# Virtual Conference – Medicare Essentials: Appeals, Overpayments and Cost Reports

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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# Today's Presenters

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# Objectives

- After this session, attendees will be able to
  - Understand and utilize the Medicare appeals process
  - Properly submit claim adjustments and cancel claims
  - Identify Medicare overpayments and respond appropriately
  - Correctly submit credit balance and cost reports
- Acronyms used in this PPT are defined on the NGS Acronym Search Tool

# Agenda

- Appeals
- Adjustments and Cancel Claims
- Overpayments
- Credit Balance Reporting
- Cost Reports
- Questions and Answers

# Reopenings and Appeals

# Claim Appeals

- Processed claim considered initial determination by Medicare
  - Full or partial denial may occur on claim
- When provider disputes initial determination resulting in denial by Medicare, may submit appeal for redetermination
- Visit our website for appeals information

# Reopenings for Minor Errors and Omissions

- Action taken to change initial determination to correct minor errors or omissions outside of appeal process
  - Mathematical or computational mistake
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items

# How to Submit a Request for Reopening

- Complete and submit Clerical Error/Omission Reopening Request Form
  - National Government Services, Inc.
    Attn: Appeals
    P.O. Box 6474
    Indianapolis, IN 46206-6474
- Or submit request via NGSConnex
- Reopenings granted at MAC discretion
  - If denied, appeal rights apply after claim denial

# Reopening Request Change

- Bill type frequency code "Q" to be used by providers indicating a request for reopening
  - Reopening request (TOB XXQ) should only be utilized when submission falls outside of period to submit adjustment bill

# Appeals Overview Chart

| Appeal Level | Time Limit For Filing | 2019 Monetary Threshold |
|---|---|---|
| Redetermination | 120 days from date of receipt of RA | None |
| QIC Reconsideration | 180 days from redetermination notice | None |
| ALJ Hearing | 60 days from reconsideration notice | $160 |
| DAB Review | 60 days from the ALJ decision | None |
| Federal District Court Review (Judicial) | 60 days from DAB decision | $1,630 |

# How to Submit Redetermination Requests

- Within 180 days from date of receipt of denial, submit redetermination request to MAC
  - Submit an Appeal Electronically with NGSConnex
  - Submit an Appeal Electronically via esMD

# Redeterminations

- Submit all necessary medical documentation to support services billed on claim
  - Complete medical record
  - CMS IOM Publication, *Medicare Claims Processing Manual*, Chapter 29 – Appeals of Claims Decisions, Section 310.5
- Redetermination decision letter provided within 60 days of receipt of appeal request

# How to Submit QIC Reconsideration Requests

- Complete and mail
  - CMS-20033 Medicare Reconsideration Request Form, or
  - Reconsideration request form included with the redetermination decision
- Mailing address for reconsideration request
  - Submit a Reconsideration

# QIC Reconsideration

- Within 180 days of receipt of redetermination decision letter
- QIC reviews medical documentation
- QIC decision provided within 60 days of receipt of reconsideration request

# How to Submit ALJ Hearing Requests

- Submit written request to Division of Centralized Docketing (most cases)
  - OMHA Central Operations
    1001 Lakeside Avenue, Suite 930
    Cleveland, OH 44114-1158
- Always defer to address specified in reconsideration determination

# ALJ Hearing

- Within 60 days of receipt of reconsideration decision letter
  - Amount in controversy = minimum $180
- ALJ reviews medical documentation
- ALJ decision provided within 90 days of receipt of hearing request

# How to Submit DAB Review Requests

- Submit written Request for Review of Administrative Law Judge (ALJ) Medicare Decision/Dismissal form
  - Department of Health and Human Services
    Departmental Appeals Board
    Medicare Appeals Council, MS 6127
    Cohen Building Room G-644
    330 Independence Ave., S.W.
    Washington, D.C. 20201

# DAB Review

- Within 60 days of receipt of ALJ decision letter
- DAB/Medicare Appeals Council reviews medical documentation
- DAB decision provided within 90 days of receipt of review request

# How to Submit Federal Court Review Requests

- Send requests for a Federal Court Review in writing
  - Department of Health and Human Services
    General Counsel
    200 Independence Avenue, SW
    Washington, DC 20201

# Federal District Court Review (Judicial)

- Within 60 days of receipt of DAB/Medicare Appeals Council decision letter
  - Amount in controversy = minimum $1,760
- Federal court reviews medical documentation and issues decision

# Adjustments and Cancel Claims

# Claim Adjustments

- Can be made to processed (P B9997) or certain rejected claims (R B9997)
  - To change, add, or delete claim details
    - Use TOB XX7
- Reasons to submit include but not limited to
  - Reporting services not previously submitted
  - Deleting line item services billed in error
  - Correcting dates of service
  - Correcting MSP claim rejections

# What You Need to Submit Claim Adjustment

- Processed or rejected claim
- Claim change reason code (condition codes)
- Adjustment reason code (for adjustments done in FISS DDE)
- Reason for adjustment in remarks (as applicable)
- Remember, adjustments follow CMS' regulations for one year timely filing of claims

# Claim Change Reason Codes (Condition Codes) for Adjustments

| | |
|---|---|
| D0 | Changes to service dates |
| D1 | Changes to charges |
| D2 | Changes to revenue/HCPCS/HIPPS rate codes |
| D3 | Second or subsequent interim PPS bill |
| D4 | Changes in ICD diagnosis/procedure code |
| D7 | Change to make Medicare the secondary payer |
| D8 | Change to make Medicare primary payer (use when changing an MSP claim to Medicare primary) |
| D9 | Any other change (Remarks required); use when adjusting claim rejected for MSP to make Medicare primary |
| E0 | Change in patient status |

# Timely Filing Adjustment

- Claims rejected for timely filing where valid exception exists can request exception
  - Adjust original claim (type of bill XX7)
  - Use D9 claim change reason code (condition code)
  - Enter remarks using the following script: “Please bypass timely filing because… (insert reason here)”
- Claims processor approves or rejects based on justification

# FISS Adjustment Reason Code File

- Use FISS Inquiries sub-menu option 16 to determine two-digit adjustment reason code to report on claim adjustments

```
 1  BF BF H HHPPS FINAL NOT RECEIVED
 1  BL BL A This overpayment is a result of a claim being processed with
 1  BM TB A ORIGINALL PROCESSED A SBLACK LUNG, NOW MAKE MEDICARE PRIME.
 1  CA CA I This claim adjustment is a result of the cost outlier approval.
 1  CB CB A This overpayment is the result of the credit balance report.
 1  CC CC A This overpayment is a result of the change in the charge amount.
 1  CD CD I This overpayment is a result of a Quality Improvement Organizati
 1  CE OT A REVENUE CODE CORRECTION.
 1  CF CF A This overpayment is a result of a change in coverage.
 1  CH OT O CORRECTION OF OUTPATIENT CASH DEDUCTIBLE.
 1  CI OT A CORRECTION OF PATIENT CASH DEDUCTIBLE.
 1  CN OT I CHANGE IN COV TO NONCOV/NONCOV TO COV DAYS
 1  CO CO I This overpayment is a result of a Quality Improvement Organizati
 1  CP CP I This overpayment is a result of a partially approved cost outlie
 1  CR CR A A claim reconsideration adjustment has been processed.
      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

# To Adjust or to Cancel…? That is the Question

| If you are trying to… | Then you should… |
|---|---|
| Report services not previously billed | Adjust claim |
| Delete services billed in error | Adjust claim |
| Correct DOS | Adjust claim |
| Add/change units | Adjust claim |
| Correct diagnosis codes | Adjust claim |
| Change MSP rejected claim to primary | Adjust claim |
| Correct provider/MBI number | Cancel claim |
| Return a duplicate Medicare/OIG payment | Cancel claim |
| Withdraw OP claim for services that apply to 3-day payment window policy | Cancel claim |

# Adjusting LCD or NCD Partially Denied

- Claims partially denied by automated edits for LCDs or NCDs (no ADR involved)
  - Line item denial reason code 55A00, 55A01, 52NCD, 53NCD, or 54NCD
- Submit adjustment
  - Make corrections to DX or other code(s) that caused denial
  - Claim change reason code = D9 (add remarks)
  - Adjustment reason code = LN
  - Delete and rekey denied line(s) back to covered

# Adjusting Other Partially Denied Claims

- Adjust partially denied claim if not disputing line item denial
  - Example – to bill additional services and charges
- Submit adjustment
  - Claim change reason code = D9
  - Adjustment reason code = OT
  - Remarks = "Not disputing medically denied line(s), adjusting to…"
    - Provide clear and concise explanation

# Adjusting Claims Rejected for MSP

- Adjust primary claims rejected for MSP (34XXX)
  - Do not resubmit; will reject as duplicate
- Submit adjustment
  - Claim change reason code = D7 if MSP or D9 if Medicare primary
  - Adjustment reason code = depends on reason
  - Remarks = For D9 to add why Medicare primary
  - May need explanatory coding and/or to contact BCRC

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# Claim Cancels

- To void claim record - use TOB XX8
  - Processed (P B9997) or rejected (R B9997) claims
- Reasons to submit include, but not limited to:
  - Voiding duplicate payment
  - Claim submitted with wrong MBI or provider number
  - Certain outpatient services that fall within one/three days of inpatient hospital stay (payment window)
  - Outpatient overlap of skilled nursing facility benefit period
  - Change TOB

# What You Need to Submit Claim Cancel

- Processed or rejected claim
  - Do not cancel MSP claims
  - Do not cancel claims for reasons related to MSP
- Claim change reason code (condition codes)
  - D5 = Cancel to correct MBI or Provider ID number
  - D6 = Cancel to repay duplicate payment or OIG overpayment (includes cancellation of outpatient claim when services must be on inpatient claim)
- Reason for cancel in remarks (as applicable)

# Overpayments

# Definition of Overpayment

- Payment received in excess of amounts properly payable under Medicare statutes/regulations
- Once identified, amount of overpayment becomes debt owed to federal government
  - Federal law requires Medicare attempt to recover all identified overpayments
  - Failure to report and return overpayment may result in Civil Monetary Penalties under Public Law 111-148 of ACA

# Why Overpayments Occur

- Duplicate claim submissions
- Furnishing and billing for excessive or noncovered services
- Payment for excluded or medically unnecessary services
- Payment to incorrect payee
- Payment made primary when Medicare secondary payer

# Collection Process - Medicare Modernization Act of 2003

- Overpayment collection process
  - Money not taken back at time adjustment finalizes
  - Providers protected in first and second levels of appeal
  - Process known as "Limitation on Recoupment"
- Subject to 935 limitation on recoupment
  - Post-payment denials of claims by MAC and other review contractors
  - HH final claims – not RAPs
  - MSP recovery claims

# Overpayments Not Subject to Limitation on Recoupment

- Not subject to 935 limitation on recoupment:
  - Provider-initiated adjustments
  - Overpayments arising from cost report determination
  - HH RAPs under HH PPS
  - Hospice cap calculations
  - Accelerated/advanced payments

# Voluntary Refunds

- Provider self-identifies overpayment and refunds excess monies to Medicare
- Whenever possible, complete refund by initiating adjustment through claims system
- If adjustment not possible, complete voluntary refund form
  - Part A Overpayment Recovery Unit Voluntary Refund Form
    - Choose correct line of business (JK/J6)

# Voluntary Refund Options

- Two options available when submitting voluntary refund form
  - Submit check with voluntary refund form
    - When claim(s) adjusted, Medicare applies monies to overpayment
  - Submit voluntary refund form without a check
    - When claim(s) adjusted, Medicare takes back overpayments through offset process

# MSP Post-Pay Adjustments

- Medicare paid primary but another insurance carrier primary and overpayment identified:
  - Complete and submit Part A Overpayment Recovery Unit Voluntary Refund Form
  - Separate form required for each claim needing adjustment
  - Reason code must be completed assigning appropriate MSP provision to overpayment (no fault, workers' compensation, etc.)
  - Include EOB from primary payer with voluntary refund form

# MSP Post-Pay Adjustment Options

- Two options available when submitting voluntary refund form related to MSP overpayment
  - Submit check with voluntary refund form
    - When claim(s) adjusted, Medicare applies monies to overpayment
  - Submit voluntary refund form without a check
    - When claim(s) adjusted, Medicare takes back overpayments through offset process

# Demand Letters – Monetary Threshold

- Overpayment recovery process threshold = overpayment of $25 or more
  - Initial demand letter sent requesting repayment once threshold reached
  - All overpayments aggregated in order to meet threshold amount for initial demand letter
  - If aggregated overpayment amount does not reach $25 within fiscal quarterly reporting period, debt written off

# What is in a Demand Letter?

- Demand letters explain
  - Medicare made an overpayment
  - Why provider is responsible
  - Interest accrues if not repaid in full within 30 days
  - Options to request immediate recoupment or ERS
  - Rebuttal/appeal rights
  - Information regarding what to do if you've filed a bankruptcy petition

# Interest Charged on Overpayments

- If not repaid in full within 30 days from date of final determination
  - Accrues from date of demand letter
  - Assessed for each 30-day period that payment delayed after initial refund request
- References -
  - CMS IOM Publication 100-06, *Medicare Financial Management Manual,* Chapter 4, Section 30
  - 42 CFR Section 405.378

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# Responding to a Demand Letter

- Several options available responding to initial demand letter
  - Make immediate payment
  - Request immediate recoupment
  - Request standard recoupment process (automatic offset/withholding)
  - Request ERS
  - Submit rebuttal
  - Request redetermination to appeal overpayment

# Response Option #1: Make Immediate Repayment

- Request in writing
  - Include copy of demand letter
- When check received by us, applied toward intended receivable(s) as follows
  - First applied toward any interest owed then principal
  - Next applied toward other outstanding debts for provider or affiliated facilities before refunding money back to provider
    - If overpayment previously offset or satisfied

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# Response Option #2: Request Immediate Recoupment

- Considered voluntary repayment
- Request must be received no later than 16th day from date of initial demand letter
  - Option to avoid interest when debt recouped in full prior to/by 30th day from initial demand letter date
- Request may be submitted via mail, fax or Electronic Email Form
  - Receive confirmation email of submission, no additional follow-up notices issued regarding request

# Three Immediate Recoupment Options

- One-time request
  - All current overpayment(s) addressed in referenced demand letter and all future overpayments
- All current overpayment(s) addressed in referenced demand letter only
- Request to terminate previously established immediate recoupment agreement

# Response Option #3: Standard Recoupment Process

- If no action taken after receiving demand letter, recoupment automatically begins on day 41 according to 935 Limitation on Recoupment schedule
  - Interest begins accruing on day 31

# Response Option #4: Request Extended Repayment Schedule

- If more than 30 days needed to repay full amount of overpayment, request ERS
- Can be requested at any time during debt collection process
  - Set Up an Extended Repayment Schedule – J6 Part A
  - Applying For An Extended Repayment Schedule - JK Part A
- Submittal within first 30 days of demand letter date may decrease necessity to withhold interim payments

# ERS Interim Payment Withholding

- We may still withhold interim payments while considering ERS
  - If ERS application submitted within 15 days of demand letter, interim payment withholding may be reduced from 100% to 30% during review process
  - Any payments withheld applied to outstanding overpayment and not refunded
  - Requests for ERS greater than 36 months forwarded to CMS for approval

# ERS and Interest Payments

- Interest rate charged on overpayments repaid through approved ERS schedule is rate in effect for quarter determination made
  - Rate remains constant unless provider defaults (i.e., misses two consecutive installment payments) on ERS agreement

# Response Option #5: Submit Rebuttal

- Providers may submit rebuttal for any proposed recoupment action within 15 days of demand letter receipt
  - Separate from Limitation on Recoupment regulations
  - Rebuttal can be used to submit proof recoupment would adversely affect provider's financial situation
  - Rebuttal process occurs prior to appeals process
    - Does not constitute an appeal or means of disagreeing with overpayment determination

# Response Option #6: File Appeal

- If you disagree with overpayment decision, you may file appeal
- Overpayment not recouped until decision made
  - Interest continues to accrue in event of affirmation of denial
  - Once first two appeal levels completed
    - If decision is affirmation, collection may resume within designated timeframes and accrued interest charged

# Bankruptcy

- If demand letter received and involved in bankruptcy proceeding/filed for bankruptcy, please contact us immediately
  - Contact information included in demand letter
  - MACs work with CMS and Department of Justice to ensure particular situation handled properly
- Medicare bankruptcy regulations
  - CMS IOM Publication 100-06, *Medicare Financial Management Manual*, Chapter 3, Section 140

# What Happens to Delinquent Debt?

- If we cannot recoup debts owed after day 41 through normal recoupment process, we
  - Phone provider if debt more than 60 days delinquent
  - Issue ITR letter to provider between days 61-150 advising debt turned over to US Treasury Dept. if not refunded
  - Place second call to provider at least seven days before debt is referred to US Treasury Dept.
  - Once Treasury Dept. responsible for debt, provider may face lien placed on payments until debt refunded in full

# Overpayment Collection Timeframe

| Timeframe | MAC Action |
|---|---|
| Day 1 | We send Demand Letter to you |
| Day 1-16 | We begin immediate recoupment by Day 16, if requested by you |
| Day 16 | We begin standard recoupment for overpayments not subject to Limitation on Recoupment |
| Day 31 | Interest begins to accrue if overpayment not paid in full by day 30 |
| Day 41 | We begin standard recoupment for overpayments subject to Limitation on Recoupment |

| Timeframe | MAC Action |
|---|---|
| Day 90 | We attempt to contact you by phone if debt is 60 days delinquent |
| Day 61-150 | We issue Intent to Refer (ITR) on eligible delinquent debts |
| Day 120-180 (Day 120 – last day to submit Appeal request) | We enter eligible delinquent debt into Debt Collection System (DCS) |
| At least 7 days prior to referral to Treasury | We make a second call to you before debt is referred to Treasury |

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# Identifying Overpayments and Recoupments on Remittance Advice

# Did You Know…

- While limitation on recoupment forbids immediate recoupment, providers
  - Often confused by way 935-related claim adjustments appear on their RA
  - Mistakenly believe monies related to adjusted claim(s) have been recouped

# How to Recognize 935 Adjustment on RA

- RA reflects negative amount at claim level because adjustment processed in normal fashion in FISS
- RA summary page adds adjusted amount back to net provider payment in "Adjustment to Balance" field
  - 935 Limitation on Recoupment funds not recouped immediately

# Common RA Remark Codes Related to Overpayments

- N469 - Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
- N432 – Alert: Adjustment based on a Recovery Audit

# PLB Codes

- PLB codes reflect adjustments made on RA not related to specific claim or service
  - Can describe offsets, refunds, interest, incentive payments, and appeal decisions
  - On SPR, locate on last page under Totals of All Claims line
  - On PC-Print and Electronic Remittance Advice, locate in Payee Summary Report section
- Listings and definitions of current valid PLB codes found in CMS CR 7068

# PLB Codes Related to Overpayments and Withholdings

- FB - Forwarding Balance
  - Represents monies owed back to Medicare from previous remittance
  - Monies not available or not able to be recouped at time remittance advice processed
    - Balance moved forward to future RA to be reconciled
  - Original DCN and MBI/patient control number applied for tracking purposes.

# PLB Codes Related to Overpayments and Withholdings

- WO - Overpayment Recovery
  - Occurs due to RA, PSC, CERT or other post-pay adjustment resulting in recoupment of payment
  - Subject to 935 limitation on recoupment statute
  - Demand letter also issued notifying provider of overpayment to Medicare
- WO represents principal amount and E3 represents amount applied to interest

# PLB Codes Related to Overpayments and Withholdings

- OB - Offset for Affiliated Providers
  - Occurs on RA due to money withheld for affiliated provider's debt
  - On ERA, PLB03-2 segment contains information to assist identifying affiliated provider and/or their debt owed to Medicare
  - Providers need to work with their affiliated facility(s) to recoup money from those facility(s)

# PLB Codes Related to Overpayments and Withholdings

- WU - Unspecified Recovery
  - Occurs on RA when debt provider owes other than Medicare debt
  - Currently utilized for IRS debts owed by provider
  - Toll-free telephone number provided on RA to contact US Treasury to determine which debt withheld money applied
  - When balancing RA, billing staff should post account as usual then determine what needs to be done to document where payment went instead towards paying IRS debt

# Tips for Reporting and Refunding Overpayments

- To ensure reported overpayments process timely and avoid accrual of interest
  - Send all forms and checks to correct fax number/address
    - Fax/address information found on all Part A overpayment forms
  - Complete forms entirely
  - Include all requested documentation with submitted forms
  - Ensure your address information is correct
    - Demand letters mailed to provider's master address listed on CMS-855A enrollment application

# Credit Balance Reporting

# What is a "Credit Balance"?

- Improper or excess payment made to provider due to patient billing or claim processing errors
  - Overpayment not refunded to Medicare at of end of quarterly reporting period where overpayment claim processed
  - Credit balance reporting applies only to provider-identified overpayments
  - Use date claim appears on RA to determine which CBR quarterly period claim falls under
    - Not based on DOS

# What is Not a "Credit Balance"?

- Post-pay adjustments subject to 935 Limitation on recoupment regulations should not be reported on CBR
  - Demand letter situations created by post-pay denials and not reported on CBR
    - MAC MR
    - RA
    - CERT
    - ZPIC
    - OIG

# Examples of Credit Balance

- Examples include when providers are
  - Paid twice for same service
  - Paid for services planned but not performed
  - Paid for noncovered services
  - Overpaid because of errors calculating cost-sharing amounts
  - Paid for outpatient services already reimbursed on inpatient claim

# Due Dates

- Credit balance reports due within 30 days after end of calendar quarter
- Suspension warning letters issued 45 days after end of calendar quarter (15 days after due date)
- Providers placed on 100% payment suspension 60 days after end of calendar quarter (30 days after due date)

# Credit Balance Timeframes

| Quarter End | Credit Balance Report Due Date | Suspension Warning Letters Issued | Providers Placed on 100% Suspension |
|---|---|---|---|
| March 31 | April 30 | May 15 | May 30 |
| June 30 | July 30 | August 14 | August 29 |
| September 30 | October 30 | November 14 | November 29 |
| December 31 | January 30 | February 14 | February 29/ March 1 |

# Cost Reports

# Cost Reports

- Medicare-certified institutional providers required to submit annual cost report to their MAC
- Used for purposes of determining provider's Medicare reimbursable cost
- MCR package consists of variety of cost report materials
  - Accepted by MAC when all information submitted
- Provider Reimbursement Manual - Part II

# Cost Reports

- Contains provider information such as
  - Facility characteristics
  - Utilization data
  - Cost and charges by cost center (in total and for Medicare)
  - Medicare settlement data
  - Financial statement data

# MCReF

- Ability to electronically file 100% of MCR package directly to MAC, including all supporting documentation
  - Fiscal Year Ends on or after 12/31/2017
- Successful MCReF submissions will immediately be received by provider's MAC to begin 30-day cost report acceptance process
- Medicare Cost Reporting e-Filing System User Manual (PDF)

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# HCRIS

- CMS maintains cost report data in HCRIS
  - Consists of elements included in HCRIS extract created for CMS by provider's MAC
- Cost report data available on CMS website
  - Cost Reports by Fiscal Year | CMS
  - Medicare Provider Cost Report Public Use Files
- HCRIS Frequently Asked Questions (PDF)

# Thank You!

- Questions?

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