Centers for Medicare & Medicaid Services, HHS

§476.98 Review period and reopening of initial denial determinations and changes as a result of DRG validations.

(a) General timeframe. A QIO or its subcontractor—
   (1) Within one year of the date of the claim containing the service in question, may review and deny payment; and
   (2) Within one year of the date of its decision, may reopen an initial denial determination or a change as a result of a DRG validation.

(b) Extended timeframes. (1) An initial denial determination or change as a result of a DRG validation may be made after one year but within four years of the date of the claim containing the service in question, if CMS approves.

   (2) A reopening of an initial denial determination or change as a result of a DRG validation may be made after one year but within four years of the date of the QIO’s decision if—
      (i) Additional information is received on the patient’s condition;
      (ii) Reviewer error occurred in interpretation or application of Medicare coverage policy or review criteria;
      (iii) There is an error apparent on the face of the evidence upon which the initial denial or DRG validation was based; or
      (iv) There is a clerical error in the statement of the initial denial determination or change as a result of a DRG validation.

(c) Fraud and abuse. (1) A QIO or its subcontractor may review and deny payment anytime there is a finding that the claim for service involves fraud or a similar abusive practice that does not support a finding of fraud.

   (2) An initial denial determination or change as a result of a DRG validation may be reopened and revised anytime there is a finding that it was obtained through fraud or a similar abusive practice that does not support a finding of fraud.