



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.

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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

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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

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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

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- (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);

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- 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.

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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

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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, if 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 2 nd level appeal
Day 61- 75	Recoupment could begin on the 61 st 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.

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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.

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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

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

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