

## Chapter 12 Contents

1. Overpayments and Refunds
2. Overpayment Offsets
3. Referral of Delinquent Debt
4. Extended Repayment Plan
5. Overpayment Appeals

## 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 \$10 or more. If you owe several small overpayments, each of which is less than \$10, the total amount owed will be considered in the decision to request the refund. Refunds will be requested for overpayments totaling \$10 or more. Although not requested by the DME MAC, refunds of less than \$10 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 \$10 tolerance does not apply to MSP overpayments.

It is your responsibility to refund overpayments. You should respond to the request for refund according to the instructions provided in the request. When submitting voluntary refund checks 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.**

Refund checks should be made payable to CIGNA Government Services (CGS) and mailed to:

**CIGNA Government Services  
JC DME MAC  
PO Box 955152  
St. Louis, MO 63195-5152**

The Voluntary Overpayment Refund form is available on our website at <http://www.cignagovernmentservices.com/jc/forms/> or by following the link below:

[Voluntary Overpayment Refund Form \(12K\)](#)  Acrobat 4.0

## 2. Overpayment Offsets


You will be notified by letter when an overpayment has been identified and a refund is requested. A second request is made in 30 days if no response has been received and interest is assessed on the principal balance. If, after 10 additional days, you have not contacted our office regarding the overpayment, offset withholdings are initiated.

Although the recommended solution for any overpayment is to send a refund, 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 FCN 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 1.615.782.4477 or mail to CGS JC DME MAC, PO Box 20010, Nashville, TN 37212.

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. The Offset Details indicate if the claim was offset (WO) or adjusted (CS). Other details can be found in the glossary listed below the Offset Details on the RA. If the claim is offset, a number will be listed in the Financial Control Number (FCN) column. This number is used to match the RA to the corresponding overpayment letter previously received. The FCN is located in the lower right hand corner of the overpayment letter. The amount field details the dollars offset or adjusted depending on the indicator in the Offset Details column. If the claim is offset, the amount is the difference between the Total Provider Paid column and the Amount of Check column minus any adjustments involved. See Chapter 17 of this manual for information about RAs.

The Offset Request form is available on our website at <http://www.cignagovernmentservices.com/jc/forms/> or by following the link below:

[Offset Request Form](#) (42K)  Acrobat 4.0

### 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), the third demand letter will be sent. The third 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 Plan

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

A debtor is expected to repay any overpayment as quickly as possible. If you cannot refund the total overpayment within 30 days after receiving the first demand letter, you should request an extended repayment plan (ERP) immediately; however, an ERP request may be received and will be reviewed at any time in which the overpayment is outstanding. You must explain and document your need for

an extended (beyond 30 days) repayment plan. A repayment plan may be established to recover all or part of an overpayment. Any approved ERP will run from the date of the initial demand letter.

You must submit a written request that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the approximate monthly payment amount (principal and interest, if possible), and include the first payment.

Please provide the following when requesting an ERP:

### If sole proprietor:

- **Form CMS-379** “Financial Statement of Debtor” (see below)
- **Income tax statements** – from the most recent calendar year

The CMS-379 is available on the CMS website at <http://www.cms.gov/cmsforms/> or by following the link below:

[Financial Statement of Debtor](#) (16K)  Acrobat 4.0

### If entity other than a sole proprietor:

- **Amortization Schedule** – this schedule must contain the proposed repayment schedule, including length of schedule, dates of payment, and payment amount broken down between principal and interest for the life of the schedule.
- **Balance sheets** – the most current balance sheet and the one for the last complete Medicare cost reporting period or the most recent fiscal year (preferably prepared and certified by your accountant).

**NOTE:** If the time period between the two balance sheets is less than six months (or you cannot submit balance sheets prepared by your accountant), you must submit balance sheets for the last two complete Medicare reporting periods (if you file a cost report) or last two complete fiscal years.

- **Income statements** – related to the balance sheets (preferably prepared by your accountant).

The CMS suggests that both the balance sheets and income statements include the following statements:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION  
CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE  
PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OF ADMINISTRATOR OF PROVIDER(S)

(For physicians/suppliers, CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by \_\_\_\_\_ and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed  
Officer or Administrator of  
Provider(s)  
Title

\_\_\_\_\_

Date

(For physicians/suppliers: Signed Officer or Owner of Debtor(s) Title)

- **Statement of Sources and Application of Funds** – for the periods covered by the income statements (see CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual*, Chapter 4, Section 50.3, Exhibit 2 for recommended format).
- **Cash flow statements** – for the periods covered by the balance sheets (see CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual*, Chapter 4, Section 50.3, Exhibit 3 for recommended format). If the date of the request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than three months after that of the most recent balance sheet, a projected cash flow statement should be included for the six months following the date of the request.

- **Projected cash flow statement** – covering the remainder of the current fiscal year. If fewer than six months remain, a projected cash flow statement for the following year should be included (See CMS Manual System, Pub. 100-8, *Medicare Program Integrity Manual*, Chapter 4, Section 50.3, Exhibit 3 for recommended format).
- **List of restricted cash funds** – by amount as of the date of request and the purpose for which each fund is to be used.
- **List of investments** – by type (stock, bond, etc.), amount, and current market value as of the date of the report.
- **List of notes and mortgages payable** – by amounts as of the date of the report and their due dates.
- **Schedule showing amounts** – due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet—such as Accounts Receivable, Notes Receivable, etc.
- **Schedule showing types** – and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.
- **Loan Applications** – requests for extended repayment of 12 months or more. You must include at least one letter from a financial institution denying your loan request for the amount of the overpayment. Also include a copy of the loan application with the denial letter from the bank.

All financial records must be for the business participating in the program. They should not be for the owner if the business is a partnership or a corporation. If the financial aspects of the business are

managed by an outside facility, your individual financial records must still be submitted as well as the financial records of the outside facility.

If you are unable to furnish some of the documentation, you should fully explain why you are unable to do so.

## **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, please see the MLN Matters Article # MM6183 "Limitation on Recoupment (935) for Provider, Physicians and Suppliers". You can view the article at the following web address: <http://www.cms.gov/MLN MattersArticles/downloads/MM6183.pdf>.

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