

Chapter 9: Overpayments and Offsets

Overpayments and Offsets

Overpayments are Medicare payments a provider/supplier has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is considered a debt owed by the debtor to the United States Government and the contractor must attempt recovery of the overpayment in accordance with the Centers for Medicare & Medicaid Services (CMS) regulations. The CMS requires the contractor to request refunds on overpayments of \$10 or more.

The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demands for repayment, establishment of repayment schedules, and recoupment or offset, where appropriate.

Overpayment Refunds

An overpayment refund request can be initiated by the contractor or the refund can be voluntarily issued by the debtor.

Contractor Initiated Overpayments

When the contractor (NHIC, Corp. DME MAC Jurisdiction A) determines that a provider/supplier has been overpaid, a refund request will be sent to the debtor in the form of an overpayment demand letter. This demand letter will include a document control number (DCN) that must be referenced in any communication with the contractor. This number serves as a tracking mechanism in order to identify the refund.

The debtor has 30 days from the date of the demand letter to refund the contractor. If the overpayment is not paid within the timeframe specified in the initial demand letter, interest begins to accrue on the refund amount.

A second demand letter is sent between the 31st and 45th day. If full payment is not received by the 40th day from the date of the initial demand letter, the recoupment process will begin in the form of an offset. Current and future payments will be offset until the overpayment is completely recouped.

Unsolicited Voluntary Overpayment Refunds

When a provider/supplier believes that an overpayment has been received and makes an unsolicited voluntary refund, it is accepted by the contractor regardless of the amount. The DME MAC A *Overpayment Refund Form*, or a similar document containing all of the required information, should accompany every unsolicited/voluntary refund so that the receipt of check is properly recorded and applied. If the specific Patient/HICN/Claim number information is not provided, no appeal rights shall be afforded.

The *Overpayment Refund Form* is available on the DME MAC A Web site at: http://www.medicarenhic.com/dme/dme_forms.shtml. Once the form is complete, it is to be mailed, along with the overpayment refund check, to the Accounting (Refund Checks) Post Office Box found in Chapter One of this manual.

Note: *If the unsolicited voluntary refund does not satisfy the overpayment, the same rules will apply regarding the overpayment demand letters. In addition, the same interest and offset rules will apply if the overpayment is not satisfied in a timely manner.*

Overpayment Offsets

An offset can be initiated by the contractor or can be requested by the debtor.

Debtor Requested Immediate Offset

Once an overpayment is discovered or a demand letter is received by the provider/supplier, a request for an immediate offset can be made. A provider/supplier may fax a request for an immediate offset by completing the DME MAC A *Offset Request Form*, which is available on the DME MAC A Web site at http://www.medicarenhic.com/dme/dme_forms.shtml#Forms

This form must be completed in its entirety and faxed to the Payment Offset Requests Fax Number included on the form and also listed in Chapter One of this manual. Both the demand letter and the Medicare Remittance Advice indicating the overpayment must be included. In addition to the *Offset Request Form*, the debtor must also attach a completed *Overpayment Refund Form* for each faxed offset request.

Once the claims have been adjusted and the accounts receivable created, the debt will be immediately set up for offset. Once the offset is complete, a Remittance Advice will be sent to notify the provider/supplier of the offset.

Note: *A demand letter will still be generated.*

Contractor Initiated Offset

If a refund is not received within the allotted time frame, an offset will be initiated by the contractor. On behalf of Medicare, the contractor will decrease the amount of present or future payments until the full amount of the specified debt is satisfied. During this time, interest is still accrued on the refund amount every 30 days.

The Medicare Remittance Advice will include a Financial Control Number (FCN) to notify the provider/supplier of the offset. This number is used to match the Remittance Advice to the corresponding overpayment demand letter previously received. The FCN on the Remittance Advice will match the DCN from the initial demand letter.

Note: *Details of contractor initiated offsets are recorded at the bottom of the Remittance Advice. The FCN, reason code and amount are referenced.*

Appealing an Overpayment Refund Demand

If the provider/supplier disagrees with an overpayment request, then an appeal request may be initiated through the first level of the appeals process, the Redetermination. However, if the overpayment was initiated as a result of a Redetermination, then the provider/supplier must request a Reconsideration by the Qualified Independent Contractor (QIC) which is the second level of the appeals process.

When an overpayment demand letter is received by a provider/supplier and the letter is requesting a refund, the provider/supplier should **immediately** refund the amount requested and then file an appeal, if necessary. This will avoid interest accrual or a possible offset.

Note: *The overpayment demand letter has detailed instructions on how to file an appeal.*

Limitation of Recoupment

Section 1893 (f)(2)(a) of the Social Security Act provides limitations on the recoupment of Medicare overpayments. This section provides protection to Providers, Physicians, and Suppliers during the initial stages of the appeal process. The limitations extend to the redetermination and the reconsideration level if the provider meets all conditions. These limitations do not affect a provider's

right to appeal and the timeframes associated with appealing; however to stop recoupment a provider must act decidedly to appeal.

When a valid first level appeal request (redetermination) or a valid second level (reconsideration) request is received from a provider on an overpayment subject to these limitations the Medicare contractor will cease recoupment or not begin recoupment at the normally scheduled time (41 days for 1st level and 76 days for 2nd level).

During this appeal process, the Medicare contractor cannot recoup or demand the debt; however, the debt continues to age. Once both levels of appeal are completed and CMS prevails, collection activities, including demand letters and internal recoupment, may resume within the timeframes set forth.

For complete details on this process, refer to the *CMS Medicare Financial Management Manual*, Publication 100-06, Chapter 3, Section 200, which is available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/fin106c03.pdf>.

Extended Repayment Plan (ERP)

A debtor is expected to repay any overpayment as quickly as possible. If the debtor does not comply with the first demand letter requesting that full refund of the overpayment be made, however acknowledges the existence of an overpayment, the debtor should immediately contact the contractor to request an extended repayment plan (ERP). A repayment plan may be established to recover all or part of an overpayment and may be received and shall be reviewed at any time the overpayment is outstanding.

An ERP request must be submitted in writing and provide specific details. The debtor must explain and document the need for an extended (beyond 30 days) repayment plan. For additional information regarding ERPs and for details on what type of information is required when requesting an ERP, refer to the *CMS Medicare Financial Management Manual*, Publication 100-6, Chapter 4, Section 50, which is available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/fin106c04.pdf>