3. Providers/suppliers who are included in the TPE process will receive a notification letter from their MAC. This letter will outline why the provider/supplier has been selected for review as well as what to expect throughout the review and education process.

Q4. Why are the TPE probe sample sizes generally set at 20-40 claims?

A4. The 20-40 claim sample size is intended to allow the MACs to review enough claims to be representative of provider/supplier behavior. This allows MACs and to assess whether claims generally have the necessary supporting documentation to meet Medicare rules and requirements, while not being overly burdensome.

Q5. What happens if there are errors in the claims reviewed?

A5. At the conclusion of each round of 20-40 reviews, providers/suppliers will be sent a letter detailing the results of the reviews and offering a 1-on-1 education session. MACs will also educate providers/suppliers throughout the TPE review process, when errors that can be easily resolved are identified, helping the provider to avoid additional similar errors later in the process. CMS' experience has shown this educational approach is well received by

providers/suppliers and helps to prevent future errors.

Q6. What should a provider/supplier expect during a 1-on-1 education session?

A6. During a one 1-on-1 education session (usually held via teleconference or webinar), the MAC will educate the provider regarding claims with errors representative of those identified during review. Providers/suppliers will have the opportunity to ask questions regarding their claims and the CMS policies that apply to the item/service that was reviewed.

Q7. What error percentage is considered a “high denial rate” and what other factors are used to determine whether a provider moves on for additional review?

A7. The error percentage that qualifies a provider/supplier as having a high denial rate varies, based on the service/item under review. The Medicare Fee-For-Service improper payment rate for a specific service/item or other data may be used in this determination, and the percentage may vary by MAC. Other factors that determine the need for additional review may include but are not limited to decrease in error rate with each round, as well as participation in and improvement with education.

Q8. Can claims reviewed as part of the TPE process be appealed? If a claim is appealed and overturned, would this impact the provider denial rate?

A8. The appeals process is unchanged under the TPE process. If a claim denial is appealed and overturned, this would be taken into consideration in subsequent TPE rounds. *If the appeals results are not available at the time a provider progresses to a second or third round of TPE, but are available when the provider is referred to CMS, CMS takes these results into consideration when determining the need for additional action. If a provider's adjusted error rate, after appeals, indicates no need for additional review, CMS will make that recommendation, and the provider will be monitored by the MAC as they would be had they passed the TPE process and been released from review.*

Q9. Under the TPE program, do the MACs send a letter to the provider/supplier with details regarding the results of their reviewed claims?

A9. At the conclusion of each round of review, the MAC sends the provider/supplier a letter detailing the results of the 20-40 claims reviewed during that round, including details regarding claim errors. This letter may be sent before or after the final one-on-one educational call.

Q10. Is the education provided after each round provider/supplier-specific or general education given to all providers/suppliers?

A10. The education session after each round is developed based on the review findings from the most recently completed round of reviews and is not the same as that given to other providers/suppliers unless errors found in the reviewed claims are the same. The education will reinforce corrections that should be made for errors that continue to be identified.


Q11. Will previous Probe and Educate (P&E) review results be used to identify providers who will be

included in TPE?

A11: CMS is encouraging MACs to use all available sources of data when selecting providers to include in the TPE process. The results of previous P&E programs is one source of data MACs will use to select providers for review. MACs will also use provider billing and utilization patterns, as well as provider specific error rates.

Q12: Can a provider/supplier be included in multiple TPE probes at the same time?

A12: Yes, if a provider/supplier has multiple National Provider Identifiers (NPIs), each NPI could be subject to TPE review. Additionally, if a provider/supplier submits claims to Medicare for more than one item or service, each item/service could be subject to a separate probe as part of the TPE program. Providers/Suppliers and the specific items and services included in the TPE process are those who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers.

 Q13. *When a provider/supplier is moved to an additional round of TPE review, when should the provider expect the additional reviews to start?*

A13. MACs can begin sending documentation requests for claims with dates of service no earlier than 45 days after the previous post-probe one-on-one education. This time gives the provider/supplier the opportunity to make changes based on the education received prior to being subjected to additional review. If a provider declines to schedule education within a reasonable time after receiving the offer, subsequent reviews will be for claims with dates of service no earlier than 45 days from the one-on-one post probe education offer.

 Q14. *How many provider/suppliers were reviewed on TPE in Fiscal Year 2019?*

A14. From October 2018 to September 2019 approximately 13,500 providers and suppliers were started on TPE. Of those started, less than 2% of providers and suppliers have failed all three rounds of TPE. *Note, this percentage is based on all providers/suppliers who started round 1 of TPE and those who have completed all three rounds. Providers and Suppliers still on review, are not yet counted.*

 Q15. *How many claims were reviewed and accepted as billed in the TPE program in Fiscal Year 2019?*

A15. Approximately 435,000 claims were reviewed from October 2018 to September 2019 and approximately 60% were accepted as billed.

 Q16. *How many educational contacts were completed in Fiscal Year 2019?*

A16. There were approximately 90,000 intra- and post-probe educational contacts. Educational contacts include, but not limited to: phone calls, face-to-face visits, webinar/e-visits, emails, and letters.

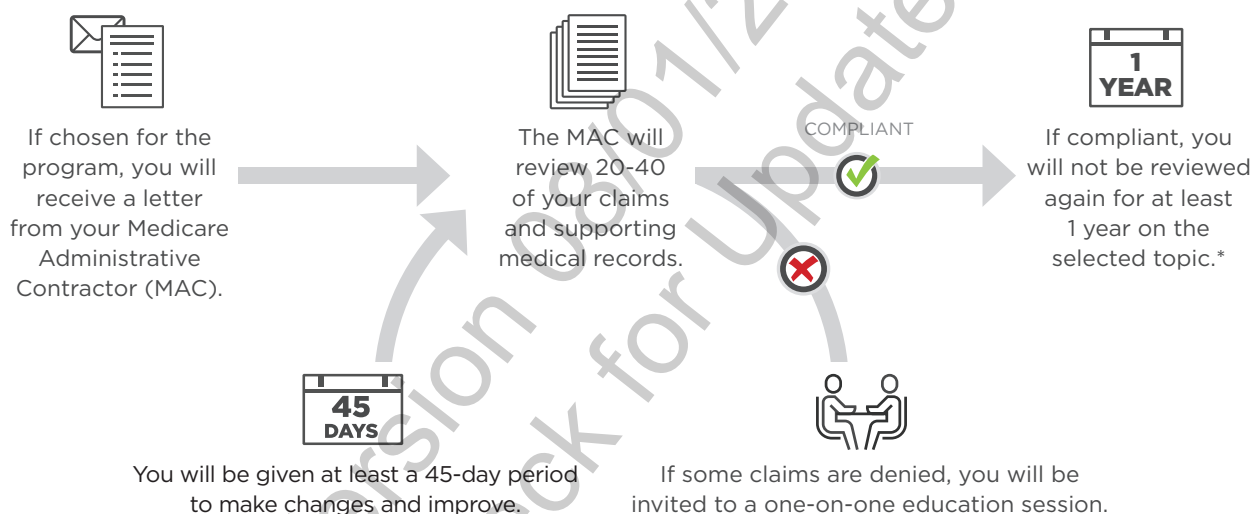
IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

The **Targeted Probe and Educate (TPE)** program includes one-on-one help to reduce claim errors and denials.

When Medicare claims are submitted accurately, everyone benefits.

Most providers and suppliers will never need TPE. The process is only used with those who have high denial rates or unusual billing practices. If you are chosen for the program, the goal is to help you quickly improve. Often, simple errors – like missing a signature – are to blame. The process is designed to identify common errors in your submissions and help you correct them.

HOW DOES IT WORK?







**MACs may conduct additional review if significant changes in provider billing are detected.*

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

-  The signature of the certifying physician was not included
-  Encounter notes did not support all elements of eligibility
-  Documentation does not meet medical necessity
-  Missing or incomplete initial certifications or recertification

Version 08/01/2025
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