

Section 935 Recoupment Basics

Recoupment is the act of recovery by a Medicare contractor of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount recouped to the indebtedness. It can apply to the recovery of funds for all Medicare Part A and Medicare Part B claims for which a demand letter is issued. All RAC adjustments and therefore their related debts are subject to 935 appeals rights.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 935 amended Title XVIII of the Social Security Act to add a new paragraph to Section 1893(f)(2)(a), which required the Centers for Medicare & Medicaid Services (CMS) to change:

- How it recoups certain overpayments to providers, physicians, suppliers; and
- How it pays interest to a provider, physician, or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal.

Prior to the enactment of MMA of 2003, Medicare would recoup the debt as soon as the adjustment finalized; therefore, the provider would be without their funds before having the ability to appeal. Section 935 of the MMA amended that process to protect providers through the first and second levels of appeal by limiting the recoupment process while the appeal is underway. Provider appeal rights and the time frames for filing an appeal have not changed.

Steps in the Recoupment Process—Medicare Part A

1. Claim is Adjusted

After a post-pay medical review (Comprehensive Error Rate Testing [CERT] or medical review) or Medicare Secondary Payer (MSP) recovery and during the Medicare Part A claim adjustment process if an adjustment results in an additional payment to the provider, existing underpayment policies are followed.

If an adjustment results in an overpayment and the 935 rules apply, the claim will be identified as subject to 935 provisions. American National Standards Institute (ANSI) code N469 will appear on the remittance advice. If the adjustment is due to a RAC review, an N432 code will be displayed (effective July 2010). When the claim finalizes, the provider will see a negative adjustment in the remittance advice/voucher; however, what appears as a take-back is added to the “adjustment to balance” line item on the summary page of the remittance and added back to the total EFT or check payment. Providers will need to fully reconcile their remit from the remittance detail to the EFT in order to balance their ledger.

Once the adjustment appears on the remittance, the provider can pay the debt via check; request an immediate offset against future claims payments via fax (414-459-6007), or send an appeal. If the provider does none of the above, the debt will recoup with interest on the 41st day from the day the adjustment became final (one day prior to the remit date). If an appeal is received by the 30th day, NHIC, Corp. will stay all recoupment efforts until the outcome of the appeal is decided. If the appeal request was received prior to the end of the 30-day timeframe and the recoupment was stayed, NHIC, Corp. sends a confirmation letter to the provider communicating that the recoupment was stayed on those claims that were appealed.

2. **Accounts Receivable Created/ Demand Letter Sent**

Once the claims process, the adjusted claims marked for recoupment trigger the creation of an account receivable and a demand letter is generated. For all 935 demands that are not RAC related, CMS standard systems generate the letter and the demand is mailed the same day of the remittance date. For all RAC related demands, NHIC, Corp. sends the RAC a file the same day the remit is dated and the RAC has 7 days from the receivable date (adjustment date) to generate and send the demand letter. Due to this difference in process, providers may see that their RAC demand letters come slightly later than their non-RAC 935 demand letters. Providers should also recognize that the RAC sends another letter prior to the demand that identifies initial findings of their review, if the review was based on medical documentation submitted to them by the provider. This letter is sometimes confused with the demand letter.

NHIC, Corp. Demand Letters

NHIC, Corp. demand letters are generated out of the Healthcare Integrated General Ledger Accounting System (HIGLAS) using the address listed as the master address in the Fiscal Intermediary Standard System (FISS) provider file. HIGLAS is programmed to use only the master address on file for providers. An accounts receivable is set up when the demand letter is generated. Recoupment occurs at the accounts receivable level; therefore monies recouped are applied to the oldest accounts first.

RAC Demand Letters

The RAC generates its own demand letters. Providers have the option of contacting the RAC to give a specific name and address to which they want their demand letters mailed. If the RAC has requested medical records and performed a complex review, they will send a Review Results Letter prior to the demand letter explaining their findings. If an appeal will be requested providers must wait until the claim is adjusted and appears on the remittance advice.

Demand Letter Tips

- Timeliness of the appeal request is important. During the appeal process, interest continues to accrue.
- If the appeal decision is affirmation, upholding the RAC's decision, collection may resume within the designated time frames.
- A provider, who has filed a bankruptcy petition or is involved in a bankruptcy proceeding, should contact NHIC, Corp. immediately. Contact information is included within the demand letter.

3. Stopping Recoupment Once a Demand Letter is Received

Medicare will stop recoupment upon receipt of a valid and timely request for a redetermination within 30 days from the date of the demand letter; or following an unfavorable or partially favorable redetermination decision if the provider decides to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor.

Providers can Choose How to Respond to the Demand Letter

Providers have a choice regarding how they want to respond to demand letters.

- Submit a request for early recoupment
 - Fax a copy of the RAC demand letter and a statement identifying the claims which you would like the recoupment to begin early
 - Requesting early recoupment may reduce the amount of interest assessed if collections occur prior to the 30th day.
- Allow recoupment from future payments. Recoupment will occur 41 days after the date of the demand letter unless we receive a valid appeal request before that time.
 - Please be aware that interest is assessed on day 30.
- Request an Extended Repayment Plan (ERP). If a provider needs longer than 30 days to repay the entire amount, they have the option of asking NHIC, Corp. for an ERP.
 - An ERP can be requested at any time during debt collection process.
 - Submitting the request within 15 days may decrease the necessity to withhold all interim payments.
 - Information regarding ERP is included in demand letter.
 - ERP requests for RAC determined overpayments must be sent to the RAC that issued the demand letter

- **Submit a rebuttal**

- The provider has the option to submit a rebuttal statement and evidence as to why the recoupment of the overpayment will cause them financial hardship. The statement and accompanied evidence will be reviewed by NHIC, Corp. and a decision will be sent to the provider within 15 days of the receipt of the rebuttal. The decision may or may not affect the recoupment of the overpayment.
- A rebuttal is not an appeal or a means of disagreeing with the overpayment. It is strictly a means of providing proof that the recoupment would adversely affect the provider's financial situation.
- If a provider does not agree with a RAC determined overpayment, they should contact the RAC during the discussion period or file an appeal.

The Appeals Process

Level 1 Redetermination and Level 2 Reconsideration

Only submission of a valid and timely request for redetermination will start the appeal process in motion. Correspondence stating "intent" to appeal will not be accepted.

Upon the receipt of a provider's valid and timely request for a redetermination of overpayment, NHIC, Corp. will take the following steps:

- Either stop recoupment of overpayment that is the subject of the appeal or will not initiate recoupment if it has not yet started.
 - To ensure recoupment will not be initiated, the valid appeal request must be received by the Appeals unit within NHIC, Corp. prior to day 30. It is in the provider's best interest to submit the valid appeal request as early as possible to allow enough time for delivery, validation and processing.
 - A valid appeal post marked on day 30 does not ensure recoupment will not be initiated.
- Retain any amounts recouped, if already collected before processing the request for redetermination. Any amounts already recouped will be applied first to interest and then to principal.
- Continue to collect any other debts the providers might owe, but will not withhold or place in suspense any monies related to this particular debt, while it is in an appeal status.
- The NHIC, Corp. Overpayment Recovery Unit (ORU) will send a notice to the provider briefly stating that a valid and timely request for appeal has been received and that recoupment has been stopped pending the outcome.

There are three possible outcomes for a redetermination or reconsideration:

- **Full Reversal:** The provider is reimbursed for covered items and/or services. NHIC, Corp. will adjust the overpayment and amount of interest charges. The amount held may be applied to any other debt the provider may owe and any excess will be refunded to the provider.
- **Partial Reversal:** The provider will be partially reimbursed for covered items and/or services. In addition, any recouped funds and interest already paid will be repaid to the provider.
- **Full Affirmation:** The overpayment determination is upheld. The provider will receive a Medicare Redetermination Notice (MRN) which will state the timeframe to file for the next level of appeal. The time frame begins with the date on the MRN. The MRN will be followed by a demand letter.

Note: The MRN issued is the same letter used for any type of appeal. It is not specific to the MMA Section 935 recoupment process.

If the provider chooses to submit a request for reconsideration to the QIC, the QIC will notify NHIC, Corp. of their receipt of the valid and timely request.

NHIC, Corp.:

- Stop recoupment of the overpayment (or if it has not yet begun it will not be initiated);
- Retain monies recouped and apply first to interest and then to principal (if recoupment process had already begun before the reconsideration request was processed);
- Continue to collect other debts that provider might owe but will not withhold or place in suspense any monies related to this debt while it is in appeal status.

For financial reporting purposes, the status of the debt during the redetermination and reconsideration appeal levels is “appeal.”

When recoupment begins or resumes, the status will be changed to reflect the status “eligible for offset.”

Level 3 Administrative Law Judge

The third level of appeal is the administrative law judge (ALJ). It is important to understand that following a QIC decision to fully or partially uphold the overpayment decision, Medicare will continue to recoup until the debt is satisfied in full, whether or not a provider subsequently appeals overpayment to the ALJ, Medicare appeals council or federal court.

If an appeal is decided in favor of the provider by the ALJ (level 3) or later, the provider may be eligible for an interest payment that may be added to the refund returned to the provider.