CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 141	**Date: September 12, 2008**
	Change Request 6183

SUBJECT: Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments

I. SUMMARY OF CHANGES: Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended Title XVIII of the Social Security Act (the Act) to add a new paragraph (f) to section 1893 of the Act, the Medicare Integrity Program requires us to change the way we recoup certain overpayments. It also changes how interest is to be paid to a provider or supplier whose overpayment determination is reversed at administrative or judicial levels of appeal above the Qualified Independent Contractor (QIC).

NEW / REVISED MATERIAL
EFFECTIVE DATE: *September 29, 2008
IMPLEMENTATION DATE: September 29, 2008

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
N	3/200/Table of Contents
N	3/200/Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments
N	3/200.1/Overpayments That are Subject to Limitation on Recoupment
N	3/200.1.1/ Overpayments That are Not Subject to Limitation on Recoupment
N	3/200.1.2/How Does the Rebuttal Process Work With the Limitation on Recoupment?
N	3/200.1.3/Adjustment of the Part A Claim (or All Claims Adjusted by the Fiscal Intermediary Standard System- This Includes Part B of A Claims)
N	3/200.1.4/Adjustment of the Part B Claims (All Claims Adjusted by the Medicare Carrier System or the VMS System)
N	3/200.2/Additional Requirements for Demand Letters
N	3/200.2.1/Example 1- Sample of the 935 First Demand Letter for Part A and B

N	3/200.2.2/Recoupment After the First Demand: When Does it Begin?
N	3/200.3/What to Do When a Valid Request for Redetermination for Appeal is Received
N	3/200.3.1/What to Do When a Valid and Timely Request for a Reconsideration is Received
N	3/200.3.2/Administrative Law Judge (ALJ) Third Level of Appeal
N	3/200.4/Extended Repayment Schedules (ERS) With an Appeal That is Subject to Limitation on Recoupment
N	3/200.5/ Payment Suspension
N	3/200.5.1/Payments Made Upon Notice of Demand
N	3/200.5.2/Assessment of 935 Interest
N	3/200.6/Interest Rate and Calculation Periods for Appeal Decisions on Recouped Funds for Purposes of Paying 935 Interest.
N	3/200.6.1/Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date
N	3/200.6.2/Computing 935 Interest at the ALJ and Higher Levels
N	3/200/6/3/How to Calculate 935 Interest
N	3/200.6.4/Obligation to Pay the Providers, Physicians, or Suppliers Late Payment Interest
N	3/200.7/Tracking and Report on Limitation of Recoupment Overpayments

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

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:
Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 141	Date: September 12, 2008	Change Request: 6183

SUBJECT: Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments

EFFECTIVE DATE: September 29, 2008

IMPLEMENTATION DATE: September 29, 2008

I. GENERAL INFORMATION

A. Background: Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173) amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to § 1893 of the Act, the Medicare Integrity Program. The statute requires us to change the way we recoup certain overpayments. This provision changes how interest is to be paid to a provider or supplier, whose overpayment is reversed at subsequent administrative law judge (ALJ) or judicial levels of appeal. This final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the qualified independent contractor (QIC). Before the MMA was enacted, if a provider or supplier elected to appeal an overpayment determination, there was no effect on Medicare's ability to recover the debt. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

B. Policy: Section 1893(f)(2) Limitation on Recoupment implements a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that prohibits recouping Medicare overpayments when an appeal is received from a provider or supplier until a decision is rendered. This MMA provision requires that if a provider of services or a supplier seeks reconsideration by a QIC on an overpayment determination, CMS and its Medicare contractors may not recoup the overpayment until the decision on the reconsideration has been rendered. The contractor redetermination is the first level and the reconsideration, QIC is the second level of appeal in the Medicare claims appeal process. CMS has determined that the limitation on recoupment under § 1893(f)(2) applies to the recovery of funds for all Part A and Part B claims for which a demand letter is issued; with the exception of Part A cost reports, Hospice Caps calculations, provider initiated adjustments, Home Health Raps, Accelerated/Advanced Payments and certain claims adjustments at the contractors discretion that will not be subject to the Limitation of Recoupment. If the contractor redetermination results in a full or partial affirmation of the overpayment, contractors can begin or resume recoupment starting no earlier than 61 days and no later than 76 days after giving notice unless the provider appeals to the QIC in the interim. The contractor will cease or not begin recoupment if the QIC notifies the contractor that a valid and timely request for a reconsideration (second level appeal) has been received. Following final decision by the QIC, the contractor can initiate or resume recoupment after a 30-day notice is sent to provider or supplier; whether or not the provider subsequently appeals to the ALJ, the third level of appeal. For financial reporting purposes, the status of the debt during the redetermination and reconsideration processes will be "appeal"; however, when recoupment begins or resumes, the status shall be changed to reflect the status "eligible for internal offset" for financial reporting purposes. Once the demand letter process resumes, normal status codes used for debt collection activities will resume. This CR does not change the rebuttal process for this recovery. It does not alter the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, nor the decision making time frames. The normal debt collection and referral process is unchanged unless specifically varied by this CR.

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	
6183.1	Medicare contractors shall cease recoupment or not begin recoupment at the normally scheduled time when a valid first level appeal (redetermination) or a valid second level (reconsideration) is received from providers, physicians, and suppliers on an overpayment subject to these limitations. During this appeal process, the Medicare contractor cannot recoup or demand the debt; however, the debt continues to age.	X	X	X	X	X					
6183.2	Medicare contractors shall identify the claims subject to the limitation of recoupment that applies to the recovery of funds for all Part A and B claims for which a demand letter is issued and adjust the claims in the affiliated claims processing system.	X	X	X	X	X					
6183.3	Medicare contractors shall, based on the rebuttal statement, determine to stop recoupment or proceed with recoupment. In contrast the limitation on recoupment provision mandates that recoupment stop when a valid and timely request for a first level or second level appeal is received. In 42 CFR 405.373 through 405.375, regulations require that providers, physicians and suppliers be given an opportunity to rebut any proposed recoupment action by submitting a statement within 15 days of the notice indicating action to take a recoupment action. These procedures are separate from the requirements of the limitation on recoupment. The rebuttal process occurs prior to the appeals process, and permits the providers, physicians and suppliers a vehicle to indicate why the proposed recoupment should not take place.	X	X	X	X	X					
6183.4	Medicare contractors shall determine if the limitations apply to the claim at the time of the adjustment. If the adjustment results in a refund due the providers, physicians and suppliers, Medicare contractors shall follow existing underpayment policies. This will trigger the creation of the first demand letter unless previously issued which will include information for the provider concerning recoupment protections. This will also trigger	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	
	recoupment to begin on the 41st day after the date of the demand letter. **In most instances this instruction supercedes Chapter 3 § 40, unless the AR's do not qualify.**										
6183.5	Medicare contractors shall adjust claims in the normal process issuing a first demand letter and beginning recoupment no earlier than 41 days after the date of the demand letter.	X	X	X	X	X					
6183.6	Medicare contractors shall issue demand letters for all overpayments subject to the limitation on recoupment protections.	X	X	X	X	X					
6183.7	Medicare contractors shall follow the specific requirements for 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)	X	X	X	X	X					
6183.8.1	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.	X	X	X	X	X					
6183.8.2	Medicare contractors demand letters shall clearly state that the provider may submit a rebuttal statement to any proposed offset 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 405.375 however, does not mandate that recoupment stop.	X	X	X	X	X					
6183.8.3	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.	X	X	X	X	X					
6183.8.4	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 or only part of the claims.	X	X	X	X	X					
6183.8.5	Medicare contractors shall insert in the demand letter, language that clearly explain that recoupment will	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	
	begin on the 41st day from the date of the first demand letter if 1) payment is not received in full, 2) an acceptable request for an extended repayment schedule, 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.										
6183.8.6	Medicare contractors shall send the demand letter by first class mail.	X	X	X	X	X					
6183.9	Medicare contractors shall refer to example 1 for the standard format for each 935 demand letter to be used for Part A & B demand letters resulting from the limitation of Recoupment.	X	X	X	X	X					
6183.10	Medicare contractors shall follow the recoupment requirements. Recoupment can proceed on day 41 from the first demand letter unless a valid and timely request for a redetermination is received. To limit recoupment the provider must file the request for a redetermination by the 30th day following the date of the first demand letter.	X	X	X	X	X					
6183.10.1	Medicare contractors shall refer to Publication 100-04; Medicare Claims Processing Manual, Chapter 29 to determine what constitutes a valid request for a redetermination. **Recoupment can begin no earlier than the 41st day.**	X	X	X	X	X					
6183.11	Medicare contractors shall ensure that recoupment does not proceed if a valid request for a redetermination is received.	X	X	X	X	X					
6183.11.1	Medicare contractors shall develop internal procedures for appeals staff to alert overpayment staff that an acceptable appeal has been filed.	X	X	X	X	X					
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.	X	X	X	X	X					
6183.12.	Medicare contractors shall cease recoupment of the	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	
	overpayment that is the subject of the appeal upon receipt of a timely and valid request for a redetermination of an overpayment.										
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.	X	X	X	X	X					
6183.12.2	Medicare contractors shall not initiate recoupment if the recoupment has not yet gone into effect.	X	X	X	X	X					
6183.12.3	Medicare contractors shall retain any recouped amounts if funds were recouped before a timely and valid request for a redetermination was received. The recouped amount shall be applied first to interest and then to principal.	X	X	X	X	X					
6183.12.4	Medicare contractors shall continue to collect other debts owed by the provider, if an overpayment is appealed and recoupment stopped, but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.	X	X	X	X	X					
6183.12.5	Medicare contractors shall report the debts in an appeal status and the debts will continue to be aged and interest continues to accrue.	X	X	X	X	X					
6183.12.6	Medicare contractors shall send a notice to providers, physicians and suppliers that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as the example in Chapter 3, § 200.3 (6) of the manual instructions.	X	X	X	X	X					
6183.12.7	Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with Chapter 3 and Chapter 4 §30 if the (1st level appeal) redetermination decision is fully **favorable.**	X	X	X	X	X					
6183.12.7.1	If an amount was held, that amount would be applied to any other debt owed by the provider physician or suppliers; any excess would then be released to the provider or supplier.	X	X	X	X	X					
6183.12.7.2	Medicare contractors should effectuate following a favorable redetermination decision for the provider, physician or other suppliers. An Explanation of Benefits (EOB) would be acceptable in place of a written notice.	X	X	X	X	X					
6183.12.7.3	Medicare contractors shall pay interest to the	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	
	provider, physician or other suppliers if the underpayment is not paid within 30 days from the final determination .										
6183.12.8	Medicare contractors shall recalculate the correct amount of both underpayment and overpayment from a **(partially favorable)** decision of the overpayment determination in which the decision reduces the debt below the amount already recouped. If necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29, §§ 310.5 and 310.7 for further guidance.	X	X	X	X	X					
6183.12.9	Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with Chapter 3 and 4 if this is a full affirmation (u**nfavorable**) decision of the overpayment determination; the contractor shall issue the 2nd or 3rd demand letter whichever is ppropriate.	X	X	X	X	X					
6183.12.10	Medicare contractors should effectuate (when necessary) the redetermination decision if the redetermination is a **fully favorable** decision of the overpayment determination. An Explanation of Benefits (EOB) would be acceptable in place of a written notice, or send the applicable notice when necessary. See Chapter 3, §200.3 (G) Example 3 Revised Notice, or revised Demand Letter), or as explained in Publication 100-04, Medicare Claims Processing Manual, Chapter 29, § 310.8.	X	X	X	X	X					
6183.12.11	Medicare contractors shall effectuate the redetermination decision and issue a revised overpayment notice or a revised (2nd) demand letter to the provider of the revised overpayment amount if the redetermination results in a **partially favorable** decision which reduces the overpayment amount.	X	X	X	X	X					
6183.12.11.1	Medicare contractors shall state in the notice/ letter that you can begin to recoup no earlier than the 61st day from the date of the revised overpayment determination in the absence of receipt/notification by the QIC of a timely and valid request for a reconsideration.	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	
6183.12.11.2	Medicare contractors shall also state in this notice that the provider has the opportunity for a rebuttal on the proposed offset action (see Chapter 3, § 200.1.2) and you will review it and consider whether to proceed or stop the offset. This is still permitted under 42 CFR 405.373 through 405.375; however this does not mandate that recoupment will stop.	X	X	X	X	X					
6183.12.11.3	Medicare contractors shall state in the notice (to effectuate the redetermination decision) must 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 (reconsideration) of the overpayment within 60 days from the date the notice (to effectuate the reconsideraton decision). Submission of a rebuttal statement under 42 CFR 405.374 will not stop recoupment. (see Chapter 3 § 200.1.2)	X	X	X	X	X					
6183.12.12	Medicare contractors shall use one of the following required notices if the redetermination decision is fully unfavorable (affirmation)	X	X	X	X	X					
6183.12.12.1	Medicare contractors should use the standard Medicare Redetermination notice but if and only if the initial demand letter contained language comparable to that shown in Chapter 3, § 200.2.1 Example 1, which specifically states that the contractor can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice (in the absence of receipt by a QIC of a timely and valid request for a reconsideration.. Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29, § 310.8. Again rebuttal language shall be included.	X	X	X	X	X					
6183.12.12.2	Medicare contractors should send the 2nd or 3rd demand letter if they were not sent (because the overpayment was in appeal status) this can be modified to indicate when recoupment may begin to recoup no earlier than 61st calendar day from the notice of the revised overpayment determination notice (in the absence of receipt by the QIC of a timely and valid request for a reconsideration). Again, rebuttal language shall be included (see Chapter 3, § 200.1.2).	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	
6183.12.12.3	Medicare contractors should use a brief notice which states when recoupment can begin as stated in 12.12.1 or 12.12.2 above.	X	X	X	X	X					
6183.12.12.4	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. Medicare contractors shall initiate or resume recoupment when the debt has been in an appeal status. The status of the debt shall be changed to reflect "eligible for internal offset" or resume offset.										
6183.13	Medicare contractors shall cease and not resume recoupment upon receipt of a timely and valid request for a reconsideration by the QIC.	X	X	X	X	X					
6183.14	Medicare contractors should review the example table in Chapter 3, § 200.3(F) **new 935 instructions to determine when recoupment begins or resumes after the redetermination.**	X	X	X	X	X					
6183.15	Medicare contractors should use the Example Letter for Part A & B Overpayment revised notice/ Revised Demand Letter resulting from the 1st level (Redetermination) Appeal decision provided in Chapter 3, § 200.3 (G).	X	X	X	X	X					
6183.16	Medicare contractors can initiate or resume recoupment immediately if a provider, physician, or other supplies has requested a withdrawal of a request for reconsideration, or the QIC issues a dismissal of a request for reconsideration (see CFR 42 §405.972).	X	X	X	X	X					
6183.17	The QIC shall determine the validity and timeliness	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	
	of a request for a reconsideration. However, to limit recoupment of the overpayment a provider must request a reconsideration and have it postmarked by the 60th day.										
6183.18	Medicare contractors shall cease recoupment of the overpayment in question upon receiving notification from the QIC of a valid and timely request for a r**econsideration**. Refer to Chapter 3, §200.3 (E) of the manual instructions for additional information regarding QIC contractor communication regarding the filing of a request for reconsideration.	X	X	X	X	X					
6183.18.1	Medicare contractors shall not initiate recoupment if the recoupment has not yet gone into effect.	X	X	X	X	X					
6183.18.2	Medicare contractors shall retain any recouped funds if you recouped before a timely and valid request for a reconsideration was received and applied first to interest and then to principal.	X	X	X	X	X					
6183.18.3	Medicare contractors should continue to collect other debts owed by the provider; but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status if an overpayment is appealed and recoupment stopped.	X	X	X	X	X					
6183.18.4	Medicare contractors shall report the debt in an appeal status and shall continue to be aged and interest continues to accrue.	X	X	X	X	X					
6183.18.5	Medicare contractors shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. You can construct a short paragraph with the example provided in Chapter 3 § 200.3 (6).	X	X	X	X	X					
6183.18.6	Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4 § 30 if the QIC reconsideration results in a **fully favorable decision** of the overpayment as modified by the redetermination.	X	X	X	X	X					
6183.18.6.1	Medicare contractors shall apply the amount held to any other debt owed by the provider, physician or supplier first; if there is any excess monies remaining then release it to the provider, physician or other suppliers, if the reversal for the provider, physician or supplier occurs. Interest may be payable by	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	
	Medicare if the underpayment is not paid within 30 days of the final decision.										
6183.19	Medicare contractors shall effectuate the reconsideration **partially favorable decision**. This reduces the overpayment plus the assessed interest below the amount already recouped. The excess amount may be applied to other debts, including interest owed by the provider, physician or supplier before any excess monies is released back to the provider, physician or other supplier. In accordance with Publication 100-04, Medicare Claims Processing Manual, Chapter 29, § 320.9.	X	X	X	X	X					
6183.19.1	Medicare contractors shall follow current policies **if** the QIC reconsideration results in an ***unfavorable*** decision of the overpayment recoupment by adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4, § 30	X	X	X	X	X					
6183.19.2	Medicare contractors shall resume on the 30th calendar day after the date of the notice of the reconsideration. This gives time for the provider to request a repayment plan or make payment.	X	X	X	X	X					
6183.20	Medicare contractors shall begin recoupment at day 30 from the date of the QIC decision or from the revised written final determination due to effectuation.	X	X	X	X	X					
6183.20.1	Medicare contractors shall send a notice that recoupment (Offset) will occur on day 30; and the providers, physicians and suppliers 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.	X	X	X	X	X					
6183.20.2	Medicare contractors shall not be issue demand letter (2nd or 3rd) for a total of 60 days following the QIC decision via offset. 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.	X	X	X	X	X					
6183.20.3	Medicare contractors shall keep the overpayment in "eligible for internal offset" status until it has been paid in full or referred to Treasury through cross-servicing.	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	
6183.21	Medicare contractors should effectuate the reconsideration decision. Contractors may send an applicable notice if necessary consistent with Publication 100-04, Medicare Claims Processing Manual, Chapter 29, § 320.9" if the reconsideration decision results in **a favorable decision (full reversal).**	X	X	X	X	X					
6183.22	Medicare contractors shall issue a notice to the provider of the revised overpayment amount and effectuate the reconsideration **partially favorable decision (partial reversal)** which reduced the overpayment amount.	X	X	X	X	X					
6183.22.1	Medicare contractors shall state in this notice or letter that the contractor can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give providers, physicians and suppliers an opportunity to make payment arrangements.	X	X	X	X	X					
6183.22.2	Medicare contractors shall include language in your notice that affords the provider the opportunity to rebut the recoupment according to 42 CFR 405.373 and 375. (See Chapter 3, § 200.1.2)	X	X	X	X	X					
6183.23	Medicare contractors should use (Example 5) The Medicare Revised Demand letter for Part A & B resulting from (Reconsideration) Appeal decision in Chapter 3, § 200.3.1(D).	X	X	X	X	X					
6183.24	Medicare contractors shall initiate or resume recoupment whether or not the provider subsequently appeals to the Administrative Law Judge (ALJ-third appeal level), following the final decision by the QIC.	X	X	X	X	X					
6183.24.1	Medicare contractors shall initiate or resume recoupment no earlier than the 30th calendar day after the date of the written notice to the provider of the revised overpayment amount if the reconsideration decision is partially favorable (partial reversal).	X	X	X	X	X					
6183.25	Medicare contractors shall continue to recoup until the debt is satisfied in full. Whether or not the provider or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, recoupment remains in	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	
	effect as provided in CFR 42 § 405.373 (e). Refer to Publication 100-04 Chapter 29 § 330-330.										
6183.26	Medicare contractors shall understand that if a providers, physicians and suppliers are granted an extended repayment schedule (ERS) and submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, the providers, physicians and suppliers will not be considered in default if payments were not made by them. The appeal would supersede the ERS agreement; (under normal circumstances this would have been put on withhold due to default of payment). The contractor shall send a notice to the provider that it must resume its ERS payments or be placed on recoupment according to Chapter 4 §50.	X	X	X	X	X					
6183.27	Medicare contractors shall not include payments made by a provider under an ERS as recoupment for the limitation provision and are not subject to 935 interest if reversed at the ALJ appeal or above. However, if a provider defaults on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupments are subject to payment of interest under the 935 interest requirements.	X	X	X	X	X					
6183.28	Medicare contractors shall not include suspended funds involving providers, physicians and suppliers who have been put on payment suspension; under §405.372 (e) suspended funds are not a "recoupment" for purposes of the limitation on recoupment. Suspended funds is not a "recoupment" as this term is defined in §405.370. The CMS is only limited by § 1893(f)(2) of the Act from recouping Medicare payments, we are not restricted in our ability to apply suspended funds to reduce or dispose of an overpayment.	X	X	X	X	X					
6183.29	Medicare contractors shall decide if the suspended payments are insufficient to fully eliminate any overpayment. If the providers, physicians and suppliers meets the requirements under § 1893(f)(2) of the MMA then the suspended payments will be applicable to any remaining balance still owed to CMS.	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	
6183.30	Medicare contractors shall ensure that payments made by a provider in response to a demand are not considered recoupment 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.	X	X	X	X	X					
6183.31	Medicare contractors shall calculate 935 interest, which is payable on an underpayment where the reversal occurs at the ALJ level or subsequent levels of administrative appeal based on the period that Medicare recouped the provider's or supplier's 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.	X	X	X	X	X					
6183.32	Medicare contractors shall pay simple interest rather than compound interest, and **we will not pay interest on interest; this mirrors the manner** in which we assess interest against providers, physicians and suppliers**.** Monies we recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider.	X	X	X	X	X					
6183.32.1	Medicare contractors shall calculate periods of recoupment in full 30-day periods; and interest **will not** be payable for any periods of less than 30 days in which we had possession of the recouped funds.	X	X	X	X	X					
6183.33	Medicare contractors shall calculate interest for each 30-day period using the interest rate in effect on the ALJ decision date or the (revised written final determination date).	X	X	X	X	X					
6183.33.1	Medicare contractors shall have 30 days to calculate and refund the provider from the ALJ decision date or the final determination date.	X	X	X	X	X					
6183.33.2	Medicare contractors shall need to issue a revised written determination to the provider, physician or other supplier in accordance to Publication 100-04, Medicare Claims Processing Manual, Chapter 29.	X	X	X	X	X					
6183.34	Medicare contractors shall ensure that the Medicare	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	
	interest paid under 935 is only applicable at the ALJ or further appeal level when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds.										
6183.35	Medicare contractors shall follow this simple formula for calculating interest: 1) Time; 2) Rate; and 3) Amount for each recoupment action.	X	X	X	X	X					
6183.35.1	Medicare contractors shall determine the total Julian Days starting from the recoupment date to the ALJ decision date or date the revised notice with the new overpayment, if applicable. Divide the number of Julian days by 12 to compute the number of 30-day periods. The interest will not be payable for any periods of less than 30 days in which we had possession of the recouped funds.	X	X	X	X	X					
6183.35.2	Medicare contractors shall use the annual rate of interest at the time of the ALJ decision date or from the revised new written determination date from an effectuation and convert **interest rate to a monthly interest rate.** (For example: The rate of interest as of April 18, 2008 is 11.375%). Convert annual Rate to a monthly rate by dividing by 12.	X	X	X	X	X					
6183.35.3	Medicare contractors shall use the recouped principal amounts (resulting from any involuntary payments) as the basis to compute 935 interest. The recouped monies that were applied to interest are not included (calculated) in determining the 935 interest	X	X	X	X	X					
6183.35.3.1	Medicare contractors shall **only use** those principal funds recouped via withholding (e.g. payments recouped under a defaulted ERS and or offsets). Do not include payments a provider makes under an ERS or other voluntary payments made by the provider.	X	X	X	X	X					
6183.35.3.2	Medicare contractors shall not include payments a provider makes under an ERS or other voluntary payments made by the provider.	X	X	X	X	X					
6183.35.3.3	Medicare contractors shall calculate multiple recoupments separately where there are 935 interest for each recoupment action and then total for the amount due the provider.	X	X	X	X	X					
6183.35.3.4	Medicare contractors shall calculate each recoupment action separately where there are multiple recoupments. Add the individual totals for the 935	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	
	interest amount due the provider.										
6183.36	Medicare contractors shall have the obligation to pay the provider, physician and suppliers' interest if the overpayment determination is reversed at the first (redetermination) and second (reconsideration) level of the administrative appeal process and the decisions are not effectuated timely. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment **is not paid within 30 days of the final determination decision. See § 30.1 of Chapter 4.**	X	X	X	X	X					
6183.37	Medicare contractors shall report 935 interest paid based on an ALJ or later decision that fully or partially reverses the previous decision each calendar quarter.	X	X	X	X	X					
6183.37.1	Medicare contractors shall report the 935 Interest payment amounts aggregated by provider type. The content in the report will include the Provider Type (i.e. HHA, Inpatient Hosp, Skilled Nursing, Ambulance ABC, DME supplier , etc.), total of providers, physicians and suppliers in each category and the total amount for each type. There is an example in Chapter 3 § 200.7. This report will be sent via email to: CMS_Medicareoverpayments@cms.hhs.gov. The contractor will have 30 days from the end of the calendar quarter to submit the report to CMS.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

[Note: When a CR has Provider impact]

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	
6183.38	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly 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.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

New workloads associated with demand letters, withholding and appeals are created by these requirements.

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediary (RHHIs):*

Funding for implementation activities will be provided to contractors through the regular budget process.

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.

Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents
(Rev.141, 09-12-08)

200-Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Section 1893 (f)(2)(a) of the Social Security Act provides limitations on the recoupment of Medicare overpayments. This section provides protection to Providers, Physicians, and Suppliers during the initial stages of the appeal process. The limitations extend to the redetermination and the reconsideration level if the provider meets all conditions. These limitations do not affect a provider's right to appeal and the timeframes associated with appealing; however to stop recoupment a provider must act decidedly to appeal.

When a valid first level appeal request (redetermination) or a valid second level (reconsideration) request is received from a provider on an overpayment subject to these limitations (See § 200.1 below) the Medicare contractor will cease recoupment or not begin recoupment at the normally scheduled time (41 days for 1st level and 76 days for 2nd level).

During this appeal process, the Medicare contractor cannot recoup or demand the debt; however, the debt continues to age. Once both levels of appeal are completed and CMS prevails, collection activities, including demand letters and internal recoupment, may resume within the timeframes set forth.

200.1- Overpayments That are Subject to Limitation on Recoupment

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Applies to the recovery of funds for all Part B and Part A claims for which a demand letter is issued such as:

A. *Post-pay denial of claims for benefits under Medicare Part A which is determined and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record is subject to this provision);or*

B. *Post-pay denial of claims for benefits under Medicare Part B which is determined and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as result of a post payment review of the medical record is subject to this provision); or*

C. *Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or*

D. *Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).*

1. The providers, physicians and suppliers can appeal the overpayment as a revised initial determination under the Medicare Claims Appeal process at 42 CFR 401 and 405 or

2. As an initial determination for providers, physicians and suppliers MSP duplicate primary payment recoveries.

E. *The final Claims associated with an HHA Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself see below in § 200.1.1 (E).*

200.1.1- Overpayments That are Not Subject to Limitation on Recoupment

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

A. *All other Medicare Secondary Payer recoveries except those identified in Section I (C and D) above.*

B. *Beneficiary overpayments;*

C. *Overpayments that arise from a cost report determination*

D. *Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals.*

E. *HHA Request for Anticipated Payment (RAP): While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the Home Health Prospective Payment System (HH PPS) do not have appeal rights during (1) the 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP to submit the final claim; rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode Refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 10, §§ 10.1.10 through 10.1.12, 40.1 & 50*

F. *Hospice Caps calculations*

G. *Provider initiated adjustments*

H. *Accelerated/Advanced Payments*

I. *Certain claims adjustments at the contractors' discretion that will not be subject to 935 (this requires approval by CMS RO or CO)*

200.1.2- How Does the Rebuttal Process Work with the Limitation on Recoupment?

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

In 42 CFR 405.373 through 405.375, regulations require that providers, physicians and suppliers be given an opportunity to rebut any proposed recoupment action by submitting a statement within 15 days of the notice indicating action to take a recoupment action. These procedures are separate from the requirements of the limitation on recoupment. The rebuttal process ***occurs prior to the appeals process****, and permits the provider a vehicle to indicate why the proposed recoupment should not take place. The Medicare contractor may, based on the rebuttal statement, determine to stop recoupment or proceed with recoupment. In contrast the limitation on recoupment provision mandates that recoupment stop when a valid and timely request for a first level or second level appeal is received.*

200.1.3- Adjustment of the Part A Claim (or All Claims Adjusted by the Fiscal Intermediary Standard System—This Includes Part B of A Claims)

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare contractors shall determine if the limitations apply to the claim at the time of the adjustment. If the adjustment results in a refund due the providers, physicians and suppliers, Medicare contractors shall follow existing underpayment policies. This will trigger the creation of the first demand letter unless previously issued which will include information for the provider concerning recoupment protections. This will also trigger recoupment to begin on the 41st day after the date of the demand letter.

NOTE: In most instances this instruction supercedes Chapter 4 § 70.16, unless the AR's do not qualify; see the above § 200.1.1.

200.1.4- Adjustment of the Part B Claims (All Claims Adjusted by the Medicare Carrier System or the VMS system)

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare contractors shall adjust claims in the normal process issuing a first demand letter and beginning recoupment no earlier than 41 days after the date of the demand letter.

200.2- Additional Requirements for Demand Letters

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

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

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

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 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.

6. Medicare contractors shall send the demand letter by first class mail.

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

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

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 use the appropriate paragraph:

"This is to inform you 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:

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 § 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, ***(specify a date from the 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."

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. Interest Assessment:

If you do not refund in 30 days: ***i****n 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. 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

200.2.2- Recoupment After the First Demand: When Does it Begin?

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Timeframe	***Medicare Contractor***	***Provider***
Day 1	*Date of Demand Letter (Date demand letter mailed)*	*Provider receives notification by first class mail of overpayment determination*
Day 1-15	*Day 15 deadline for Rebuttal request. No recoupment occurs*	*Provider must submit a statement within 15 days from the date of demand letter.*
Day 1-40	*No recoupment occurs*	*Provider can appeal and potentially limit recoupment from occurring*
Day 41	*Recoupment begins*	*Provider can appeal and potentially stop recoupment*

Recoupment can proceed on day 41 from the first demand letter unless a valid and timely request for a redetermination is received. To limit recoupment the provider must file the request for a redetermination by the 30th day following the date of the first demand letter. Medicare Contractors shall refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decision to determine what constitutes a valid request for a redetermination. Recoupment can begin no earlier than the 41st day.

NOTE: *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.*

200. 3 - What to Do When a Valid Request for Redetermination for Appeal is Received

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Action to take*:*

1. Upon receipt of a timely and valid request for a redetermination of an overpayment, Medicare contractors shall cease recoupment of the overpayment that is the subject of the appeal.

2. If the recoupment has not yet gone into effect, Medicare contractors shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a redetermination was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor shall continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue.

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as the following:

Example 2 Receipt Notice:

Current Date

Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter serves to notify you that we have received your request for redetermination for the following_____(i.e., AR/services/ICN) or the services at issue.

Your request for redetermination dated _____ was received in our office and all collection processes have ceased on _____. However, interest will continue to accrue on any outstanding unpaid balance of the overpayment as explained in our demand letter.

You will receive a redetermination notice once the appeals department has concluded their redetermination.

If you have any questions, please contact our office at the appropriate number listed below. You may also visit us through out Web site at www._____.com

Sincerely,
(Name and title)

C. Outcome of a Redetermination (Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 10, § 360.3, Number 1)

1. ***Full reversal*** *- This is a (Fully Favorable) decision of the Overpayment determination. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with in Chapters 3 and 4 §30. The amount held may be applied to any other debt owed by the provider or supplier; any excess would then be released to the provider, physician or supplier. Following a redetermination favorable decision to the providers, physicians and suppliers, the contractor may effectuate the decision. An Explanation of Benefits (EOB) would be acceptable in place of a written notice. When the reversal in favor of the provider occurs interest may be payable by Medicare if the underpayment is not paid within 30 days of the final determination.*

2. ***Partial reversal*** *- This is a (Partially Favorable) decision of the overpayment determination in which the decision reduces the debt below the amount already recouped this will require the contractor to recalculate the correct amount of both the underpayment and the overpayment. The Medicare contractor effectuates the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Refer to publication 100-04 Medicare Claims Processing Manual, Chapter 29 §§ 310.5 and 310.7 for further guidance.*

3. ***Full Affirmation*** *- This is a (Unfavorable) decision of the overpayment determination, the contractor shall issue the 2nd or 3rd demand letter whichever is appropriate or see D4 below. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with Chapters 3 and 4.*

D. Medicare Overpayment Revised Notice or revised Demand Letter after the Redetermination decision involving Limitation on Recoupment

1. *If the redetermination is a full reversal (**Fully Favorable**) decision of the overpayment determination, Medicare contractors may need to effectuate (when necessary) the redetermination decision. Contractors send the applicable notice when necessary, see below (G) example 3 Revised Notice or revised Demand Letter) as explained in Publication 100-04 Medicare Claims Processing Manual, Chapter 29, § 310.8)*

*2. If the redetermination results in a Partial reversal (**Partially Favorable)** decision which reduces the overpayment amount, the contractor shall effectuate the redetermination decision and issue a revised overpayment notice or a revised (2nd) demand letter to the provider of the revised overpayment amount. This notice/letter must state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination in the absence of a receipt/ notification by the QIC of a timely and valid request for a reconsideration. This notice must also give the provider an opportunity to rebut the proposed recoupment action (S**ee § 200.1.2)** and you will review it and consider whether to proceed or stop the recoupment. This is still permitted under 42 CFR 405.373 through 375; however it does not mandate that recoupment will stop.*

a. The notice (to effectuate the redetermination decision) must 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 (reconsideration) of the overpayment within 60 days from the date the notice (to effectuate the reconsideration decision). Submission of a rebuttal statement under 42 CFR 405.374 will not stop recoupment. (See § 200.1.2)

*3. If the redetermination is **a full affirmation, (Unfavorable)** decision the required notice can be one of the following:*

*a. The standard Medicare redetermination notice but if and only if the initial demand letter contained language comparable to that shown in § 200.2.1 Example 1, which specifically states that the contractor can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice (in the absence of receipt by a QIC of a timely and valid request for a reconsideration.. Refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 29 **§** 310.7. Again rebuttal language shall be included.*

b. If the 2nd or 3rd demand letter has not been sent (because the overpayment was in appeal status) this can be modified to indicate when recoupment will begin to recoup no earlier than 61st calendar day from the notice of the revised overpayment determination notice (in the absence of receipt by the QIC of a timely and valid request for a reconsideration). Again, rebuttal language shall be included (See § 200.1.2). or

c. A brief notice which states when recoupment can begin as stated in a and b above.

E. Recoupment after a redetermination decision.

While the notices should state that recoupment can begin no earlier than the 61st day, contractors will have an additional 15 days to start recoupment on any unpaid balance. 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.

1. If the debt has been in an appeal status. When you initiate or resume recoupment. The status of the debt shall be changed to reflect "eligible for internal offset" or resume offset.

***NOTE:** Recoupment may not resume and must cease upon receipt of a timely and valid request for a reconsideration by the QIC.*

F. When does Recoupment Begin or Resume after the redetermination?

Timeframe	***Medicare Contractor***	***Provider***
Day 60 following revised notice of overpayment following redetermination	*Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice*	*Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal*
Day 61- 75	*No Recoupment Occurs*	*Provider appeals or pays*
Day 76	*Recoupment Begins or Resumes*	*Provider Can Still Appeal. Recoupment stops on date receipt of appeal*

G. Example Letter for Medicare Overpayment notice/ Revised Demand Letter for Part A & B resulting from the 1st level (redetermination) Appeal decision.

Example 3: Medicare Overpayment Notice/ Revised Demand Letter

Current Date

Provider Name
Address
Address
City, State ZIP code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter is in reference to the Medicare Redetermination decision dated_____, for the overpayment in the amount of $_____ issued to you on the DATE of the Demand letter. This overpayment was for medical services rendered from DATES. Based on the Medicare Redetermination decision, it is noted as Partially Favorable to the provider.

According to our records, the balance on this account is $_____.
Payment/Recoupment totaling $_____ were applied to this account.

Or

According to our records, the new balance on the Principal amount is $_____ and the interest amount due is $_____. Payments totaling $_____ are due by _____.

*When the redetermination decision is Partially Favorable and the overpayment amount must be recalculated, we may begin to recoup no earlier than **60 days** after the date of **this [Medicare Overpayment Notice or revised Demand letter]**. Please note that if recoupment is stopped, interest continues to accrue.*

If you have already sent payment, we thank you and ask that you disregard this letter. If you have any questions or concerns in this matter, please write to our office or contact me at (XXX) XXX-XXXX.

Sincerely,

Analyst Name
Title

H. Initiating or resuming recoupment after a Withdrawal or Dismissal

Medicare Contractors can initiate or resume recoupment immediately if a provider, physician, or other supplies has requested a withdrawal of a request for reconsideration, or the QIC issues a dismissal of a request for reconsideration (See CFR 42 §405.972).

200. 3.1- What To Do When a Valid and Timely Request for a Reconsideration is Received

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

The QIC determines the validity and timeliness of a request for a reconsideration. However, to limit recoupment of the overpayment a provider must request a reconsideration and have it postmarked by the 60th day. Refer to § 200.3 (E) of this section for additional information regarding QIC contractor communication regarding the filing of a request for reconsideration.

A. Actions to take:

1. Upon receiving notification from the QIC of a valid and timely request for a ***Reconsideration****. The Medicare Contractor shall cease recoupment of the overpayment.*

2. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a reconsideration was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor should continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as this:

Example 4: Receipt of Appeal Request Reconsideration to provider

Current Date

Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter serves to notify you that we have received notification from the Qualified Independent Contractor (QIC), _____[insert OIC Name], that they received your request for reconsideration dated _____ in their office on _____. You requested a reconsideration for the following [AR/services/ICN or the services at issue]. All collection processes have ceased; however, interest will continue to accrue on any outstanding unpaid balance of the overpayment as explained in our demand letter. You will receive a reconsideration notice once the QIC has concluded its reconsideration."

If you have any questions, please contact our office at the appropriate number listed below. You may also visit us through our website at www._____.com

Sincerely,
(Name and title)

C. Outcome of Reconsideration

The QIC decision may require an effectuation action by the Medicare Administration contractor. Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 § 320.9 for additional information on effectuation.

*1. **Full Reversal**- If the QIC reconsideration results in a (Fully Favorable) decision of the overpayment as modified by the redetermination, Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4. The amountheld may be applied to any other debt owed by the provider or supplier; any excess would then be released to the provider or supplier. If the reversal in favor of the provider, physician or other suppliers occurs interest may be payable by Medicare if the underpayment is not paid within 30 days of the final decision.*

*2. **Partial Reversal** - If the final action by the QIC is a reconsideration resulting in a (Partially Favorable) decision which reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to the any other debt, including interest, owed by the provider or supplier to CMS before any excess is released to the provider or supplier. This decision will require an effectuation action by the contractor. It takes an effectuation action only in response to a formal decision and Reconsideration Effectuation Notice from the QIC. In accordance with Publication 100-04, Medicare Claims Processing Manual, Chapter 29 § 320.9.*

*3. **Affirmation**- If the QIC reconsideration results in an (Unfavorable) decision of the overpayment recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives time for the provider to request a repayment plan or make payment. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4, § 30.*

D. Reconsideration Notices Involving Limitation on Recoupment

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.

1. If the reconsideration decision results in a Favorable decision (Full Reversal) Medicare contractors should effectuate the redetermination decision. Contractors may send an applicable notice if necessary consistent with Publication 100-04, Medicare Claims Processing Manual, Chapter 29, § 320.9."

2. If the reconsideration decision results in a partially favorable decision (partial reversal) which reduces the overpayment amount, the contractor shall effectuate the reconsideration decision and issue a notice to the provider of the revised overpayment amount. This notice must state that the contractor can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give providers, physicians and suppliers an opportunity to make payment arrangements. This notice must also give the provider the opportunity to rebut the recoupment according to 42 CFR 405.373 and 375. (See § 200.1.2)

3. If the reconsideration decision results in an Unfavorable decision (Full Affirmation), the contractor shall issue a notice. The notice shall state the reconsideration has been issued and Medicare can begin recoupment or resume recoupment on day 30th day from the date of the notice of the revised notice of overpayment. This will give time for the provider to make payment arrangements. This letter must state that the providers, physicians and suppliers has been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 § 405.373(2) through § 405.375. (See § 200.1.2)

Example 5: Medicare Notice /Revised Demand letter for Part A & B resulting from (Reconsideration) Appeal decision

Current Date

Provider Name
Address
Address
City, State ZIP

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter is in reference to the Medicare reconsideration decision dated_____, for the overpayment in the amount of $_____ issued to you on ***DATE of the Demand Letter.*** *This overpayment was for medical services rendered from* ***DATES.*** *Based on the Medicare reconsideration decision, it is noted as Partially Favorable to the provider.*

According to our records, the balance on this account is $_____. Payments/offsets totaling $_____ were applied to this account.

Or
According to our records, the new balance on the Principal amount is $_____ and the interest amount due is $_____. Payments totaling $_____ are due by _____.

When the reconsideration decision is Partially Favorable and the overpayment amount must be recalculated, we may begin to recoup no earlier than ***30 days*** *after the date of* ***this Medicare Notice/Demand letter****. Please note that if recoupment is stopped, interest continues to accrue.*

The next level of appeal following a reconsideration is a hearing by an ALJ. Recoupment proceeds regardless of the filing for an ALJ hearing. Following final decision by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level after 30 days from the date of this letter due to the QIC decision or dismissal.

If you have already sent payment, we thank you and ask that you disregard this letter. If you have any questions or concerns in this matter, please write to our office or contact me at (XXX) XXX-XXXX.

Sincerely,

Analyst Name
Title

E. Initiating or resuming recoupment after a reconsideration decision in the following circumstances*:*

Following final decision or dismissal by the QIC, recoupment can be initiated or resumed whether or not the provider, physician or other suppliers subsequently appeals to the ALJ (third appeal level) and all further levels of appeal.

1. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day after the date of the written notice to the provider, physician or other suppliers of the revised overpayment amount if the ***reconsideration*** *decision is partially favorable (partial reversal).*

2. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day on the remaining unpaid principal balance and interest if it has not been satisfied in full and the provider, physician or other suppliers has been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 § 405.373 through § 405.375.

200.3.2- Administrative Law Judge (ALJ) Third Level of Appeal

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Whether or not the provider, physician or other suppliers subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, the Medicare contractor shall continue to recoup until the debt is satisfied in full. Recoupment remains in effect as provided in CFR 42 § 405.373 (e). Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 § 330-330.2

200.4- Extended Repayment Schedules (ERS) With an Appeal That is Subject to Limitation on Recoupment

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

If a provider, physician or other suppliers has been granted an extended repayment schedule (ERS) and submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, the provider or supplier will not be considered in default if payments were not made by the provider. The appeal would supersede the ERS agreement; (under normal circumstances this would have been put on withhold due to default of payment). The contractor shall send a notice to the provider that it must resume its ERS payments or be placed on recoupment according to IOM 100.6 chapter 4 §50.

Payments made by a provider under an ERS are not recoupments for the limitation provision and are not subject to 935 interest if reversed at the ALJ appeal or above. However, if a provider defaults on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupments are subject to payment of interest under the 935 interest requirements. For additional information on the Filing timeframes or instructions on Extended Repayment Schedules refer to Chapter 4 §50.

200.5- Payment Suspension
(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Suspended funds involving providers, physicians and suppliers who have been put on payment suspension under 405.372 (e) are not a "recoupment" for purposes of the limitation on recoupment. Suspended funds is not a "recoupment" as this term is defined in §405.370. CMS is only limited by section 1893(f)(2) of the Act from recouping Medicare payments, we are not restricted in our ability to apply suspended funds to reduce or dispose of an overpayment.

Exception: If the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR § 405.379 "Limitation on Recoupment"provision under §1893(f)(2) of the act will be applicable to any remaining balance still owed to CMS.

200.5.1- Payments Made Upon Notice of Demand
(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

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.

200.5.2- Assessment of 935 Interest
(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

The limitation on recoupment provisions also amended the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called 935 interest, which is payable on an underpayment where the reversal occurs at the ALJ level or subsequent levels of administrative appeal based on the period that Medicare recouped the provider's or supplier's 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.

200.6- Interest Rate and Calculation Periods for Appeal Decisions on Recouped Funds for Purposes of Paying 935 Interest
(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

We will pay simple interest rather than compound interest, and ***we will not pay interest on interest; this mirrors the manner in which we assess interest against providers, physicians and suppliers.*** *Monies we recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider. The periods of recoupment will be calculated in full 30-day*

*periods; and interest **will not** be payable for any periods of less than 30 days in which we had possession of the recouped funds.*

200.6.1- Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest shall be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date). The contractor will have 30 days to calculate and refund the provider from the ALJ Decision date or the final determination Date.

***NOTE:** Contractors will need to issue a revised written determination to the provider, physician or other supplier in accordance to Publication 100-04, Medicare Claims Processing Manual, Chapter 29.*

200.6.2- Computing 935 Interest at the ALJ and Higher Levels

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest paid under 935 is only applicable at the ALJ or further appeal level when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds.

What is needed to calculate 935 interest

The simple formula for calculating interest is: 1) Time; 2) Rate; and 3) Amount
For each recoupment action:

1. ***TIME**: Determine the total Julian Days starting from the recoupment date to the ALJ Decision date or date the revised notice with the new overpayment, if applicable. Divide the number of Julian days by 30 to compute the number of 30-day periods. The interest will not be payable for any periods of less than 30 days in which we had possession of the recouped funds.*

2. ***RATE**: Use the Annual Rate of interest at the time of the ALJ decision date or from the revised New Written Determination date from an effectuation and convert interest rate to a monthly interest rate. (For example: The Rate of Interest as of April 18, 2008 is 11.375%). Convert annual Rate to a monthly rate by dividing by 12.*

3. ***AMOUNT**: The amounts that are to be used as the basis on which to compute interest earned by the provider are those amounts that are credited to principal resulting from any involuntary payments from the provider after the elimination/satisfaction of all Medicare debt. Recouped monies applied to interest are not included in determining the 935 interest. Only those principal funds recouped via withholding (e.g. payments recouped under a defaulted ERS*

or offset) are included. Do not include payments a provider makes under an ERS or other voluntary payments made by the provider.

200.6.3- How to Calculate 935 Interest

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Where there are multiple recoupments 935 interest must be calculated separately for each recoupment action and then total for the amount due the provider.

Example:

How to calculate 935 Interest:

(935 interest at the ALJ and higher levels)

Fully Favorable

ALJ Decision Date: Jan 02,2008

Recoupment Amounts	***Recoup Date***	***Rate of Interest from ALJ Decision Date***	***Length of Time Money Held***	***Interest Owed to Provider***
1) $ 9062	*March 07, 2007*	*12.5%*	*301 Julian Days (10 mos. 1 day)*	*$ 943.95*
2) $ 9806	*May 18, 2007*	*12.5%*	*230 Julian Days (7 mos. 20 days)*	*$ 715.02*
3) $ 9136	*August 08, 2007*	*12.5%*	*148 Julian Days (4 mos. 28 days)*	*$ 380.66*
			Total 935 Interest owed	***$ 2,039.63***

Calculation example: ***Time x Rate x Amount = Interest***

1. *10 x (.125 ÷12) x $ 9062.00 = $ 943.95*
2. *7 x (.125 ÷12) x $ 9806.00 = $ 715.02*
3. *4 x (.125 ÷12) x $ 9136.00 = $ 380.66*
4. *935 Interest amt owed Provider $2,039.63*

200.6.4- Obligation to Pay the Providers, Physicians, or Suppliers Late Payment Interest

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare has the obligation to pay providers, physicians and suppliers interest if the overpayment determination is reversed at the first (redetermination) and second (reconsideration) level of the administrative appeal process and the decisions are not effectuated timely. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment ***is not paid*** *within 30 days of the final determination decision. See § 30.1 of Chapter 4.*

200.7-Tracking and Report on Limitation of Recoupment Overpayments

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Each calendar quarter, the Medicare contractor shall report 935 interest paid based on an ALJ or later decision that fully or partially reverses the previous decision. Reporting will be 935 Interest payment amounts aggregated by provider type. Report will be sent via email to CMS_Medicareoverpayments@cms.hhs.gov. The contractor will have 30 days from the end of the calendar quarter to submit the report to CMS.

Example 8:

1st Quarter: October, November and December 2007

Provider Type	***Total providers'***	***Total amount***
Home Health	*20*	*$ 135,000.00*
Skilled Nursing Facility	*05*	*$ 56,000.00*
Physicians	*02*	*$ 2,500.00*
DME Supplier	*10*	*$ 35,000.00*
Grand Total	***37***	***$ 228,500.00***