# Overpayments

# MEDICARE PART B

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TrailBlazer
HEALTH ENTERPRISES, LLC℠

A CMS CONTRACTED INTERMEDIARY AND CARRIER

# ☆☆IMPORTANT☆☆

**The information provided in this handbook was current as of April 2005. Any changes or new information superseding the information in this book are provided in the Medicare Part B newsletters with publication dates after April 2005. Medicare Part B newsletters are available at: www.trailblazerhealth.com**



# ☆☆IMPORTANT☆☆

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## PHYSICIAN/SUPPLIER RESPONSIBILITY

If a physician/supplier submits a Medicare claim, receives the Medicare payment, and finds that the claim has been overpaid by the Medicare program, the physician/supplier is responsible for immediately refunding the overpayment amount to the Medicare carrier. The physician/supplier should not hold the overpaid amount until the Medicare carrier requests the refund of the overpayment.

Overpayments should be refunded to Medicare in one of two ways:

- Return the original Medicare check. Return the original check only when the entire check amount is overpaid.
- Make the refund using a business check, personal check or money order. The check or money order must be made out to TrailBlazer Health Enterprises, LLC.

When either method is used to refund an incorrect payment, please provide the following information:

- The beneficiary's Health Insurance Claim Number (HIC) as it appears on the Medicare card (including all nine digits and any alpha characters).
- The beneficiary's complete name as it appears on their Medicare card.
- A copy of the remittance notice with the overpaid claim(s) clearly indicated.
- The reason for the refund (i.e., duplicate payment, payment under the incorrect HIC, etc.).
- Send voluntary (unsolicited) refunds, accompanying material and a completed Overpayment Refund form to:

**TRAILBLAZER HEALTH ENTERPRISES, LLC**
**ATTN: CASHIER**
**3101 S. WOODLAWN**
**DENISON, TX 75020**

For your convenience, Medicare has created an Overpayment Refund form. A copy of the form is at the end of this section. An electronic version is also available on our Web site.

### REFUNDS DUE TO OVERPAYMENT DEMAND LETTERS (SOLICITED REFUNDS)

In order to ensure accurate and timely application of refunds related to an overpayment demand letter, enclose a copy of the demand letter with the refund. Send solicited and unsolicited refunds on separate checks.

# OVERPAYMENTS

## VISIT OUR WEB SITE

Useful information regarding overpayments and voluntary refunds can be found on our website. Please visit us at:

***www.trailblazerhealth.com***

- Under the Explore section, select the appropriate listed under Part B.
- Select financial resources.

## REQUESTING AUTOMATIC OFFSET

A provider/supplier may request that TrailBlazer automatically offset any identified overpayments. If a provider/supplier wishes to have their overpayments handled in this manner, they should send their written request to:

**TRAILBLAZER HEALTH ENTERPRISES, LLC**
**ATTN: PART B SOLICITED RECOVERY AREA**
**3101 S. WOODLAWN**
**DENISON, TEXAS 75020**

The request for automatic offset may be for one claim or the provider may request that TrailBlazer always automatically offset their overpayments. In the situation where the provider/supplier wishes to have their overpayments automatically offset, TrailBlazer will issue a demand letter explaining the overpayment and the fact that the overpayment was placed in automatic offset. The provider/supplier still has all their appeal rights and may protest the overpayment if they disagree with the determination. The benefit to automatic offset is that recoupment begins immediately, reducing or eliminating altogether, the amount of interest assessed. If recoupment of the overpayment is satisfied within 30 days, the provider/supplier will be charged no interest.

If a provider/supplier receives a demand letter and wishes TrailBlazer to put this overpayment into automatic offset, the provider will need to notify TrailBlazer immediately due to the fact that interest begins assessing 30 days from the date of the demand letter. Requests of this nature can be faxed to (903) 463-0615.

## CONSOLIDATED BILLING

It is the providers' responsibility to know the rules and guidelines associated with Skilled Nursing Facility (SNF) consolidated billing to prevent overpayments. Services included in the consolidated billing requirements should not be billed to Medicare Part B. Background and regulations pertaining to consolidated billing can be found at: ***www.cms.hhs.gov/medlearn/snfcode.asp*** or ***www.trailblazerhealth.com***.

Prior to the provider rendering services to Medicare patients, he should determine if the patient is enrolled in an SNF. Providers may do this by including an inquiry in their screening process (i.e., Are you a resident of a nursing home?).

# OVERPAYMENTS

The guidelines below must be followed prior to rendering services to a nursing home patient to help prevent denials/overpayments. The consolidated billing requirement grants to the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay, and physical, occupational, and speech therapy services received during a non-covered stay.

Note: Medicare Part B is notified that a patient is enrolled in a covered Part A stay once Part A receives a claim for services rendered by an SNF, normally billed on a monthly basis.

## GUIDELINES

The provider should ask whether the patient is a resident of a nursing home.

If yes, the provider should contact the nursing home and ask if the patient is in a covered Part A stay.

If the patient is in a covered Part A stay, determine if the nursing home has a contract with an entity to provide the services that fall into the consolidated billing guidelines. If the nursing home has a contract with an entity to provide the needed services, the patient will need to be referred back to the nursing home for those needed services.

If there is no entity contracted with the SNF to provide the needed services, it is the responsibility of the rendering physician to develop a business relationship with the SNF to receive payment from the SNF for services the provider renders that are included in consolidated billing.

Note: Please refer to the Web site below for a complete listing of codes included in the SNF consolidated billing:

***www.cms.hhs.gov/medlearn/snfcode.asp.***

Once the provider has determined the needed services for the patient, only those services that are excluded from SNF consolidated billing should be filed to Medicare Part B. Those services determined to be included in SNF consolidated billing should be filed directly to the SNF **only** if the provider is in a business relationship with the SNF. At that time, the SNF will bill Medicare Part A for that service. The SNF normally bills Medicare Part A once a month. Therefore, to prevent overpayments, these guidelines need to be utilized for proper distribution of funds for services rendered.

# OVERPAYMENTS

### BILLING EXAMPLE

A chest X-ray (code 71010) is rendered to the patient. The provider would bill Medicare Part B for the professional component only using the -26 modifier (71010-26).

If the provider has a business relationship with the SNF, his office would directly bill the technical component to the SNF (71010-TC).

Note: If the SNF has a contract with an entity to provide the technical component or the provider does not have a business relationship with the SNF, no payment can be made to the provider's office for this service. The patient is not liable and the provider should not file this portion of the X-ray to Medicare Part B.

### OVERPAYMENT EXAMPLE DUE TO CONSOLIDATED BILLING

The provider files services that are subject to consolidated billing to Medicare Part B prior to the SNF filing to Medicare Part A (remember, the SNF normally files on a monthly basis). At this time, Medicare Part B is not aware that the patient is in a covered Part A stay. Therefore, Medicare Part B could make payment to the provider for the services subject to consolidated billing. Once the SNF files for its services to Medicare Part A, records are sent to Medicare Part B notifying them that the patient is in a covered Part A stay. Medicare's records are then researched during the time period that the patient is enrolled for any payments made on services subject to consolidated billing. For this reason, overpayments will be identified and recoupment will occur.

### DENIAL EXAMPLE DUE TO CONSOLIDATED BILLING

The provider files services that are subject to consolidated billing to Medicare Part B after the SNF has filed its services to Medicare Part A. For example, the provider bills Part B for the total component of an X-ray. Because the Medicare national records have an SNF episode recorded, Part B will deny the total component of the X-ray. For this reason, payment can only be made once the provider has refiled his claim for the professional component of the X-ray only.

## EXTENDED REPAYMENT PLAN

A physician/supplier is expected to repay any overpayment as quickly as possible. If the total overpayment cannot be refunded within 30 days after receiving the demand letter, the physician/supplier should request an extended repayment plan immediately. The following information is needed if a provider/supplier is requesting an extended repayment plan.

# OVERPAYMENTS

**Items Included?**

**Yes No**

❑ ❑ A written request must be submitted 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.**

**If a sole proprietor:**

**Yes No**

❑ ❑ A completed Form CMS-379

❑ ❑ Income Tax Statements from the most recent calendar year

**If not a sole proprietor:**

**Yes No**

❑ ❑ Balance Sheets – The most current balance sheet and the one for the last complete fiscal year (preferably prepared by the provider's accountant). If consolidated statements (including more than one entity) are submitted, separate statements showing the individual provider's contribution must also be submitted.

**Note:** If the time period between the two balance sheets is less than six months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last TWO complete fiscal years in addition to the most current balance sheet.

❑ ❑ Income Statements related to the balance sheets (preferably prepared by the provider's accountant).

❑ ❑ Cash Flow Statements for the periods covered by the balance sheets. If the date of the request for an extended repayment plan is more than three (3) months after the date of the most recent balance sheet, a cash flow statement should be prepared for all months between that date and the date of the request.

❑ ❑ Projected Cash Flow Statement covering the remainder of the current fiscal year. If fewer than six (6) months remain, a projected cash flow statement for the following year should be included.

❑ ❑ List of restricted cash funds by amounts 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.

# OVERPAYMENTS

- ❑ ❑ 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.
- ❑ ❑ The percentage of occupancy by type of patient (Medicare, Medicaid, private pay) covered by the income statements.

## All Requests:

**Yes No**

- ❑ ❑ Requests for extended repayment of more than twelve (12) months must be accompanied by at least one letter from a financial institution denying the provider's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.
- ❑ ❑ First payment according to proposed repayment plan.
- ❑ ❑ Copy of the overpayment notification letter.

Note: If you are unable to furnish some of the documentation, you should fully explain why. Your first payment, referenced "ERP Request", should be made payable to Trailblazer Health Enterprises, LLC. This first payment and the above requested information must be mailed directly to:

**TRAILBLAZER HEALTH ENTERPRISES, LLC**
**ATTN: OVERPAYMENT DEPARTMENT**
**3101 S. WOODLAWN**
**DENISON, TEXAS 75020**

Please submit all items checked "NO" within 10 days from the date of this letter to avoid the withholding of your remittance advices.

## ADJUSTMENTS

Medicare is required to adjust overpaid claims. The overpaid claim is adjusted in both situations: when the money is voluntarily refunded to Medicare, or when Medicare identifies the overpayment and issues a demand letter. The adjusted claim replaces the previously processed claim and indicates how the claim should have originally processed.

# OVERPAYMENTS

## OFFSET PROCEDURES

Refunds made for overpayments assessed by Medicare must be returned within 30 days from the date of the initial demand letter. If payment is not postmarked within 30 days from the date of the letter, interest will be assessed. Interest will accrue for each 30-day period. Periods of less than 30 days will be counted as 30 days. On the 41st day, Medicare will automatically begin to offset the overpaid amount against any payments due for submitted claims. Offset payments will be applied to the accrued interest first and then to the principal balance. Overpayments are recovered in date order.

## PROVIDER REMITTANCE

Offsets to payments, perhaps for a prior Medicare overpayment, are shown as an adjustment from the provider's payment at the summary level rather than as an adjustment against an individual claim in that remittance notice.

Funds are being withheld from the provider - not the beneficiary for whom that claims was submitted.

### PROVIDER ADJ SECTION

| PLB REASON CODE | FCN | HIC | | AMOUNTS |
|---|---|---|---|---|
| XX | XXXXXXXXXXXXXXXXX | XXXXXXXXXXXX | XXXXXXXXXXXXXXXXX | 9999999.99 |
| . | . | . | . | . |
| . | . | . | . | . |
| . | . | . | . | . |
| . | . | . | . | . |
| XX | XXXXXXXXXXXXXXXXX | XXXXXXXXXXXX | XXXXXXXXXXXXXXXXX | 9999999.99 |

# OVERPAYMENTS

The fields under the Provider ADJ Details section are described below:

## PLB Reason Code Column

The adjustment reason code designated by the Centers for Medicare & Medicaid Services (CMS) that corresponds to the type of offset that was taken is shown under the PLB REASON CODE column. Examples are:

| | |
|---|---|
| J1 | Adjustment. Used to zero balance provider payment for Centers of Excellence Remittances and Medicare Choices Remittances. |
| AP | Advance Payment |
| WO | Offset as a result of a previous overpayment (A/R) |
| L6 | CPT interest accrued.<br><br>If the net interest is added to the “TOTAL PROV PD” amount, the offset detail will be a negative number. If it is subtracted from the “TOTAL PROV PD” amount, the offset detail will be a positive number. |
| 50 | Late Filing<br><br>If the net late filing is subtracted from the “TOTAL PROV PD” amount, the offset detail will be a positive number. If the net late filing is added to the “TOTAL PROV PD” amount, the offset detail will be a negative number. |
| B2 | Refund |
| FB | Balance Forward<br>• This can represent an amount under $1, which will be paid in the future (account payables). This value will be a positive amount.<br>• For full claim adjustments, which are overpayments, this amount represents an amount that was overpaid on a previous claim. The adjustment detail amount will be a negative amount, and the FCN will contain the original ICN and the HIC for the overpayment. |

# OVERPAYMENTS

## FCN COLUMN

The Financial Control Numbers (FCNs), which will enable the provider to associate the offset with those claims and payments that led to the withholding, is shown under the FCN column.

| Reason Code | Description of FCN Input |
|---|---|
| **WO** | The MCS Account Receivable CCN number. |
| **AP/B2** | The ICN or CCN, whichever is appropriate. |
| **L6/J1/50** | Will always be blank, as FCN information is not applicable for these types. |
| **FB** | When an Accounts Payable is created, it is tied to an ICN. The FCN field will reflect the ICN that corresponds to the Accounts Payable record or overpayment. |

## HIC COLUMN

A single HIC number is printed if the offset is for a Medicare overpayment and a HIC number is associated with the offset. The HIC number will not be supplied if none is associated with the offset. Multiple HIC numbers are not printed in this field; the notice must be consistent with the electronic remittance advice standard that only permits a single HIC in this field.

| Reason Code | Description of HIC Input |
|---|---|
| **WO** | If the A/R CCN is tied to an ICN, the HIC from the ICN will print. If the A/R CCN is **not** tied to an ICN, the HIC will correspond to the HIC number entered during setup of the A/R. If the HIC number is not entered during setup, the HIC field will be spaces. |
| **AP/B2** | If the financial transaction is tied to an ICN, the HIC from the ICN will print. If the financial transaction is **not** tied to an ICN, the HIC will be spaces. |
| **L6/J1/50** | There will always be spaces as HIC information is not applicable for these types. |
| **FB** | There will be the HIC associated with the ICN that corresponds to the Account Payable record or overpayment. |

# OVERPAYMENTS

### AMOUNT COLUMN

The amount being withheld or added in by the transaction for the FCN is always printed at the provider summary level for each offset.

| Reason Code | Description of Amount Input |
|---|---|
| **WO** | The amount that the providers payment was offset as a result of a previous overpayment (A/R). |
| **AP** | The amount of the advance payment. This amount is a positive adjustment versus an offset/negative adjustment to the provider's payment; thus the amount is shown as a negative under the AMOUNT column. |
| **B2** | The amount of the refund. This amount is a positive adjustment versus an offset/negative adjustment to the provider's payment; thus the amount is shown as a negative under the AMOUNT column. |
| **L6** | The amount of CPT interest accrued. This amount is a positive adjustment versus an offset/negative adjustment to the provider's payment; thus the amount is shown as a negative under the AMOUNT column. |
| **50** | The amount associated with any late filing penalties assessed against the provider's payment. |
| **J1** | The amount of payment that would have been paid to the provider if this hadn't been a Centers of Excellence or a Medicare Choices claim. |
| **FB** | When payment of less than $1 is withheld on a paper remittance notice, the amount being withheld is printed under the AMOUNT column. When reporting the issuance of the withheld amount in a later paper remittance notice, the amount being paid out is shown as a negative amount for balancing purposes under the AMOUNT column.<br><br>For full claim adjustments, which are overpayments, this amount represents an amount that was overpaid on a previous claim. The adjustment detail amount will be a negative amount, and the FCN will contain the original ICN and the HIC for the overpayment. |

## RECONCILIATION

To assist with reconciling the provider remittance, providers should maintain an overpayment file. This file should be maintained in date order and contain the demand letter and the listing of beneficiaries/claims involved. The file should be kept in date order because Medicare offsets in date order. Maintaining the file in date order will assist the provider in quickly reconciling offset activity.

# OVERPAYMENTS REFUND FORM

## *TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER, OR OTHER ENTITY*

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/ voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER OR OTHER ENTITY NAME: _____

ADDRESS: _____

PROVIDER/PHYSICIAN/SUPPLIER #: _____ TAX ID #: _____

CONTACT PERSON: _____ PHONE #: _____

AMOUNT OF CHECK $: _____ CHECK #: _____ CHECK DATE:_____

## REFUND INFORMATION

For each claim, provide the following:

Patient Name: _____ HIC #: _____

Medicare Claim Number: _____ Claim Amount Refunded $: _____
Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim.)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

Note: If specific patient/HIC/Claim # information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians/suppliers, and other entities who are submitting a refund under the OIG's Self-Disclosure Protocol or who are under a CIA are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For Institutional Facilities Only:

Cost Report Year (s) _____

(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? ___ Yes ___ No

Are you a participant in the OIG Self-Disclosure Protocol? ___ Yes ___No

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### *Reason Codes:*

| Billing/Clerical: | MSP/Other Payer Involvement: | Miscellaneous: |
|---|---|---|
| 01 - Corrected Date of Service | 07 - MSP Group Health Plan Insurance | 12 - Insufficient Doc |
| 02 - Duplicate | 08 - MSP No Fault Insurance | 13 - Patient Enroll HMO |
| 03 - Corrected CPT Code | 09 - MSP Liability Insurance | 14 - Svcs Not Rendered |
| 04 - Not Our Patient(s) | 10 - MSP, Workers Comp. | 15 - Medical Necessity |
| 05 - Mod. Add/Remove (Incl Black Lung) | | 16 - Other-Please Specify |
| 06 - Billed in Error | 11 - Veterans Administration | _____ |