CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 205	**Date: February 9, 2012**
	Change Request 7688

Transmittal 204, dated January 27, 2012, is being rescinded and replaced by Transmittal 205, dated February 9, 2012, to restore Exhibits 2 through 6 that were erroneously omitted in the original transmittal. All other information remains the same.

SUBJECT: Immediate Recoupment for Fee for Service Claims Overpayments

I. SUMMARY OF CHANGES: The purpose of this Change Request is to implement a standard immediate recoupment process. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/200.1.5/Immediate Recoupment Requirements
R	3/200.2/Additional Requirements for Demand Letters
R	3/200.2.1/Example 1-Sample of the 935 First Demand Letter
R	3/200.5.1/Payments Made Upon Notice of Demand or Through a Requested Immediate Recoupment
R	4/Table of Contents
N	4/80.2/Immediate Recoupment Requirements for Overpayment Recovery from the Physicians and Other Suppliers
R	4/90.2/Part B Overpayment Demand Letters to Physicians/Other Suppliers

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 205	Date: February 9, 2012	Change Request: 7688

Transmittal 204, dated January 27, 2012, is being rescinded and replaced by Transmittal 205, dated February 9, 2012, to restore Exhibits 2 through 6 that were erroneously omitted in the original transmittal. All other information remains the same.

SUBJECT: Immediate Recoupment for Fee for Service Claims Overpayments

Effective Date: **July 1, 2012**

Implementation Date: **July 2, 2012**

I. GENERAL INFORMATION

A. Background:

Currently, Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30. This Change Request will allow providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the debt is recouped in full prior to day 30.

Note: For purposes of this instruction, the term "Provider" will refer to all Part A Providers and all Part B Physician and other Suppliers.

B. Policy:

The purpose of this Change Request is to implement a standard "immediate recoupment" process. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

1. Providers who choose immediate recoupment must do so in writing to the contractors.
2. The request will be for a particular overpayment or as a permanent request for all overpayments.
3. By choosing immediate recoupment, providers are waiving their rights to section 935 interest.
4. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7688.1	Medicare contractors shall offer providers the opportunity to request immediate recoupment for **demanded overpayments only**.	X	X	X	X	X					
7688.1.1	Medicare contractors shall accept all requests in writing through regular mail, facsimile, or email.	X	X	X	X	X					
7688.1.2	Medicare contractors shall offer two options for immediate recoupment. 1. A one-time request for the current overpayment and all future overpayments. Or, 2. A request on a specific overpayment addressed in a demand letter.	X	X	X	X	X					RAC
7688.1.3	Medicare contractors shall incorporate the following minimum requirements for "immediate recoupment" request on its website: 1. Provider Name and contact phone # 2. Provider's Medicare Number and/or the National Provider Identification (NPI) 3. Provider or CFO's signature 4. Letter number 5. Which option the provider is requesting.	X	X	X	X	X					RAC
7688.1.4	Medicare contractors shall consider all written requests for an immediate recoupment as a voluntary payment arrangement.	X	X	X	X	X					RAC
7688.1.5	Medicare contractors shall not consider any recoupment after the Qualified Independent contractor (QIC) proceedings (30 days after QIC decision) as voluntary payments; after this point it is excluded from being considered a voluntary payment.	X	X	X	X	X					RAC
7688.1.6	Medicare contractors shall follow the 935 (f)(2) rules for overpayments subject to 935 for all recoupment activity after the QIC decision. Refer to Publication 100.06, Chapter 3, §200.6.1 Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date	X	X	X	X	X					
7688.1.7	Medicare contractors' demand letter and website shall explain that if there is a remaining principal balance after the initial immediate recoupment contractors' shall continue recoupment and other	X	X	X	X	X					RAC and HIGLAS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	collection activities.										
7688.1.8	Medicare contractors' website shall include instructions for providers currently in an immediate recoupment arrangement to submit a new request to continue the immediate recoupment process.	X	X	X	X	X					RAC
7688.1.9	Medicare contractors shall allow previous immediate recoupment agreements to continue when requested, while awaiting the submission of the new request.	X	X	X	X	X					
7688.1.10	Medicare contractors shall update each AR associated to the request within 10 business days from the mailroom stamped receipt date.	X	X	X	X	X					
7688.1.10.1	As applicable, Medicare contractors shall use the new functionality in HIGLAS which allows user to set the flag to immediate recoupment for multiple ARs instead of one AR.	X	X	X	X	X					HIGLAS
7688.1.11	Medicare contractors shall update individual or multiple AR's in the shared systems when a provider requests the immediate recoupment option.	X	X	X	X	X					
7688.1.12	Medicare contractors shall accept a written request from a provider to discontinue participation in the immediate recoupment process at anytime.	X	X	X	X	X					
7688.1.13	Medicare contractor shall discontinue the immediate recoupment process per providers' written request.	X	X	X	X	X					
7688.1.13.1	This process shall be discontinued within 10 business days from the mailroom stamped receipt date.	X	X	X	X	X					
7688.2	Medicare contractor shall include immediate recoupment language in the appropriate demand letters. Language has been provided in the following business requirements.	X	X	X	X	X					RAC and HIGLAS
7688.2.1	Medicare contractor shall use this language in the 935 overpayment demand letter: "You may elect to have your overpayment(s) repaid through the "immediate recoupment" process and avoid paying by check or waiting for the standard recoupment process that begins on	X	X	X	X	X					HIGLAS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than the 16th day from the date of initial demand letter. You must specify whether you are submitting: 1. A one-time request for the current overpayment and all future overpayments, or 2. A request for the current overpayment addressed in this demand letter only. This process is voluntary and for your convenience. Your request must specifically state you understand you are waiving potential receipt of interest payment pursuant to Section 1893(f)(2) for the overpayments. Note: Such interest may be payable for certain overpayments reversed at the Administrative Law Judge (ALJ) level or subsequent levels of appeal. Visit our website at www._____.___ or call (USA MEDICARE CONTRACTOR Name) at (XXX) XXX-XXXX for additional information and instructions for "**Immediate Recoupment"**. You may fax your request to XXX-XXX-XXXX".										
7688.2.2	Medicare contractor shall use this language in the NON-935 Part B Overpayment Demand letter. "You may elect to have your overpayment(s) repaid through the "immediate recoupment" process and avoid paying by check or waiting for the standard recoupment that begins on day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter. You must specify whether you are submitting: 1. A one-time request for the current overpayment and all future overpayments, or 2. A request for the current overpayment addressed in this demand letter only.	X	X	X	X	X					HIGLAS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	This process is voluntary and for your convenience. Visit our website at www._____.___ or call (USA MEDICARE CONTRACTOR Name) at (XXX) XXX-XXXX for additional information and instructions for "**Immediate Recoupment**"". You may fax your request to XXX-XXX-XXXX.										
7688.3	The system maintainer shall enhance the VMS system to allow Medicare contractors to have the ability to select immediate recoupment on the provider level.		X						X		
7688.3.1	This enhancement if selected for a provider shall automatically apply immediate recoupment on all future ARs (demanded overpayment) continuously unless deactivated.		X						X		
7688.3.2	This enhancement shall allow for the Medicare contractor to activate or deactivate this status at any time.		X						X		
7688.4	The system maintainer shall enhance the VMS system to allow Medicare contractors to be able to specify or query existing immediate recoupment records for a provider to generate reports.		X						X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7688.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Deborah Miller (410) 786-0331 (deborah.miller3@cms.hhs.gov) or
Theresa Jones-Carter (410) 786-7482 (theresa.Jones-carter@cms.hhs.gov).

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Financial Management Manual

Chapter 3 - Overpayments

Table of Contents
(Rev.)205, 02-09-12

200.1.5 Immediate Recoupment Requirements:

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Medicare contractors shall offer providers the opportunity to request immediate recoupment. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

A. *Medicare contractors shall offer two options.*

- *A one-time request on the specific overpayment and all future overpayments. Or*
- *A request on the specific overpayment addressed in demand letter.*

B. *Medicare contractors shall incorporate the following minimum information related to "immediate recoupment" information on its website:*

- *This option is for overpayments that receive a demand letter only.*
- *The request must be in writing, and may be submitted using regular mail, facsimile, or email.*
- *The request must include the following:*

1. *Provider Name and contact phone number*
2. *Provider's Medicare Number and/or the National Provider Identification (NPI)*
3. *Provider or CFO's signature*
4. *Letter number*
5. *Which option the provider is requesting*

C. *Contractors shall post to the website the language in the demand letter related to the immediate recoupment option.*

D. *Medicare contractors shall consider all written requests for an immediate recoupment as a payment arrangement that constitutes a voluntary payment.*

E. *Medicare contractors shall inform providers that going through the immediate recoupment process is considered voluntary payments and will not be subject to 935 (f)(2) interest pursuant to Section 1893(f)(2).*

Note: *Such interest may be payable for certain overpayments reversed at the Administrative Law Judge, (ALJ) level or subsequent levels of appeal. This information shall be included on the contractor's website.*

F. *Medicare contractors shall implement the following exclusion regarding the voluntary payment arrangements when:*

1. *The immediate recoupment continues after the QIC proceedings.*

2. *The provider appeals to the ALJ and prevails.*

3. *Any money collected 30 days after the QIC decision will no longer constitute a voluntary payment.*

G. *Medicare contractors shall follow the 935 (f)(2) interest calculation rules when the provider prevails and recoupment continued after an unfavorable QIC decision. Refer to section 200.6.1*

H. *Medicare contractors demand letter and website shall explain, when there is a remaining principal balance after the initial immediate recoupment you shall continue recoupment and other collection activities.*

I. *Medicare contractors' website shall include instructions for providers currently in an immediate (offset) arrangement to submit a new request to continue the immediate recoupment process.*

J. *Medicare contractors shall allow previous immediate offset agreements to continue when requested awaiting the submission of the new request.*

K. *Medicare contractors shall update each AR associated to the request within 10 business days from the mailroom stamped receipt date. Refer to Chapter 4 §90.2.*

L. *As applicable, Medicare contractors shall use the new functionality in HIGLAS which allows user to set the flag to immediate recoupment for multiple ARs instead of one AR.*

M. *Medicare contractors shall update individual or multiple AR's in the shared systems when a provider requests the immediate recoupment option.*

N. *Medicare contractors shall accept a written request to discontinue participation in the immediate recoupment process at anytime.*

O. *Medicare contractor shall discontinue the recoupment process per providers' written request.*

- *You shall stop this process within 10 business days from the mailroom stamped receipt date.*

200.2- Additional requirements for Demand Letters

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Medicare contractors must issue demand letters for all overpayments subject to the limitation on recoupment protections.

In addition to the requirements listed in Chapter 3 & 4, on First Demand Letters (excluding Cost Report Demand Letters) the following are specific requirements for overpayments subject to the limitation on recoupment protections:

Medicare contractors shall include a claim level detail report of the claim adjustments that comprise the overpayment along with the demand letter to each provider.

A. Medicare contractors demand letters shall clearly state that the provider may submit a rebuttal statement to any proposed recoupment action and you will review it and consider whether to proceed or stop the offset. The rebuttal is permitted under 42 CFR 405.373 through 375 however, does not mandate that recoupment stops.

B. Medicare contractors shall change the language in the demand letter to state that in order to stop recoupment under the provisions of 935 of the MMA; providers, physicians and suppliers must timely request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter. Submission of a rebuttal statement under 42 CFR 405.374 will not stop recoupment.

C. Medicare contractors shall ensure the language in the demand letter makes clear that the provider may appeal all of the claims from the overpayment demand letter or only part of the claims.

D. Medicare contractors shall insert in the demand letter, language that clearly 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, 2) an acceptable ers Request for an extended repayment schedule, (refer to Chapter 4 §50) or 3) a valid request for a contractor redetermination is not date stamped in the mailroom by day 30 from the date of the demand letter.

Note: You shall include immediate recoupment language as outlined below to the appropriate demand letters. (Refer to 200.2.1)

200.2.1 Example 1- Sample of the 935 First Demand Letter for Part A & B

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Example 1: Contents for the 935 First Demand Letter resulting from the limitation of Recoupment

Date

Provider, Physician and Supplier's Name
Address 1,
Address 2
City, State ZIP Code
First Request

Provider/Physician/other Supplier's Number:
Account Receivable Number:

Dear Provider/Physician/Suppliers' Name,

Contractors should the appropriate paragraph:

This letter is to inform you that you have received a Medicare payment in error which has resulted in an overpayment subject to Section 935(f)(2) of the Medicare Modernization Act (MMA) (Section 1893(f)(2) of the Social Security Act , Limitation on Recoupment in the amount of _____. The purpose of our letter is to request that this amount be repaid to our office.

How this overpayment was determined:

Include explanation of the overpayment determination and the amount due.

When applicable, contractor must explain the authority for reopening the claims (i.e., consistent with 42 CFR 405.980 and Publication 100-04 Medicare Claims Processing Manual, Chapter 34) and explain how the facts of the case allowed you to reopen within the timeframes established in those sections.

NOTE: This paragraph shall include **a clear explanation of how the overpayment arose**, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct. For **example: (refer to LCD, NCD, or contractor bulletin, etc.)**

Why you are responsible:

NOTE: For medical necessity determinations, the Part A & B contractor shall insert for **each item or service** an explanation (based on section 1879 of the Act) stating 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. (Applicable Authorities: Section 1870(b)(c) of the Social Security Act; §§ 405.350 - 405.359 of Title 42 CFR §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations and 20 CFR.

For example:

- Based on Bulletin _____ these procedures are only necessary in limited circumstances,
- Based on a prior decision we informed you that these type services are not medically necessary

Additionally, the Medicare contractor shall insert for each item or service an explanation (under **§**1870) why the provider was not found to be without fault in causing the overpayment. For example:

- You can use similar phrases above or any other language that provides evidence of the provider's knowledge that it should have known the services were not covered. Or you were not entitled to payment. . Therefore, you are not without fault and are responsible for repaying the overpayment amount.

I. Make a payment or arrange for payments

What you should do:

1). Make the check payable to Medicare Part A and send it with **a copy of this letter to**:
2). If you want to request an Extended Repayment Schedule please send to:

Contractor Name

Address
City, State and Postal ZIP Code

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure for details.) Any repayment plan (where one is approved) would run from the date of this letter.

II. Payment Withholding

If payment in full is not received by, **(date of the notification),** payments to you can be withheld (Recoupment)until payment in full is receive or if you haven't submitted an acceptable extended repayment request and/or a valid and timely appeal is received.

III. Rebuttal Process:

Under our existing regulations 42 CFR § 405.374, providers, physicians and suppliers will have 15 days from date of this demand letter to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence stating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. If you have reason to believe the withhold should not occur on _____ you must notify this office before ___. CMS will review your documentation. Our office will advise you of our decision in _____days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

The rebuttal statement does not cease recoupment activities consistent with section 935 of the MMA.

IV. How to Stop Recoupment:

Even if the overpayment and any assessed interest have not been paid in full you can stop Medicare from recouping any payments if you act quickly and decidedly. Medicare will permit providers, physicians and suppliers to **stop recoupment** at several points. The first occurs if Medicare receives a valid and timely request for a redetermination within 30 days from the date of this letter, if the appeal is filed later than 30 days, we will also stop recoupment at whatever point that an appeal is received but Medicare may not refund any recoupment already taken.

We will again stop recoupment if, following an unfavorable or partially favorable redetermination decision, you decide to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor (QIC). The address and details on how to file a request for reconsideration will be included in the redetermination decision letter."

V. Immediate recoupment:

"You may elect to have your overpayment(s) repaid through the "immediate recoupment" process and avoid paying by check or waiting for the standard recoupment that begins on day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter. You must specify whether you are submitting:

1. A one-time request for the current overpayment and all future overpayments, or
2. A request for the current overpayment addressed in this demand letter only.

This process is voluntary and for your convenience. Your request must specifically state you understand you are waiving potential payment of interest pursuant to Section 1893(f)(2) for the overpayments. Note: Such interest may be payable for certain overpayments reversed at the Administrative Law Judge level or subsequent levels of appeal.

*Visit our website at www._____.___ or call (USA MEDICARE CONTRACTOR Name) at (XXX) XXX-XXXX for additional information and instructions for "**Immediate Recoupment**".*

You may fax your request to XXX-XXX-XXXX.

What are the timeframes to stop recoupment:

First Opportunity: To assist us in expeditiously avoid the recoupment the appeal request must be filed within 30 days of this letter. We request that you clearly indicate on your appeal request that this is an **overpayment** appeal and you are requesting for a redetermination to:

Contractor Name
Address
City, State and Postal ZIP Code

Second Opportunity: If the redetermination decision is 1) **unfavorable** we can begin to recoup no earlier than the 61st day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter), or, 2) if the decision is **partially favorable**, we can begin to recoup no earlier than the 61st day from the date of the Medicare revised overpayment Notice/Revised Demand Letter or, 3) If the appeal request was received and validated after the 60th day we will stop recoupment. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What Happens following a reconsideration by a Qualified Independent Contractor.

Following decision or dismissal by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to any further level.

NOTE: Even when recoupment is stopped, interest continues to accrue.

V*I*. Interest Assessment:

If you do not refund in 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of __ % will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ %. In addition, please note that Medicare rules require that payment be either received in our office by _____ or use the United States Postal Service Postmark by that date for the payment for the payment to be considered timely. A metered mail postmark received in out office after _____ will cause an additional month's interest to be assessed on the debt.

VI*I*. If you wish to appeal this decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination 120 days from the date of this letter**. However, if you wish to avoid recoupment from occurring and assessment of interest of this overpayment you need to file your request for redetermination within 30 days from the date of this letter as described above**. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. "

VII. If you have filed a bankruptcy petition:

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. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Should you have any questions please do not hesitate to contact _____ at _____.
If we can assist you further in the resolution of this matter, <Contractor Name> shall be glad to do so.

Sincerely,
(Name and title)
Enclosure
Cc

200.5.1 Payments Made Upon Notice of Demand *or through an Immediate Recoupment Request*

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Payments made by a provider in response to a demand are not recoupments as defined in 405.372(e). 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 935 interest. *Refer to section 200.1.5 Immediate Recoupment requirements.*

Medicare Financial Management

Chapter 4 - Debt Collection

Table of Contents

(Rev. 205, 02-09-12)

80.2 Immediate Recoupment requirements for NON-935 Overpayment Recovery from the Physicians and Other Suppliers

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Medicare contractors shall offer providers the opportunity to request immediate recoupment. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

A. *Medicare contractors shall offer two options.*

- *A one-time request on the specific overpayment and all future overpayments. Or*
- *A request on the specific overpayment addressed in demand letter.*

B. *Medicare contractors shall incorporate the following minimum information related to "immediate recoupment" information on its website:*

- *This option is for demanded debts only.*
- *The request must be in writing, and may be submitted using regular mail, facsimile, or email.*
- *The request must include the following:*

1. *Provider Name and contact number*
2. *Provider's Medicare Number and/or the National Provider Identification (NPI)*
3. *Provider's or the CFO's signature*
4. *Letter number*
5. *Which option the provider is requesting*

C. *Medicare contractors shall post to the website the language in the demand letter related to the immediate recoupment option.*

D. *Medicare contractors shall consider all written requests for an immediate recoupment as a payment arrangement that constitutes a voluntary payment.*

E. *Medicare contractors shall inform providers that going through the immediate recoupment process is considered voluntary payments. Refer to chapter 3 section 200 for overpayments subject to 935.*

F. *Medicare contractors demand letter and website shall explain, when there is a remaining principal balance after the initial immediate recoupment you shall continue recoupment and other collection activities.*

G. *Medicare contractors' website shall include instructions for providers currently in an immediate (offset) arrangement to submit a new request to continue the immediate recoupment process.*

H. *Medicare contractors shall allow previous immediate offset agreements to continue when requested awaiting the submission of the new request.*

I. *Medicare contractors shall update each AR associated to the request within 10 business days from the mailroom stamped receipt date. Refer to Chapter 4 §90.2.*

J. *As applicable, Medicare contractors shall use the new functionality in HIGLAS which allows user to set the flag to immediate recoupment for multiple ARs instead of one AR.*

K. *Medicare contractors shall update individual or multiple AR's in the shared systems when a provider requests the immediate recoupment option.*

L. *Medicare contractors shall accept a written request to discontinue participation in the immediate recoupment process at anytime.*

M. *Medicare contractor shall discontinue the recoupment process per providers'written request.*

- *You shall stop this process within 10 business days from the mailroom stamped receipt date.*

90.2- Part B *NON-935* Overpayment Demand Letters to Physicians/Suppliers

(Rev.205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

When a physician/supplier is liable for an overpayment of $10 or more, the carrier shall attempt recovery through the following procedures. It shall recover an overpayment made to a physician/supplier as an individual or to a professional corporation (following the procedures described below) only from the party to whom the overpayment was made. It shall make no attempt to recover an overpayment made to an individual physician/supplier from a professional corporation with which they may be associated as an employee or stockholder. Conversely, it shall not attempt recovery from an individual physician/supplier where the overpayment was made to a professional corporation with which they are, or were, associated.

A. Overpayment Amount Is At Least $10

When the carrier determines an overpayment it shall issue a demand letter that requests the physician/supplier to pay the debt in full within 30 days, or the amount owed and any assessed interest will be collected by offset.

B. Overpayment Demand Letter

The purpose of an overpayment demand letter is to notify the physician/supplier of the existence and amount of an overpayment, and to request repayment. The demand letter shall be written in such a manner as to fully explain the nature of the overpayment and the amount determined. Each demand letter shall be:

- Sent to the physician/supplier by first class mail; and

- Determined within forty-five (45) calendar days of the discovery of the overpayment and mailed within seven (7) calendar days of the creation of the accounts receivable and generation of the demand letter. Longer amounts of time in between discovery and determination must be supported by additional documentation. In the case of the second request, the letter must be mailed within 45 days but no earlier than 30 days after the date of the first demand letter.

A. Content of Demand Letters

- Sent to the physician/supplier.

- For a first request, mail within seven (7) calendar days of determination of the overpayment.

- Each demand letter is an explanation of the nature of the overpayment, how it was established, in addition, the amount determined.

- *The Medicare contractor shall include the model immediate recoupment process language within the content of the Part B non-935 overpayment demand letters to physicians and other suppliers for the Part B Non-MSP overpayment demand letters.*

- *The demand letter shall offer the physician and other supplier the opportunity to request an immediate recoupment. Refer to section 80.2.*

- The demand letter shall offer the physician/supplier the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be approved using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter.

- The demand letter constitutes a request to the physician/supplier to refund the overpaid amount.

- The demand letter informs physicians/suppliers that the carrier will recover the overpayment through the recoupment of current payments due or from future claims submitted unless the carrier receives repayment or the physician/supplier provides a statement within 15 days of the date of the letter of why this action should not take place. The demand letter shall also inform physicians/suppliers that this recoupment will begin on the 41st day from the date of the letter.

- The demand letter informs physicians/suppliers that interest will accrue on the overpayment if payment in full is not received by the 31st day from the date of the letter. The demand letter shall also inform physicians/suppliers of the applicable interest rate that will accrue if payment in full is not received by the 31st day from the date of the letter.

- The demand letter informs physicians/suppliers that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) A review is available for disputed overpayments of any amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least $100.

- Bankrupt providers. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.

The *Medicare contractor* shall refer to Exhibits I through VI for the standard formats for each demand and voluntary refund letters to be used in various overpayment situations.

B. Recovery by Recoupment

If, within 15 days of the date of the initial demand letter, the physician/supplier submits a statement *(rebuttal)* and/or evidence as to why *recoupment* should not be effectuated, the carrier shall promptly evaluate the material. This is different from a request for appeal (see subparagraph F) in that you are deciding only whether there is a basis to not effectuate *recoupment*. Any correspondence dealing with the basis of the overpayment does not affect your decision concerning *recoupment* . If the carrier determines that *recoupment* shall begin, it shall notify the physician/supplier in writing of its determination. It shall give specific reasons for its decision.

If no such statement *(rebuttal)* is received or an extended repayment *schedule* has not been requested, the contractor shall initiate recovery by recoupment 40 days after the date of the initial demand letter (day 41), unless the physician/supplier refunds the overpaid amount in full. The contractor shall apply any amounts payable to the physician/supplier by reason of assignment on behalf of **any** beneficiary to recoup the overpayment. It shall apply any amount recouped first to the accrued interest and then to the principal.

If it is not possible to make an immediate recoupment, the contractor shall annotate the physician's account so that the overpayment can be recouped from future Medicare benefits payable. When recoupment is used, the contractor sends the regular Medicare Summary Notice (MSN) to the beneficiary. However, it includes with the physician's/supplier's MSN an explanation that the benefits (or a specified amount of the benefit) are being applied to the overpayment and that the physician may not request the beneficiary to pay the amount applied to the overpayment.

The contractor shall discontinue recoupment only when the overpayment, plus all accrued interest, is recovered, it is determined on appeal that the physician/supplier was not overpaid or an acceptable extended repayment plan request is received (See Chapter 4, §50). After a favorable appeal decision, the contractor shall refund any excess amount withheld through recoupment. Also, it shall refund any interest that was collected.

C. Follow-up Request

If the initial demand letter for an overpayment of $10 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

D. Physician Appeals Within 30 Days of Notification of the Intent to Recoup

If, within 30 days after the date of the initial demand letter informing the physician/supplier of the intention to recoup, the physician/supplier submits a request for a review or hearing or otherwise protests the recovery, the carrier shall make every effort to conclude the appeal procedure expediently. However, it shall begin recoupment 40 days after the initial demand, if payment has not been made, regardless of the status of any appeal request. (See subparagraph D.)

E. Demand Letter to Physician Returned as Undeliverable

Where a refund letter is returned as undeliverable, the carrier shall attempt to locate the physician/supplier using such sources as telephone directories, city directories, postmasters, driver's license records, automobile title records, State and local medical societies, the American Medical Association or its own Medicare beneficiary records. (See Chapter 4, §80.)

F. Direct Contact with Physician

If attempted recoupment of the overpayment is unsuccessful for 30 days, the carrier shall contact the physician/supplier by telephone. (See Chapter 4, §80.) **Third Demand Letter**

If the overpayment has not been recouped and the debt is eligible for referral to the Department of Treasury an intent to refer letter shall be sent once the overpayment becomes 90 days delinquent. (See CR 1683 or Chapter 4, §70)

EXHIBIT 1- SAMPLE DEMAND LETTERS

Exhibits I through VI include: the initial demand letter with optional opening paragraphs and the follow-up letter. It also includes a limited set of optional paragraphs to be used in specific situations, e.g., medical necessity denials, and installment payments. The carrier shall follow these formats, with the optional paragraphs, when preparing demand letters.
This section also includes standard letters to be used when the physician/supplier voluntarily submits a check to the carrier. These letters are optional if the carrier uses the remittance advice to inform physicians/suppliers of receipt of their refund checks.

EXHIBIT 1 - INITIAL *Non-935* DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code
Date
Dear Dr. Smith:
Contractors should use the appropriate paragraph:

"This is to let you know that you have received Medicare payment in error which has resulted in an overpayment to you of $_____ for services dated _____ . The following explains how this happened."

or

"We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention."

or

"We have received your check in the amount of $_____. We thank you for bringing this overpayment to our attention. While we appreciate you submitting payment to us, our review found that the overpaid amount was $_____. Please remit the additional $_____."

How this overpayment was determined: NOTE: This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.

Why you are responsible:

NOTE: For medical necessity determinations, the carrier shall insert appropriate paragraphs. It shall be sure to give an 1879 determination for each claim as well as the regulatory and statutory references for the 1879 determination.
You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below.
(Applicable Authorities: Section 1870(b) of the Social Security Act; §§ 405.350 - 405.359 of Title 42, §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.)

What you should do:

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

Carrier Name
Address
City, State and Postal ZIP Code

Immediate Recoupment request:

"You may elect to have your overpayment(s) repaid through the "immediate recoupment" process and avoid paying by check or waiting for the standard recoupment that begins on day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter. You must specify whether you are submitting:

1. A one-time request for the current overpayment and all future overpayments, or
2. A request for the current overpayment addressed in this demand letter only.

This process is voluntary and for your convenience.

*Visit our website at www._____.___ or call (USA MEDICARE CONTRACTOR Name) at (XXX) XXX-XXXX for additional information and instructions for "**Immediate Recoupment**".*

You may fax your request to XXX-XXX-XXXX.

If you do not refund in 30 days:

In accordance with 42 CFR 405.378 simple interest at the rate of __ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ .
We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure for details.) Any repayment plan (where one is approved) would run from the date of this letter.
If payment in full is not received by, (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is received. If you have reason to believe that the withhold should not occur on _____ you must notify <contractor> before ___. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

If you wish to appeal this decision:
If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:
Address of Redetermination Department

If you have filed a bankruptcy petition:
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. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.
Should you have any questions please do not hesitate to contact _____ at _____.
If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.
Sincerely,
(name and title)
Enclosure

EXHIBIT 2 - FOLLOW UP DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Dear (Name of Physician/Supplier):

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the initial letter sent to you which explains how the overpayment was determined and why you are responsible. As of today, we have not heard from you, either to request an overpayment appeal or to make payment. The overpaid amount is _____ (principal plus interest) for your claim that paid on _____. $_____ has been recovered.

As stated in our initial letter, offset of the overpayment amount, plus interest, will be made against any pending and future assigned Medicare claims.

If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact us at _____.

Sincerely,

(Name of individual)

Enclosure

EXHIBIT 3- INTENT TO REFER LETTER

When an eligible physician/supplier overpayment remains delinquent for 90 or more days, the carrier shall send an intent to refer letter. (See CR 1683 and Chapter 4, §70 for more information.)

EXHIBIT 4 - OPTIONAL OVERPAYMENT CUSTOMIZING PARAGRAPHS

A1 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."

Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because (i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community).
(Applicable Authorities: Section 1879 of the Social Security Act; §§411.404 and 411.406 of Title 42 of the United States Code of Federal Regulations.)

NOTE: The carrier shall be sure to include the applicable authorities at the end of the §1879 language as it appears here.

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary.

This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge.

The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

B2 - The carrier shall include one of the appropriate paragraphs below in all overpayment letters that involve duplicate payments.

- The overpayment resulted from excess payments caused by multiple processing of the same charge.

- The overpayment resulted from Medicare payment on an assigned claim for which the beneficiary also received payment on an itemized bill and turned his payment over to you. Therefore, you are liable for $_____ which represents that portion of the total amount paid in excess of the fee schedule amount.

- You have mistakenly received duplicate primary payment from both Medicare and another entity (Specific payer). (Specific payer) is the appropriate payer. As such, you are liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer.

- This overpayment resulted from duplicate Medicare payments to you for services you provided to (**named beneficiary**).

NOTE: The above paragraphs are not all-inclusive.

EXHIBIT 5 - SAMPLE LETTER - CHECK INCLUDED FOR CORRECT AMOUNT

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention, thereby protecting the integrity and resources of the Medicare program.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check in the amount of $_____ and applied it to the overpayment.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

EXHIBIT 6 - SAMPLE LETTER - CHECK INCLUDED BUT WRONG AMOUNT (TOO MUCH)

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid in error. We thank you for bringing this overpayment to our attention.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check for $_____. You will notice that the amount of your check exceeds the overpayment amount. We will send you a check shortly for the excess amount.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

Enclosure