Medicare Overpayment Demands and Collection Practices

AHLA Medicare and Medicaid Institute
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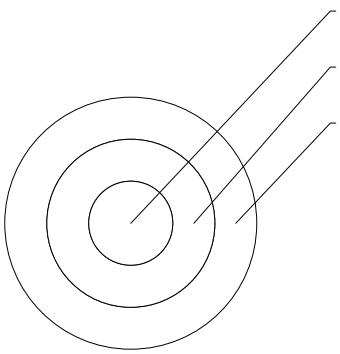
Road Map

- Changes from ACA pertinent to overpayments
- How to analyze an overpayment "situation"
- The CMS/DOJ/DOT process for recovery of overpayments
- "FAQs"

ACA Changes Relating to Overpayments



ACA Changes: 60-day Refund Requirement

(1) IN GENERAL. — If a person has received an overpayment, the person shall—
- (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
- (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS. — An overpayment must be reported and returned under paragraph (1) by the later of—
- (A) the date which is 60 days after the date on which the overpayment was identified; or
- (B) the date any corresponding cost report is due, if applicable.

(3) ENFORCEMENT. — Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

Social Security Act Section 1128J(d), 42 U.S.C. § 1320a-7K(d)

ACA Changes: Adds Statutory Overpayment Definition (Finally)

- Section 6402:
  - Overpayment – The term "overpayment" means any funds that a person receives or retains under title XVIII [Medicare] or XIX [Medicaid] to which the person, after applicable reconciliations, is not entitled under such title

Social Security Act, Section 1128J(d)(4)(B); 42 U.S.C. § 1320a-7k(d)(4)(B)

ACA Changes: Collection Across Tax Identification Numbers

- Medicare typically collects only from the provider or supplier which has been determined to be overpaid
- ACA Section 6401 – payments may be adjusted to payments to other providers/suppliers under the same TIN

Social Security Act Section 1866(j)(A)(6); 42 U.S.C. § 1395cc(j)(a)(6)

ACA Changes: Enrollment Disclosures

- Providers and suppliers must disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has an uncollected debt

ACA Section 6401, amending Social Security Act Section 1866(j); 42 U.S.C. § 1395cc(j)

ACA Change Deleted

- ACA Section 6502 added Social Security Act 1902(a)(78)
  - the State agency. . .exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—
    - (A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;. . . .

Medicare and Medicaid Extenders Act of 2010 struck Section 1902(a)(78)
Note SB 454, introduced by Sen. Grassley on March 2, 2011

Analyzing Medicare Overpayments and Collection Efforts

Analyzing Medicare Overpayments

- Types of Medicare Overpayments
  - MSP vs. non-MSP
  - Part A/Part B
- Determine the Context: the notices look a lot alike!
  - Notice of Overpayment/Demand Letters
  - Suspension of Payments
  - Recoupment
  - Billing Privileges Deactivation/Revocation
  - Outside Collection Agency
  - OIG Office of Audit Services

Analyzing Medicare Overpayments: The Facts

- Proper Party/Address
- Proper Notices (compare to sample letters)
- Other actions pending (e.g., pre-pay review, investigation)?
- Provider/Supplier history
- Medicare/Medicaid population served; other unique factors (e.g., trauma unit)
- What is the story with the overpayment?

Other Common Overpayment Issues for Continuing Providers/Suppliers

- Calculation of the Overpayment
  - Extrapolation – MMA restrictions
  - Sample selection
  - Reopening
- Extended Repayments
- Appeal Strategy
- Recoupment – Rebuttal
- Interest Calculations
- Application of suspended funds

Medicare Overpayment Collection Process

Overpayment Collection Process

- Recoupment by CMS against ongoing Medicare payments is the norm
- But: sometimes recoupment is not possible
  - Provider/supplier has discontinued operations (voluntarily or involuntarily)
  - Ongoing operations, but overpayment exceeds foreseeable payments
  - Collection will disrupt beneficiary access to services (no cash = no services)
  - Bankruptcy filing

CMS Process of Collection

- Overpayment Demand Letters (series)
- Recoupment against ongoing Medicare/Medicaid payments
- Reference for Treasury Offset Program/Cross-servicing
- Litigation (DOJ)

Federal Agencies Involved in the Collection Process

- CMS/Contractors
- Dept. of Justice
- Dept. of Treasury
- IRS
- Medicaid State Agencies
- If fraud, then OIG will also be involved
  - OIG Self-Disclosure Protocol – not available for "simple" overpayments
  - OIG Audits – CMS must still determine the overpayment

Types of Overpayments Referred for Collection Efforts

- Determined overpayments
- Not [yet] applicable to self-determined overpayments
  - Consider: Stark disclosure/repayment (not through the SRDP)

Debt Collection Improvement Act

- Debts more than 180 days delinquent are referred to Treasury Dept. for further action
- Applies to HHS/CMS
  - *But*: CMS has told contractors not to refer debts of active providers to DOT if the debt may be collected within 3 years of delinquency
- Tools include:
  - Treasury Offset Program – tax refunds, vendor payments, etc. offset against debt
  - Demand letters, telephone calls, skip-tracing, private collection agencies, Federal salary offset, and administrative wage garnishment
  - Efforts based on Taxpayer Identification Number

31 U.S.C. § 3720C.

"Intent to Refer" Letter

- DCIA requires specific notice to debtors before referring a debt for cross-servicing and/or the Treasury Offset Program
- Medicare sends this letter as its final demand letter
  - Contractors are directed not to send until the debtor has been on recoupment status for at least 30 days
  - Letter to be sent regardless of previous collections on the debt, unless there is an approved extended repayment plan in place

Cross-Servicing: Treasury DMS Process

Demand Letter. DMS will send out a standard demand letter, on Treasury letterhead within 5 days after acceptance of an account. The demand letter gives the debtor 10 days to respond.

Phone Calls. DMS will begin making phone calls 10 days after the date of the demand letter, depending upon the amount of the debt.

Credit Bureau Reporting. This begins 60 days after a consumer debt is referred and 30 days after a commercial account. The reason for the delay is to ensure that a consumer debtor has the full 60 days from when the demand letter was mailed to make payment.

Dept. of Treasury, Financial Management Service, Debt Management Services, Cross-Servicing Implementation Guide (Rev. Aug. 2008)

Cross-Servicing: Treasury DMS Process, cont.

***Offset*.** Twenty days after the date of the demand letter, the debt will be routed into the Treasury Offset Program. It may stay in the Treasury Offset Program until the time for collection by Offset expires (generally 10 years), or for a period of time specified by the creditor agency.

Collection Agencies. Thirty days (or fifteen days if no phone number for the debtor has been provided) after the date of the demand letter, the debt will be referred to a private collection agency (PCA). A debt may be referred to two PCAs, each PCA will service the debt for a period of 270 days. Treasury has a government-wide contract in place and all referrals will be made to the Treasury contractors. The PCAs will be paid on their collections only. The PCAs are evaluated, and based on their performance may receive monetary bonus' or additional accounts.

Department of Justice. DMS may recommend, and upon agency concurrence refer debts to the Department of Justice (DOJ). DMS will prepare the Claims Collection Litigation Report (CCLR) and monitor case progress while at DOJ.

Administrative Offset Has No Time Limit!

- Offset against other payments (cf., offset as defined under Medicare regulations)
- 31 U.S.C. § 3716(e)(1), specifically made applicable to amounts payable under Title XVIII in § 3716(c)(1)(D)
- IRS limits offset to 10 years (26 C.F.R. § 301.6402-6(c)(1))

Use of Private Collection Agencies

- Part of cross-servicing through Department of Treasury
- Treasury's Financial Management Service (FMS), Debt Management Services (DMS) provides federal agencies with debt collection and management services
- The CBE Group, Inc.
- Diversified Collection Services, Inc.
- Linebarger, Goggan, Blair, & Sampson, LLP
- Pioneer Credit Recovery, Inc.
- Progressive Financial Services, Inc.
- Debts referred before 3/2010: Allied Interstate, Inc.; Ocwen Federal Bank

FAQs

Can We Repay Our Medicare Debt Over Time?

- Extended Repayment plans are available through Treasury and the Private Collection Agencies
- Extended Repayment Plans are available from CMS
  - MMA requires CMS to provide ERPs
  - Manual Provisions require proof that a bank has declined a loan request

Can We Just Settle This Overpayment With Medicare?

- Provisions for suspension and termination of collection and compromise of claims – 42 C.F.R. § 405.376
- 31 U.S.C. § 3711 – head of an agency (as delegated) may compromise a claim of not more than $100,000; see also 31 C.F.R. § 903.1
- Note: Private Collection Agencies may pursue settlement/compromise

How Far Back Can Medicare Go in Determining an Overpayment?

- An overpayment determination typically requires reopening a prior determination, and follows the "good cause" rules
- Distinguish "lookback" from the Statute of Limitations for affirmative overpayment recoveries (6 years), as set forth in 28 U.S.C. § 2415
- Recoupment/administrative offset has no SOL

We Just Bought This Provider, How Can Medicare Charge us an Overpayment?

- Successor liability can apply for entities where there is a transfer of a provider agreement or equivalent

Does Medicare Charge Interest On Outstanding Overpayments?

- As of 1/24/2011, the Medicare interest rate was 11.25 %!
- Rate is set by Treasury regulations

Why is Medicare Recouping Before Our Appeal Time Expires?

- Recoupment is stayed upon the filing of an appeal (redetermination), with slight accommodation for the second level (reconsideration)
- After the second level decision, recoupment is not stayed for further appeals

Could I Get Away From This Debt Just By Filing For Bankruptcy?

Answer: *It depends.*

- **Filing bankruptcy draws a line in the sand the automatic stay - prepetition and post-petition claims**
- **Jurisdictions vary in their decisions how Medicare can use recoupment and set-off for overpayment recovery**
- **CMS can enact a temporary administrative freeze (sometimes called a Strumpf freeze) on funds owed to Debtor**

Bankruptcy Issues, cont.

- Discharge Order or Plan Confirmation does not necessarily bar collection of very claim
- For example, no discharge in a chapter 7 corporate liquidation or liquidating chapter 11
- Note: CMS will look to successor or predecessor liability as basis for recovery

Could I Be Personally Liable as a Board Member, Director, or Officer?

Answer: *It depends.*

- Also note: CMS may deny enrollment if the current owner of an applicant (as defined in 42 C.F.R. § 424.502) physician or non-physician practitioner has an existing overpayment at the time of filing of an enrollment application 42 C.F.R. § 424.530(a)(6)

Questions?

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MEDICARE PAYMENT DEMANDS AND OVERPAYMENT COLLECTION PROCEDURES

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I. INTRODUCTION

A. This discussion focuses on collection efforts for Medicare overpayments, including the most common process for offset or recoupment of debts against ongoing payments, and the affirmative efforts that the government may take if recoupment/offset are not possible.[1]

B. Query: How is "overpayment" defined? The 2010 Affordable Care Act (ACA) added a definition in Section 6402:

> (B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.[2]

This is a broad definition, which would seem to include both excess payments and formally defined debt to the program.[3] (This section of the ACA added the 60-day provider/supplier refund obligations for overpayments; note the reference to "retains" in the language quoted above.) However, it is still important to distinguish what type of "overpayment" is under discussion: e.g., Part A vs. Part B; a claims-based or cost report- based overpayment, other?

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[1] *See* 42 C.F.R. § 405.370 *et seq.*
[2] Section 1128J(d)(4)(B) of the Social Security Act, 42 U.S.C. § 1320a-7k(d)(4)(B).
[3] *See also,* 42 C.F.R. § 424.565.

These distinctions may impacts upon the government's collection efforts, interest assessments, and appeal rights, all of which may help define options.

C. Medicare regulations provide that overpayment collection efforts will proceed against the Medicare provider or supplier.[4] ACA Section 6401 added the option to adjust payments against entities sharing a tax identification number.

> (6) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—
>
> > (A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier….[5]

II. THE PROCESS FOR COLLECTING MEDICARE OVERPAYMENTS

A. Medicare debts are generally divided into two categories:

1. *Medicare Secondary Payer* (MSP) debts, which arise when Medicare conditionally pays for a service that is subsequently determined to be the financial responsibility of another payer. MSP debts include those in which beneficiaries had other insurance or a liability settlement ensued which included payment for medical expenses. This discussion does not address MSP collection efforts.

2. *Non-MSP debts*, which include cost report overpayments and improperly paid claims. When a provider's cost-reporting year is over, the provider files a cost report specifying its costs and cost report debts arise as a result of the cost settlement

[4] *See*, *e.g.*, 42 C.F.R. § 405.376.

process, which includes audits and reviews by Medicare Administrative Contractors (formerly known as fiscal intermediaries and carriers) when it is determined that the amount an institution was paid based on its cost report exceeds the final settlement amount. A cost report debt can also arise if an institutional provider fails to submit a timely cost report and the amount of the debt equals the full amount disbursed for the year in which the provider failed to submit a timely report.

B. CMS's policies and procedures require that the initial demand for an overpayment refund be issued by the Medicare contractor. [6] The CMS manual outlines the minimum requirements that must be fulfilled by the Medicare contractor for claim based and cost report based overpayments + as many as three overpayment demand letters are to sent by the contractor to the Part A provider within 90 days of the date of final determination of the overpayment. Up to two demand letters within 45 days are to be sent to Part B suppliers.

C. Under the Debt Collection Improvement Act of 1996 (DCIA),[7] federal debts which are delinquent for more than 180 days are to be referred to the Treasury Department for further collection efforts.[8] This statute applies to HHS. Among the additional collection tools available under the DCIA is the Treasury Offset Program (TOP), which performs

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[5] Section 1866(j)(a)(6) of the Social Security Act; 42 U.S.C. § 1395cc(j)(a)(6).
[6] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, "Debt Collection." Section 10 *et seq.* deals with requirements for fiscal intermediaries and cost report demand letters; Section 90 *et seq.* deals with the requirements for carriers relating to physician/supplier overpayments. Both carriers and fiscal intermediaries are now known as Medicare Administrative Contractors. Section 100 *et seq.* addresses affiliated contractor and PSC interaction with the non-MSP Recovery Audit Contractors.
[7] P.L. No. 104-134, 110 Stat. 1321, 1358 (April 26, 1996); 31 U.S.C. §3720C.
[8] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70 *et seq.*

payment offset of certain benefit payments, vendor payments, eligible state payments, and tax refunds.[9] Where the Taxpayer Identification Number (TIN) and name of the debtor match the TIN and name of a payee, the payment to the payee is offset and monies that would have gone to the payee are sent to the creditor agency to satisfy the debt.

D. Per DCIA referral criteria, a "delinquent debt" is defined as debt: (1) that has not been paid (in full) by the date specified in the agency's initial written notification (i.e., the agency's first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement.[10]

E. Cross servicing is a process whereby Federal agencies refer eligible delinquent debt to Treasury for collection.[11] As the agency referring the debt, CMS retains responsibility for reporting the debt on the Treasury Report on Receivables Due from the Public. CMS is also responsible for removing accounts from its receivables when Treasury directs it to write off the debt. As part of these efforts, Treasury issues demand letters, conducts telephone follow-up, initiates skip tracing, refers debts for administrative offset. It also refers debt to private collection agencies, which *shall* attempt collection of the debt, using collection tools such as skip tracing, credit report search, demand letters and telephone calls. Other collection tools may include Federal salary offset and administrative wage garnishment.

1. There is no limitation on the period in which administrative offset may be initiated or taken.[12]

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[9] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.3.
[10] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, section 70.4,
[11] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.2.
[12] 31 U.S.C. §3716(e)(1), specifically made applicable to amounts payable under Title
Continued…

F. CMS is mandated to refer all eligible debt, 180 days delinquent, for cross-servicing and/or Treasury Offset Program.[13] Non-MSP debts ineligible for referral include those: (1) in bankruptcy status, (2) in an appeal status (pending at any level), (3) at the Department of Justice, (4) where the debtor is deceased, (5) federal entity debt where the debtor is a federal agency, (6) where the principal balance is less than $25, or (7) debt under fraud and abuse investigation where the investigating unit has provided the contractor with specific instructions not to attempt collection.[14] The Treasury Department has also approved a waiver for the mandatory referral of unfiled cost report debt for cross servicing and/or TOP and for debts less than $100 that do not have a Taxpayer Identification Number. Medicare contractors are required to monitor debt previously ineligible for referral that becomes eligible for referral.

1. The DCIA requires specific notice to debtors before referring a debt for cross-servicing and/or the Treasury Offset Program.[15] Medicare contractors are accordingly required to sent an "Intent to Refer" letter as their final demand letter for all eligible delinquent debt. The final demand letter is that which is routinely sent to debtors to request payment, and shall be sent by the contractor when or before the debt is 90 days delinquent (120 days from the determination date). The letter may be sent before the debt is 90 days delinquent; however, the letter should not be sent until the contractor has placed the debtor on recoupment status for at least 30 days. The letter is to be sent regardless of previous collections on the debt, unless there is an approved current extended repayment

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XVIII of the Social Security Act (Medicare), 31 U.S.C. §3716(c)(1)(D). *But see also*, 26 C.F.R. § 301.6402-6(c)(1) (IRS limits offset to 10 years).

[13] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.5.

[14] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.6.

agreement in effect. This letter may also be sent for debt currently ineligible for referral if the contractor belies the debt shall become eligible in the future (should include language to the effect, "[i]f, after sixty calendar days from the date of this letter we have not received such evidence, your debt, if it is still outstanding and eligible for referral, shall be referred to the Department of Treasury or its designated Debt Collection Center for cross-servicing/offset."[16] The letter should not be sent if the debt is in a status that excludes it from receiving demand letters.

2. The debtor has 60 days to respond to an Intent to Refer letter.[17] If there has been a partial recoupment or collection, but the collection is not the result of a current repayment agreement that is in default, the debt *shall* be referred. Before inputting [forwarding] the matter for cross-servicing, Medicare contractors should first determine if the debt should be referred to the Regional Office for litigation rather than to Treasury for cross-servicing.

G. Affirmative collection efforts such as discussed here are generally only necessary when recoupment against ongoing payments is unsuccessful. CMS has instructed contractors not to refer debts of active providers to the Department of Treasury, if the debt may be collected within three years of delinquency by Medicare recoupment.[18] [Note: contractors may deactivate a provider's Medicare billing privileges if the provider does not submit any Medicare claims for 12 consecutive calendar months. Program Integrity Manual, CMS Publication 100-08, Chapter 10, § 13.1.] Therefore, while a provider remains active,

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[15] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.7
[16] *Id.*
[17] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.8.
[18] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.10.

there likely is some present or future payment from which the contractor can recoup the overpayment. Accordingly, even if the contractor cannot immediately recoup a debt, CMS has instructed contractors not to terminate collection activities on the debt while that possibility still exists.

H. Extended Repayment Schedules – Treasury and the Private Collection Agencies have the authority to approve extended repayment schedules up to 60 months without requesting CMS approval; requests for more than 60 month are referred to CMS for consideration.[19] Note: this is a different process than that discussed below for extended repayments granted by CMS.

I. Debts can be returned to CMS by Treasury for many reasons, including that the debt is uncollectible, the debtor is out of business, and a "miscellaneous dispute."[20] If the debt's return to CMS is based upon a status of "uncollectible" or "out of business," the Medicare contractors must determine if pursuing litigation is a viable option, and if so, follow established procedures for referring the debt for litigation.[21] If litigation is not an option, the Medicare contractor is required to consider recommending the debt for write-off, if, for example, the debt is over 10 years. Debts with principal balances of less than $100,000 should be recommended for write-off if there have been no collections in the past two years and the Medicare contractor believes the possibility of future collection is unlikely.

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[19] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.14.6.
[20] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 70.17.
[21] The procedures for referral to the Department of Justice are set forth in the Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 3, Section 120. The Federal Claims Collections Act requirements are set for th in 31 C.F.R. Parts 900 – 904, and include provisions for compromise of claims (31 C.F.R. § 902.2).

III. INTEREST ASSESSMENTS

A. As a general rule, interest is assessed at a prevailing rate specified by the Secretary of Treasury unless an overpayment is recouped within 30 days of a "final determination."[22] Treasury regulations establish the rate as the higher of (1) the private consumer rate, subject to quarterly revision; or (2) the current value of funds rate prevailing on the date of final determination.[23] As of January 24, 2011, the interest rate was set at 11.25%.[24]

IV. EXTENDED REPAYMENT PLAN REQUESTS

A. Section 935 of the 2003 Medicare Modernization Act (MMA) provided that if the repayment of an overpayment within 30 days constitutes a hardship, CMS shall, at the request of the supplier of provider, enter into a repayment plan with the provider or supplier for repayment of the overpayment.[25] For Medicare providers that file cost reports, the statute defines hardship as the aggregate amount of overpayments exceeding ten percent of the amount paid under Medicare to the provider during the cost period covered by the most recently submitted cost report.[26] For providers and suppliers that do not file cost reports, hardship is defined as the aggregate amount of overpayments exceeding 10 percent of the amount paid to the provider by Medicare during the previous calendar year.[27]

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[22] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 30, *et seq.*
[23] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 30.2.
[24] Pub. 100-06, Trans. 182, CR 7154 (Jan. 14, 2011).
[25] 42 U.S.C. § 1395ddd(f)(1)(A)-(B); implementing regulations at 42 C.F.R. § 401.601 – 401.607(c)(2).
[26] 42 U.S.C. § 1395ddd(f)(1)(B)(i)(I).
[27] 42 U.S.C. § 1395ddd(f)(1)(B)(i)(II).

B. CMS has the discretion to determine the length of a repayment plan within the limits provided by statute, ranging from 6 months to 3 years, (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary.)[28]

C. Providers and suppliers who are unable to repay a debt in full may apply for an extended repayment plan.[29]

1. A physician who is sole proprietor, must complete and return a Form CMS-370 (Financial Statement of Debtor), and a copy of the physician's income tax filing for the most recent calendar year.[30] If the request is for a period of more than 12 months, it must be accompanied by at least one letter from a financial institution denying the debtor's loan request, and a copy of the loan application.

2. A provider must submit an amortization schedule, balance sheets, and income statements, income statements, a statement of sources and applications of funds, cash flow statements, and multiple other documents. Requests for extended repayment periods of 12 months or more must include at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment, plus a copy of the loan application.[31]

V. RECOUPMENT

A. 2009 Final Recoupment Rule: Prohibits the recoupment of Medicare overpayments during a provider's or supplier's appeal to a QIC. Limits recoupment of

[28] 42 U.S.C. § 1395ddd(f)(1)(A).
[29] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 50.
[30] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 50.1.
[31] Medicare Financial Management Manual, CMS Pub. 100-06, Chap. 4, Section 50.2.

Medicare overpayment when provider or supplier seeks redetermination until the decision is issued.[32]

B. If an entity remains in business, but sells its ongoing operations, and the provider agreement under Part A is transferred to a subsequent purchaser, Medicare can simply recoup the overpayment from future payments pursuant to 42 U.S.C. § 1395g(a).

C. Recoupment is also used for Part B entities, although the statutory basis is less clear (as opposed to common law doctrine) The Medicare regulations state that Medicare payments to supplier may be recouped if CMS determines that the supplier has been overpaid. 42 C.F.R. § 405.371. At least one Circuit Court of Appeals has recognized 42 U.S.C. § 1395gg(b) as the basis for CMS's statutory right to recoup Part B overpayments.[33]

D. Prior to the passage of the 2003 Medicare Modernization Act (MMA), CMS could recoup overpayments regardless of whether a provider or supplier had appealed. Section 935(f)(2) of the MMA prohibits recoupment of Medicare overpayments during the period a provider or supplier appeal to the Qualified Independent Contractor (QIC).[34]

E. Note that CMS is not restricted in its ability to apply suspended funds to reduce or dispose of an overpayment, and there is no statute of limitations for recoupment efforts (but *cf.* regulations relating to time limits on and appropriate reasons for reopening determinations.

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[32] 74 Fed. Reg. 47458 (Sept. 26, 2009), 42 C.F.R. § 405.370 *et seq.*
[33] *See Chaves Cty. Home Health Serv. Inc. v. Sullivan*, 931 F.2d 914, 918 (D.C. Cir. 1991).
[34] Section 1892(f) of the Social Security Act], 42 U.S.C. § 1395ccc.

F. CMS has long standing authority to collect Medicare debts from Medicaid amounts due.[35] The procedures and sample form letters that CMS would send to the State Medicaid agency can be found at CMS Medicaid Manual, Section 2850 (still in paper manual).

VI. SUSPENSION/TERMINATION OF COLLECTION EFFORTS; COMPROMISE

A. Suspension and termination of collection and compromise of claim procedures are discussed at 42 C.F.R. § 405.376. CMS is legally required to aggressively collect all claims due to the United States.[36] 31 U.S.C. § 3711 permits the head of an agency to compromise a claim "of not more than $100,000" (excluding interest) and further permits the head of an agency to terminate collection of such debt when, inter alia, "it appears that no person liable on the claim has the present or prospective ability to pay a significant amount of the claim."[37] This authority does not apply to claims based on fraud or misrepresentation.[38]

B. The related federal claims collection regulations guide agencies in determining the amount of the claim for purposes of applying 31 U.S.C. § 3711. The $100,000 cap on compromises does not include: (1) interest; (2) penalties; (3) administrative costs; or (4) any amount already collected or offset.[39] In other words, it includes only uncollected principal.

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[35] 42 U.S.C. § 1396m; 42 C.F.R. § 447.30
[36] 31 C.F.R. § 901.1. 31 C.F.R. Parts 900 – 904 implement the Federal Claims Collection Act requirements.
[37] 31 U.S.C. § 3711(a)(3).
[38] 31 U.S.C. § 3711(b)(1).
[39] Under 31 C.F.R. § 903.1(a),

C. Standards for termination of collection efforts. The federal claims collection standards provide five criteria for termination, the two specified in the statute plus three additional items that logically flow from the statutory criteria:

1. Inability to collect any substantial amount.

2. Cost will exceed recovery.

3. Inability to locate debtor.

4. Claim is legally without merit; and

5. Claim cannot be substantiated by evidence.

D. CMS has implemented the federal claims collection standards and the implemental regulation can be found at 42 C.F.R.§ 401.601 et seq. Supplemental regulations include those found at 42 C.F.R. §§ 405.377-378 (Medicare overpayments). An action by CMS in connection with the compromise of a claim against an individual or the suspension or termination of a collection action does not qualify as an initial determination for the purpose of an appeal under CMS' claim review procedures.[40] Further, the failure of CMS to comply with its debt collection and compromise procedures is not available as a defense to the debtor.[41] Thus, for example, CMS may assert that the failure to issue timely demand letters, would not be a defense to recoupment.[42]

E. Bankruptcy can affect the collection of a claim in several ways. When a bankruptcy case is filed, CMS must refer the claim to DOJ for collection. This is required by 31 C.F.R. § 901.2(h), which mandates that agencies seek legal advice and file a claim when an agency's debtor files bankruptcy. This requires a referral to DOJ because only DOJ has

[40] 42 C.F.R. §§ 401.625; 405.376(j).
[41] 42 C.F.R. § 401.605.

litigation authority. Once an agency has referred a claim to DOJ, the agency lacks sole authority to compromise or terminate collection of the claim, regardless of the claim amount.

F. CMS may terminate collection efforts on claims above $100,000 without referring the claim to DOJ if the claim is "clearly without legal merit."[43] A claim is legally without merit if there is no legal basis for recovery by the United States. This standard is the one exception to the requirement to refer all claims over $100,000 to the Justice Department. If an agency (including HHS) determines that its claim is clearly without legal merit, it may terminate collection action without Justice Department approval regardless of the amount of the claim.[44]

1. A claim could be determined to be without merit if the claim has been discharged in bankruptcy. Before CMS terminates collection under this scenario, however, the claim and discharge order will be examined carefully. This is because a discharge order or plan confirmation in bankruptcy does not necessarily bar collection of every claim. The order may except certain debts from discharge, or certain debts may be statutorily exempt from discharge.[45] Moreover, a broad discharge may be ineffective to cancel a government debt if the government did not receive adequate notice of the bankruptcy case (see especially 11 U.S.C. § 523(a)(3)) or if the discharge otherwise contravenes applicable law. In addition, it must be determined whether "no person liable on the claim" has an ability to pay.[46] In some cases an individual provider (e.g., a doctor) may be liable where only the practice went

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[42] HHS-wide collection regulations can be found at 45 C.F.R. Part 30.
[43] 31 C.F.R. § 903.1(b).
[44] 4 C.F.R. § 104.1(b); 31 C.F.R. § 903.1(b).
[45] *See* 11 U.S.C. § 523(a)(1)-(19).
[46] *See* 31 U.S.C. § 3711(a)(3).

through bankruptcy. CMS may also pursue remedies against individuals or successors under the common law.

G. If an administrative collection efforts ultimately prove unsuccessful, the case may be referred to the Department of Justice to file a lawsuit.[47] The DOJ requires the submittal of a Claims Collection Litigation Report (CCLR) for overpayment litigation of claims. The CCLR is a checklist of all administrative collection actions. If need be the Regional Office will assist the contractor in obtaining a copy of the CCLR. The contractor will follow the advice received by their Regional Office of the General Counsel in completing the CCLR.

1. For corporate debtors, this referral must include information including the name, home address, credit data and SSN of each officer, stockholder, and director. This type of information is also required for owners of sole proprietorships, or partners in partnerships, when these entities have referred debts. Some of this information may be contained in the CMS Form 855 which providers and suppliers complete as part of their enrollment in the Medicare program.

2. The contractor must provide additional documentation that will assist in the identification of the overpayments and substantiate the request for refunds and recovery efforts.

3. DOJ has delegated authorities to compromise claims to its various components (e.g., in some cases, the U.S. Attorney's Office), based on the same sorts of considerations as are espoused in the Federal Claims Collection provisions.[48]

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[47] Medicare Financial Management Manual, Chap. 3, Overpayments, Section 120.
[48] *See* U.S. Attorneys Manual, Civil Resource Manual, Title 4, Chap. 4-300 *et seq.*; 28
Continued…

4. The government's statute of limitations for filing suit is 6 years.[49]

VII. SUCCESSOR LIABILITY- OVERVIEW

A. Sale or transfer of facility and impact upon the Medicare provider agreement: when a provider is sold or otherwise transferred as an ongoing operation, the purchaser runs the risk that CMS will find it liable for any overpayments existing -- or which may be subsequently determined -- in connection with the ongoing Medicare provider agreement.

1. Current Regulations

a. 42 C.F.R. § 489.18, Assignment of Agreement, provides in pertinent part:

> When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

b. 42 C.F.R. § 489.18(d), Conditions that apply to assigned agreements, provides in pertinent part:

> An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following: (1) Any existing plan of correction. (2) Compliance with applicable health and safety standards. (3) Compliance with ownership and financial interest disclosure requirements (4) Compliance with civil rights requirements.

c. Note that the regulation does not expressly include overpayments in the list of conditions to be assigned.

2. Manual Provisions

C.F.R. Section O, Subpart Y [Appendix to that subpart includes the redelegations of authority to compromise and close cases].

[49] 28 U.S.C. § 2415(a).

a. CMS's State Operations Manual set forth the principal of successor liability when there is a change of ownership (CHOW) of a provider including that a provider agreement is assigned. Specifically, the SOM states, in relevant part:

> Automatic assignment of the existing provider agreement to the new owner means the new owner is subject to all the terms and conditions under which the existing agreement was issued. [50]

Medicare sanctions and penalties are assigned to the new owner with limited exceptions.[51]

> The new owner is not responsible for money owed the Federal Government due to a determination that the previous owner is personally guilty of fraud. (However, if a determination of fraud is made against the corporation, and if the corporation is purchased and not incorporated as a new and separate corporation by the new owner, the new owner is subject to all Medicare penalties, sanctions, and liabilities). [52]

3. The Cases Asserting Successor Liability

4. *Vernon:* The Seminal successor liability case, and the genesis for nationwide application of successor liability for overpayments, was the decision of the Fifth Circuit Court of Appeals in Vernon.[53] The Fifth Circuit concluded that federal law would preempt state corporate law with respect to liability for pre-sale debts. The court further concluded that any purchase of assets that involves the assignment of the provider agreement is subject to the relevant statutory and regulatory conditions. One of these conditions is that adjustments [to ongoing payments] are made for overpayments, pursuant to 42 U.S.C. § 1395g(a).[54] Also noted by the court was the fact that the purchaser had the option not to

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[50] State Operations Manual, CMS Pub. 100-07, Chap. 3, Section 3210.
[51] State Operations Manual, CMS Pub. 100-07, Chap. 3, Section 3210E.
[52] *Id.*
[53] *United States v. Vernon Home Health, Inc.*, 21 F.3d 693 (5th Cir. 1994).
[54] *Vernon*, 21 F.3d at 696.

accept the automatic assignment of the provider agreement; [b]y accepting that assignment, [the purchaser] agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme.[55]

5. *Deerbrook Pavilion* extended Vernon's overpayment holding to impose civil monetary penalties (CMPs) upon the subsequent owner of a skilled nursing facility (SNF), also referenced as a long term care facility.[56] In reaching this decision, the court cited language in (then) HCFA's preamble to HCFA regulations regarding long-term care facility compliance and, in particular, 42 C.F.R. § 488.404, as follows:

> [A] facility's prior compliance history should be considered, regardless of a change in ownership. A facility is purchased 'as is.' The new owner acquires the compliance history, good or bad, as well as the assets.[57]

In the referenced preamble, HCFA explained that a poor compliance history may be a predictive factor as to the facility's ability to maintain compliance (and for this reason, the burden of proof is placed on a new owner to demonstrate that it can do so). *Deerbrook* referred approvingly to CMS's argument that CMPs are imposed to ensure compliance with quality care standards, and the court cited various commentaries regarding the need to curb fraud specific to the nursing home industry. Additionally, the *Deerbrook* court addressed the plaintiff's policy argument that successor liability for CMPs could lead facilities to close for lack of a buyer willing to pay the CMPs owed. The court dismissed this argument on the grounds that (i) the amount of unpaid CMPs would simply be reflected in a lower purchase price, as SNF surveys are a matter of public record, and the buyer could easily protect itself by reviewing these prior to purchase; and (ii) a new operator could simply apply for a new

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[55] *Id.*

[56] *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1104 (8th Cir. 2000).

provider agreement for the facility, thereby avoiding successor liability.

VIII. DENIAL OF ENROLLMENT BASED ON OVERPAYMENT

A. CMS may deny enrollment if the current owner (as defined in §424.502), physician or nonphysician practitioner has an existing overpayment at the time of filing of an enrollment application.[58]

IX. ACA ADDITIONS

A. Enrollment (including revalidations): Providers and Suppliers must disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has an uncollected debt.[59]

B. Under the ACA, self-identified refunds are now mandatory. Providers and suppliers must REPORT and RETURN and NOTIFY within 60 days of "identification" of the overpayment. Failure to meet the deadline renders the overpayment an "obligation" under the FCA, and also subjects the provider or supplier to potential CMPs.[60]

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[57] 235 F.3d at 1104 (citing 59 Fed. Reg. 56, 174 (1994)).
[58] 42 C.F.R. § 424.530(a)(6).
[59] ACA Section 6401, amending Social Security Act Section 1866(j), 42 U.S.C. § 1395cc(j).
[60] ACA Section 6402(a); Social Security Act §1128J(d); 42 U.S.C. § 1320a-7k(d).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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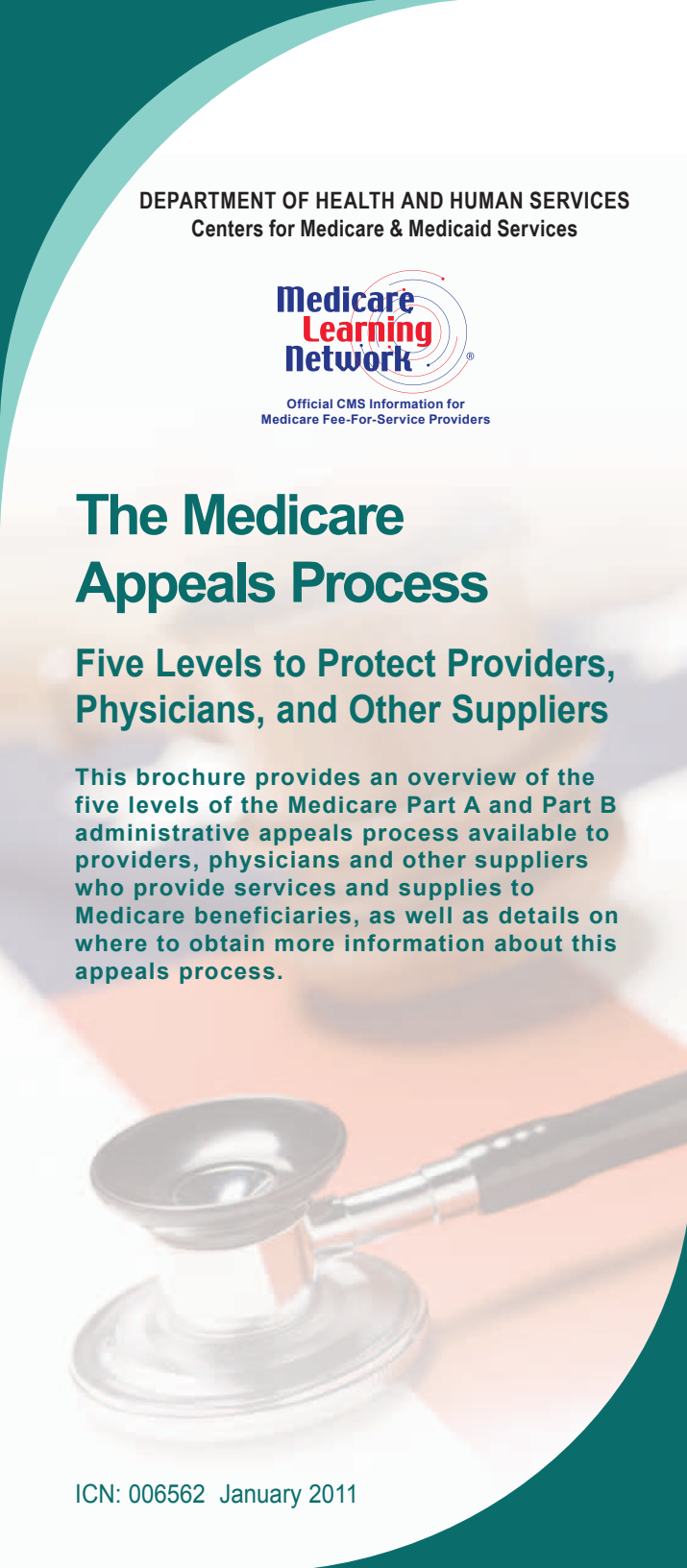
Official CMS Information for
Medicare Fee-For-Service Providers

The Medicare Appeals Process

Five Levels to Protect Providers, Physicians, and Other Suppliers

This brochure provides an overview of the five levels of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.



ICN: 006562 January 2011

Background

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as reconsiderations, be conducted by Qualified Independent Contractors (QICs).

The reconsiderations that are conducted by the QICs have replaced the Hearing Officer Hearing process for Medicare Part B claims and established a new second level of appeal for Medicare Part A claims.

Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies (called carriers for Part B, fiscal intermediaries (FIs) for Part A, or Medicare Administrative Contractors (MACs) to perform many processing functions on behalf of Medicare, including local claims processing and the first level appeals adjudication functions.

NOTE: Medicare Contracting Reform (MCR) Update—In Section 911 of the Medicare Prescription Drug, Improvement, and Moderniza ion Act of 2003 (MMA), Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

Appealing Medicare Decisions

- Once an initial claim determination is made, providers, participating physicians and other suppliers have the right to appeal.
- Physicians and other suppliers who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians, or other suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 must be completed and signed by the beneficiary and the non-participating physician or supplier to transfer the beneficiary's appeal rights.
- All appeal requests must be made in writing.

Five Levels in the Appeals Process

Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- Redetermination by an FI, carrier or MAC
- Reconsideration by a QIC
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter "the Appeals Council")
- Judicial review in U.S. District Court

First Level of Appeal: Redetermination

A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination

A request for a redetermination may be filed on Form CMS-20027 available at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage.* A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

NOTE: Contractors can no longer correct minor errors and omissions on claims through the appeals process. For information on how to correct minor errors and omissions, please see the following MLN Matters article, SE 0420, located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0420.pdf on the CMS website.

Second Level of Appeal: Reconsideration

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Requesting a Reconsideration

A written reconsideration request must be filed within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN. If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the redetermination

The request should clearly explain why you disagree with the redetermination. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

Reconsideration Decision Notification

Reconsiderations are conducted on-the-record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information on further appeals rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

Third Level of Appeal: Administrative Law Judge Hearing

If at least $130* remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of

the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

ALJ hearings are generally held by video-teleconference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Appellants may also ask the ALJ to make a decision without a hearing (on-the-record). Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level.

***NOTE:** The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of he consumer price index for all urban consumers. The amount in controversy threshold for 2011 is $130.

Fourth Level of Appeal: Appeals Council Review

If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)

In general, the 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 an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Appeals Council to escalate the case to the Judicial Review level.

Fifth Level of Appeal: Judicial Review in U.S. District Court

If at least $1,260* or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

***NOTE**: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2011 is $1,300.

For More Information

For more information about the Medicare appeals process, please visit the Medicare Fee-For-Service Appeals web page located at *http://www.cms.hhs.gov/OrgMedFFSAppeals/* on the CMS website.

Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo/* on the CMS website.

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The Medicare Overpayment Collection Process

FACT SHEET

This publication provides the following information about the collection of Medicare physician and supplier overpayments:

- Definition of an overpayment;
- The overpayment collection process; and
- Resources.

Definition of a Medicare Physician or Supplier Overpayment

A Medicare overpayment is a payment that a physician or supplier has received in excess of amounts due and payable under Medicare statute and regulations. Once a determination of an overpayment has been made, the amount of the overpayment becomes a debt owed by the debtor to the Federal government. Federal law requires the Centers for Medicare & Medicaid Services (CMS) to seek the recovery of all identified overpayments.

In Medicare, physician or supplier overpayments occur due to:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services; or
- A pattern of furnishing and billing for excessive or non-covered services.

The Overpayment Collection Process

When Medicare discovers an overpayment of $10 or more, the overpayment recovery process will be initiated.

Demand Letters

- The first demand letter will be sent requesting payment. This letter explains that interest will accrue from the date of the letter if the overpayment is not received by the 31st calendar day from the date of the letter.
- If no response is received from the physician or supplier 30 calendar days after the date of the first demand letter, a second demand letter will be sent.
- If a full payment is not received 40 calendar days after the date of the first demand letter, recoupment procedures will begin on day 41. Recoupment means that the overpayment will be recovered from current payments due or from future claims submitted. If a debt has not been paid or recouped (unless a valid appeal has been filed), a third demand letter will be sent within 120 days indicating that the overpayment may be eligible for referral to the Department of Treasury for offset or collection.

Repayment Plans

If the physician or supplier is unable to pay the entire amount of the overpayment in full, he or she may contact the Contractor to request an extended repayment plan.

Rebuttals

A physician or supplier may submit a rebuttal statement to the Contractor within 15 calendar days from the date of a demand letter. The rebuttal statement explains or provides evidence regarding why recoupment should not be initiated. The rebuttal process is not considered an appeal and does not cease Contractor recoupment activities.

ICN: 006379/July 2010

Appeals

If a physician or supplier disagrees with an overpayment decision, he or she may file an appeal with the Contractor that issued the original decision. A redetermination is the first level of appeal in which a qualified employee of the Contractor conducts an independent review of the decision. A redetermination request must be filed within 120 calendar days from the date of the demand letter. In order to stop the initial recoupment process, the redetermination request must be filed within 30 calendar days from the date of the demand letter. If the redetermination request is filed later than 30 calendar days from the date of the demand letter, the recoupment process will stop when the appeal is filed; however, any recoupment already taken will not be refunded.

Following an unfavorable or partially favorable redetermination decision, a physician or supplier may request a second level of appeal or reconsideration by a Qualified Independent Contractor (QIC). A request for reconsideration by a QIC must be filed within 180 calendar days of the date the redetermination decision is received. In order to stop the recoupment process from starting, a reconsideration request must be filed within 60 days from the redetermination decision date. The recoupment process will stop when the reconsideration by a QIC request is received and validated. After the QIC's decision or dismissal, the recoupment process will resume for any overpayment amount that has not been paid in full regardless of whether the physician or supplier requests further appeal levels.

Resources

Additional information about the Medicare overpayment collection process for physicians and suppliers is available in Chapter 34 of the *Medicare Claims Processing Manual* (Pub. 100-04) and Chapters 3 and 4 of the *Medicare Financial Management Manual* (Pub. 100-06) located at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website. Contractor contact information is available in the *Provider Call Center Toll-Free Numbers Directory*, which can be accessed in the Downloads Section at http://www.cms.gov/MLNGenInfo/30_contactus.asp on the CMS website.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Flu Shot Reminder - Flu Season Is Coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. *(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)* And don't forget, health care workers also need to protect themselves. Get Your Flu Shot. – Not the Flu. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, visit *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS website. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing, go to *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS website.

MLN Matters Number: MM6183 Revised
Related Change Request (CR) #: 6183
Related CR Release Date: September 12, 2008
Effective Date: September 29, 2008
Related CR Transmittal #: R141FM
Implementation Date: September 29, 2008

Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments

Note: This article was revised on September 18, 2008, to make minor clarifying changes on page 2 and to delete some unnecessary language on pages 5 and 9. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare Administrative Contractors (A/B/MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided or supplied to Medicare Beneficiaries.

What You Need to Know

CR 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a Qualified Independent Contractor (QIC).
- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.
- If the ALJ level process reverses the Medicare overpayment determination, Medicare will refund both principal and interest collected, and also pay 935 interest on any recouped funds that Medicare took from ongoing Medicare payments. (If a provider has any other outstanding overpayments, Medicare will apply the amount *collected* first to those overpayments and any excess monies will then be refunded back to the provider.)
- Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.
- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

This article provides more detail on these general points and clarifies which overpayments are subject to this limitation on recoupment and which types of overpayments are not subject to this limitation. Make sure that your billing staffs are aware of these changes as described below.

Background

Before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted, a provider's electing to appeal an overpayment determination did not affect Medicare's prerogative to recover the debt. However, through an amendment of Title XVIII of the Social Security Act (the Act); MMA Section 935 changed this process, by adding a new paragraph (f) to section 1893 of the Act.

This amendment requires the Centers for Medicare & Medicaid Services (CMS) to change: 1) the way it recoups certain overpayments to providers, physicians and suppliers; and 2) how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent administrative (Administrative Law Judge (ALJ)) or judicial levels of appeal.

CR 6183 describes these changes to the providers, physicians and suppliers overpayment recoupment process. Specifically, Section 1893 (f)(2)(a) of the Social Security Act protects providers physicians, and suppliers during the initial stages of the appeal process (both first level

appeal – contractor redetermination, and second level appeal -- Qualified Independent Contractor (QIC) reconsideration) by limiting the recoupment process for Medicare overpayments while the appeals process is underway.

It requires that when a valid first or second level appeal is received from a provider on an overpayment, subject to certain limitations (see below), CMS and its Medicare contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Overpayments that ARE subject to Limitation on Recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision);
- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued;
- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or
- Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).
- The final Claims associated with a Home Health Agency (HHA) Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself (see Table 2, below).

Overpayments that ARE NOT Subject to Limitation on Recoupment

- All other Medicare Secondary Payer recoveries except those identified in the preceding section of this article;
- Beneficiary overpayments;
- Overpayments that arise from a cost report determination;
- Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals;
- HHA Requests for Anticipated Payment (RAP) under HH PPS;
  Note: While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the Medicare Claims Processing Manual, Chapter 10 (Home Health Agency Billing), Sections 10.1.10

(Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment (RAP)), and 50 (Beneficiary-Driven Demand Billing Under HH PPS). This manual is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.)

- Hospice Caps calculations;
- Provider initiated adjustments;
- Accelerated/Advanced Payments; and
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The Rebuttal Process

Here is how the rebuttal process with the limitation on recoupment works.

You are given an opportunity to rebut any proposed recoupment action submitting a statement within 15 days of the notice of an impending recoupment action. These rebuttal procedures occur prior to the appeals process and are separate from the requirements of the limitation on recoupment.

The rebuttal process gives you a vehicle to indicate why the proposed recoupment should not take place; but you should remember that, as opposed to the limitations that CR 6183 describes, your Medicare contractor may (based on the rebuttal statement) determine to either stop, or proceed with, recoupment.

Step One -- Overpayments

Part A

As a result of post-pay reviews or MSP recoveries and during the Part A claim adjustment process (including Part B of A claims), Medicare FIs, RHHIs, and/or MACs, will determine if the limitations apply to the claim and annotate the system of the MMA Section 935 adjustment. If the adjustment results in a refund to the provider, they will follow existing underpayment policies; however, if the adjustment is deemed an overpayment and the 935 rules apply, they will mark the claim as being available for the limitation on recoupment protections.

Part B

As a result of post-pay reviews or MSP recoveries and during the Part B claim adjustment process, Medicare carriers and MACs, including DME MACs, will adjust claims in the normal manner.

Step Two -- Demand Letter

These adjustments will trigger the creation of the first demand letter (unless previously issued) which (in addition to the requirements listed in the *Medicare Financial Management Manual,* Chapter 3 (Overpayments), and Chapter 4 (Debt Collection)) will:

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment);

- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter;
- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct;
- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, or (when appropriate) why the provider was not found to be without fault in causing the overpayment.
- Explains that recoupment will begin on the 41st day from the date of the first demand letter if: 1) payment is not received in full, or 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter. However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received and validated, but Medicare may not refund any recoupment already taken.

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.
2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities may resume within the designated timeframes.
3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

Step Three -- How to Stop Recoupment:

First Level Appeal (Redetermination)

Recoupment can proceed on day 41 from the first demand letter unless you submit a request for a redetermination by the 30th day following the date of the first demand letter, in which case recoupment will stop.

Table 1, below displays the time frame for the recoupment process after the first demand letter.

Table 1
Timeframe for Medicare Recoupment Process After the First Demand Letter

Timeframe	Medicare Contractor	Provider
Day 1	Date of Demand Letter (Date demand letter mailed)	Provider receives notification by first class mail of overpayment determination
Day 1-15	Day 15 deadline for Rebuttal request. No recoupment occurs	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs	Provider can appeal and potentially limit recoupment from occurring
Day 41	Recoupment begins	Provider can appeal and potentially stop recoupment

Redetermination or Reconsideration (Appeals) Requests

Upon receiving your valid request for a redetermination of an overpayment, your Medicare contractor will take the following actions:

- Cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started;
- Retain any amounts recouped, if they had already recouped funds before receiving the request for redetermination, and apply them first to interest and then to principal; **and**
- Will continue to collect any other debts that you might owe, but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A Redetermination can have three possible outcomes:

1. Full reversal of the overpayment decision.
   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (they may apply these funds to any other debt that you might owe and then release any excess to you).
2. Partial reversal (Partially Favorable) of the overpayment decision
   In this instance (in which the debt is reduced below the initial stated amount) Medicare contractors will recalculate the correct amounts of both the underpayment and the overpayment, make appropriate payments to you if due; or, if necessary, issue a revised demand letter for the newly calculated overpayment amount. This letter will state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination if they have not been notified by the QIC that you have requested a reconsideration. It will also state that in order to stop recoupment under the provisions of Section 935 of the MMA, you must request a valid appeal (reconsideration) of the overpayment

within 60 days from the date of the notice. It will also remind you that you have an opportunity to rebut the proposed recoupment action (but keep in mind that a rebuttal does not mandate that recoupment will stop).

3. Full Affirmation of the overpayment decision–

   With this "unfavorable" decision that upholds the overpayment determination, the Medicare contractor will issue the 2nd or 3rd demand letter (as appropriate), which will state that they can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice, it they have not been notified by the QIC that you have requested a reconsideration.

Table 2, below displays the time frame for the recoupment process after redetermination.

Table 2
Timeframe for Medicare Recoupment Process After Redetermination

Timeframe	Medicare Contractor	Provider
Day 60 following revised notice of overpayment following redetermination	Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice	Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal
Day 61- 75	Recoupment could begin on the 61st day	Provider appeals or pays
Day 76	Recoupment Begins or Resumes	Provider Can Still Appeal. Recoupment stops on date receipt of appeal

Second Level Appeal (Reconsideration)

You can also stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the appropriate notice/letter.

When your Medicare contractor receives notification from the QIC of your valid and timely request for a reconsideration, they will:

- Cease recoupment of the overpayment, or not initiate recoupment if it has not yet begun;
- Retain the amount recouped, and apply it first to interest and then to principal (if the recoupment process had begun before the reconsideration request was received);
- Will continue to collect other debts that you might owe, if an overpayment is appealed and recoupment stopped; but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A QIC Reconsideration can have three possible outcomes:

1. Full Reversal
   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (the amount held may be applied to any other debt that you might owe and any excess refunded to you);

2. Partial Reversal
   In this instance, this reduces the overpayment. Medicare contractors effectuate the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Medicare contractors may apply the excess to any other debt (including interest) that you might owe before releasing payment to you.

   They will issue you a notice of the revised overpayment amount, which will also state that they can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give you an opportunity to make payment arrangements or to rebut the recoupment as described above.

3. Affirmation
   If the QIC reconsideration results in an "unfavorable" overpayment decision, recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives you time to make payment or to request a repayment plan.

Note: Medicare Contractors can initiate (or resume) recoupment immediately upon receipt the QIC's decision or dismissal notice of a physician's, provider's, or supplier's request for reconsideration, regardless of a subsequent appeal to the ALJ (third appeal level) and all further levels of appeal (see below).

Third Level of Appeal (Administrative Law Judge (ALJ))

Whether or not the provider, physician or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, the Medicare contractor will continue to recoup until the debt is satisfied in full.

Additional Details of CR6183

CR 6183 also provides some additional specific payment details, i.e.:

1. If you have been granted an extended repayment schedule (ERS) and have submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, you will not be considered in default if your payments were not made. The appeal would supersede the ERS agreement.

   Further, Payments that you make under an ERS are not recoupment for the limitation provision and are not subject to Section 935 interest, if reversed at the ALJ appeal or above. However, if you default on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupment are subject to payment of interest under the Section 935 interest requirements.

2. Suspended funds involving providers who have been put on payment suspension are not a "recoupment" for purposes of the limitation on recoupment. Medicare is not restricted from applying suspended funds to reduce or dispose of an overpayment. However, if the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR, Section 405.379 "Limitation on Recoupment," provision under section 1893(f)(2) of the Social Security Act, Section 935 of the MMA Act will be applicable to any remaining balance still owed to CMS.
3. Payments made by a provider in response to a demand are not recoupments. Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are not subject to Section 935 interest.
4. Lastly, CR 6183 amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called Section 935 interest, which is payable on an underpayment when the reversal occurs at the ALJ level or subsequent levels of administrative appeal, when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds (based on the period that Medicare recouped the provider's or supplier's funds). Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions, and is only payable on the principal amount recouped. In these instances, Medicare will pay simple interest rather than compound interest, and ***will not pay interest on interest; (mirroring the manner in which interest against providers is assessed).*** Monies recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider.

   The periods of recoupment will be calculated in full 30-day periods; and interest will not be payable for any periods of less than 30 days in which Medicare had possession of the recouped funds; and will be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date).

Finally, please be aware that CR 6183 does not change the rebuttal process for this recovery, nor the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, or the decision making time frames.

Additional Information

You can find the official instruction, CR6183, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf* on the CMS website. You will find the updated *Medicare Financial Management Manual,* Chapter 3 (Overpayments), as an attachment to CR 6183.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at

http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare Learning Network
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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – As stated in the Centers for Medicare & Medicaid Services (CMS) provider listserv messages that were sent last fall concerning Change Requests (CRs) 6417 and 6421, CMS has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in Medicare's systems that contain an NPI). This file is downloadable by going to the Medicare provider/supplier enrollment website at *http://www.cms.gov/MedicareProviderSupEnroll* and clicking on "Ordering/Referring Report" on the left-hand side.

MLN Matters® Number: MM6870 Revised
Related Change Request (CR) #: 6870
Related CR Release Date: March 19, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R659OTN
Implementation Date: July 6, 2010

Reporting of Recoupment for Overpayment on the Remittance Advice (RA)

Note: This article was revised on December 8, 2010, to add a reference to MLN Matters® article MM7068, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7068.pdf*, which instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries. (CR6870 does not apply to suppliers billing Durable Medical Equipment (DME) MACs.)

Provider Action Needed

This article is based on Change Request (CR) 6870 which instructs Medicare System Maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC Program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You can review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm* on the Internet. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the MLN Matters® article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.)

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

- Step I: Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here);
- Step II: Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the Remittance Advice (RA) to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare System Maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an Internal Control Number (ICN) or Document Control Number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:

Claim Level:

The original payment is taken back and the new payment is established

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II:

Claim Level:

No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional Information

CMS provides more information including an overview of and recent updates for the RAC program at *http://www.cms.gov/RAC/* on the CMS website. You can find the *Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers* at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* on the CMS website.

The official instruction, CR6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R659OTN.pdf* on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.