CMS-6025-P-1 **Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments**

Submitter : **Mr. Rogelio Hilario** **Date & Time:** **09/26/2006**

Organization : **RH Health Services, Inc.**

Category : **Home Health Facility**

Issue Areas/Comments

Provisions

Provisions

As a DME supplier, we do routine and regular monitoring of our patients, however, there are many times that we are not able to contact some patients especially if they've been admitted to a SNF or Rehab Facility. This would result to an overpayment to us. We believe that Medicare and its contracting subsidiaries should have full and immediate knowledge of these occurences and, therefore, halt payment right from the start. If these occurences are monitored by Medicare, overpayments and the burdens of refunding funds should be minimized.

CMS-6025-P-2 **Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments**

Submitter : **Dr. Matthew Stevenson** **Date & Time:** **10/17/2006**

Organization : **anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a practicing anesthesiologist, I am concerned about the proposed cuts in Medicare reimbursement for anesthesia services. I fear such reductions in payment will only further limit access to quality health care. Thank you for your time.

Sincerely,

Matthew Stevenson M.D.

CMS-6025-P-3 **Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments**

Submitter : **Ms. Ellie Tabar** **Date & Time:** **11/03/2006**

Organization : **Spinal Injection Institute**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

Background

Background

No comment

CMS-6025-P-4 **Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments**

Submitter : **Mr. Walter Racette** **Date & Time:** **11/16/2006**

Organization : **American Orthotic and Prosthetic Association**

Category : **Device Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-6025-P-4-Attach-1.DOC

#4

November 15, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6025-P
P.O. Box 8017
Baltimore, MD 21244

Re: Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments

Dear Sirs:

On behalf of the American Orthotic & Prosthetic Association (AOPA), we would like to respond to the Centers for Medicare and Medicaid Services' on the proposed rule entitled, "Limitation on Recoupment of Provider and Supplier Overpayment" [File Code CMS-6025-P].

AOPA is the largest national trade association representing the interests of patient care facilities, distributors and manufacturers of orthoses (orthopedic braces) and prostheses (artificial limbs.) With nearly 2,000 corporate members, the association is dedicated to raising awareness of the profession and advocating for policies that impact the future of the O&P field and the patients we serve.

We are pleased that CMS has proposed to limit recoupment action until the date of the decision on a request for reconsideration. We believe that this provision will ensure that suppliers maintain adequate cash flow during the appeals process.

However, we would like to bring to your attention two concerns we have with the proposed rule:

- The proposed rule only allows the supplier or provider 30 days after the date of the redetermination decision to file an appeal to the Qualified Independent Contractor (QIC) before recoupment actions start. However, the appeals regulation allow suppliers and providers 180 days to submit an appeal to the QIC and frequently it takes that long to gather all of the supporting documentation. All supporting documentation must be submitted by this level of appeal so it is unreasonable to impose an artificial deadline of only 30 days.

Therefore, we recommend that recoupment action not start until 180 days after the date of the redetermination decision to remain consistent with the timeframe of the appeals process.

- There are no provisions in the proposed rule to notify the supplier or provider that recoupment procedures have stopped once the supplier or provider submits an appeal to the QIC.

  We recommend that the suppliers or providers be provided written notification that recoupment efforts have ceased once they file an appeal to the QIC.

If you need further information about our comments, please contact me, by phone (571) 431-0810, or by email kdodson@aopanet.org.

Sincerely,

Walter Racette
President, American Orthotic & Prosthetic Association

Cc: AOPA Board of Directors
AOPA Government Relations Committee
AOPA Coding Committee

Submitter : **Date: 11/20/2006**

Organization :

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6025-P-5-Attach-1.DOC

H 5

Felice L. Loverso, Ph.D.
Casa Colina Centers for Rehabilitation
AMRPA Chairman of the Board

November 20, 2006

Leslie Norwalk, J.D.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-6025-P
P.O. Box 8017
Baltimore, MD 21244

By electronic and hand delivery

Re: CMS-6025-P, Medicare Program: Limitation Recoupment of Providers and Supplier Overpayments, Proposed Rule, 71 F. R. 55404, September 22, 2006

Dear Administrator Norwalk:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national trade association that represents inpatient rehabilitation hospitals and units, outpatient rehabilitation providers, and some skilled nursing facilities. Most, if not all, of our over 350 members are Medicare providers providing services to numerous Medicare beneficiaries in need of intense medical rehabilitation services. We have reviewed the above referenced proposed rule and our comments follow.

The proposed rule would implement Section 935(a) of the Medicare Prescription Drug Improvement and Modernization Act of 2003. It amended Section 1893 of the Social Security Act by adding subsection (f) Recovery of Overpayments. The proposed rule seeks to implement Section 1893(f) (2) regarding Limitation on Recoupment. This paragraph prohibits recoupment of Medicare overpayments when an appeal is received by a Medicare contractor until a decision is rendered by the Qualified Independent Contractor (QIC).

We are very interested in the implementation of this provision as well as the entire appeals and recoupment process. At this time, our field is experiencing an unprecedented number of denials of claims by fiscal intermediaries (FIs) as well as the Recovery Audit Contractors (RACs) authorized under Section 306 of the Medicare Modernization Act (Public Law 108-173). Over the past several years, a number of fiscal intermediaries have drafted and implemented Local Coverage Determinations (LCDs) dealing with medical necessity and coverage policies, and have been citing them as the basis for claim denials at the Administrative Law Judge (ALJ) level. In addition, several FIs are conducting pre- and post-payment claims reviews. These have resulted in a number of cases being denied; cases being appealed; and the FIs seeking to recoup overpayments. Many of our members are experiencing very high reversal rates of FI denials, and immediate recoupment is particularly inequitable, given the large number of appeals that are eventually resolved in favor of the providers. In several instances the disputed payments

involved are sizable, and if the entire sums are recouped at once, both the providers' continuing survival and patients' access to inpatient hospital rehabilitation services are jeopardized.

In addition to these actions by the FIs the activity of the RAC contractors, particularly in California, are having a seriously detrimental effect on the financial condition of many inpatient rehabilitation hospitals and units in the state. Usually, an initial determination is made by an FI. However, in a RAC audit, the initial determination is made by the RAC. CMS has stated that fiscal intermediaries must process an appeal of a RAC determination identically to "any other appeal request" as stated in this rule. For purposes of initiating a redetermination request, an overpayment determination is considered a revised initial determination pursuant to the Medicare Financial Management Manual chapter 4, Section 100.7. Therefore, when a RAC issues an overpayment determination, the regulations give the provider a right to request redetermination by the FI. A provider need not await recoupment.

For the reasons stated below, we urge that CMS acknowledge the current FI practices in seeking full recoupment prior to the provider receiving a notice of an initial overpayment determination, address these practices and also extend the rules to the actions of the RACs.

I. Background

This section provides the pertinent legislative history and some of CMS's thinking in implementing the provision regarding recoupment and assessment of interest. We have several comments.

A. *Recoupment*

1. *Rebuttal Process*

   The preamble provides a chart of the changed appeals and determination process. CMS notes however that the MMA changes did not change the rebuttal process. However there is no citation given to where the rebuttal process is set forth. **We recommend** that references to it be included in the final rule.

2. *Interpretation*

   CMS notes that the statutory language of Section 1893(f)(2) would allow it to recoup payment during the period in which a provider is pursuing an appeal at the first level (redetermination) and before it appeals to the QIC level. According to the current process and chart on page 55406, a provider has 120 days to file with the Medicare contractor once it has received an overpayment determination, e.g. claim denial. CMS states that instead of following this strict language of the statute and given its interpretation of Congressional intent, it proposes to cease recoupment when a valid first level appeal is received. If the provider loses at the first level, CMS would proceed to recoup 30 days after giving the provider notice unless the provider appeals to the QIC in the interim.

   AMRPA understands however, that it is standard Medicare practice to process overpayments prior to affording a provider the right to appeal, and RAC overpayments are processed in the same manner. We are concerned that this practice

prevents a provider from exercising its rights under Section 935(a) of the MMA (now Section 1893(f)) to halt recoupment.

We support CMS's decision to forgo recoupment during the period that the provider seeks a first level of appeal (redetermination).

We recommend however that CMS not seek recoupment until after the entire filing period of 120 days between the initial overpayment determination and the deadline to file for redetermination with the fiscal intermediary. We also **recommend** that if a provider does not prevail at the redetermination stage, that CMS not seek recoupment until the entire period of 180 days for filing a request for reconsideration with a QIC has expired.

CMS states that if the provider loses at the first level it would proceed to recoup 30 days after giving notice to the provider unless the provider appeals to the QIC. Allowing only 30 days before recoupment is initiated essentially reduces the filing period to the QIC to 30 days as opposed to 180 for providers who wish to avoid recoupment. In our experience, these recoupements for large numbers of claims, and therefore payments, can seriously disrupt a provider's cash flow during the appeals period. Furthermore we believe that not recouping any funds until after a decision to appeal to the QIC is more in concert with the Congressional intent and language of Section 1893(f)(2). Finally, it allows the provider adequate time to analyze the denied cases and determine which should be appealed, which in the long run saves both the QIC and provider time and money. A smaller number of cases might then be filed for appeal. Otherwise, the provider may feel it has to rush to file an appeal for all cases.

Also, the RAC's overpayment notices qualify as an initial determination that triggers a provider's right to request redetermination. We believe one RAC in fact characterized its letters to providers as a "determination." **We recommend** that the proposed rule also be extended to the actions of the RACs.

B. ***Assessment of Interest***

CMS notes that Section 935(a) requires that if a provider does not prevail in its appeal, interest shall accrue from the date of the original notice of overpayment. These interest payments, which CMS states were at the rate of 12.625% on September 22, 2006, may be a substantial disincentive for providers to exercise their appeal rights. An appeal through the reconsideration phase can take over fourteen months from the date of the initial determination.[1] At the rate of 12.625%, a provider would owe $7,365 in interest on a $50,000 claim over 14 months.

[1] A provider is permitted 120 days from the date it receives the initial determination to file for redetermination. The fiscal intermediary must issue a redetermination decision 60 days after receiving the provider's redetermination request. The provider then has 180 days from the date of receipt of the redetermination decision to file for reconsideration. The QIC has 60 days to issue a reconsideration decision. The provider is presumed to have received the initial determination and the redetermination five days after the date on those notices. These deadlines establish a maximum timeframe of 430 days for a reconsideration decision,

We recommend that CMS amend the regulations implementing Section 935(a) to furnish a provider with the option of either halting recoupment during the first two levels of appeal or of repaying the funds immediately, even if the provider appeals the overpayment determination. This latter option will allow a provider who believes that a case should be paid by Medicare, but who nonetheless may be unwilling to risk incurring substantial interest charges, to exercise its appeal rights without penalty. If the provider subsequently prevails in its appeal, the funds would be returned to the provider.

This proposed amendment is supported by Section 935(a). That statutory provision states that the Secretary and his contractors "may not take any action" to recoup overpayments until a reconsideration decision is rendered. The emphasis of this provision is clearly on the actions of the Secretary and his agents. Section 935(a) does not preclude a provider from voluntarily returning funds during the administrative appeals process. It is appropriate, therefore, for CMS to implement a process whereby providers can choose either to return funds deemed to be an overpayment or to halt recoupment as specified in Section 935(a).

II. Provisions

A. *Change to Section 405.370 Definitions*

We recommend that the definition of Medicare contractor be amended to include specifically Recovery Audit Contractors. These entities were authorized under Section 306 of the Medicare Modernization Act (Public Law 108-173) to conduct a three-year demonstration program to identify underpayments and overpayments and to recoup overpayments under the Medicare program under Part A or Part B of the program. Section 306 specifies that RACs are "under the Medicare Integrity Program." Similarly, Section 935(a) of the MMA amended the statutory provisions at 42 U.S.C. § 1395ddd regarding the Medicare Integrity Program by adding a section to halt recoupment of an overpayment during the period of a provider's appeal of that overpayment. By placing RACs "under the Medicare Integrity Program," Congress expressed its intent that RACs should be subject to the limits on recoupment imposed by Section 935(a). This is logical because RACs are participating in and conducting the same activities as the other entities included in the proposed definition of Medicare contractor.

The RAC in one of the states is proceeding to seek recoupment through the fiscal intermediary for overpayment 30 days after it makes the initial denial of the claim, and the FI is refusing to accept first level appeals (redeterminations) prior to the funds being recouped. Once it receives a notice of denial of a claim from the RAC, the provider is notified that if it seeks to appeal the denial, it is required to use the existing Medicare claims appeals process discussed in the proposed rule. Hence, we believe that claims denials and overpayments made by the RACs should receive the same treatment as other claim denial overpayments as defined in proposed Section 405.379.

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assuming that the QIC's deadline is not extended due to additional documentation being submitted by the Provider subsequent to filing the reconsideration request.

This same RAC has been denying claims more aggressively than most fiscal intermediaries. The RAC is causing substantial and ongoing financial hardship to providers. The RAC often makes its overpayment determinations with minimal or no review of the medical records. We anticipate that a large number of the RAC's denials will eventually be overturned on appeal. It is extremely important, therefore, that providers who are subject to RAC audits be afforded the opportunity to halt recoupment under Section 935(a).

We recommend that the definition be amended to read:

> "Medicare contractors, unless the context otherwise requires, includes a fiscal intermediary, carriers, Medicare Administrator Contractor, and Recovery Audit Contractor."

B. ***Proposed Changes to Section 405.379***

1. *Section 405.379(b) Overpayments subject to limitation*
   We recommend that in the preamble to the final rule it be made explicit that these rules apply to overpayments which are determined by RAC contractors. Specifically, they would be included in the claims defined in Section 405.379(b)(1)(i)(A), Post-pay denial of c laims for benefits under Medicare Part A which is determined and for which a written demand for payment has been made on or after November 24, 2003.

2. *Section 405. 379(d)(1) General Rules*
   As noted above, **we support** CMS's decision to acknowledge the legislative intent of the MMA provision by halting recoupment at the redetermination level (first level of appeal) as stated in Section 405.379(d)(1). **We recommend** that the preamble to the final rule state that the provision also applies to initial determinations of overpayments made by RACs. **We recommend** that the provision be amended to specify that contractors must issue written overpayment determinations and may not initiate recoupment until 120 days following a provider's receipt of the written determination of overpayment. This will enable providers to exercise the right to halt recoupment while effectively preserving the statutory right to request redetermination within 120 days of an initial determination.

3. *Section 405.379(e)(1) Initiating or Resuming Recoupment After Redetermination Decision*
   As noted above, **we recommend** that the period of resuming recoupment be extended from the 30 days proposed to the entire period allowed for the provider to file with the QIC which is 180 days in order for the provider to make a fair determination if it wishes to appeal the redetermination results. Otherwise many providers may rush to file appeals to forestall recoupment when, if additional time is granted, they may file more considered appeals, thereby saving both the QIC and provider considerable time and expense. Therefore, we recommend Section 405.379(e) (1) be amend in each instance to delete "30th calendar day" and insert "on the 181st calendar day."

III. Summary

In summary we:

A. Support CMS decisions to forgo recoupment during the period that the provider seeks a first level of appeal (redetermination).

B. Recommend that CMS require contractors to issue written notices of overpayment determinations and not seek recoupment until the 120-day period to file for redetermination has expired.

C. Recommend that CMS not seek recoupment until after the appeal period to the QIC has been exhausted by amending Section 405.379(e)(1) in order to avoid interest charges.

D. Recommend that CMS provide the option of halting recoupment or of repaying alleged overpayments during the period of appeal.

E. Recommend that CMS make it explicit that this rule (and the entire appeal process applies to Recovery Audit Contractors (RACs) in the preamble to the final rule and by amending section 403.350. Definitions by amending the definition of a "Medicare contractor".

We would be pleased to meet you to discuss these issues with you. Please contact Carolyn Zollar, Vice President for Government Relations and Policy Development, at the AMPRA office at 202-223-1920 or by email at czollar@13x.com.

Sincerely,

Bruce M. Gans, MD
Chair, AMRPA Consumer and Clinical Affairs, LCD Task Force

Submitter : **Mr. Bruce Yarwood** **Date: 11/21/2006**

Organization : **American Health Care Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachmcnt

CMS-6025-P-6-Attach-1.DOC

#6

American Health Care Association

202-898-2858
byarwood@ahca.org

November 21, 2006

ELECTRONICALLY AND BY OVERNIGHT DELIVERY

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-6025-P: Comments on Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments, 71 Fed. Reg. 55,404 (September 22, 2006)

Dear Ms. Norwalk:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, *Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments,* CMS-6025-P, 71 Fed. Reg. 55,404 (September 22, 2006). AHCA is the nation's leading long term care organization. AHCA and its membership are committed to performance excellence and Quality First, a covenant for healthy, affordable and ethical long term care. AHCA represents more than 10,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities.

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) implements Section 1833(f)(2) of the Social Security Act added by Section 935 of the Medicare Modernization Act of 2003 (MMA) (Pub. L. 108-173). In the MMA, Congress sought to prevent recoupment of alleged Medicare overpayments before the provider of services has had the opportunity to appeal. In addition, it sought to improve the position of the provider with regard to the assessment of interest. It is the position of AHCA that CMS has interpreted both the limitation on recoupment and the assessment of interest too narrowly – in some respects putting providers and suppliers in a worse position than they now are under the current regulations – and that it is within CMS' authority under Title 18 to modify its position to achieve the intent of

Congress with regard to both issues. AHCA recommends that CMS provide the full 120 day filing period for a redetermination to providers and suppliers before starting recoupment of an overpayment, provide the full 180 day filing period to providers and suppliers for a reconsideration before starting recoupment of an overpayment, and provide for the payment of interest to providers and suppliers on recouped monies from the date of recoupment regardless of when the provider wins on appeal.

RECOUPMENT OF OVERPAYMENTS

I. Background: The Current Rebuttal Process and Recoupment of Overpayments

CMS currently gives providers and suppliers two ways to refute an overpayment determination: rebuttal and appeal. The current regulations on rebuttals are located at 42 C.F.R. §§ 405.374-375. Section 405.374 gives providers and suppliers an opportunity for rebuttal after receiving a "notice" of suspension, offset or recoupment of an overpayment. The regulation directs that the notice must state that the provider or supplier has at least 15 days to submit the rebuttal statement. The intermediary or carrier can specify a shorter or longer period of time for rebuttal, but only for good cause. The provider or supplier can (but is not required to) submit a "statement" to the intermediary or carrier explaining why the suspension, offset or recoupment should not be put into effect.

Section 405.374 requires that the intermediary or carrier consider the rebuttal statement, along with any "pertinent evidence" submitted, and "any other material bearing on the case" to determine whether the facts justify suspension, offset or recoupment, "or if already initiated, justify the termination of the suspension, offset, or recoupment." 42 C.F.R. § 405.374(a). The regulation states that "[s]uspension, offset, or recoupment is not delayed beyond the date stated in the notice in order to review the statement." Id. The date stated in the notice refers to the 15 days for filing a rebuttal, or such shorter or longer period the intermediary or carrier states for good cause. Also, Section 405.373(d) says that if the intermediary or carrier does not receive a rebuttal statement at the end of the 15 days or other time specified in the notice, "the recoupment or offset goes into effect automatically." Currently, then, the general rule is that Medicare contractors can initiate recoupment of overpayments 15 days after notice to the provider or supplier.

If a timely rebuttal statement is received, the intermediary or carrier must send the provider or supplier written notice of its determination after reviewing the rebuttal statement and other evidence, within 15 days after it received the rebuttal statement. But the contractor's review of the rebuttal statement does not delay recoupment.

II. Proposed Rule: Only a Quick Appeal Filing Can Prevent Recoupment

The proposed rule states: "Once an overpayment is determined and the substantive and procedural requirements to afford the provider or supplier an opportunity for rebuttal under § 405.374 and § 405.375 are satisfied, recoupment can proceed unless and until a valid request for a redetermination is received." 71 Fed. Reg. at 55,410. CMS talks about waiting to recoup until after the requirements to afford the provider or supplier "an opportunity for rebuttal" are satisfied – currently 15 days – not after the intermediary or carrier reviews the rebuttal and issues a determination. Thus, CMS is not altering its current policy on when it can initiate recoupment of overpayments with this proposed rule. This means that providers and suppliers only have a guaranteed 15 days from the date of the overpayment notice to submit a request for redetermination to the intermediary or carrier. After 15 days, the intermediary or carrier can initiate recoupment of the overpayment, and must do so, as soon as the overpayment can be satisfied from future reimbursement (unless other means of repayment have been approved, such as an extended repayment schedule). Under the proposed rule, the intermediary or carrier can still choose to terminate the recoupment after reviewing the rebuttal statement and other evidence. Whether it decides to terminate or continue to recoup, it must notify the provider or supplier within 15 days of its evaluation of the rebuttal statement.

What CMS is proposing to change with this proposed rule is the ability of the provider or supplier to suspend recoupment, whether started or not yet started, by filing a request for redetermination with the intermediary or carrier. But to guaranty that the intermediary or carrier will not initiate recoupment, that appeal filing must be received by the intermediary or carrier within the first 15 days from the notice of overpayment. Therefore, under the proposed rule, only a very quick appeal filing can prevent recoupment from being initiated.

III. Discussion

A. CMS Should Provide the Full 120 Day Filing Period to Providers and Suppliers for a Redetermination Before Starting Recoupment of an Overpayment

Section 935 of the Medicare Modernization Act of 2003 (MMA) (Pub. L. 108-173), codified at Section 1893(f) provides as follows:

> In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

The regulations define "recoupment" as "[t]he recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness." 42 C.F.R. § 405.370. In the preamble to the proposed rule, CMS explains that based on the statutory language, CMS could recoup during the period in which the provider is actively pursuing an appeal at the first level which is the request for a redetermination. However, CMS rejects this interpretation on the basis that CMS would have recouped the overpayment before a provider could request a reconsideration and thereby invoke the benefit of the limitation on recoupment. CMS concluded that this approach would be inconsistent with Congressional intent and instead proposed "... in this rule to cease recoupment when a valid first level appeal is received. If the provider loses at the first level, CMS proposes to recoup 30 days after giving notice to the provider unless the provider appeals to the QIC in the interim. CMS concludes that "A provider who acts in a timely fashion can preclude any recoupment until the QIC decision is rendered as contemplated under the MMA."

The key factor is the meaning of acting in a "timely fashion." We agree that the limitation on the Medicare contractor's ability to recoup should apply to the redetermination level as well as the reconsideration level. However, CMS has not been clear in the proposed rule, and in fact is misleading, by failing to explain that a provider must file for redetermination within 15 days after receipt of a notice of overpayment in most cases or be subject to recoupment.

Proposed 42 C.F.R. § 405.379(d) provides that "upon receipt of a timely and valid request for a redetermination of an overpayment, the Medicare contractor shall cease recoupment of the overpayment in question. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment" (emphasis added). "Timely and valid request" is defined in proposed 42 C.F.R. § 405.379(c)(2) as follows: "[f]or purposes of this section, what constitutes a valid and timely request for a redetermination is to be determined in accordance with §405.940 through §405.958."

42 C.F.R. §405.942 provides the time frame for filing a request. It indicates that "any request for redetermination must be filed within 120 days from the date a party receives the notice of the initial determination." This reference could lead a provider to believe that they have 120 days within which to file a request for reconsideration during which time frame the fiscal intermediary or carrier cannot initiate a recoupment. However, this is not the case due to the provision pertaining to the rebuttal process.

CMS makes clear in the preamble to the rule that the new MMA provision and the implementing rule do not alter the rebuttal process. The rebuttal process is governed by 42 C.F.R. §§ 405.374-.375. It is clear that the provider or supplier has 15 days after a notice of denial to rebut the denial. The monies in question will not be recouped within those 15 days but can be recouped after the 15th day.[1]

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[1] 42 C.F.R. § 405.374(a) provides the general rule: "If prior notice of the suspension of payment, offset, or recoupment is given under §405.372 or §405.373, the intermediary or carrier must give the provider or supplier an

Thus, under the proposed rule, the CMS contractor could initiate recoupment some time after the first 15 days following the notice of overpayment (the rebuttal filing period), unless a valid appeal (request for redetermination) is filed with the contractor. Recoupment might occur on the 16th day, the 45th day, or some other date, but not before the first 15 days, depending on when and how often the provider or supplier gets paid. To know precisely when, a provider or supplier that receives a notice of overpayment will have to check to see when it next gets paid by Medicare and how much it expects to get paid to know (1) when the contractor can begin to recoup by withholding Medicare reimbursement, and (2) how long it will take the contractor to recover the full amount of the overpayment.

Therefore, the provider or supplier will always have at least 15 days to prevent recoupment by filing for redetermination and the provider could have more time depending on the above factors. But, as a rule of thumb, provider and suppliers will know that only an initial appeal filing within the first 15 days guarantees that recoupment will not be initiated in every case.

The bottom line is that the provider does not have 120 days to file for a redetermination while simultaneously delaying recoupment. In short, 120 days does not in fact constitute a "valid and timely request" as suggested by proposed 42 C.F.R. §405.379(c) to invoke the statutory limitation on recoupment. At a minimum, CMS should provide clear notice to the public of the fact that this rule will not allow the provider the full 120 days for filing a redetermination before the contractor will initiate recoupment.

CMS can and should amend the regulations, consistent with the intent of the MMA, to provide that a timely request for redetermination and a timely request for reconsideration will prevent recoupment from being initiated. AHCA recommends, however, that the proposed rule be changed to allow the provider or supplier the full 120 days for filing a redetermination before the contractor will initiate recoupment. There are a number of reasons for adopting this approach.

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opportunity, before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. Except as provided in paragraph (b) of this section, the provider or supplier has at least 15 days following the date of notification to submit the statement."

In addition, 42 C.F.R. § 405.375(a) addresses submission and disposition of evidence: "If the provider or supplier submits a statement, under §405.374, as to why a suspension of payment, offset, or recoupment should not be put into effect, or, under §405.372(b)(2), why a suspension should be terminated, CMS, the intermediary, or carrier must within 15 days, from the date the statement is received, consider the statement (including any pertinent evidence submitted), together with any other material bearing upon the case, and determine whether the facts justify the suspension, offset, or recoupment or, if already initiated, justify the termination of the suspension, offset, or recoupment. Suspension, offset, or recoupment is not delayed beyond the date stated in the notice in order to review the statement."

First, CMS has determined by regulation that 120 days is a reasonable and appropriate length of time for a provider or supplier to evaluate the denial, decide whether to appeal, prepare the appeal documentation and evidence, and submit the request for redetermination to the contractor.

Second, CMS has not struck a balance of the interests at stake, despite its assertions to the contrary, because a 120-day delay to recoup an overpayment is reasonable and more aligned with the intent of Congress in the MMA than the very brief period of time proposed by CMS.

Third, interest will continue to accrue on the overpayment while the provider or supplier prepares its appeal, so the Medicare trust fund will be made whole if recoupment is postponed for an additional 105 days (or less). The accrual of interest satisfies the concern that the contractor may not know whether a provider or supplier will file an appeal and the contractor's responsibility to recover overpayments. If an appeal is not filed within this 120-day period, all that would really happen is that recoupment would be deferred during this time. But, again, because interest would still accrue on the overpayment, Medicare is made whole in the end, and the provider has been afforded an amount of time that has been determined to be reasonable under current law for preparing a meaningful appeal, without the pressure to rush an appeal filing in order to stay recoupment.

Finally, all providers and suppliers will be motivated to file an appeal within the time set by CMS in order to prevent recoupment. With only a guaranteed 15 days to prevent recoupment by filing an appeal, the proposed rule creates a race to request a redetermination. Providers and suppliers will file a redetermination to forestall recoupment even if they do not have all their evidence and arguments together, rendering redeterminations and the entire rebuttal process meaningless. Ultimately, the redetermination process could start to function as an automatic response to overpayment determinations – wasting the time and resources of all involved – providers, suppliers, fiscal intermediaries, and carriers.

The proposed rule will create an incentive for fast appeal filings that few providers and suppliers will be able to resist. If finalized, CMS will erode the due process rights built into the appeal system and the quality of appeals will suffer greatly. Thus, the 120-day period for filing requests for redetermination must be observed with this change in CMS policy on recoupment of overpayments. And CMS must implement the intent of Congress by delaying recoupment when a timely appeal is filed. The combination of these two factors requires that CMS revise its proposed rule to afford providers and suppliers the full 120 days to request a redetermination before recoupment of an overpayment is initiated.

B. CMS Should Provide the Full 180 Day Filing Period to Providers and Suppliers for a Reconsideration Before Starting Recoupment of an Overpayment

In proposed 42 C.F.R. § 405.379(e), CMS provides that the intermediary or carrier can recoup unless the provider files for reconsideration with a Qualified Independent Contractor (QIC) within 30 days following a notice of redetermination. The proposed rule states in relevant part:

> (1)...Recoupment may be resumed under any of the following circumstances:
> (i) Immediately upon receipt by the Medicare contractor of the provider's or supplier's request for a withdrawal of a request for a redetermination in accordance with § 405.952(a).
> (ii) On the 30th calendar day after the date of the notice of redetermination issued under § 405.956 if the redetermination decision is an affirmation in whole of the overpayment determination in question.
> (iii) On the 30th calendar day after the date of the written notice to the provider or supplier of the revised overpayment amount if the redetermination decision is an affirmation in part which has the effect of reducing the amount of the overpayment.
> (2) Notwithstanding paragraphs (e)(i), (ii) and (iii) of this section, recoupment must not be resumed, or if resumed, must cease upon receipt of a timely and valid request for a reconsideration by the QIC.

42 C.F.R. §405.379(e)(1). CMS does not provide the basis for the 30 day period in paragraphs (ii) and (iii). More importantly, the choice of 30 days conflicts directly with the intent of the MMA law which provides that:

> In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), <u>the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.</u>

Social Security Act § 1893(f)(2) (emphasis added). Congress clearly intended that monies not be recouped until the reconsideration decision has been rendered.

Secondly, the 30 days picked by CMS is not to be found in any statute nor in any regulation. Further, the choice of 30 days is not explained in the preamble. No basis for the 30 days is provided. In addition, the 30-day number in (ii) and (iii) conflicts with two other proposed policies taken together: it conflicts with 42 C.F.R. §405.379(e)(2) to the effect that recoupment must not be resumed, or if resumed, must cease upon receipt of a timely and valid request for a reconsideration by the QIC, and it conflicts with 42 C.F.R. §405.962(a) which provides the

timeframe for filing a request: "any request for a reconsideration must be filed within 180 calendar days from the date the party receives the notice of the redetermination." Read together, the "timely and valid request" in 42 C.F.R. §405.379(e)(2) must be understood to be the 180 days provided in 42 C.F.R. §405.962(a).

Indeed, since CMS has considered the 180 days to be a reasonable length of time to consider and prepare a request for a reconsideration, and CMS has not provided overriding reasons why this period should in effect be foreshortened with regard to the limitation on recoupment, recoupment should not be initiated until the 180-day filing period has expired. CMS did indicate that in implementing the MMA it was exersizing flexibility to strike a balance among various objectives. AHCA would argue that providing the full 180 days prior to recoupment does not violate any of those objectives including fairness and fiduciary responsibility. As a practical matter, this provision will only apply to providers who previously requested a redetermination in time to stay recoupment of at least part of an overpayment. So for the same reasons articulated above with respect to redetermination requests, the agency's imposition of an arbitrary 30-day rule to *again* prevent recoupment is inappropriate. **A provider that has exercised its appeal rights once and receives an unfavorable decision should be presumed to appeal again.** The full 180 days to file for reconsideration is the proper length of time to wait before recoupment can begin or restart. AHCA asks that the proposed rule be revised to give providers and suppliers the full 180 days to file a request for reconsideration before recoupment is resumed.

INTEREST ON UNDERPAYMENTS

I. Background: Current Rules on Payment of Interest for Underpayments

Currently, the regulation on interest states as follows:

(b) *Basic rules.* (1) CMS will charge interest on overpayments, and pay interest on underpayments, to providers and suppliers of services (including physicians and other practitioners), except as specified in paragraphs (f) and (h) of this section.

(2) Interest accrues from the date of the final determination as defined in paragraph (c) of this section, and either is charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed.

42 C.F.R. § 405.378(b). The regulation continues by defining a "final determination" to mean the following for non-cost report underpayments:

(ii) In cases in which an NPR is not issued as a notice of determination (that is, primarily under Part B) one of the following determinations is issued—

[...]

(B) A written determination of an underpayment; or

(C) An Administrative Law Judge (ALJ) decision that reduces the amount of an overpayment below the amount that CMS has already collected.

42 C.F.R. § 405.378(c)(1)(ii).

In the preamble to the proposed rule CMS says:

> Previously, we paid interest on underpayments solely in accordance with sections 1815(d) and 1833(j) of the Act. An ''underpayment'' would usually result when we had recovered, through recoupment or otherwise, an overpayment; the decision was reversed at some point in the appeal process; and after appropriate adjustments, we owed the balance to the provider or supplier. Interest accrues from the date of the ''final determination'' and is owed if the underpayment is not paid within 30 days. Following an appeal decision favorable to a provider, the Medicare contractor must effectuate the decision and make a written determination of the amount Medicare owes. This is considered a new final determination, and interest accrues from that date.

71 Fed. Reg. at 55,407.

However, this statement is not entirely correct. Sections 1815(d) and 1833(j) of the Social Security Act do not define a final determination. The regulations provide a definition of the term "final determination" at 42 C.F.R. § 405.378(c), quoted in the previous section. The effect of that regulation is that interest accrues on non-cost report underpayments from the date of a written notice of determination (*e.g.*, a remittance advice or letter from the contractor specifying the underpayment) or the date of an ALJ decision that partially or fully reverses an overpayment amount CMS has already collected. An underpayment can occur in a variety of ways before an appeal is ever filed. For example, the contractor could erroneously pay a claim in part, discover the error on its own or at the prompting of the provider or supplier, notify the provider or supplier of the error (a final determination under the rules), and then pay the balance owed. Similarly, the contractor could erroneously recoup more Medicare reimbursement from monies owed the provider or supplier than the amount of an outstanding overpayment, discover the error, notify the provider or supplier of the mistake (a final determination under the rules), and repay the overage. In addition, the current regulations state that an ALJ decision is a final determination, not that a subsequent letter from the contractor concerning an ALJ decision is a final determination.

II. Proposed Rule: CMS Would Redefine a "Final Determination" to Delay the Date When Interest Starts to Accrue on Overpayments Reversed on Appeal

In the proposed rule, CMS discusses section 1893(f)(2)(B) of the Social Security Act on interest, enacted as part of the MMA. With respect to payment of interest to the provider or supplier, that part of the statute states that a decision reversing an overpayment determination following the reconsideration level of appeal requires the payment of interest "for the period in which the amount was recouped." Social Security Act § 1893(f)(2)(B).

CMS proposes to implement this part of the MMA by amending the regulations to change its method of paying interest where an overpayment is reversed by an ALJ or subsequent levels of administrative appeal or judicial review. CMS states: "At these higher levels of administrative appeal or judicial review, interest becomes payable by Medicare based on the period we recouped and retained the provider's or supplier's funds." 71 Fed. Reg. at 55,407. AHCA agrees with this change in the regulations and finds it consistent with the MMA.

CMS also states in the proposed rule that:

> There has been no change in the obligation of Medicare to pay the provider or supplier interest if the overpayment determination is reversed at the first (redetermination) or second (reconsideration) level of the administrative appeal process. 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.

Id. But here CMS proposes to postpone the accrual of interest on underpayments even longer than current regulations dictate by creating two new definitions of a "final determination," which CMS explains as follows:

> Second, we propose to add an additional definition for a final determination, at paragraph (c)(1)(ii)(C), arising from a full or partial reversal at the redetermination level of appeal. This change is designed to clarify that if an overpayment is reversed in whole or in part at the first level of appeal —the redetermination level —interest accrues from the date of the "final determination" and is owed by Medicare if the underpayment is not paid within 30 days. *Following a redetermination decision favorable to a provider or supplier, the contractor must effectuate the decision and make a written determination of the amount Medicare owes. Interest accrues from the date of the written determination.*
>
> Finally, we propose to add paragraph (c)(1)(ii)(D) as an additional type of final determination. This is a written determination arising from a full or partial reversal of an overpayment determination at the QIC reconsideration level (the second level of appeal). *This addition is designed to clarify that if an overpayment determination is reversed in whole or in part at the QIC reconsideration, the final determination for purposes of*

> *assessing interest is the date the contractor effectuates the QIC reconsideration decision and make a written determination of the amount Medicare owes. Interest accrues from the date of this written determination and is owed to the provider or supplier if the underpayment is not paid within 30 days.*
>
> These changes to the final determination definitions are intended to work in conjunction with the limitation on recoupment requirements in the new proposed §405.379. Providers and suppliers can take advantage of the limitation on recoupment by not paying during the redetermination and reconsideration levels of appeal, yet interest will still continue to accrue during those periods. If a provider or supplier loses at either level of appeal, and they did not pay their overpayment during the appeal, they will owe both the overpayment amount and accrued interest. Therefore, they receive a benefit during the first two levels of appeal by retaining their funds, but by doing so, they run the risk that they will owe interest on the unpaid overpayment amounts.

71 Fed. Reg. at 55,409 (emphasis added).

III. Discussion: CMS Should Provide For Interest on Recouped Monies From the Date of Recoupment Regardless of When the Provider Wins on Appeal

AHCA does not believe the two new definitions of a final determination at proposed sections 405.378(c)(1)(ii)(C)-(D) make sense or are fair to providers and suppliers for a number of reasons.

First, with the enactment of section 1893(f)(2)(B) of the Social Security Act, Congress has made clear that it is inequitable for the government to retain monies that rightfully belong to a provider or supplier without paying interest on those amounts for the time the monies were recouped.

Second, there is nothing unique about monies recouped at the first level of appeal or any subsequent level of appeal. When a contractor, a QIC, an ALJ, the Departmental Appeals Board, or a court decides that an overpayment determination by CMS was incorrect and there are monies to be repaid, interest should be paid from the time CMS erroneously recouped those monies.

Third, providers and suppliers are not in the business of providing interest-free loans to the Medicare program. If the proposed amendments to the regulations are finalized, that is just what providers and suppliers will be doing if they win at the first or second levels of appeal, but not at subsequent levels of appeal.

Finally, from the statements quoted above, it appears that CMS is trying to justify a postponement in the accrual of interest on underpayments (*i.e.*, reducing the amount of interest that would be paid to a provider or supplier that wins on appeal) based on the benefit to the

provider or supplier of delayed recoupment during the first two levels of appeal. That rationale simply doesn't work.

The "risk" that interest will be owed on an unpaid overpayment is evaluated when the provider or supplier decides whether to pursue an appeal. Whether or not to file an appeal is a business decision and if a provider believed that the appeal would be unsuccessful, then the provider would not file the appeal to begin with. Therefore the "risk" of paying interest has already been factored into the business decision of whether to file an appeal or not. Interest can no longer be considered a risk after the appeal is filed. The provider or supplier *knows* that interest is accruing and will be owed if they do not succeed in getting the overpayment reversed.

Likewise, CMS should know when the provider or supplier files an appeal that interest will accrue from the date monies are recouped and will be owed if the overpayment is reversed. Under the proposed rule, that would not be the case. The agency is giving itself special treatment by delaying the point in time when interest would start to accrue by redefining a "final determination" *only in cases when the provider or supplier wins its appeal.* Moreover, CMS is assuming in its discussion of this change that all providers and suppliers will act quickly enough to prevent recoupment during the first two levels of appeal. As discussed above, that is not a reasonable assumption. What *can* be assumed is that Medicare contractors will continue to identify overpayments and they will recoup those overpayments as soon as they are authorized to do so, unless an appeal is filed very quickly. The rules on payment of interest should not be so one-sided.

For these reasons, AHCA asks that CMS revise its proposed rule to allow for interest on recouped monies from the date of recoupment, regardless of when the provider wins on appeal.

* * * *

AHCA appreciates the opportunity to present these comments to CMS. We hope the information presented will be useful to CMS in revisiting the policies set forth in the proposed rule and developing regulations that are fair to providers and suppliers and more faithful to the intent of the Congress that was clearly expressed in the MMA.

Respectfully submitted,

Bruce Yarwood
President and CEO
American Health Care Association

Submitter : **Ms. Denise Bonn** **Date: 11/21/2006**

Organization : **National Association for Home Care & Hospice**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

"Sce Attachment"

CMS-6025-P-7-Attach-1.DOC

#7

Ruth L. Constant
Chairman of the Board

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
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Val J. Halamandaris
President

November 21, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6025-P
P.O. Box 8017
Baltimore, MD 21244-8014

Via: Electronic submission

Re: Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments

71 Fed. Reg. 55404 (September 22, 2006)

To whom it may concern:

Thank you for the opportunity to provide comments on the above-referenced Proposed Rule. The National Association for Home Care and Hospice, Inc. ("NAHC") is the largest trade association in the country representing the interests of home care and hospice providers and their patients. As a central part of its membership, NAHC represents over 6,000 Medicare participating Home Health Agencies ("HHA"), hospices and providers of Durable Medical Equipment ("DME"). Accordingly, the Proposed Rule is of great interest to NAHC and its members.

Comments on "Provisions"

CMS states that this proposed rule implements the limitation on recoupment Congress adopted in section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"). This section of the MMA added a new section (f) to section 1893 of the Social Security Act which prohibits CMS or its contractors (hereinafter referred to collectively as "CMS") from recouping an overpayment from a provider who has filed an appeal of the overpayment until the Qualified Independent Contractor ("QIC") issues a decision on reconsideration.

The home care industry welcomes the limitation on recoupment enacted by Congress. Section 935(a) changes prior Medicare policy in which the filing of an appeal to challenge an overpayment determination did not stop recoupment of the overpayment. The result of this policy has been that CMS's recoupment of the overpayment could force a provider out of business, or cause severe cash flow problems, before the provider had the opportunity to challenge the overpayment determination.

Section 935(a) is a compromise. While it protects providers from recoupment through the second level of appeal, it does not protect providers through the total administrative appeal process, which would be through the Administrative Law Judge ("ALJ") level. Although the second level of appeal is performed by a QIC, that appeal is not adjudicated by an ALJ. In addition, interest continues to run from the date of the overpayment. If a provider is unsuccessful in its appeal, and the QIC rules against it in full or in part, although the provider has avoided immediate recoupment of the overpayment, the provider incurs significant interest charges from the date of the original overpayment notice.

In both the Preamble and the proposed regulation, CMS acknowledges that Congress tied the limitation on CMS's recoupment of an overpayment to the appeals process. Preamble, 71 Fed. Reg. 55404, 55407; proposed regulation section 405.379(a). However, in its implementation of section 935(a) of the MMA, CMS did not tie recoupment to the appeals process. CMS tied its limitation on recoupment to different periods, depending upon where a provider or supplier was in the appeal process. When an overpayment is first determined, CMS limits its recoupment of the overpayment during the rebuttal period, 71 Fed. Reg. at 55410. This period is stated in the Preamble; however, no such period is contained in proposed regulation section 405.379. According to the proposed regulation, CMS may commence recoupment at any time when an overpayment determination is made until "receipt of a timely and valid request for a redetermination of an overpayment..." Since a contractor has 60 days to determine if a valid redetermination request was filed, 42 C.F.R. §405.950, CMS may have significantly recouped the funds before this determination is made. If a redetermination decision is issued affirming the overpayment in full or in part, CMS limits its recoupment during the twenty-nine days following the redetermination decision, proposed regulation section 405.379(e) (1) (ii), (iii). Recoupment can commence on the thirtieth day, and can continue until the QIC receives a "timely and valid request for a reconsideration...." *Id.* and at §405.379 (e) (2). Since the QIC has sixty days to determine if a timely and valid request for reconsideration has been filed, 42 C.F.R. §405.970, CMS again may have significantly recouped the funds before this determination is made. If the QIC issues a decision affirming all or a part of the overpayment, CMS may commence recoupment upon the transmission of its decision. 405.379(f). Since transmission includes mailing, 42 C.F.R. §405.970, recoupment can commence before the provider even knows that the QIC has issued a decision, or the nature of that decision.

CMS has ignored the plain language of section 935(a). Congress restricted CMS from taking any action to recoup the overpayment until the reconsideration decision is

issued, if the provider seeks a reconsideration by the QIC. Congress was aware that this was the second level of appeal for providers. Congress created this new level of review by the QIC's in 2000 in section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000, (Pub. L. 106-554) ("BIPA"). CMS interprets the language in section 935(a) as permitting CMS to start recoupment before a provider reaches this level of appeal, indeed to start recouping before a provider even exercises its statutory 120-day right to appeal to the first level, redetermination. 42 U.S.C. §1395ff, Social Security Act §1869(a) (3) (C) (i). Once CMS receives what it determines to be a valid and timely request for reconsideration, CMS will temporarily stop recouping, only to start again after the intermediary issues a redetermination decision, if the latter affirms all or part of the overpayment. CMS will once again temporarily stop the recoupment when it receives what it determines to be a valid and timely request for reconsideration. CMS proposes to implement an unmanageable, start and stop recoupment process, which is not supported by the Congressional text.

NAHC's interpretation of the clear language of Congress is supported by the interest provision of section 935(a), which is the paragraph directly below the limitation on recoupment. Congress did not expect CMS to start recoupment until after the QIC issued its decision. Congress stated:

Insofar as the **determination on such appeal** [referring back to reconsideration in the prior paragraph] is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is **later reversed** [at the ALJ or subsequent appeal level], the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped. Emphasis added.

Ignoring this plain language of Congress, CMS proposes regulations which permit CMS to start recoupment before a provider has time to request a redetermination of the overpayment, and yet not obligate CMS to pay the provider interest from the date of this recoupment if the overpayment is reversed in the redetermination decision or the reconsideration decision. This is not what Congress told CMS to do.

NAHC respectfully requests that CMS implement the plain language of Congress and revise its proposed regulations to clearly state that:

1) Recoupment of an overpayment may not commence until after the expiration of the 120-day period in which a provider or supplier may file a request for redetermination;

a) If such a request is filed, recoupment may not commence regarding any of the claims appealed or the Medicare Secondary Payment subject of the appeal.

b) If such a request is not filed, recoupment may commence against any of the claims not appealed or the Medicare Secondary Payment subject of the appeal.

2) Recoupment of an overpayment may not commence until after the expiration of the 180-day period in which a provider or supplier may file a request for reconsideration with a QIC;

a) If such a request is filed, recoupment may not commence regarding any of the claims appealed or the Medicare Secondary Payment subject of the appeal.

b) If such a request is not filed, recoupment may commence against any of the claims not appealed or the Medicare Secondary Payment subject of the appeal.

Although CMS has stated that the rebuttal process will remain unchanged, CMS has not addressed the Extended Repayment Plan ("ERP") procedure. Before the MMA was enacted, the filing of an appeal did not stop recoupment. Once an overpayment was determined, a provider or supplier who wanted to pay out the overpayment on an installment basis, instead of having the overpayment recouped, needed to file a request for an ERP. This had to be filed before the recoupment was to go into effect. Section 935(a) of the MMA changes this process so that a provider who files an appeal stays the recoupment. Such a provider may need to seek an ERP later in the appeal process, for example if the provider loses at the redetermination level and chooses not to appeal, or if the provider loses at the QIC level, whether the provider appeals to an ALJ or not. CMS should clarify in the regulations that recoupment may not occur until a period after thirty days to provide time for a provider or supplier to request an ERP, and to provide time for CMS to meaningfully review and approve the ERP prior to implementing recoupment.

In addition, CMS should require that overpayment notices clearly advise providers and suppliers that if they file a request for redetermination by a specified date, that recoupment will be stayed until the time period for appeal to the QIC has elapsed, or the QIC has issued its decision. Further, these letters should state that interest will continue to accrue from the date of the original overpayment notice.

In the alternative, if CMS disagrees with the above, revisions are still needed to the proposed regulations. CMS has not given clear guidance to providers and suppliers regarding how much time they have to submit a request for redetermination before the contractor will commence recoupment. Similarly, CMS has not given clear guidance to contractors regarding how much time they must give providers or suppliers to appeal before they may commence recoupment. In the Preamble, CMS states that recoupment can proceed after providers and suppliers have been given the opportunity for rebuttal under proposed regulation sections 405.374 and 405.375, 71 Fed. Reg. at 55410. CMS has not stated how long this period is. The rebuttal regulations cited by CMS give the provider or supplier 15 days following the date of the notification to submit a rebuttal.

The contractor then has up to 15 days to consider the provider or supplier's submission. The provider does not have to pay interest on the overpayment until thirty days after the date of the overpayment. The rebuttal and interest time periods dovetail to a thirty-day period in which a provider should be able to submit a request for redetermination before a contractor may initiate recoupment of the overpayment. Indeed, longstanding CMS policy for more than ten years through 2003 gave a provider thirty days from the date of the overpayment notice before recoupment could commence. Medicare Intermediary Manual, HIM -13, Ch. 3, §3710.1. (In this Manual provision, CMS actually referred to recovery of the overpayment by reduction of subsequent Medicare payments due the provider as "offset.")

In proposed regulation section 405.379(b)(1)(i)(A), CMS implies that current policy permits CMS to recoup Medicare Part A overpayments 15 days from the date of the overpayment notice. CMS states that this is current policy, but furnishes no citation for this policy. 71 Fed. Reg. at 55410. Nor does CMS state whether this policy was in effect when Congress enacted the limitation on CMS's recoupment policy. Fifteen days is the time period in which a provider or supplier can submit a rebuttal to a notice of recoupment in an overpayment demand. 42 C.F.R. §405.374. For CMS to decide to recoup a Part A overpayment on the fifteenth day after the notice of overpayment makes a mockery of the rebuttal process. If CMS tells the contractor to recoup on the fifteenth day, why should the contractor bother to review the provider or supplier's rebuttal papers? Recoupment is a foregone conclusion.

We note also that Congress amended the ERP process in section 935(a). In this provision, Congress required CMS to provide for an ERP "if the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship...." In this provision, Congress clearly told CMS that providers have at least 30 days to repay an overpayment. CMS's interpretation that it can commence recoupment within 15 days conflicts with this language.

CMS also states in the proposed regulation and in the Preamble, that current policy permits CMS to recoup Medicare Part B overpayments 40 days from the date of the overpayment notice, 71 Fed. Reg. at 55410; proposed regulation section 405.379(b) (1) (i) (B). Again, no citation is furnished for this policy. Nor can we discern any rational basis for such disparate recoupment treatment of Part A and Part B overpayments.

The forty-day Part B period before recoupment can begin is a rational implementation of a thirty-day period to permit an appeal prior to recoupment. Since the appeal is filed in a different office than the office which performs the recoupment, and since the appeal needs to be entered into the computer for the various parts of the contractor to know that the appeal has been filed, adding additional days to the thirty-day period before recoupment can begin affords rational processing. It also gives the contractor a reasonable amount of time to evaluate the provider's or supplier's rebuttal, before deciding whether recoupment should commence.

CMS states in proposed regulation section 405.379(e) (1) (ii), (iii), that once a redetermination decision is issued, it can commence recoupment of all or part of the overpayment on the 30th calendar day after the date of the notice of redetermination. CMS does not explain how it came up with this thirty-day period, or what its authority is for this period.

NAHC also seeks clarification of CMS's language in proposed regulation sections 405.379(e) (1) and (f) (1) (i). CMS states that recoupment may commence after redetermination and reconsideration "if the provider or supplier has been given the opportunity for rebuttal in accordance with the requirements of Sec. 405.373 through Sec. 405.375." Does this language mean that a provider or supplier will have an opportunity to file a rebuttal after a redetermination decision is issued and after a reconsideration decision is issued, but before recoupment is commenced? If so, NAHC reiterates it comments above regarding the rebuttal procedure: recoupment cannot occur as soon as the provider or supplier submits its rebuttal. Rather, the recoupment date should be set beyond the fifteen-day period in which CMS can review any rebuttal submitted so that CMS can meaningfully review whether recoupment should be commenced.

CMS also needs to make changes to its proposed interest provisions in regulation section 405.378(j). If CMS intends to recoup before a provider files for redetermination and before a provider files for reconsideration, and all or part of the overpayment is reversed on redetermination or reconsideration, CMS must pay interest from the date of the recoupment. CMS cannot interpret section 935(a) to permit it to recoup overpayments on this basis, and then not pay interest on the amount recouped.

For overpayments reversed at the ALJ level, CMS should revise proposed regulation section 405.378(j) to state that interest is owed from the date(s) of recoupment. Further, there is no authority in section 935(a) for CMS to toll the payment of interest during the period in which an ALJ's adjudication period to conduct a hearing is tolled under 42 C.F.R. §405.1014, or during the period in which the Medicare Appeals Council's ("MAC") adjudication period to conduct a review is tolled under 42 C.F.R. §405.1106. Moreover, CMS established the tolling periods referenced in these appeal regulations to extend the very limited period in which the ALJ or MAC must issue its decision under the rules. CMS will continue to retain the provider's or supplier's funds during these tolling periods, which CMS created for the benefit of the ALJ and the MAC. NAHC urges CMS to reconsider its position and revise this interest provision to delete proposed regulation sections 405.378(j)(3)(iv) and (v).

CMS should also make the changes referenced on page 4 above regarding ERP's and language which should be included in the overpayment notices. In regard to the overpayment notices, language should clearly advise the provider or supplier that if it files a request for redetermination by a specified date, that recoupment will be stayed, and should specify the time period in which recoupment will be stayed. The interest language referenced on page 4 should also be included in the overpayment notice.

Comments on "Background"

In regard to suspension, NAHC continues to have significant concerns regarding CMS's authority and application of the suspension regulations. There is no statutory right of suspension. CMS's interpretation of its suspension authority in this proposed rulemaking grants providers and suppliers greater protections when CMS has determined an overpayment, than when CMS merely suspects an overpayment and implements suspension. NAHC fails to see any rational basis for this policy.

Comments on "Impact"

CMS decided not to prepare an analysis under the Regulatory Flexibility Act ("RFA"). CMS acknowledges that the "RFA requires agencies to analyze options for regulatory relief of small businesses," and that "[f]or purposes of the RFA, all providers and suppliers affected by this regulation are considered to be small entities." 71 Fed. Reg. at 55412. CMS states that it is "uncertain how many small entities would be affected by this proposed rule as this would depend in part upon voluntary actions on the part of the provider or supplier." *Id.* NAHC respectfully disagrees. CMS should have performed an impact analysis under the RFA, because the rules as proposed by CMS will have a significant negative impact upon small providers. CMS is proposing to commence recoupment before the time period for filing for redetermination has expired; indeed, as soon as fifteen days after the notice of overpayment. CMS can determine the impact this would have upon small providers based upon its current overpayment data. NAHC strongly believes that if implemented, the proposed regulations will not furnish the protection to providers from CMS's current recoupment policy that Congress intended. NAHC is also concerned that when paired with the ERP process enacted by Congress in section 935(a), which is harsher than current policy, the negative impact upon providers will be even greater.

Thank you for the opportunity to submit these comments.

Respectfully Submitted,

Denise Bonn
Deputy Director
Center for Health Care Law
National Association for Home Care
& Hospice

Submitter : **Dr. Michael Maves** **Date: 11/21/2006**

Organization : **American Medical Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-6025-P-8-Attach-1.PDF

#'8

Michael D. Maves, MD, MBA, Executive Vice President, CEO

November 21, 2006

Ms. Leslie Norwalk
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6025-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments

Dear Administrator Norwalk:

The American Medical Association (AMA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would implement certain elements of section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The AMA was a strong proponent of the inclusion of Section 935 in the MMA.

Prior to the passage of this provision of Title IX of the MMA, physicians were frequently required to repay alleged Medicare overpayments totaling hundreds of thousands of dollars within 30 days. Many physicians protested that these funds had to be repaid so quickly that they did not have time to get the paperwork completed and approved to obtain a loan for the funds, placing the continued viability of their medical practices in jeopardy. In addition, many of the overpayment demands were based on extrapolation of mistakes found in a review of a small number of claims to a much larger set of claims that had not been specifically reviewed. Physicians also raised strong objections to being required to repay the alleged overpayments before having an opportunity to contest them in an appeal.

American Medical Association 515 North State Street Chicago Illinois 60610
phone: 312 464 5000 fax: 312 464 4184 www.ama-assn.org

The portion of section 935 of the MMA that is the subject of the proposed rule addresses many of these concerns by prohibiting recoupment of Medicare overpayments that are appealed by a physician until a Qualified Independent Contractor (QIC) renders a decision. It also changes the way interest is paid when an appeal is successful at the latter stages of the appeals process.

Under the proposed rule, once an alleged overpayment is identified and the substantive and procedural requirements afforded a physician or supplier for rebuttal are satisfied, recoupment ceases only if/when a valid request for a redetermination by the Medicare contractor is received. The redetermination is the first level of appeal, and a physician or supplier has 120 days to file a request for such redetermination. If the physician or supplier loses at this first level, CMS would then proceed to recoup the overpayment 30 days after giving notice to the physician or supplier unless the physician or supplier decides to appeal the adverse redetermination decision by filing a request for reconsideration. Recoupment would cease upon receipt of such request for reconsideration and could not be initiated or resumed until an administrative or judicial decision is rendered.

In addition, the proposed rule would change how interest is paid to a physician or supplier who is successful in having an overpayment determination fully or partially reversed in the latter stages of the appeals process. Under the proposed rule, when a reversal occurs at the Administrative Law Judge (ALJ) level or subsequent levels of administrative appeal or judicial review, interest becomes payable by Medicare based on the period CMS recouped and retained the physician's or supplier's funds.

The AMA has long believed that interest should be held in abeyance until appeals are completed. Where appeals are unsuccessful, we suggested that interest be backdated from the date the overpayment occurred. By undertaking this change, CMS has ensured that physicians appealing overpayment allegations are not penalized by being forced to remit alleged overpayments and interest payments prior to a hearing. CMS' proposed changes would give physicians the same rights that taxpayers have when the IRS audits them; that is, as long as interest accrues, taxpayers do not have to repay alleged overpayments while administrative appeals are pending.

We are pleased that CMS is moving forward with adoption of new recoupment provisions and we support CMS in this effort. We appreciate the opportunity to provide our views on the implementation of the proposed rule and look forward to working further with CMS on this important matter. Should you have any questions regarding these comments please contact Mari Johnson, Federal Affairs, at 202-789-7414, or mari.johnson@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Submitter : Mr. Tyler Wilson **Date:** 11/21/2006

Organization : American Association for Homecare

Category : Other Association

Issue Areas/Comments

Background

Background

I. Comments on the Provisions of the Proposed Regulations

A. Initiating Recoupment After Notice of an Overpayment

The proposed regulations define the overpayments to which the recoupment limitation applies, explain how the limitation works as part of the appeals process, and describe the change in CMS obligation to pay interest to a provider whose appeal is successful at levels above the QIC.[2] Under CMS proposal, the recoupment limitation applies from the time a provider timely appeals to the first two levels of appeal until the QIC renders its decision.[3] Recoupment of an overpayment, once initiated, will be stopped at the redetermination and the reconsideration levels of appeal when a timely and valid appeal request applicable to that level is received. The provider need not take any affirmative action to invoke the limitation on recoupment beyond the act of appealing.

We support CMS decision to exercise its discretion to interpret ?935 broadly by applying the recoupment limitation to both the redetermination and reconsideration levels of appeal. Although the MMA explicitly references only the QIC level of appeal, CMS reasons that, because providers must request a redetermination from the Medicare Administrative Carrier (MAC) before requesting a reconsideration, Congress intent under ?935 would not be given effect unless the recoupment limitation applied to requests for a redetermination as well. We agree with this reasoning in light of Congress mandate to the Secretary under ?935.

For similar reasons, we believe that CMS proposal to commence recoupment immediately after the overpayment is determined and the requirements for rebuttal[4] are satisfied is overly narrow. Under the proposed rule, recoupment will stop once the provider makes a valid and timely request for a redetermination of the overpayment decision, but CMS may recoup until then. Consequently, the proposed rule forces providers to request a redetermination as early as possible inasmuch as CMS can begin to recoup until the request is received. Similarly, following a redetermination that affirms the overpayment determination in whole or in part, the contractor can resume recoupment of any outstanding principal and interest within 30 days of the redetermination notice. Recoupment must stop once the provider makes a valid and timely request for reconsideration, but the proposed rule would permit recoupment to occur until then.[5]

CMS proposal creates a significant conflict between a provider s right to timely appeal a determination or a redetermination and its right under ?935 to limit recoupment. BIPA mandates that providers have 120 days from the date of a determination to timely request a redetermination and 180 days from the redetermination to request a timely reconsideration. The proposed rule undermines these requirements by forcing providers to choose either initiating an early appeal to foreclose recoupment, or taking full advantage of the timeframe for filing the appeal in order to increase their success on appeal. Moreover, providers who fail to introduce all relevant evidence before the QIC, will be precluded from presenting new evidence to an Administrative Law Judge (ALJ) absent good cause. As a practical matter, any provider that desires to preserve the opportunity for a successful appeal will recognize the need to forgo its right to limit recoupment in order to prepare the appeal.

GENERAL

GENERAL

Impact

Impact

We do not dispute that CMS obligation is to protect public funds used to finance the Medicare program. We also understand that, once a payment to a provider has been determined to be in error, CMS must seek a refund. However, recoupment should not begin where there is a factual or legal dispute about the overpayment decision. Congress passed ?935 precisely so that these disputes could be resolved, at least in part, before the provider is obligated to make a repayment. Clearly, CMS should have no interest in recouping funds that it has no legitimate right to recoup. By superimposing its own deadline on the timeframe established by Congress for requesting an appeal, CMS perpetuates the imbalance that ?935 was intended to address. We recommend that CMS revise the proposed rule to preclude recoupment until the time for filing a timely request a redetermination or reconsideration has expired. Alternatively, CMS could require a provider to inform the contractor of its intent to initiate an appeal as part of the rebuttal procedure. Providers expressing their intent to appeal would not be subject to recoupment.

B. Initiating or Resuming Recoupment after QIC Final Action on Reconsideration Request

Under the statutory recoupment limitation, once a provider has sought a reconsideration by the QIC, CMS may not initiate or resume recouping the overpayment until the date the decision on the reconsideration has been rendered. The proposed regulations interpret this phrase to be the date on which the QIC issues its final action with respect to a reconsideration.[6] The proposed regulation describes four possible final actions that the QIC may take that are further governed by other regulations. The earliest to occur of these actions is a final action for purposes of ending the limit on recouping overpayments: (1) the QIC transmits a written notice of dismissal, (2) the QIC receives a timely and valid request to withdraw the request for reconsideration, (3) the QIC transmits a written notice of the reconsideration, or (4) the QIC notified the parties in writing that the reconsideration is being escalated to an ALJ.[7]

An escalation to an ALJ without a final decision on the reconsideration would occur after the QIC notifies a provider that it cannot meet the mandated timeline

for issuing the reconsideration. Under this scenario, the provider may exercise its right to have a timely disposition of its appeal by escalating the appeal to the ALJ. Allowing a recoupment to resume in this case would penalize the provider for exercising this right. We recommend that CMS also limit recoupment in these instances.

II. Conclusion

AAHomecare appreciates the opportunity to submit these comments. We remain available to discuss them with you in greater detail. Please feel free to contact me

If there is any way I can be of assistance.

Provisions

Provisions

The American Association for Homecare (AAHomecare) submits the following comments in response to the Centers for Medicare and Medicaid Services (CMS) request for comments on the above captioned proposed rule. AAHomecare is the only national association representing every line of service within the homecare community. AAHomecare members include providers of oxygen equipment and therapy, providers and manufacturers of durable medical equipment (DME), prosthetics, orthotics, and supplies (collectively DMEPOS) including rehab and assistive technologies, home health agencies, and pharmacies that provide home infusion and inhalation drug therapies to patients in their homes. Our membership reflects a cross-section of the homecare community, including national, regional, and local providers and suppliers. With approximately 800 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value of quality health care services at home.

As you are aware, ?935 of the Medicare Modernization Act (MMA) amended ?1893 of the Social Security Act (the Act) by adding a new paragraph (f) that limits the Secretary s authority to recoup Medicare overpayments. Specifically, the Secretary may not take any action, or permit a contractor to take any action, to recoup an overpayment from a provider[1] that seeks a reconsideration from a qualified independent contractor QIC until the date a decision on the reconsideration has been rendered. Before Congress passed ?935, a provider was subject to recoupment within 30 days of an overpayment notice regardless of whether the provider requested an administrative review of the overpayment determination. Providers were subject to immediate recoupment despite the existence of a legitimate dispute about the factual or legal basis for the overpayment and notwithstanding that a substantial majority of providers that appealed an overpayment decision succeeded in having it overturned. In passing ?935, Congress rectified an imbalance in CMS process which permitted it to recoup substantial funds from a provider even though the basis for the recoupment was disputed.

AAHomecare strongly supported the inclusion of ?935 in the MMA. We similarly support the need to implement this legislation through rulemaking. Nonetheless, we are concerned that the provisions of the proposed rule undermine Congress intent as expressed in ?935 and when considered in light of the Medicare appeals process reforms Congress passed under the Benefit Improvement and Protection Act of 2000 (BIPA). Although BIPA established the timeframes for initiating timely appeals from determinations and redeterminations, the proposed rule would compromise these rights for providers that want to avoid recoupment. We question CMS authority to limit appeal rights in this fashion. As we explain more fully below, CMS should implement the recoupment limitation in a manner that is consistent with Congress intent under ?935 and the BIPA Medicare appeals reforms.

CMS-6025-P-9-Attach-1.PDF

#9

Via Electronic Transmission

November 21, 2006

Ms. Leslie Norwalk, J.D.
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Notice of Proposed Rulemaking on Limitation on Recoupment of Medicare Overpayments [CMS – 6025 p]**

Dear Ms. Norwalk:

The American Association for Homecare (AAHomecare) submits the following comments in response to the Centers for Medicare and Medicaid Services' (CMS') request for comments on the above captioned proposed rule. AAHomecare is the only national association representing every line of service within the homecare community. AAHomecare members include providers of oxygen equipment and therapy, providers and manufacturers of durable medical equipment (DME), prosthetics, orthotics, and supplies (collectively "DMEPOS") including rehab and assistive technologies, home health agencies, and pharmacies that provide home infusion and inhalation drug therapies to patients in their homes. Our membership reflects a cross-section of the homecare community, including national, regional, and local providers and suppliers. With approximately 800 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value of quality health care services at home.

As you are aware, §935 of the Medicare Modernization Act (MMA) amended §1893 of the Social Security Act (the "Act") by adding a new paragraph (f) that limits the Secretary's authority to recoup Medicare overpayments. Specifically, the Secretary may not take any action, or permit a contractor to take any action, to recoup an overpayment from a provider[1] that seeks a reconsideration from a qualified independent contractor "QIC" until the date a decision on the reconsideration has been rendered. Before Congress passed §935, a provider was subject to recoupment within 30 days of an overpayment notice regardless of whether the provider

[1] We are aware that the individuals and entities that furnish DMEPOS items are included within the definition of "suppliers" under the Act and CMS regulations. These comments use the term "provider/s" interchangeably with "suppliers."

requested an administrative review of the overpayment determination. Providers were subject to immediate recoupment despite the existence of a legitimate dispute about the factual or legal basis for the overpayment and notwithstanding that a substantial majority of providers that appealed an overpayment decision succeeded in having it overturned. In passing §935, Congress rectified an imbalance in CMS' process which permitted it to recoup substantial funds from a provider even though the basis for the recoupment was disputed.

AAHomecare strongly supported the inclusion of §935 in the MMA. We similarly support the need to implement this legislation through rulemaking. Nonetheless, we are concerned that the provisions of the proposed rule undermine Congress' intent as expressed in § 935 and when considered in light of the Medicare appeals process reforms Congress passed under the Benefit Improvement and Protection Act of 2000 (BIPA). Although BIPA established the timeframes for initiating timely appeals from determinations and redeterminations, the proposed rule would compromise these rights for providers that want to avoid recoupment. We question CMS' authority to limit appeal rights in this fashion. As we explain more fully below, CMS should implement the recoupment limitation in a manner that is consistent with Congress' intent under §935 and the BIPA Medicare appeals reforms.

I. Comments on the Provisions of the Proposed Regulations

A. <u>Initiating Recoupment After Notice of an Overpayment</u>

The proposed regulations define the overpayments to which the recoupment limitation applies, explain how the limitation works as part of the appeals process, and describe the change in CMS' obligation to pay interest to a provider whose appeal is successful at levels above the QIC.[2] Under CMS' proposal, the recoupment limitation applies from the time a provider timely appeals to the first two levels of appeal until the QIC renders its decision.[3] Recoupment of an overpayment, once initiated, will be stopped at the redetermination and the reconsideration levels of appeal when a "timely and valid" appeal request applicable to that level is received. The provider need not take any affirmative action to invoke the limitation on recoupment beyond the act of appealing.

We support CMS' decision to exercise its discretion to interpret §935 broadly by applying the recoupment limitation to both the redetermination and reconsideration levels of appeal. Although the MMA explicitly references only the QIC level of appeal, CMS reasons that, because providers must request a redetermination from the Medicare Administrative Carrier (MAC) before requesting a reconsideration, Congress' intent under §935 would not be given effect unless the recoupment limitation applied to requests for a redetermination as well. We agree with this reasoning in light of Congress' mandate to the Secretary under §935.

For similar reasons, we believe that CMS' proposal to commence recoupment immediately after the overpayment is determined and the requirements for rebuttal[4] are satisfied is overly narrow.

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[2] These proposed changes are to be codified in 42 CFR §§ 405.370, 405.373, 405.378, and 405.379.

[3] Proposed to be codified as 42 CFR §§ 405.373(e), 405.379.

[4] As authorized under 42 CFR §§ 405.374, 405.375, proposed 42 CFR § 405.379(e)(1).

Under the proposed rule, recoupment will stop once the provider makes a valid and timely request for a redetermination of the overpayment decision, but CMS may recoup until then. Consequently, the proposed rule forces providers to request a redetermination as early as possible inasmuch as CMS can begin to recoup until the request is received. Similarly, following a redetermination that affirms the overpayment determination in whole or in part, the contractor can resume recoupment of any outstanding principal and interest within 30 days of the redetermination notice. Recoupment must stop once the provider makes a valid and timely request for reconsideration, but the proposed rule would permit recoupment to occur until then.[5]

CMS' proposal creates a significant conflict between a provider's right to timely appeal a determination or a redetermination and its right under §935 to limit recoupment. BIPA mandates that providers have 120 days from the date of a determination to *timely* request a redetermination and 180 days from the redetermination to request a *timely* reconsideration. The proposed rule undermines these requirements by forcing providers to choose either initiating an early appeal to foreclose recoupment, or taking full advantage of the timeframe for filing the appeal in order to increase their success on appeal. Moreover, providers who fail to introduce all relevant evidence before the QIC, will be precluded from presenting new evidence to an Administrative Law Judge (ALJ) absent good cause. As a practical matter, any provider that desires to preserve the opportunity for a successful appeal will recognize the need to forgo its right to limit recoupment in order to prepare the appeal.

We do not dispute that CMS' obligation is to protect public funds used to finance the Medicare program. We also understand that, once a payment to a provider has been determined to be in error, CMS must seek a refund. However, recoupment should not begin where there is a factual or legal dispute about the overpayment decision. Congress passed §935 precisely so that these disputes could be resolved, at least in part, before the provider is obligated to make a repayment. Clearly, CMS should have no interest in recouping funds that it has no legitimate right to recoup. By superimposing its own deadline on the timeframe established by Congress for requesting an appeal, CMS perpetuates the imbalance that §935 was intended to address. We recommend that CMS revise the proposed rule to preclude recoupment until the time for filing a timely request a redetermination or reconsideration has expired. Alternatively, CMS could require a provider to inform the contractor of its intent to initiate an appeal as part of the rebuttal procedure. Providers expressing their intent to appeal would not be subject to recoupment.

B. Initiating or Resuming Recoupment after QIC "Final Action" on Reconsideration Request

Under the statutory recoupment limitation, once a provider has sought a reconsideration by the QIC, CMS may not initiate or resume recouping the overpayment "until the date the decision on the reconsideration has been rendered." The proposed regulations interpret this phrase to be the date on which the QIC issues its "final action" with respect to a reconsideration.[6] The proposed

[5] Proposed to be codified as 42 CFR § 405.379(e)(1)(ii).

[6] Proposed to be codified as 42 CFR § 405.379(f).

regulation describes four possible "final actions" that the QIC may take that are further governed by other regulations. The earliest to occur of these actions is a "final action" for purposes of ending the limit on recouping overpayments: (1) the QIC transmits a written notice of dismissal, (2) the QIC receives a timely and valid request to withdraw the request for reconsideration, (3) the QIC transmits a written notice of the reconsideration, or (4) the QIC notified the parties in writing that the reconsideration is being escalated to an ALJ.[7]

An "escalation" to an ALJ without a final decision on the reconsideration would occur after the QIC notifies a provider that it cannot meet the mandated timeline for issuing the reconsideration. Under this scenario, the provider may exercise its right to have a timely disposition of its appeal by escalating the appeal to the ALJ. Allowing a recoupment to resume in this case would penalize the provider for exercising this right. We recommend that CMS also limit recoupment in these instances.

II. Conclusion

AAHomecare appreciates the opportunity to submit these comments. We remain available to discuss them with you in greater detail. Please feel free to contact me
If there is any way I can be of assistance.

Sincerely,

Tyler Wilson
President and CEO

[7] Proposed to be codified at 42 CFR § 405.379(f)(2). The provider who elects to escalate the appeal from the QIC to the ALJ thus loses the benefit of the limitation on recoupment (since recoupment could begin).

CMS-6025-P-10

Submitter : Mr. Eric Sokol **Date:** 11/21/2006

Organization : Power Mobility Coalition

Category : Device Association

Issue Areas/Comments

Background

Background

Scc attachmcnt

GENERAL

GENERAL

Scc attachmcnt

Impact

Impact

Scc attachmcnt

CMS-6025-P-10-Attach-1.DOC

#10

The Power Mobility Coalition

WORKING TOGETHER FOR FREEDOM AND INDEPENDENCE

November 21, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

VIA ELECTRONIC SUBMISSION

RE: **Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments [CMS-6025-P]**

Dear Dr. McClellan:

On behalf of the Power Mobility Coalition (PMC), a nationwide association of manufacturers and suppliers of motorized wheelchairs and power operated vehicles (POVs), we are submitting the following comments concerning the Notice of Proposed Rule Making entitled, "*Limitation on Recoupment of Provider and Supplier Overpayments.*" 71 Fed. Reg. 55,404 (2006).

We note at the outset that the practice of assessing overpayments has the potential to cause great harm to suppliers and providers within the Medicare program. The PMC understands that across the board, these overpayment determinations continue to have high reversal rates throughout the appeals process, which remains long and costly for suppliers and providers. While we oppose the imposition of overpayments that are regularly reversed, we do applaud Congress' recognition of the hardship imposed on these entities and the agency's implementation of these sections of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

We focus our comments on the interest repayment provisions contained in the proposed rule. Pursuant to Section 1893(f)(2)(B) of the Social Security Act, Congress addressed the manner in which interest would be paid to a supplier or provider when an overpayment determination is overturned:

> COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such

determination against the provider of services or supplier is later reversed, ***the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped*** (emphasis added).

The following sections of the proposed rule provide limitations on the assessment of interest repayments, even though the Congress did not provide for such limitations.

Proposed 42 C.F.R. § 405.378(b)(2)

Proposed 42 C.F.R. § 405.378(b)(2) provides that interest will accrue from the date of a final determination (*e.g.*, a written determination by a Qualified Independent Contractor). Should recoupment be made before the overpayment is overturned (*e.g.*, the supplier voluntarily pays prior to appealing or the agency recoups before the limitation on recoupment is initiated by the appeal), interest does not accrue for this period, even though the agency is in possession of the funds before the overpayment is overturned.

It is our position that the interest should accrue as soon as the agency receives payment from the supplier.

Proposed 42 C.F.R. § 405.378(j)(3)(iii)

Proposed 42 C.F.R. § 405.378(j)(3)(iii) provides that when the supplier has paid for an overpayment that is overturned at the Administrative Law Judge level (ALJ) or beyond, interest begins to accrue when the agency takes possession of the funds. However, proposed 42 CFR §405.378(j)(3)(iv)-(v) provides that the agency subtract days to account for the adjudication by the ALJ and Medicare Appeals Council.

It is our contention that these days should not be subtracted in the calculation of interest.

Proposed 42 C.F.R. § 405.378(b)(2) & 405.378(j)(3)(iii)

Proposed 42 C.F.R. § 405.378(b)(2) and proposed 42 C.F.R. § 405.378(j)(3)(iii) provide that when the supplier has paid for an overpayment that is overturned at any level, interest is only payable for full 30-day periods. Interest is not paid for periods of less than 30 days.

It is our position that interest should be paid for the entire period during which the agency possesses the supplier's funds, even if that means paying prorated monthly interest.

We appreciate the opportunity to submit these comments and look forward to working with you on this and other issues of mutual concern.

Respectfully Submitted,

Eric W. Sokol
PMC Director

Stephen M. Azia
PMC Counsel