DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

MLN Matters® Number: MM7688 Revised

Related Change Request (CR) #: 7688

Related CR Release Date: February 9, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R205FM

Implementation Date: July 2, 2012

Immediate Recoupment for Fee for Service Claims Overpayments

Note: This article was revised on February 10, 2012, to reflect the revised CR7688 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7688 were revised. All other information is the same.

Provider Types Affected

This MLN Matters® article is intended for all Part A, and all Part B Providers, Physicians, and Suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) Durable Medical Equipment (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7688 is policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the Key Points section of this article for specifics.

Background

Currently, Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key Points

The "immediate recoupment" process implemented in CR7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment. Also, note the following:

1. Providers who choose immediate recoupment must do so in writing to the contractors.
2. The request may be for:
    a. a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
    b. a permanent request for the specific demanded overpayment and all future overpayments.
3. The request may be submitted via regular mail, facsimile, or e-mail and the request must include the Provider's name, contact phone number, Medicare number and/or National Provider Identifier (NPI), Provider or Chief Financial Officer's signature, demand letter number and what option the provider is requesting.
4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.
5. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after Qualified Independent Contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision. These rules are explained in Chapter 3, Section 200 of the "Medicare Financial Management Manual" that is available at http://www.cms.gov/manuals/downloads/fin106c03.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

You may further review all of the specifics of this change along with the applicable manual section changes by reading the official instruction for CR7688 issued to your Medicare contractor. The web address for CR7688 is listed in the Additional Information section of this article.

Additional Information

The official instruction, CR7688, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R205FM.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.