Chapter 12 Contents

1. Overpayments and Refunds

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 3, §170.6

The Centers for Medicare & Medicaid Services (CMS) requires the DME MAC to request refunds on non-MSP overpayments of $25 or more. If you owe several small overpayments, each of which is less than $25, the total amount owed will be considered in the decision to request the refund. Refunds will be requested for overpayments totaling $25 or more. Although not requested by the DME MAC, refunds of less than $25 will be accepted. If a lump sum refund would cause a severe financial hardship, repayment may be accepted over an extended period. You must submit specific documentation to support such a request. The $25 tolerance does not apply to MSP overpayments.

It is your responsibility to refund overpayments.

1. If you have received a demand letter you should respond to the request for refund according to the instructions provided in that letter.

2. If you are submitting a voluntary refund check(s) to the DME MAC, the Voluntary Overpayment Refund form (see below) must be completed and returned to ensure proper recording and receipt of the check. This will allow for the timely processing of your refund. If you are returning funds due to Medicare Secondary Payer, you must submit the primary insurance company's explanation of benefits in order for CGS to complete your request. Incomplete/Inaccurate forms will delay processing and may lead to loss of appeal rights in certain situations.

   The Voluntary Overpayment Refund form is available on our website at https://www.cgsmedicare.com/jb/forms or by following the link below:

   Voluntary Overpayment Refund Form
   (https://www.cgsmedicare.com/jb/forms/pdf/jb_overpay_form.pdf) PDF

   As stated on the form, voluntary overpayment refunds should be made payable to CGS and mailed to:

   CGS
   DME MAC Jurisdiction B
   PO Box 953479
   St. Louis, MO 63195-3479

3. You can initiate an adjustment for an overpaid claim. Examples of when you would initiate an adjustment include: item returned, billing error, or overpayments involving Medicare Secondary Payer (MSP). Refer to Chapter 11 of this manual for information about MSP.

When submitting a request for adjustment of an overpaid claim, please include any supporting documentation, such as a corrected claim or, for MSP, a copy of the primary insurance explanation of benefits.

To initiate an adjustment for an overpaid claim, complete the Overpayment Recovery Request Form and submit it to CGS through fax or mail to the fax number or mailing address on the Overpayment Recovery Request Form.

The Overpayment Recovery Request form is available on our website at https://www.cgsmedicare.com/jb/forms or by following the link below:

Overpayment Recovery Request Form
(https://www.cgsmedicare.com/jb/forms/pdf/dme_overpay_recovery_form.pdf) PDF

2. Overpayment Offsets

You will be notified by letter when an overpayment has been identified and a refund is requested. If a balance remains after 30 days, interest will be assessed on the principal balance. If after 10 additional days you have not contacted our office regarding the overpayment, offset withholdings are initiated.

You may request an overpayment be placed into immediate offset. If the principal amount is offset prior to 30 days from the date of the letter, no interest will be assessed. If a balance remains after 30 days, interest will be assessed on the principal balance. Please include the DCN number located on the demand letter on your request or any other correspondence sent to our office in reference to the overpayment. If requesting immediate offset, please complete the form “Offset Request” located below and fax to 1.615.782.4508 or mail to CGS JB DME MAC, PO Box 20007, Nashville, TN 37202.

Offset withholdings sometimes create a difficulty in bookkeeping for a supplier's office. Understanding the offset information on a Medicare Remittance Advice (RA) may alleviate some of the confusion. When an overpayment has been identified and a recoupment is set up, the recoupment is reported on the RA in a two-step process, as detailed below.

Step 1—Reversal and correction of the payment (actual recoupment of money has not yet occurred).

When reporting the correction of the payment, the RA displays the following information:

- Reason code FB (Forward Balance)*
- Claim Control Number (CCN) of the adjusted claim being recouped
- Patient Account Number of the beneficiary on the claim being recouped (if reported on the claim)
- Medicare ID of the beneficiary on the claim being recouped (only if the Patient Account Number was not reported or is not available)
- DCN of the overpayment (previously labeled as FCN)
- Dollar amount of the adjustment

Step 2—Reporting of the actual recoupment (money is offset).

When a recoupment (offset) has been taken, the RA displays the following information:

- Reason code WO (Overpayment Recovery)
- Claim Control Number (CCN) of the adjusted claim being recouped
- Patient Account Number of the beneficiary on the claim being recouped (if reported on the claim)
- Medicare ID of the beneficiary on the claim being recouped (only if the Patient Account Number was not reported or is not available)
- DCN of the overpayment (previously labeled as FCN)
- Dollar amount recouped

Note that the RA will display only one of either the Patient Account Number or the Medicare ID. If the Patient Account Number was reported on the original claim, then it will display in the overpayment information on the RA. If there was no Patient Account Number reported on the original claim, then the Medicare ID will display on the RA.

The DCN is the Medicare document control number for the overpayment case. Previously on the RA, this was labeled as the FCN.

Immediate Offsets

You can elect to have your profile updated to always place any and all overpayments (supplier and/or contractor identified) into immediate offset at the time of determination, which would eliminate the need to submit multiple requests at the time of receipt of demand letters. To initiate this profile update, complete the Offset Request Form and select the "Provider/Supplier level offset - Offset the current overpayment and all future overpayments" option.

Note: CGS does not accept offset requests at the time of claim reopenings/adjustments. If you would like to request an immediate offset, you must wait until you receive a demand letter.

Requesting an immediate offset will waive potential receipt of interest payment pursuant to Section 1893(f)(2) for the overpayment.

The Offset Request Form is available on our website at https://www.cgsmedicare.com/jb/forms or by following the link below:

Offset Request Form (https://www.cgsmedicare.com/jb/forms/pdf/jb_offset_request_form.pdf) PDF

The Offset Request Form is a PDF that allows you to fill in the information on your computer by typing in the fields. Typing directly in the form, rather than completing the form by hand, allows us to process your offsets in a faster, more efficient manner.

Sending in an Offset Request

When submitting a request for an Immediate Offset, you must provide the following:

1. Complete the form with the Date of the Overpayment Letter, Provider/Supplier Name, Provider/Supplier Number or PTAN, Provider/Supplier NPI, Amount of Overpayment, and the Document Control Number.

   Note: The Amount of the Overpayment Letter should equal the total amount of the demand letter and not an individual claim.

   Note: The Document Control Number (Accounts Receivable or FCN) can be located in the lower right hand corner of the overpayment demand letter. The lower right hand corner of the overpayment demand letter shows a series of numbers such as this example: 999 1XXXXXXXXXXXX 0000011. Please only enter the 14 digit middle number (the number listed as 1XXXXXXXXXXXX in the example).

2. Select only one offset type option.

3. Complete the Signature of Requestor field with a signature, fill in the Date of Request, and provide a contact phone number in the Requestor Contact Information.

4. Include at least the first page of the overpayment letter for the corresponding offset request.

3. Referral of Delinquent Debt

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 4, §§70.1 - 70.7

If the overpayment amount has not been refunded in full (principal plus interest) before the time the overpayment is 90 days delinquent (120 days from the determination date), another demand letter will be sent. This demand letter is referred to as an "Intent to Refer" letter. It will provide specific notice to debtors before referring a debt to the Department of Treasury or its designated Debt Collection Center (DCC) for cross servicing/offset collection efforts. The "Intent to Refer" letter may be sent for debt currently ineligible for referral based on the status if the contractor believes the debt shall become eligible for referral in the future. If the "Intent to Refer" letter is returned as undeliverable and a better address cannot be located, the DME MAC will input the debt into the Debt Collection System (DCS) upon receipt.

Once the debt is referred for cross servicing, active collection efforts by the DME MAC and/or CMS shall cease except for internal recoupment, financial reporting, and interest accrual. The types of payments that can be offset by the Department of Treasury may include tax refunds, vendor payments, benefit payments with certain restrictions, and eligible state payments. All inquiries need to be directed to the Department of Treasury or its designated Debt Collection Center for consideration.

4. Extended Repayment Schedule

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 4, §50

According to CMS guidelines, a supplier is expected to repay any overpayment as quickly as possible. If CGS notifies you of an overpayment and you acknowledge that the overpayment exists but are unable to refund the entire amount within 30 days, you may contact CGS to request an Extended Repayment Schedule (ERS).

CMS established the ERS process to enable suppliers experiencing hardship to maintain their cash flow from Medicare. In order for Medicare to evaluate hardship, you must provide certain financial documents along with your request. Not all requests will meet the hardship eligibility requirements,

and some requests may be approved for timeframes other than those requested. Requests for less than six months will not be considered.

A repayment schedule may be established for all or part of an overpayment and may be requested at any time as long as the overpayment is outstanding and has not been referred to the Treasury. If you have also requested an appeal on the overpayment, it is in your best interest to include a copy of your most recent appeal decision letter with your request to assist in determining the appropriate balance. Additionally, overpayments established after or outside of an ERS request are not automatically included in the ERS, and you must separately request repayment plans or submit revised requests to include those overpayments.

An ERS request must be made timely to avoid withholding of the unpaid balance. You must make your first proposed payment in addition to sending the required documents and must continue to make your scheduled payments during the review in order to prevent a full withholding until a decision on the ERS request has been made. Proposed and good faith payments should be based on an amortization schedule which includes interest to be accrued over the life of the loan and must not be less than 1/60th of the total amount owed.

A request for an ERS does not stop interest accrual, and all payments are applied first to interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the interest rate referenced in the Medicare overpayment letter. The proposed amortization schedule should include this interest. If a request is made more than 30 days after the date of the initial Medicare overpayment letter, repayment of any remaining balances of previously accrued interest should also be included in the schedule. CGS has provided some examples of amortization schedules at https://cgsmedicare.com/ers/amortization.html.

You may receive a tentative amortization schedule to follow during review of your application and, if so, will be expected to follow this schedule instead of your own proposed schedule until Medicare makes a decision on the ERS request. On approving an ERS request, Medicare will provide a final amortization schedule for you to follow. In some cases, scheduled tentative or approved ERS payments will be automatically deducted from Medicare payments. Medicare will notify you in advance via an ERS tentative or approval letter if this is going to occur. Should changes in your billing practices or other events later prevent recoupment of these ERS payments, you should contact CGS to make other payment arrangements because such delays may result in additional interest charges and changes to the loan amortization. Cumulative shortages in monthly payments may also result in a default status if not addressed.

Supplier with an approved ERS may request refund of an underpayment identified by submitting an Underpayment/Manual Refund Election form, which is available at https://cgsmedicare.com/ers/ers_underpayment_refund_election.pdf. This must be done within 15 calendar days from the underpayment notification letter in order to be considered.

Payments made by check must be received on or before the due date. If you do not make monthly payments as scheduled, additional interest charges may accrue which can result in changes to the loan amortization and final payment amount. Missing one payment will result in default of the installment plan. Should you default on an approved ERS, the remaining balance of the loan will become due in full, and Medicare will initiate withholding from your Medicare payments.

Sending in a Request

In submitting a request for an Extended Repayment Schedule, you must submit the following:

1. A signed written request that provides the specific overpayment for which the extended repayment is being requested, the number of months requested, and the approximate monthly payment amount.

   Request for an Extended Repayment Schedule
   (https://www.cgsmedicare.com/ers/ers_form_re.pdf)

2. A completed *Extended Repayment Schedule Checklist*.

   Sole Proprietor Checklist (https://www.cgsmedicare.com/ers/sole_ers_checklist_re.pdf)

   Other Entity Checklist (https://www.cgsmedicare.com/ers/sole_ers_checklist_re.pdf)

3. A copy of each document referenced on the *Extended Repayment Schedule Checklist*.

   Note: If you are unable to furnish one or more of the applicable Checklist documents with the request, you must explain the reason why the document is unavailable or will be provided later. All items must be received within 15 days of the request.

4. The first payment referencing the provider number and "ERS Request" made payable to CGS Administrators, LLC and sent to the payment address noted in the Medicare overpayment letter

   Note: A list of available CGS payment addresses can be found at https://www.cgsmedicare.com/ers/payment_addresses.html. A copy of the check should also be included with the request documents.

Failure to provide any of the above items within 15 days will result in closure of the request and normal collection activities will resume.

All ERS requests and documentation should be faxed to 615.664.5949 or mailed to:

CGS Administrators, LLC
ATTN: CFO Extended Repayments
P.O. Box 20018
Nashville, TN 37202

If you have questions about a pending or approved ERS, send an email to CGS.ERS.CORR@CGSADMIN.COM.

5. Overpayment Appeals

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 3, §200

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (which amended Title XVIII of the Social Security Act to add a new paragraph to Section 1893) limits Medicare's recoupment rights for overpayments that are appealed for certain types of cases. This means that when a provider files an appeal on a case that is "935" eligible, then Medicare cannot recoup payments until after the appeal has been effectuated. This does not change any appeal rights on "non-935" overpayments, only Medicare's right to recoup.

For more information about appeals, please see Chapter 13 of this manual.