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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® (or MLN) within CMS, and they provide official information for Medicare Fee-For-Service providers.

If you are a Medicare Fee-For-Service provider who submits claims to Medicare Administrative Contractors, or MACs, you will benefit from this podcast! It will give you information to help you comply with requirements for the collection of Medicare physician and supplier overpayments, including the definition of an overpayment, the collection process, and resources.

This podcast is based on the MLN fact sheet titled "The Medicare Overpayment Collection Process" which CMS issued to help physicians and suppliers comply with Federal law requiring CMS to recover all identified overpayments.

The fact sheet includes three helpful pieces of information which we will be discussing with you today:

- First, the definition of an overpayment
- Second, the overpayment collection process and
- Third, resources to find additional information about the process.

You should consider this important information, and take the necessary steps to meet Medicare requirements. **The fact sheet information is intended as an educational guide and does not ensure compliance with Medicare regulations.**

Let's begin with the definition of a Medicare physician or supplier overpayment. It is a payment a physician or supplier receives that exceeds amounts due and payable under Medicare statute and regulations. Once the overpayment is determined, the amount becomes a debt owed by the debtor to the Federal government. Federal law requires CMS to seek the recovery of all identified overpayments.

In Medicare there are four (4) ways that physician or supplier overpayments occur:

- One (1) Duplicate submission of the same service or claim;
- Two (2) Payment to the incorrect payee;
- Three (3) Payment for excluded or medically unnecessary services; and
- Four (4) A pattern of furnishing and billing for excessive or non-covered services.

Now we'll discuss the Overpayment Collection Process. This begins when Medicare discovers an overpayment of $10 or more.

The first demand letter is sent requesting payment. This letter explains that interest accrues from the date of the letter if the overpayment is not received by the 31st calendar day.

If no response is received from the physician or supplier 30 calendar days after the date of the first demand letter, a second demand letter may be sent.

If a full payment is not received 40 calendar days after the date of the first demand letter, recoupment procedures will begin on day 41. Recoupment means that the overpayment will be recovered from current payments due or from future claims submitted. If a debt has not been paid or recouped (unless a valid appeal is filed) an Intent to Refer letter is sent within 120 days indicating that the overpayment may be eligible for referral to the Department of the Treasury for offset or collection.

Next we'll briefly describe extended repayment plans, rebuttals, appeals and their respective timeliness requirements.

If the physician or supplier is unable to pay the entire amount of the overpayment in full they may request an extended repayment plan from the Medicare Contractor.

A physician or supplier may submit a rebuttal statement to the Contractor within 15 calendar days from the date of a demand letter. The rebuttal statement explains or provides evidence why recoupment should not be initiated. The rebuttal process is not considered an appeal, and does not stop the Contractor's recoupment activities.

If a physician or supplier disagrees with an overpayment decision, they may file an appeal with the Contractor that issued the original decision. A redetermination is the first level of appeal in which a qualified employee of the Contractor conducts an *independent* review of the decision. Section 1893 paragraph (f) (2) (a) of the Social Security Act provides limitations on the recoupment of Medicare overpayments. Overpayments subject to Section 935 paragraph (f) (2) of the Medicare Modernization Act (or MMA) must be filed within 120 calendar days from the date of the demand letter.

In order to stop the initial recoupment process, the redetermination request must be filed within 30 days from the date of the demand letter. If the redetermination request is received and validated later than 30 days from the date of the demand letter, the recoupment process will stop for those overpayments subject to Section 935 paragraph (f) (2) of the MMA. Any recoupment already taken will not be refunded to the physician or supplier.

Following an unfavorable or partially favorable redetermination decision, a physician or supplier may request a second level of appeal or reconsideration by a Qualified Independent Contractor (or QIC - "quick"). A request for reconsideration by a QIC must be filed within 180 calendar days of the date the reconsideration is received. In order to stop the recoupment process, a reconsideration must be filed within 60 days from the redetermination decision date. The recoupment process will stop when the reconsideration request is received and validated by the QIC. After the QIC's decision or dismissal, the recoupment process will resume for any overpayment amount that was not paid in full – regardless of

whether the physician or supplier requests further appeal levels.

Please visit the MLN Provider Compliance web page at www.cms.gov/MLNProducts for educational Fee-For-Service provider materials to help you understand – and avoid – common billing errors.

More questions? To learn more about Medicare Overpayments contact your Medicare contractor or visit our website http://www.cms.gov/MLNGenInfo and follow the links to MLN Products and download the full fact sheet on this subject titled **"The Medicare Overpayment Collection Process." Be on the lookout for future MLN podcasts on subjects of interest to you.**
