CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 424	**Date: DECEMBER 24, 2008**
	Change Request 6298

SUBJECT: HIGLAS Part A Changes for Limitation on Recoupment

I. SUMMARY OF CHANGES: To ensure that HIGLAS is including 935 interest on a 1099-INT form. Also to allow for the first demand letter to be sent along with the second demand systematically.

New / Revised Material
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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):

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 424	Date: December 24, 2008	Change Request: 6298

SUBJECT: HIGLAS Part A Changes for Limitation on Recoupment

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

I. GENERAL INFORMATION

A. Background: Section 1893(f) (2), added by Section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires CMS to change the way Medicare recoups certain overpayments. CR 6183, Transmittal 141-Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments, instructs the contractors to pay a provider interest at the ALJ and subsequent levels if the appeal is found in the providers favor. Also, the contractor shall pay interest to the provider if they were to take an administratively long amount of time (more than 30 days) refunding the provider monies due. This interest is considered income for the provider and shall be reported on a 1099-INT form. Currently the HIGLAS System for Part A does not apply this income on the 1099-INT form and the HIGLAS System does not produce a report which should only include 935 interests paid to the provider.

Along with the 1099-INT changes there will be changes to the letter submission portion of the HIGLAS system for Part A. Currently the system sends out the second demand letter without the first demand letter. This is a requirement for the contractors to send the first demand along with the second demand. To lower burden on the contractor the HIGLAS system shall be changed to send the first demand out with the second systematically. The system shall generate various reports for the contractors to supply to CMS.

B. Policy: This CR does not constitute policy to implement the limitation on recoupment. It is one of a series of CRs that are being or have been issued designed to fully implement section 1893(f) (2) and the final implementing regulation when published and in effect.

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	
6298.1	The HIGLAS system shall process interest to be paid to the provider at the ALJ and subsequent levels of appeal.										HIGLAS
6298.1.1	The HIGLAS system shall process interest to be paid to the provider for contractors taking an administratively long amount of time refunding the provider's monies.										HIGLAS
6298.1.2	All RAC Identified overpayments are subject to 935 and will be recorded in HIGLAS as a 935 Overpayment.										HIGLAS
6298.2	The HIGLAS system shall generate this data on a 1099-INT form for the providers tax use.										HIGLAS
6298.3	The HIGLAS system shall supply a report which would include the interest data collected in 6298.1 and 6298.1.1 for the contractor to submit to CMS each calendar quarter.										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	
	Report will be sent via email to: CMS_Medicareoverpayments@cms.hhs.gov.										
6298.4	The HIGLAS system shall include a copy of the first demand letter and it's enclosure along with the second demand letter and a revised enclosure.										HIGLAS
6298.5	The HIGLAS shall create new Receivable Activities for FISS. • WRO COMPRIMSE FULL 935- APPEAL –INT • WRO COMPRIMSE FULL 935- APPEAL – PRINC • WRO COMPRIMSE PARTIAL 935- APPEAL –INT • WRO COMPRIMSE PARTIAL 935- APPEAL – PRINC										HIGLAS
6298.6	The HIGLAS system shall produce Daily 935 appeals detail reports for Redetermination, Reconsideration and ALJ appeals. The 935 appeals reports shall capture all collection activities and should include but are not limited to the following: • Account Receivable number • Account Dollar amount • Provider Number/NPI • Appeal dates • Decision dates • Decision determination • Accrued Interest • Pending/Closed Status • Demand Letter Notification date • Decision Age • Scheduled Offset date • Date of Last Activity Report will be sent via email to: CMS_Medicareoverpayments@cms.hhs.gov. A final report is due quarterly to CMS but available daily for contractor use.										HIGLAS
6298.6.1	The HIGLAS system shall provide to contractor monthly and quarterly summary reports for Redetermination, Reconsideration and ALJ appeals in Excel format which include: • Number of pending A/R										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	
	• Number of pending A/R will Appeals received • Number of pending A/R with Favorable, Partial and Unfavorable decision • Number of A/R with offset • Number of A/R with decision pending closure • Number of A/R closed • Average Age of pending Appeals • Average Age of closed Appeals • Dollar amount of outstanding A/R pending Appeal • Dollar amount of closed A/R appealed • Dollar amount of Accrued Interest										
6298.6.2	The HIGLAS system shall provide the needed information to allow for the contractor to generate these reports.										HIGLAS

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	
	None.										

IV. SUPPORTING INFORMATION

X-Ref Requirement Number	Recommendations or other supporting information:

V. CONTACTS

Pre-Implementation Contact(s):
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Post-Implementation Contact(s):
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VI. FUNDING

Section A: For ***Fiscal Intermediaries (FIs) and Carriers****:*

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)***:

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.

Attachment

Overpayment ConferenceAugust 13-14, 2008
935 Questions

1. If more than one 935 A/R is created on the same day, the CR states that all will appear under one control number/one ACS demand letter. If one of the items is appealed, how is it separated from other items on the same control number?

Response: Refer to JSM/TDL, 09/24/08. This process has been postponed until CR 6204 and 5986 are implemented in 2009. When all systems are in place for part B claims, they will be creating individual ARs for each claim that becomes an overpayment.

2. From the DCIA perspective in HIGLAS, will the "935 Appeal Reconsider Denied" delay referral for 30 days? If not, what is the best way to delay DCIA referral or should there be a delay at all?

Response: Yes, it will delay until the user changes the status.

3. HIGLAS Debt Collection due to timing, it is possible for the ITR letter to be sent prior to the Reconsideration Appeal being received and validated. At the point the Reconsideration decision is received & upheld, we allow the provider 30 days for recoupment.

Response:Yes your statement is correct. Keep in mind that if the reconsideration is denied or partially (unfavorable) before the 2nd or 3rd ITR went out, then those letters will need to be sent out 60-days following the QIC decision. The status isn't automatic; the end user must put it in the system.

4. What does this statement mean? We see less collected, not more. "These CR requirements will have an impact on contractors' budgets; estimates have shown that the overpayment recovery amount associated with this project significantly exceeds the cost."

Response: This language was deleted out of Section 7 in the Business Reg.

5. Business Requirement 6183.12.10: This states an EOB would be acceptable in place of a written notice; however, page 12 of the manual states that a revised demand letter should be sent. Which one would be correct? Can clarification be given to the group?

Response: Yes, the EOB is acceptable.

6. CR 5986: How will dismissals be tracked; should they be tracked?

Response: There is no dismissal tracking requirement.

7. Assumption – a.) CMS manual allows 2nd demand for Part B from 30th to 45th day. Based on Overpayment Conference discussion: b.) CMS is considering revising the 2nd letter date from the 30th day from 1st demand to the 41st day in order to reduce expense to the program as volume would decrease through recoupment, requiring fewer demand letters.

Response: **a.** This will need to addressed with the Manual workgroup to update this request in chapters 3 & 4. **b.** I will suggest this request to be changed in the Demand Letter section in Chapter 4 to ref Part B which will be out later this year.

8. Would CMS consider the 43rd or 45th day? This will allow FISS to recoup on the 41st day when activated on the 40th day and then recoup in the overnight cycle.

Response: We will consider your request. If we do this change it would be in the CR for chapter 3 & 4 or a new CR with revisions to CR6183.

9. Are CWF-automated adj. resulting in overpayments included in 935? (i.e., SNF, HHA, MCO, etc.)? Background: Updates to HIMR result in discovery of overpayments made under Part B to providers whose patients were in a Part A coverage spell. Most of these claims are adjusted and finalize automatically, without human intervention. No 935 'indicator' can thus be manually set. These are not provider- initiated, nor are they discovered in a medical review process. They are post-pay adjustments to collect, initiated by an automated *process by CWF*.

Response: No not at this time. We will need to research this to see if they should be subject to 935.

10. HIGLAS changes are needed: -- need to put A/R in appeal status (can do now)-- need to be able to add dates for appeal info (start/end) & be able to pursue recovery 60 to 75 days -- need flags/ triggers /alerts/reports to manage & meet timeframes -- mentioned on EIC call (7/21/08), HIGLAS letters changed to meet 935 requirements; cannot find any HCR for Part B letters or any info on any changes. Where can we get what the changes are?

Response: All of these changes are addressed in CR 5986, 5873 and 6204.

11. Concern about the delay in recoupment & interest accruing once appeal is completed. a) Will provider education be provided? b) Can provider request recoupment to begin immediately? Few 1st-level appeals result in subsequent appeals.

Response: a. Yes, the Med Learn letter is out and on the web for the provider community. b. Yes, the provider can request recoupment to begin immediately.

12. There are two inconsistent dates; which one is correct? 6183.12.1 = 10 days & 200.2.2 = 2 days:

Response: This was updated and corrected to 6 days: 6183.11.2: Medicare Contractors shall establish internal controls to ensure recoupment does not proceed if a valid request for a redetermination is received. The appeal unit or a qualified appeal staff (in mailroom) who receives the appeal request will have 2-4 business days to validate the appeal and communicate to the Overpayment/Financial Division who will have an additional 2 business days to stop the recoupment process. In general, the process of stopping recoupment based on a valid appeal request should take no more than 6 business days. ***6183.12.1***: Medicare contractors shall update the system to stop recoupment within 2 calendar days from the appeal notification of the valid appeal request. This is a repeat to the above BR and should have been deleted.

13. Will FISS create 20 A/Rs if there are 20 adjustments on one remittance? How does 935 & Non-935 apply to how A/Rs are set up & what will it look like on remittance?

Response: Refer to JSM/TDL, 09/24/08 which addresses postponed on individual ARs until implementation in January 2009 when the systems will be upgraded to do handle this function.

14. When the A/R is recouped, how is that info shown on the remittance?

Response: There will be a reason code which will trigger a message that would be on the remit.

15. Is FISS going to be programmed to produce the demand letter when the adjustment sets up the A/R? Do not currently use ACS.

Response: Yes and if the contractor is on Higlas then the letter will come out of Higlas then.

16. Some timeframes to begin recovery state 60 to 75 days and others state 60 to 76 days. Is 75 or 76 correct?

Response: Please refer to 6183.12.12.4 states: Medicare contractors will have an additional 15 days to start recoupment on any unpaid balance. While the notices should state that recoupment can begin no earlier than the 61st day, The 15 day period between when the provider is informed recoupment can begin (day 61) and when recoupment must begin no later than (day 76) is designed to facilitate communication between the QIC and the contractor (MAC/AC), should a reconsideration request be received or payment is received. However, if you are provided documentation by the provider that a reconsideration request has been sent to the QIC, and you have not heard from the QIC, and the 75th day is approaching; you may but are not required to contact the QIC to check whether in fact an appeal has been received to avoid subsequent problems with the provider. *CMS (The division of Debt Management) requests contractors to hold off recoupment until day 76.*

17. If a provider goes to a bank and gets a loan to repay Medicare debt and then files an appeal & wins the appeal, who is responsible for the interest the provider pays on the loan? Should Medicare reimburses the provider for the interest he has paid on the loan?

Response: No, this is not Medicare's responsibility.

18. Notice of Receipt Appeal Request Redetermination and Recoupment Stopped Letter – Which Department should issue this letter, appeals or A/R?

Response: The contractor decides this, more than likely it would be the area that handles overpayments.

19. When reviewing the HIGLAS reason codes, please keep in mind there is still a need for reason codes that do not produce demand letters.

Response: This was reviewed and the reason codes for FISS and MCS are addressed in CR(s) 5986 and 5873.

20. Is HIGLAS going to be corrected to recognize MSP debt & follow the appropriate MSP recovery timeframes and interest accrual?

Response: Yes. All MSP claims that are associated with the 935 provision will be recognized and follow the 935 guidelines

21. If recoupment is not stopped for ALJ, why do we wait 30 days before recovering after a QIC decision?

Response: Limitation on Recoupment is for the *1st and 2nd level 935 appeals only*. If the provider files for the ALJ and higher the contractor will not stop recoupment. After the QIC decision a notice will go out stating recoupment will begin 30 days from the decision date. Please review section ***200. 3.1*** (***D). Which states- The*** contractor can begin recoupment at day 30 from the date of the QIC decision or from the revised written final determination due to effectuation and shall send a notice that offset will occur on day 30; and the provider or supplier has been afforded the opportunity for a rebuttal in accordance with the requirements of § 405.373 through § 405.375 within 15 days of the notice. However, no demand letter (2nd or 3rd) shall be issued for a total of 60 days following the QIC decision. After 60 days the contractor shall issue the 2nd follow up demand letter or 3rd intent to refer letter (whichever is appropriate) and referral to treasury as needed. The overpayment shall remain in "eligible for internal offset" status until it has been paid in full or referred to Treasury through cross-servicing.

22. 935 Interest – Typically, if Medicare has recovered interest and there is a reversal of the overpayment, Medicare will return interest recovered. Also, if Medicare takes longer than 30 days to return an overpayment after a reversal, Medicare pays interest to the provider. What is 935 interest given the above info?

Response: **Y**es if the provider has a favorable outcome the recouped funds in P& I must be applied to any outstanding overpayment first and any excess amount is refundable. However, the "935 Interest" is only paid out to the provider at the ALJ level or higher if the provider wins. The Medicare contractors shall calculate 935 interest, which is payable on an underpayment where the reversal occurs at the ALJ level or subsequent higher levels based on the period Medicare recouped provider or supplier funds. 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. The amounts that are to be used as the basis on which to compute interest earned by the provider. Those amounts that are credited to principal resulting from any involuntary payments from the provider. If the contractor can't refund a provider by the 30th day from the final determination, and then there will be a late interest payment due which is not the same as the 935 interest. There are two separate types of interest payments altogether. **Note:** *If the contractor is late getting out a refund at any level of appeals a late payment will be necessary.*

23. To stop recoupment in FISS, change the override field to Y; do you also change the recoup field to N?

Response: Yes.

24. Aging of the A/R – For purposes of the 2nd & 3rd demand letter, Intent to Refer letter and referral to Treasury, how will a redetermination/reconsideration interrupt this process? Will the timeframes for the stop recoupment process be taken in to consideration? How about the aging buckets on CFO/TROR and other financial reports?

Response: The contractor will continue to age the debt regardless it is in an appeal status. You will continue to report the debts in an appeal status and use the appropriate codes (A-I) for the amount of days delinquent for reporting purposes on the CFO/TROR.

25. Who inputs 1st demand date into FISS? When is the first demand issued? **Day 1** 60 days from origination date? What is Day 1?

Response: The contractor inputs the demand dates in your normal processes**.** The first letter is issued the same as your current policy, that hasn't changed, you still have the 7 days to get the letter out from the determination date. In chapter 4 and in CR 6183 section 200-Day-1 means the day you sent the demand letter out. The 60 days is use in the revised demand letter or a notice out with the 1st level appeal decision to get the 2nd level request in by day 60 to avoid the recoupment from starting back up.

26. What if our FISS does not use ACS? How will we know to generate demands?

Response: FISS must have the letter in place to activate Sept 29 for the CR6183 implementation. Please contact Theresa Jones-Carter if there are any issues with this requirement.

27. Currently, if an overpayment is set up in MCS & FISS, we must continue to recover the overpayment because the system will reissue the check. I am sending this one in e-mail because it is complicated.

Response: The systems will have a reason codes in place- to start recoupment on day 41 if no appeal has been received and a flag to stop the recoupment is not on. The contractor must stop the recoupment in system once they received the valid appeal request.

28. If we have received a check from a provider & there are excess funds from the check, we apply the funds to a 935 A/R. A/R is later appealed & the overpayment is partially or fully reversed. Are the excess funds considered an involuntary payment in regards to 935 interest? (CR 3274).

Response: Yes you would include that amount as a recoupment (involuntary) because the contractor initiated the application on the refunded amount to the 935 debt.

29. Highmark does not review any ERS that does not include all the info in the manual. There are docs that do not play into the decision, please change the manual to reflect flexibility.

Response: Thank you for your comment. We will take this into consideration when updating the manual.

30. 3-Year Presumption – If a LCD/NCD is changed retroactively & at the time the service was billed, it followed the LCD/NCD in effect. After 3 years has passed & it is found for the date of service the LCD/NCD should have denied the service; do we pursue the overpayment even though the service paid based on the LOCD/NCD in effect when the claim was submitted?

Response: If CMS deems that a service is non-covered and payment was made in error the monies is to be recouped within the reopening period.

31. HIGLAS has many issues with demand letters (see HMS issues log, MNTs & HCRS'). Will these corrections also be made?

Response: Yes.

32. Extrapolated Overpayment – If an extrapolated overpayment is reviewed and the overpayment is revised, who is responsible to issue the info about the revision? Currently, our PSC sends a letter to the provider about the sample; but, if it is revised, they refuse to send another letter.

Response: The Medicare contractor will need to send it.

33. Please describe an involuntary payment vs. payment made at the request of the provider. (provider requests withhold).

Response: 1) *Involuntary*: The contractor recoups the funds without receiving any checks, request from a provider to offset/withhold. 2) *Voluntary:* When the provider sends in a check for that overpayment, or requests an extended repayment plan.