



Part B Overpayment Collection/Offset

Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States government. Under the Federal Claims Collection Act of 1966, as amended, each agency of the federal government (pursuant to regulations jointly promulgated by the attorney general and the comptroller general of the United States) must attempt collection of claims of the federal government for money arising out of the activities of the agency.

Offsets

Once an initial demand letter is sent, the outstanding balance must be satisfied within 40 days or recovery by offset begins. Offset applies current and future payments due the debtor first to the accrued interest and then to the principal.

Note: Offsets are taken from the final dollar amount of a Medicare check and not from a specific beneficiary’s account on the Medicare Remittance Advice (MRA).

A provider/supplier may request TrailBlazer automatically offset any identified overpayments by faxing a request to (903) 463-0615 or mailing a written request to:

TrailBlazer Health Enterprises, LLC
Attn: Part B Debt Collection & Referral
3101 S. Woodlawn
Denison, TX 75020

- The request for automatic offset may be for only one claim or the provider/supplier may request TrailBlazer always automatically offset overpayments.
- The written request must clearly indicate if the provider/supplier is requesting TrailBlazer to offset all overpayments or only one particular overpayment.

Matching Overpayment Letters With the MRA

Medicare sends an overpayment demand letter when money is due back from a provider. If the requested overpayment is not received in our office within 41 days, this amount is withheld from other monies due to the provider. The MRA shows a Financial Control Number (FCN) in the Provider Adjustment Detail. The FCN is also on the original overpayment letter on the claim’s listing attached to the overpayment demand letter and can be found as the Invoice Number.

Invoice Number 90960xxxxxxxxxx

Claim No.	Beneficiary Name	HIC No.	Service Date From	Service Date To	Amount Overpaid	Paid Date Performing	Provider No.
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Note: When the offset occurs and the Withholding (WO) shows up on the MRA, it will only show the FCN and the amount. There will not be patient-specific information for the FCN. See tips below to assist the office staff in matching the MRA with the WO to the original demand letter. The original demand letter will have the patient information.

Tips

When the original demand letter is received with the FCNs and the patient-specific information:

- Create an Excel worksheet.
- Save the worksheet to a drive on the computer that all office staff can access.
- Insert the FCN, dollar amount, patient Health Insurance Claim Number (HICN), date of service, a brief description of overpayment on the worksheet and save.

Often times the demand letter is sent to one area of the office or separate office than the one that receives the MRA, which shows the withholding. By creating a spreadsheet that all office staff can access, the area that receives the MRA with the WO amount and the FCN can access the spreadsheet, search the FCN and find the patient information that belongs to that particular FCN.

Adjustments

Each time a claim is determined to be overpaid (solicited or unsolicited), an adjustment is performed and the claim is reprocessed to show the correct settlement amounts. The physician/supplier will receive an MRA explaining how the claim was processed and what payment amount is being made, what applied to the deductible, what services were denied and why. The beneficiary will also receive a Medicare Summary Notice (MSN) explaining the reprocessed claim.

The Provider ADJ section of the provider remittance gives a list of adjustments to payments (offsets and/or interest payments). 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 advice. Funds are withheld from the provider, not the beneficiary for whom a claim was submitted and paid on the MRA.

For overpaid claims, the total initial claim payment will be listed on the remittance as a negative amount. The adjustment claim will be listed on the remittance with a positive correct payment amount. A PLB reason code of FB does not mean an offset has occurred. Offsets will be identified with a WO PLB reason code. A FB PLB reason code can indicate an adjustment for additional payment, an adjustment because Medicare has identified an overpayment (a demand letter will follow), or an adjustment because a voluntary refund has been received and applied to a claim.

The reason for the adjustment is listed under the PLB REASON CODE column:

- **WO** – Offset as a result of a previous overpayment. The net offset amount is subtracted from the TOTAL PROV PD amount and will be a positive number.
- **L6** – Interest accrued. The net interest is added to the TOTAL PROV PD amount and will be a negative number.
- **50** – Late filing. The net late filing is subtracted from the TOTAL PROV PD amount and will be a positive number.

- **FB** – Balance Forward – This amount represents an adjustment to a previously paid claim. If the amount is positive, the initial claim was overpaid; if the amount is negative, an additional amount is being allowed to the initial payment.

More information concerning overpayments is available at:

<http://www.trailblazerhealth.com/Payment/Overpayment-Voluntary Refund/Default.aspx>