PUBLICATION

New CMS Recoupment Rules For Overpayments, Interest Effective Nov. 16 Providers May Avoid Repayment in First

October 26, 2009

New regulations published by the Centers for Medicare & Medicaid Services (CMS) on September 16, 2009 prohibit the recoupment of an overpayment if a provider timely requests a redetermination or reconsideration of an overpayment determination. That 'stay' on recoupment lasts until a decision on the redetermination or reconsideration request is rendered.

This is good news for providers, practitioners and suppliers whose claims with the Medicare program are denied, either in standard post-payment review or other audits, including RAC audits. If these Medicare participants file appeals within a time frame shorter than the actual limit for filing appeals, Medicare will not recover funds from current remittances. The new rules are effective November 16.

Background

Before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted, any overpayment determination resulted in Medicare's recovery of the funds overpaid — either through a cash repayment or a recoupment from current Medicare receivables. A provider's electing to appeal any overpayment determination did not affect Medicare's prerogative to recover the debt.

MMA Section 935 changed this process by adding a new paragraph (f) to section 1893 of the Act. This amendment required CMS to change the way it recoups certain overpayments to providers, physicians and suppliers (collectively referred to hereinafter as "providers") and how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent administrative (Administrative Law Judge [ALJ]) or judicial levels of appeal.

Medicare Appeals and Recoupment

The Medicare Appeals process is a five-step process. The first level of appeal is known as "redetermination" and the second level of appeal is known as "reconsideration." A provider or supplier has 120 days from an initial determination to request a redetermination. Following the receipt of a redetermination, a provider has 180 days to file a reconsideration request. [1]

	APPEAL DUE	DUE DATE TO AVOID RECOUPMENT
REDETERMINATION (CONTRACTOR)	120 DAYS FROM DENIAL/INITIAL DETERMINATION	WITHIN 41 DAYS FROM DENIAL/INITIAL DETERMINATION
RECONSIDERATION (QIC)	180 DAYS FROM DENIAL/INITIAL	BY THE 60TH DAY FROM THE

Although a provider or supplier has 120 days to appeal to the fiscal intermediary/carrier at the first level and 180 days to appeal to the Qualified Independent Contractor (QIC) at the second level, a shorter appeals time span applies when a provider or supplier wishes to avoid recoupment. In the Final Rule, CMS provides that a provider must file a redetermination request within 41 days before a Medicare contractor can begin recoupment and must file a reconsideration request within 60 days before a contractor can begin recoupment. The contractor may recoup on the 41st day following the initial notice of overpayment. The contractor may recoup an overpayment on the 60th day after the date of the redetermination if no reconsideration appeal notice is received. Notably, there is no 'stay' on recoupment after the QIC level of appeal. Recoupment will commence if the amount determined to be due by the QIC is not otherwise repaid by the provider.

It must be noted that the 'stay' on recoupment is not in effect for all appeal levels. If the provider or supplier loses after the second level of appeal, recoupment action can begin even if there is an appeal to the ALJ. The recoupment notice is in the form of the remittance advice from the Medicare contractor.

Providers and suppliers can take advantage of the limitations on recoupment by not paying during the redetermination and reconsideration levels of appeal. However, interest on the overpayment that is ultimately determined to be due will still continue to accrue during those periods.

Interest on Over- and Under-payments

The new regulations include provisions on interest assessed against the provider for overpayments. Interest will accrue beginning on the original adverse determination if the provider or supplier loses on appeal, or fails to appeal to the next level of review. The rate of interest is assessed at the higher of the private consumer rate or the current value of funds in accordance with 42 CFR § 405.378. This is a simple rate of interest. Interest accrues daily but is assessed and calculated in full 30-day periods. If the provider or supplier is successful in part on appeal, the interest is calculated on the only overpayment determined to be due.

If the provider has already had funds recouped, and is later successful on appeal, interest may be due to the provider. If a denial overturned at the first level (redetermination) or second level (reconsideration) generates a net underpayment to the provider, interest will be paid from the date of the final determination (written decision) and is owed only if the underpayment is not repaid to the provider within 30 days of the date of the final determination. If a successful appeal is only achieved at the ALJ or subsequent appeal levels, interest becomes payable by Medicare from the date the funds were recouped.

These rules do not affect overpayments that arise from a cost report determination or overpayments that are appealed to the Provider Reimbursement Review Board. The new regulations do not apply to the recovery of overpayments from providers or suppliers that have been placed on payment suspension or the separate appeal process for providers that appeal overpayments that follow suspension. The changes are effective November 16, 2009.

1. The other steps are Administrative Law Judge at the Office of Medicare Hearings and Appeals, the Medicare Appeals Council and ultimately, federal court.

For more information, contact your Baker Donelson attorney or any of the attorneys in the Health Care Regulatory Group.