Limitation on Recoupment

Section 935(f)(2) of the Medicare Modernization Act (MMA)

Social Security Act §1893 (f)(2), 42 USC 1395ddd (f)(2)

AGENDA

- Background
- Who is affected by § 935(f)(2)
- What §935(f)(2) did not change
- Changes to the Provider overpayment recoupment process, required by Section 935(f)(2)
  - -Overpayments Subject to Limitation on Recoupment
  - -Overpayments Not subject to Limitation on Recoupment
  - -Payment Suspension
- Understanding Limitation on Recoupment
- Appealing after the QIC decision to The Administrative Law Judge (ALJ) 3rd level appeal or subsequent levels
- Voluntary Payments
- Limitation on Recoupment Rights and approved ERS
- How § 935(f)(2) works in tandem with the appeal process .
  - -Filing for a Redetermination (1st level) Appeal request and effectuating the Redetermination
  - -Filing for a Reconsideration (2nd level) Appeal request and effectuating the Reconsideration
  - -Potential payment of 935 (f)(2) interest on successful appeals at the Administrative Law Judge (ALJ) or Subsequent levels of Appeal
- Recoupment Timeframe chart
- Recap
- Questions

Background

- Section 935(f)(2)(a) of the Medicare Modernization Act of 2003 (MMA) required CMS to change the way Medicare recoups certain Provider, Physician, or other Supplier overpayments and requires the payment of interest when the Provider, Physician or other Supplier prevails at the ALJ or subsequent levels of appeal. *Refer to 42 CFR § 405.379 (74 FR 47458 09/16/09)*

- **Providers, Physicians or other Suppliers will be referred to generically as "Providers" in this presentation.**

- Before the MMA was enacted, CMS could recoup whether or not a provider appealed.

Who is affected by § 935 (f)(2)

All Providers who submit fee-for-service claims to Medicare claims processing Contractors.

What § 935(f)(2) did not change

- It did not change the appeal requirements.

- It did not change the appeal timeframes:
  - 120 days to file for the 1st level
  - 180 days to file for the 2nd level
  - 60 days to file for the 3rd level
  - 60 days for 4th, and 60 days for the 5th)

- It did not change the requirement on interest accrual and assessment for each 30-day period from the date of the demand letter if the overpayment is not fully paid within 30 days of the demand notice or until the debt is fully paid off. (Refer to 42 CFR 405.378)

- It did not change the existing underpayment interest requirements. (Refer to 42 CFR 405.378)

- It did not change the existing rebuttal requirements. (refer to 42 CFR 405.373-405.375)
  Note: Rebuttal statements are **not** appeal requests. Only appeal requests trigger § 935 Limitation on Recoupment.

- It did not change payments which have been suspended.

Changes to the Provider overpayment recoupment process, required by § 935(f)(2)

- Recoupment ceases at certain levels of appeal.
- Limitation on recoupment extends to the 1st level appeal “redetermination” and the 2nd level appeal “reconsideration”.
- The timeframe to request an appeal is longer than the timeframe for initiating recoupment. Consequently if a provider wants to avoid recoupment it must submit the appeal request within the (30 day’s from demand letter) shorter timeframe.

Overpayments subject to Limitation on Recoupment

Generally– fee-for-service claims based overpayments for which a demand letter is issued.

- Post-pay denial of claims where a demand letter was issued as a result of a post payment review with or without medical or billing records.

Here are a few examples:

1) Recovery Audit Contractor (RAC)
2) Program Safeguard Contractor (PSC) and Zone Program Intermediary Contractor (ZPIC)
3) Office of Inspector General (OIG) determined overpayments
4) Cost outlier denied claims

Note: Excluding PIP payments and adjustments for providers on PIP

Overpayments subject to Limitation on Recoupment (cont.)

- Medicare Secondary Payer (MSP) recovery where the Provider received a duplicate primary payment (DPP) and a written demand letter was issued.

- Providers failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B.

- When an overpayment demand letter is issued because a final claim was not submitted for the (Request for Anticipated Payment (RAP)) under the Home Health Prospective Payment System (HH PPS).

Overpayments NOT Subject to Limitation on Recoupment include but Are Not Limited To:

- Overpayments that arise from a cost report determination
- Overpayments that are appealed under the Provider reimbursement Payment (PRB) process of 42 CFR part 405 subpart R-Provider/Reimbursement Determinations and appeals.
- Hospice Caps calculations
- Provider initiated adjustments
- Accelerated/Advanced Payments
- Mass adjustments due to system errors
- Periodic Interim Payment (PIP) denied(claims)

Payment Suspension

A suspension of payment is not considered a recoupment “for 935 Limitation on Recoupment.

Additionally, under 42 CFR § 405.372(e), suspended payments will be applied to any Outstanding overpayments.

Payment Suspension Examples

1st example

- $ 100,000 suspended payment
- $ 80,000 outstanding
- $ 80,000 applied to overpayment
- $ 0 no outstanding overpayment
- $ 20,000 released to provider and not subject to § 935 Limitation on Recoupment

2nd example

- $ 100,000 suspended payment
- $ 150,000 outstanding overpayment/s
- $ 100,000 applied to overpayment/s
- $ 50,000 remaining overpayment, which is Potentially subject to §935 Limitation on Recoupment process. (Suspended payments were insufficient to eliminate overpayment/s).

Understanding Limitation on Recoupment

Redetermination (1st level appeal) and Reconsideration (2nd level appeal)

- Limitation on Recoupment extends to the 1st and 2nd level appeal ONLY.
- Medicare will not begin recoupment of overpayments (or will cease recoupment that has started) when it receives notice that the provider has requested a redetermination (first level appeal) or a reconsideration second level appeal at the Qualified Independent Contractor (QIC).
- After the QIC determination, Medicare will begin to recoup on any remaining outstanding overpayment .

Appealing after the QIC decision to The Administrative Law Judge (ALJ) 3rd level appeal or subsequent levels

- If the ALJ level process reverses the Medicare overpayment determination (in other words the provider prevails), Medicare will refund principal and interest collected as appropriate:

1. If a provider has any other outstanding overpayments, Medicare will apply the amount collected to any outstanding overpayments (monies are applied to interest first and then to principal) and,
2. If there is any excess monies remaining, the contractor will refund to the provider.

- Payment of Section 935 (f)(2) interest is only applicable to overpayments recovered through recoupment under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped (excluding payments on existing Extended Repayment Schedules and voluntary payments).

Voluntary Payment

Voluntary payments including payments made on Extended Repayment Schedules (ERS) are not subject to 935 Interest if the provider prevails at the ALJ or Subsequent levels.

Limitation on Recoupment Rights and Approved ERS

- The provider will not be considered in default if payments were not made while the overpayment was in 1st or 2nd level appeal .
  (No recoupment will occur)

- If the provider prevails at the ALJ or subsequent levels of appeal, any payments that were paid under the ERS will not be subject to 935 interest.

How MMA 935 (f)(2) works in tandem with the appeal process:

Filing for a Redetermination (1st level) Appeal request

- To ensure recoupment will not start on day 41, the appeal request must be received and validated by the 30th day from the demand letter date.
- If the appeal request is received after recoupment has started the Medicare claims processing contractor shall stop the recoupment. Any monies recouped will not be refunded back to the provider.
- If an appeal is received and validated at anytime during the appeal timeframe (120 days), the Medicare claims processing contractor will stop (or not start) the recoupment process, if appropriate,

Effectuating the Redetermination – (1st level) Appeal decision

Fully Favorable (Full reversal)

- Medicare claims processing contractors will adjust the overpayment to zero.
- Amounts held (voluntary payments, payments on ERS, or recouped amounts) will be applied to any other debt owed by the provider and any excess would then be released to the provider.

Effectuating the Redetermination – (1st level) Appeal decision (cont.)

Partially Favorable (Partial reversal)

- The Medicare claims processing contractor will recalculate the overpayment and interest owed based on the redetermination decision.

- If there was a collection done by a recoupment or a payment received.

  The favorable amount is applied to reduced overpayment.

  Provider receives a revised overpayment notice or letter with a new revised overpayment.

- In order to stop recoupment the provider must request an appeal (reconsideration) to the QIC within 60 days from the date of the redetermination decision.

Effectuating the Redetermination – (1st level) Appeal decision, (cont.)

Full Affirmation (Unfavorable)

- The Medicare claims processing contractor may begin recoupment without sending any additional notices if the initial demand letter contained language stating that the contractor can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice.
- The Medicare claims processing contractor resumes other collection activities such as the follow-up letter and Intent to Refer letter.
- In order to stop recoupment the provider must request an appeal (reconsideration) to the QIC within 60 days from the date of the redetermination decision.

Filing for a Reconsideration – 2nd level Appeal by a QIC

- To avoid recoupment, the Provider must file the appeal request within 60-days from the redetermination decision letter to **ensure the recoupment process will not begin or resume.**

- The QIC determines if the appeal request is valid.

  1. The QIC will request the 1st level appeal case file from the Medicare claims processing contractor; and

  2. After the Medicare claims processing contractor receives the QIC request form for the case file, they will stop or (not to resume) recoupment as appropriate.

- If the QIC receives the appeal request after day 60, recoupment could start. Any recouped funds shall be retained and not refunded to the provider.

Following a dismissal by the QIC, recoupment will be initiated or resumed immediately.

Effectuating the Reconsideration – 2nd level Appeal decision from the QIC (cont.)

Fully Favorable (Full reversal)

- Medicare claims processing contractor will adjust the overpayment to zero.
- Any funds collected on the overpayment either through voluntary payment or recoupment will be applied to any other debt owed by the provider first and any funds in excess would then be released to the provider.

Effectuating a Reconsideration – 2nd level Appeal decision (cont.)

Partially Favorable (Partial Reversal):

- The Medicare claims processing contractor will effectuate the decision and if there are any excess funds remaining including any necessary recalculations the Medicare claims processing contractor will first apply those funds to any other outstanding debt before releasing payment to the provider.

- The Medicare claims processing contractor sends a letter to advise the provider on the outstanding balance.

  This letter will explain that recoupment will begin 30 days from the date of the revised notice.

  The provider can submit a payment or request an Extended Repayment Plan .

- 60 days from the QIC decision the Medicare claims processing contractor will issue the 2nd demand letter or the Intent to Refer letter, or refer the debt to Treasury, as appropriate.

Effectuating the Reconsideration – 2nd level Appeal decision from the QIC (cont.)

Fully Unfavorable (Affirmation)

- The Medicare claims processing contractor will resume or start recoupment 30 days from the date of the reconsideration decision.
- Those extra days give the provider time to make payment or to request an extended repayment plan.
- 60 days from the QIC decision the Medicare claims processing contractor will issue the 2nd demand letter or the Intent to Refer letter, or refer to the debt to Treasury, as appropriate.

Potential payment of 935 (f)(2) interest on successful appeals at the Administrative Law Judge (ALJ) or Subsequent levels of Appeal

- When the Provider receives a favorable decision, the 935 Interest will be calculated only on the recouped amount applied to the principal balance.

- Whether or not the provider subsequently appeals the overpayment to the ALJ, Department Appeals Board (DAB), or Federal court, the Medicare claims processing contractor will continue to recoup until the debt is satisfied in full unless an ERS is requested. All ERS requests must be accompanied by a good faith check .

- If an overpayment was referred to Treasury and the provider files an appeal:

  1) The Medicare claims processing contractor will recall the debt from Treasury, *and*

  2) Will continue to recoup the overpayment until the debt is satisfied in full

  3) If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to Treasury if provider does not pay the remaining balance or does not request an Extended Repayment Schedule (ERS).

Initial Demand Of An Overpayment	If a Provider appeals a Redetermination First Level Appeal	If a Provider appeals a Reconsideration (QIC) Second Level	If a Provider appeals to Administrative Law Judge (ALJ) Third level appeal
Day 1 Demand Letter date	**Day 30** To avoid Recoupment on day 41.	**Day 60** Recoupment timeframe (following Redetermination Notice)	**Day 30** Recoupment timeframe (following Reconsideration Decision)
A Demand Letter, with appeal rights, sent to Provider	To avoid recoupment starting on day 41, the provider must request the 1st level appeal within 30 days from the date of the Demand Letter. If appeal is received after day 30 and recoupment started on day 41, the recoupment process will stop on the remaining balance.	To avoid recoupment beginning or resuming, the provider must submit the 2nd level appeal request to the QIC no later than the 60th day from the overpayment letter (if applicable) or from the decision letter. If appeal request is received after day 60, the recoupment process will stop on the remaining balance.	Limitation on recoupment ends after the 2nd level appeal. Recoupment shall begin 30 days from the appeal decision and will continue until debt is satisfied, whether or not provider appeals to the ALJ or subsequent levels.

RECAP

MMA Section 935(f)(2):

- Applies to most fee-for-service claims appeals.
- Limits when Medicare may recoup an overpayment if appealed – 1st and 2nd level appeals
- Provides for the payment of interest on refunds of recouped amounts applied to principal – ALJ level or subsequent levels of appeal.
- Does not change the appeal process – it works in tandem with the existing appeal process.

Normal time frames to file an appeal apply, however to stop or cease recoupment:

- File 1st level appeal within 30 days of the date of the overpayment demand letter.
- File 2nd level appeal within 60 days of the date of the redetermination decision.
- For appeals filed outside of these time frames, recoupment will cease if it has been started (recouped funds will not be returned to the provider).
- Rebuttal statements do not qualify as appeals; the provider must specifically file an “appeal” for the limitation on recoupment to apply.

Miscellaneous:

- A provider in an extended repayment schedule (ERS) will not be considered in default if the provider discontinues payment while a 1st or 2nd level appeal is pending.
- Interest continues to accrue/be assessed when recoupment is ceased.

QUESTIONS

THANK YOU