Technology Laboratory Superfund Site without prior notice of intent to delete because we view this as a non-controversial revision and anticipate no adverse comment(s). EPA has explained our reasons for this deletion in the preamble to the direct final deletion. If EPA receives no adverse comment(s) on this notice of intent to delete or the direct final notice of deletion, EPA will not take further action on this notice of intent to delete. If EPA receives adverse comment(s), EPA will withdraw the direct final notice of deletion and it will not take effect. EPA will address all public comments in a subsequent final deletion notice based on this notice of intent to delete as appropriate. EPA will not institute a second comment period on this notice of intent to delete. Any parties interested in commenting must do so at this time. For additional information, see the direct final notice of deletion located in the Rules section of this **Federal Register**.

DATES: Comments concerning this Site must be received by October 23, 2006.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–SFUND–1994–0009, by one of the following methods:

- *www.regulations.gov:* Follow the on-line instruction for submitting comments.
- *E-mail: keckler.kymberlee@epa.gov.*
- *Fax:* (617) 918–0385.
- *Mail:* Kymberlee Keckler, Remedial Project Manager, U.S. Environmental Protection Agency, Region 1, 1 Congress Street, Suite 1100 (HBT), Boston, Massachusetts 02114–2023.
- *Hand delivery:* 1 Congress Street, Suite 1100 (HBT), Boston, Massachusetts 02114–2023. Such deliveries are only accepted during normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA ''HQ–SFUND–1994–0009. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *www.regulations.gov* or e-mail. The *www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body or your comment. If you send an e-mail comment directly to EPA without going through *www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM that you submit. If EPA cannot read your comment because of technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

FOR FURTHER INFORMATION CONTACT: Kymberlee Keckler, Remedial Project Manager, U.S. EPA, 1 Congress Street, Suite 1100 (HBT), Boston, Massachusetts 02114–2023, (617) 918–1385 or toll-free at 1–800–252–3402 extension 81385.

SUPPLEMENTARY INFORMATION: For additional information, see the Direct Final Notice of Deletion located in the Rules section of this **Federal Register**.

INFORMATION REPOSITORY: All documents in the docket are listed in *www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.*, CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically at *www.regulations.gov* or in hard copy at the U.S. Environmental Protection Agency, Region 1, Superfund Records Center, 1 Congress Street, Suite 1100, Boston, Massachusetts 02114–2023 and at the Watertown Free Public Library, 123 Main Street, Watertown, MA 02472. The EPA Superfund Records Center is open Monday through Friday from 9 a.m. to 5 p.m. and the Watertown Free Library is open Monday through Thursday from 9 a.m. to 9 p.m., Friday and Saturday from 9 a.m. to 5 p.m., and Sunday from 1 p.m. to 5 p.m. The EPA Superfund Records Center's telephone number is (617) 918–1440 and the Watertown Free Library's telephone number is (617) 972–6431.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous waste, Hazardous substances, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR 1991; Comp., p. 351; E.O. 12580, 52 FR 2923; 3 CFR 1987 Comp., p. 193.

Dated: September 12, 2006.

Robert W. Varney,

Regional Administrator, U.S. EPA New England.

[FR Doc. 06–7965 Filed 9–21–06; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 405

[CMS–6025–P]

RIN 0938–AN42

Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement a new provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that prohibits recouping Medicare overpayments when an appeal is received from a provider or supplier until a decision is rendered by a Qualified Independent Contractor (QIC). The QIC is the second level of appeal in the Medicare claims appeal process. This provision changes how interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal. This proposed rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 21, 2006.

ADDRESSES: In commenting, please refer to file code CMS–6025–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues

in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address *only:* Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6025–P, P.O. Box 8017, Baltimore, MD 21244.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Nancy Braymer, (410) 786–4323.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–6025–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

[If you choose to comment on issues in this section, please include the caption ''*Background*'' at the beginning of your comments.]

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) amended Title XVIII of the Social Security Act (the Act) to add a new paragraph (f) to section 1893 of the Act, the Medicare Integrity Program. This new sub-section contains eight substantive provisions addressing the recovery of overpayments. This proposed rule would implement the second of these provisions—the limitation on recoupment.

The statute requires CMS to change the way we recoup certain overpayments. It also changes how interest is to be paid to a provider or supplier whose overpayment determination is reversed at administrative or judicial levels of appeal above the Qualified Independent Contractor (QIC). Since these changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure, we will start with a general discussion of the appeal process. Then we will explain the changes to CMS's overpayment recoupment policy, and how CMS will now pay interest on reversals of overpayment determinations at certain levels of the appeal process.

Medicare Claims Appeals Process

The Medicare, Medicaid and SCHIP Benefits and Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) amended section 1869 of the Act to require a major restructuring of the Medicare claims appeals process. CMS incorporated these changes in federal regulations found at 42 CFR Part 405, Subpart I. The appeals process was changed to make one unified structure for both Parts A and B of Medicare. Further, QICs were created as new independent review entities that conduct second level appeals after Medicare contractors conduct a redetermination of initial determinations. An overpayment determination is considered a revised initial determination.

The chart below outlines the levels of appeal and decision-making time frames under this restructured process:

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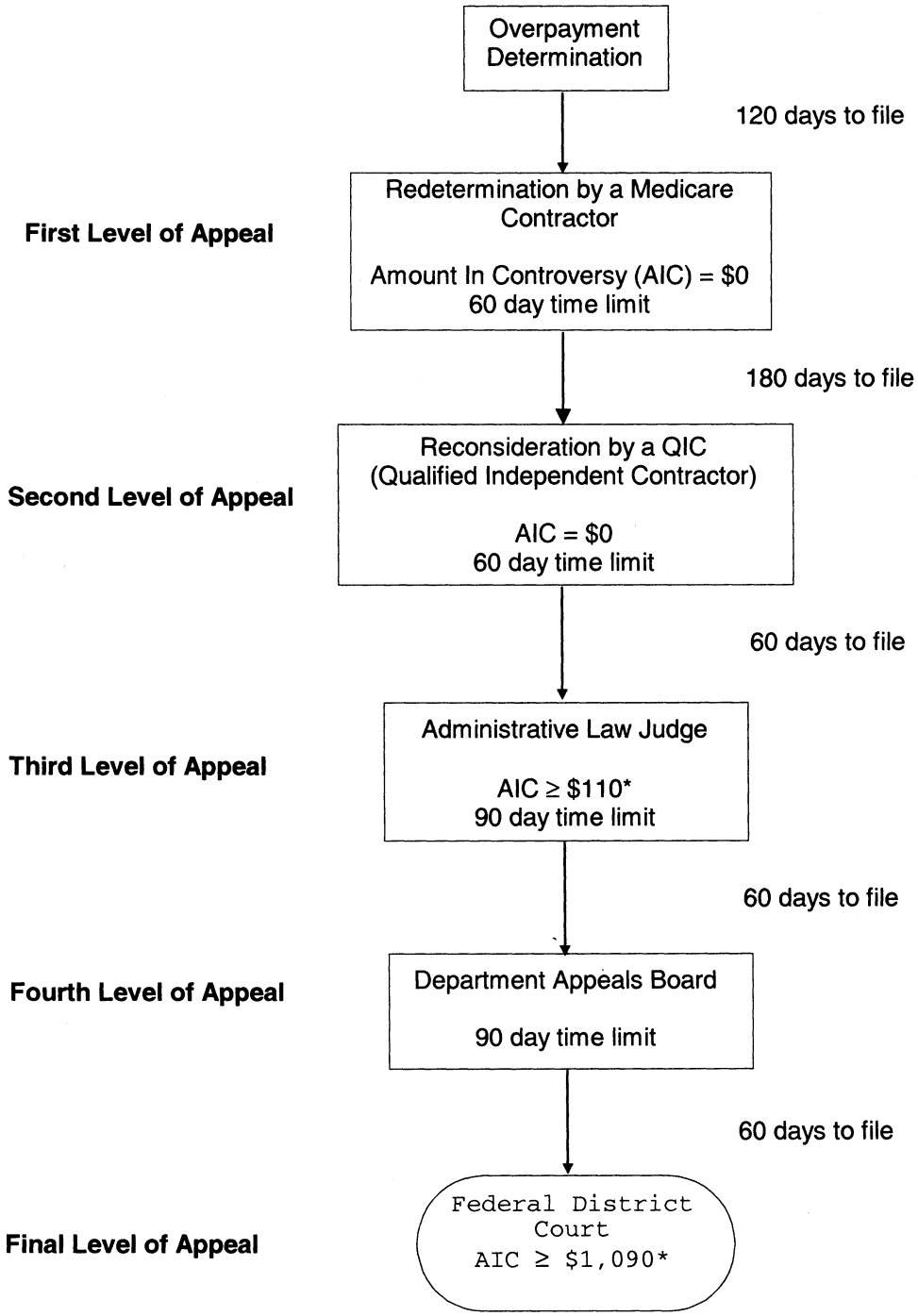
BIPA/MMA Fee-For-Service Appeal Process



* The Amount in Controversy requirement for an Administrative Law Judge hearing and Federal District Court will be adjusted in accordance with the medical care component of the consumer price index.

BILLING CODE 4120–01–C

Limitation on Recoupment

Recoupment is the recovery of a Medicare overpayment by reducing present or future Medicare payments and applying the amount withheld against the debt. Under our existing regulations, providers and suppliers can challenge an overpayment determination through both the rebuttal and appeals processes. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence stating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. The new MMA

provision and this implementing rule do not alter the rebuttal process.

An appeal is an examination of the validity of the overpayment. Before section 1893(f)(2) of the Act was enacted, if a provider or supplier elected to appeal, there was no effect on our ability to recover the debt. However, if the overpayment determination were reversed in whole or in part at any stage of the administrative or judicial appeal process, appropriate adjustments would be made to the overpayment and the amount of interest assessed.

When section 1893(f)(2) was enacted, our recoupment process was changed. The relevant statutory text is as follows:

> In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

To the extent that the statutory language affords any discretion in implementation, we have exercised that flexibility to strike a balance among the following three objectives:

> (1) To give effect to Congressional intent that providers and suppliers be given expedited access to an objective party (independent from the originating contractor) to review the overpayment determination, prior to recouping, in the interest of fairness;
>
> (2) To carry out our fiduciary responsibility to recover erroneous payments to providers or suppliers; to allow them to retain program funds to which they are not entitled under the Medicare statute would be unfair to the intended beneficiaries of Medicare and to the taxpayers who contribute to the trust funds; and
>
> (3) To ensure that providers' and suppliers' procedural due process rights to challenge an overpayment determination through the appeal process are not adversely affected.

Under the statutory language of section 1893(f)(2), if a provider or supplier seeks a reconsideration by a QIC on an overpayment determination, CMS and its Medicare contractors may not recoup the overpayment until the date the decision on the reconsideration has been rendered. Yet before reaching the QIC, a provider or supplier must initially go through the first level of appeal by requesting a redetermination by the Medicare contractor.

Based on the statutory language, we could recoup during the period in which the provider is actively pursuing an appeal at this first level. This approach would reduce the administrative complexity of implementing this new statutory provision. Also, it would shorten the period of deferred recoupment under the Act thereby minimizing risk to the Medicare trust funds. However, this approach would mean, in many instances, we would have recouped the overpayment before a provider could request a reconsideration and thereby invoke the benefit of the limitation on recoupment. Although legally permissible, we believe this is inconsistent with Congressional intent.

Instead, we propose in this rule to cease recoupment when a valid first level appeal is received. If the provider loses at the first level, we would then proceed to recoup 30 days after giving notice to the provider unless the provider appeals to the QIC in the interim. A provider who acts in a timely fashion can preclude any recoupment until the QIC decision is rendered as contemplated under the MMA.

Assessment of Interest

In addition to tying the recoupment process to the appeals process, section 1893(f)(2) of the Act also has the effect of changing how we pay interest to a provider or supplier who is successful in having an overpayment determination fully or partially reversed at the latter stages of the appeal process. Previously, we paid interest on underpayments solely in accordance with sections 1815(d) and 1833(j) of the Act. An ''underpayment'' would usually result when we had recovered, through recoupment or otherwise, an overpayment; the decision was reversed at some point in the appeal process; and after appropriate adjustments, we owed the balance to the provider or supplier. Interest accrues from the date of the ''final determination'' and is owed if the underpayment is not paid within 30 days. Following an appeal decision favorable to a provider, the Medicare contractor must effectuate the decision and make a written determination of the amount Medicare owes. This is considered a new final determination, and interest accrues from that date.

The new interest provision found in section 1893(f)(2)(B) of the Act amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (the QIC reconsideration). The statutory text is as follows:

> Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

This language did not specifically amend sections 1815(d) and 1833(j) of the Act. Nor did the MMA conference report reference these sections. The statute and the conference report are both silent on the relationship between paying or collecting interest (a) based on the final determination concept embodied in sections 1815(d) and 1833(j) of the Act; and (b) the concept of paying interest based on how long we held funds, ultimately determined through the latter stage of the appeal process to belong to the provider, as incorporated in section 1893(f)(2)(B) of the Act.

There has been no change in the obligation of the provider or supplier to pay interest if the overpayment determination is affirmed at any level of administrative or judicial appeal. Interest continues to accrue from the final determination in accordance with sections 1815(d) and 1833(j) of the Act. Section 1893(f)(2)(B) of the Act explains that if an appeal of an overpayment is upheld before the QIC, ''interest on the overpayment shall accrue on and after the date of the original notice of overpayment.'' For overpayments subject to the limitation on recoupment, the first final determination is the date of the demand letter. Therefore, section 1893(f)(2)(B) of the Act is consistent with sections 1815(d) and 1833(j) of the Act and does not alter our ability to assess interest against the provider or supplier.

In addition, there has been no change in the obligation of Medicare to pay the provider or supplier interest if the overpayment determination is reversed at the first (redetermination) or second (reconsideration) level of the administrative appeal process. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment is not paid within 30 days of the final determination. The change in the method of paying interest resulting from section 1893(f)(2)(B) of the Act is applicable only where the reversal occurs at the Administrative Law Judge (ALJ) level or subsequent levels of administrative appeal or judicial review. At these higher levels of administrative appeal or judicial review, interest becomes payable by Medicare based on the period we recouped and retained the provider's or supplier's funds.

We determine the rate of interest in accordance with 42 CFR 405.378 by

comparing the private consumer rate with the current value of funds rate. Interest is assessed at the higher of these two rates that is in effect on the date of the final determination of the amount of the overpayment or underpayment. The current interest rate for Medicare overpayments and underpayments is 12.625 percent (the private consumer rate). Since February, 2001 to the present time, it has ranged from a low of 10.75 percent to a high of 14.125 percent. By regulation 42 CFR 411.24(m)(2), interest is calculated on Medicare Secondary Payer (MSP) debts in the same manner as for Medicare overpayments and underpayments, and the same interest rate is used.

Interest accrues daily but is assessed and calculated in full 30 day periods. We charge simple rather than compound interest, and payments we receive are applied first to accrued interest and then to principal.

Interest we collect on overpayments and MSP recoveries goes to the general fund of the U.S. Treasury. The principal amount we recover is used to reimburse the applicable Medicare trust fund—the Hospital Insurance (Part A) or the Supplementary Medical Insurance (Part B and now D) trust funds, which are special accounts in the U.S. Treasury. Interest we pay on Medicare underpayments comes from the applicable Medicare trust fund.

Suspension

We note that this new MMA provision does not affect how CMS recovers overpayments from providers or suppliers that have been placed on payment suspension. Under our authority at 42 CFR 405.371, CMS, an intermediary, or carrier may suspend the payment of claims if there is reliable information that an overpayment, fraud or willful misrepresentation exists or that payments to be made may not be correct. Once an overpayment amount is determined, suspended payments must first be applied to eliminate any overpayment pursuant to § 405.372(e). We do not interpret section 1893(f)(2) of the Act as amending our authority to apply suspended payments toward reducing or eliminating an overpayment. In addition, we do not interpret the Act to require that we return the suspended payments to a provider or supplier once an overpayment is determined. Section 1893(f)(2) of the Act prevents the Secretary from taking any ''action * * * to recoup the overpayment.'' Yet, the disposition of suspended funds as explained in 42 CFR 405.372(e) is not a ''recoupment'' as that term is defined in § 405.370. When the Congress chose to limit CMS's ability to recoup funds to satisfy an overpayment, it specifically used the word ''recoup'' which has been a long-standing defined term by CMS. There is no evidence that the Congress intended to broaden or alter CMS's definition of recoupment to also apply to suspended funds. Because CMS is only limited by section 1893(f)(2) of the Act from recouping Medicare payments, we are not restricted in our ability to apply suspended funds to reduce or dispose of an overpayment.

If the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of this proposed rule, the limitation on recoupment provision under section 1893(f)(2) of the Act would be applicable to any remaining balance still owed to CMS.

We also note that section 1893(f)(2) of the Act does not alter the process for providers or suppliers to appeal overpayment determinations. Providers and suppliers may continue to appeal the full amount of an overpayment determination at the conclusion of a suspension as they could prior to the enactment of the MMA.

II. Provisions of the Proposed Regulations

[If you choose to comment on issues in this section, please include the caption ''*Provisions*'' at the beginning of your comments.]

A. Proposed Change to Authority Citation for Subpart C of Part 405

Subpart C of part 405 implements several sections of the Act including sections authorizing the recovery of overpayments and assessment of interest. We propose to revise the authority citation to explicitly add section 1893 of the Act which was amended by section 935 of the MMA to add the limitation on recoupment as well as other provisions addressing the recovery of overpayments.

B. Proposed Change to § 405.370 Definitions

Section 405.370 defines key terms that apply to subpart C of part 405. We are proposing to revise § 405.378 and add a new § 405.379 to implement the statutory limitation on recoupment. We propose to add definitions for terms used in § 405.378 and the new § 405.379. The limitation on recoupment is tied to the Medicare claims appeals process and structure (the regulations for which appear in 42 CFR Part 405). We propose that selected terms used in the proposed revisions to § 405.378 and the new § 405.379 be given the same meaning as in the appeals context. Therefore, these terms are defined by reference to the definitions set forth in § 405.902.

C. Proposed Change to § 405.373 Proceeding for Offset or Recoupment

Section 405.373 establishes the general rules and procedures to be followed once CMS or a Medicare contractor determines that an offset or recoupment should be put into effect. Paragraph (e) addresses the duration of a recoupment or offset that has been put into effect and identifies the three specific circumstances under which a recoupment or offset would stop. We propose to revise the introductory text of paragraph (e) to explicitly refer to the new § 405.379, implementing the statutory limitation on recoupment, as a separate basis to stop recoupments that have been put into effect.

D. Proposed Revisions to § 405.378 Interest Charges on Overpayment and Underpayments to Providers, Suppliers and Other Entities

Section 405.378 implements sections 1815(d) and 1833(j) of the Act which requires us to charge interest on overpayments and pay interest on underpayments if payment is not made within 30 days of the date of the ''final determination''. Under sections 1815(d) and 1833(j) of the Act, the date of the final determination dictates when interest begins to accrue whether we pay interest on an underpayment or collect interest on an overpayment. Paragraph (c) of this section defines what constitutes a final determination both for overpayments and underpayments arising from a cost report determination as well as those that are claims based. Paragraph (d) establishes the basis for the interest rate used for Medicare overpayments and underpayments as well as for other Medicare program activities, for example Medicare Secondary Payer recoveries (see 42 CFR 411.24(m) which references § 405.378(d)).

We propose to amend § 405.378 to specify how interest is assessed for the subset of overpayments subject to the limitation on recoupment under section 1893(f)(2) of the Act. The proposed revisions in § 405.378 clarify that if a provider or supplier overpayment determination is affirmed at any level of administrative or judicial appeal, interest owed by the provider or supplier continues to accrue from the final determination. If the overpayment determination is reversed in favor of the provider or supplier, interest may be payable by Medicare to the provider or supplier under one of two different

methodologies depending upon the appeal level at which the reversal occurs. If the reversal in favor of the provider or supplier occurs at the first (redetermination) or second (reconsideration) level of the administrative appeal process, interest may be payable by Medicare if the underpayment is not paid within 30 days of the final determination. It is only where the reversal occurs at the ALJ level or subsequent levels of administrative appeal or judicial review that interest becomes payable by Medicare based on the period that we recouped and retained the provider's or supplier's funds.

We propose to amend § 405.378 paragraph (a) by adding the section reference 1893(f)(2)(B) as one of the enumerated provisions of the Act that this regulatory section is designed to implement.

We propose to revise paragraph (b)(2), which states the basic rule that interest accrues from the date of final determination, to clarify there is a new exception to this rule by referencing paragraph (j) of this section.

We propose to amend paragraph (c)(1)(ii) which lists what constitutes a final determination in cases where a Notice of Amount of Program Reimbursement (NPR) is not issued. First, we removed the existing final determination definition based on certain Administrative Law Judge (ALJ) decisions under paragraph(c)(1)(ii)(C). The change in how interest is assessed under section 1893(f)(2) of the Act applies at the third level of appeal (ALJ) and subsequent administrative and judicial review levels. Therefore, these levels of appeal are now discussed in proposed paragraph (j).

Second, we propose to add an additional definition for a final determination, at paragraph (c)(1)(ii)(C), arising from a full or partial reversal at the redetermination level of appeal. This change is designed to clarify that if an overpayment is reversed in whole or in part at the first level of appeal—the redetermination level—interest accrues from the date of the ''final determination'' and is owed by Medicare if the underpayment is not paid within 30 days. Following a redetermination decision favorable to a provider or supplier, the contractor must effectuate the decision and make a written determination of the amount Medicare owes. Interest accrues from the date of the written determination.

Finally, we propose to add paragraph (c)(1)(ii)(D) as an additional type of final determination. This is a written determination arising from a full or partial reversal of an overpayment determination at the QIC reconsideration level (the second level of appeal). This addition is designed to clarify that if an overpayment determination is reversed in whole or in part at the QIC reconsideration, the final determination for purposes of assessing interest is the date the contractor effectuates the QIC reconsideration decision and make a written determination of the amount Medicare owes. Interest accrues from the date of this written determination and is owed to the provider or supplier if the underpayment is not paid within 30 days.

These changes to the final determination definitions are intended to work in conjunction with the limitation on recoupment requirements in the new proposed § 405.379. Providers and suppliers can take advantage of the limitation on recoupment by not paying during the redetermination and reconsideration levels of appeal, yet interest will still continue to accrue during those periods. If a provider or supplier loses at either level of appeal, and they did not pay their overpayment during the appeal, they will owe both the overpayment amount and accrued interest. Therefore, they receive a benefit during the first two levels of appeal by retaining their funds, but by doing so, they run the risk that they will owe interest on the unpaid overpayment amounts.

We propose to amend paragraph (c)(2) by adding the cross references to paragraphs (i) and (j) of this section which states the exceptions to assessing interest based on the date of final determination.

For purposes of clarity and to group the exceptions to the ''final determination'' rule in a logical sequence, we propose to redesignate paragraph (h) as paragraph (i). We propose to redesignate paragraph (i) as paragraph (h). The text of these redesignated paragraphs is not changed.

We propose to add a new paragraph (j). This paragraph would establish the new basis for paying interest to a provider or supplier whose overpayment determination is reversed in whole or in part at the third level of administrative appeal (ALJ) or above. This new interest provision is required by section 1893(f)(2)(B) of the Act which provides ''[i]nsofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.'' This new paragraph (j) would explain how interest is assessed against the government at any administrative and judicial appeal level above the QIC reconsideration. This new method applies only to overpayments subject to the limitation on recoupment under § 405.379. It is predicated upon the recoupment and retention of funds by CMS or the Medicare contractor at the time the decision reversing the overpayment determination, in whole or in part, is rendered.

Proposed paragraph (j)(1) states that the rate of interest is the same rate that CMS charges on overpayments and pays on underpayments to providers, suppliers and other health care entities. This rate, as provided in the existing and unchanged paragraph (d) of this section, is the higher of the private consumer rate or the current value of funds rate.

The interest rate established in accordance with paragraph (d) changes periodically. The proposed paragraph (j)(2) describes the point in time where the applicable interest rate is fixed. This is the date the decision reversing the overpayment is issued by the ALJ, Medicare Appeals Council, Federal district court or other Federal reviewing court.

The proposed paragraph (j)(3) explains how interest will be calculated. We propose that interest will be paid on the total principal amount recouped. We propose to pay simple rather than compound interest, and we will not pay interest on interest; this mirrors the manner in which we assess interest against providers. Monies we recouped and applied to interest would be refunded and not included in the ''amount recouped'' for purposes of calculating any interest due the provider. The periods of recoupment will be calculated in full 30-day periods; and interest will not be payable for any periods of less than 30 days in which we had possession of the recouped funds.

In calculating the period in which the amount was recouped, we propose to deduct days in which either or both the ALJ's or the Medicare Appeals Council's adjudication time frames are tolled due to specific actions by the appellant over the which the government has no control. Our rules on the procedures and time frames to request an ALJ hearing provide that if the appellant fails to copy the other parties or files the request with an entity other than that specified in the QIC's reconsideration, the ALJ's 90 day adjudication deadline is tolled. Similarly, our rules on the procedures and time frames to request a Medicare Appeals Council review provide that if the appellant fails to

copy the other parties or files the request with an entity other than that specified in the notice of the ALJ's action, the Medicare Appeals Council's adjudication period to conduct a review is tolled. Therefore, in paragraph (j)(3)(iv) and (v) we propose that in calculating how much interest we owe a provider or supplier, we account for these potential delays by deducting days attributable to actions by the provider or supplier which have the effect of extending the time in which we had possession of the recouped funds.

We propose in paragraph (j)(4) that, in the cases of a partial reversal of an overpayment determination, we would allocate the funds recouped first to that portion of the overpayment determination affirmed by the ALJ, Medicare Appeals Council, or any Federal court. If after this allocation excess recouped funds remain, interest would be paid to the provider or supplier on this amount in accordance with the other provisions of this new paragraph (j).

E. Proposed New § 405.379 Limitation on Recoupment of Provider and Supplier Overpayments

We propose to add a new section to subpart C of Part 405 to implement the statutory limitation on recoupment under section 1893(f)(2) of the Act.

Proposed paragraph (a) cites section 1893(f)(2) of the Act as the statutory basis for this section and briefly summarizes the underlying purpose. This is to impose a limit on our recoupment of Medicare overpayments if a provider of services or supplier appeals until a decision by a QIC is made.

Proposed paragraph (b) delineates those types of overpayments that are expressly subject to the recoupment limitation. We propose that the limitation on recoupment applies to (1) overpayments that may be appealed by the provider or supplier under the Medicare claims appeal process; and (2) post-pay denial of claims for benefits under Medicare Part A and Part B for which a demand for payment has been made. We propose that this provision also apply to a small subset of Medicare Secondary Payer (MSP) recoveries; these would be MSP recoveries where the provider or supplier received a duplicate primary payment and MSP recoveries based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program or insurer for payment.

Section 935(b) of the MMA specified that section 1893(f)(2) shall apply to ''actions'' taken after the date of enactment of the MMA; that is, ''actions'' taken after December 8, 2003. For purposes of delineating those provider and supplier overpayments subject to this provision and those that are not, we interpret ''actions'' to refer to those instances where the initial recoupment occurred or will occur on or after December 9, 2003. For ease of administration and to establish a clear rule, we are defining the initial recoupment to be the date that the Medicare contactor could have instituted recoupment in compliance with established Medicare policies whether or not a recoupment occurred in fact. Therefore, for Part A overpayments, including a MSP recovery based on the provider's failure to file a proper claim for Part A benefits, the limitation applies to debts determined on or after November 24, 2003. For Part B overpayments, including a MSP recovery based on the supplier's failure to file a proper claim for Part B benefits, the limitation applies to debts determined on or after October 29, 2003. In addition, this section applies to that small group of MSP recoveries in which the provider or supplier received a duplicate primary payment and for which a written demand for payment was issued on or after October 10, 2003.

For purposes of clarity, we propose that paragraph (b) also identify categories of overpayments to which the limitation does not apply, although this is not framed as an exhaustive list of exclusions. The limitation would not apply to all MSP recoveries other than provider/supplier MSP duplicate primary payment recoveries or MSP recoveries attributable to the provider's or supplier's failure to file a proper claim. It would not apply to beneficiary overpayments nor overpayments that arise from a cost report determination and are appealed under the provider reimbursement process.

Proposed paragraph (c) specifies how two key actions that trigger the limitation on recoupment are to be construed. The limitation on recoupment is tied to the Medicare claims appeals process. Recoupment of an overpayment once initiated will be stopped at the first two levels of the appeals process (the redetermination and the reconsideration) upon receipt of a timely and valid appeal request applicable to that level. The provider or supplier does not have to take any affirmative action to invoke the limitation on recoupment beyond the act of appealing. What constitutes a valid and timely request for a redetermination and, subsequently, what constitutes a valid and timely request for a reconsideration must be determined in accordance with established Medicare appeal regulations and implementing policies. Therefore, in this paragraph, we make the interplay between recoupment and appeals explicit by referencing the requirements for a redetermination request as those contained in § 405.940 through § 405.958 and the requirements for a reconsideration request as those contained in § 405.974 through § 405.978.

Proposed paragraph (d) lays out the general framework for implementing the limitation on recoupment.

Once an overpayment is determined and the substantive and procedural requirements to afford the provider or supplier an opportunity for rebuttal under § 405.374 and § 405.375 are satisfied, recoupment can proceed unless and until a valid request for a redetermination is received. (The redetermination is the first level of appeal, and a provider or supplier has 120 days to file a request for a redetermination of the overpayment determination.) This means we can recoup during the period when a provider's or supplier's right to request a redetermination has yet to expire. This places the obligation on the provider or supplier who wishes to capitalize on the benefit afforded by the recoupment limitation to act on a timely basis to request a redetermination.

Under BIPA, the Medicare contractor is required to make a redetermination decision within 60 calendar days of the date the contractor receives a timely filed request for a redetermination. We propose in paragraph (d)(2) that if the redetermination is an affirmation in whole or in part, we can proceed to recoup any outstanding principal and interest 30 days after notice unless a valid request for a reconsideration is received in the interim.

A provider or supplier that wishes to appeal an adverse redetermination decision (an affirmation or partial affirmation of the overpayment determination) has 180 calendar days to file a request from the date of receipt of the notice of the redetermination. Once the 30 day notice period is over and in the absence of the receipt of a valid request for a reconsideration, we propose to initiate or resume recoupment. As with the first level of appeal, this approach places the onus on the provider or supplier who wishes to take advantage of the benefit offered by the limitation on recoupment to act on a timely basis in requesting a QIC reconsideration.

We propose in paragraph (d)(3) that the Medicare contractor shall cease recoupment upon receipt of a timely

and valid request for a reconsideration. If recoupment has not yet gone into effect, the contractor shall not initiate it. The contractor may initiate or resume recoupment upon final action by the QIC in accordance with paragraph (f) which is explained in detail below.

The general rule we propose in paragraph (d)(4) and (5) is that, unless the reconsideration results in a full reversal of the overpayment determination, recoupment of outstanding principal and interest may be initiated or resumed upon final action by the QIC whether or not the provider or supplier appeals to the ALJ, the Medicare Appeals Council, or Federal court. If the provider or supplier subsequently appeals, the contractor may continue recouping outstanding overpayments in accordance with § 405.373(e).

We also propose in paragraph (d)(6) to clarify that each overpayment determination and its appeal status is separate and distinct from other debts owed by the same provider or supplier. Therefore, we make explicit that if an overpayment determination is appealed and recoupment stopped, this would not preclude the Medicare contractor from recouping other overpayments owed by the provider or supplier.

We propose in paragraph (d)(7) to make explicit that amounts properly recouped prior to the imposition of the recoupment limitation, at either or both the first and second levels of appeal, may be retained until and unless there is an administrative or judicial reversal of the overpayment determination.

We propose in paragraph (d)(8) that if an overpayment determination is reversed through the administrative or judicial process, appropriate adjustments in the debt and the amount of interest charged will be made to give effect to these decisions.

Proposed paragraph (d)(9) makes explicit that interest is payable on overpayments, subject to the recoupment limitation, in accordance with the provisions of § 405.378.

Proposed paragraph (e) states the specific rules for initiating or resuming recoupment after the redetermination decision. The necessary conditions are that the debt (remaining unpaid principal balance and interest) has not been liquidated and the substantive and procedural rebuttal requirements have been satisfied. Recoupment can resume: (i) Immediately upon receipt of a request to withdraw the redetermination request; (ii) on the 30th calendar day after the date of the notice of redetermination affirming the overpayment determination in whole; or (iii) on the 30th calendar day after a written notice to the provider or supplier of the revised overpayment amount if the redetermination results in an affirmation in part. We propose in paragraph (e)(2) that recoupment would be stopped again upon receipt of a timely and valid request for a reconsideration by the QIC.

Proposed paragraph (f) sets forth the specific rules for initiating or resuming recoupment after final action by the QIC. It also defines what constitutes final action by a QIC for purposes of this section. As is the case when recoupment is resumed after the redetermination decision, the conditions necessary for resumption are that the debt (remaining unpaid principal balance and interest) has not been liquidated and the substantive and procedural rebuttal requirements have been satisfied.

Under the statute, once a provider or supplier has sought a reconsideration by the QIC, we may not take any action to recoup the overpayment until the date the decision on the reconsideration has been rendered. We believe it is an appropriate balancing of interests and in keeping with the intent of this provision to interpret ''the date the decision on the reconsideration is rendered'' as the date on which the QIC issues its final action with respect to a reconsideration.

There are three possible actions that a QIC may take with respect to a request for reconsideration. First, it may complete its review and issue a reconsideration. Second, in appropriate circumstances, it may dismiss the request for reconsideration. Third, if the QIC is unable to complete its reconsideration within the mandated sixty (60) day time frame, it may issue a notice to the parties that it will not be able to complete its reconsideration in the allotted time and advise them of their right to escalate their appeal to the ALJ level. The parties may then notify the QIC of their intent to escalate the appeal. Following the receipt of this notice, the QIC must either issue its reconsideration within 5 days or issue a notice acknowledging the escalation request and forward the case file to the ALJ hearing office.

We propose that the earliest to occur of these three actions (a reconsideration, a dismissal, and the written notification to the parties that the reconsideration has been escalated) or the receipt of a withdrawal request from the provider or supplier would constitute the final QIC decision for purposes of ending the prohibition on our recouping an overpayment. The provider or supplier who elects to escalate the appeal from the QIC to the ALJ would thereby lose the benefit of the limitation on recoupment (recoupment could begin). However, we do not view this as a disadvantage to the provider or supplier who retains the ability to seek escalation or not. The proposed language also clarifies that where the final action is the notice of the reconsideration, in order to institute or resume recoupment, the reconsideration decision must affirm the overpayment determination in whole or in part.

Proposed paragraph (g) addresses through a series of specific rules and situations how recouped funds are to be applied. Funds recouped prior to receipt of a timely and valid redetermination request may be retained and applied first to accrued interest and then to the principal balance. If the overpayment in question is reversed at the first level of appeal, consistent with current policies, the amount held may be applied to any other debt owed by the provider or supplier; any excess would then be released to the provider or supplier. In the case of a partial reversal at the redetermination level in which the decision reduces the debt below the amount already recouped, the same policies would be followed with respect to the application of the recouped funds. In the case of an affirmation where the provider or supplier appeals to the next level, the Medicare contractor would retain the monies and apply them first to interest and then to the principal balance pending final action by the QIC on the reconsideration request.

If funds are properly recouped between a redetermination decision and a provider's subsequent request for a reconsideration, these would be retained and applied first to interest, then to principal pending final action by the QIC. If the final QIC action is a dismissal, receipt of a withdrawal, notice of escalation, or a reconsideration decision affirming the overpayment in whole, funds recouped are applied to interest, then to principal; recoupment may be resumed as necessary to liquidate the debt. If the QIC reconsideration decision is a full reversal, the amount recouped may be applied to any other debt (including interest) owed by the provider or supplier before any excess is released. If the reconsideration decision is a partial reversal and reduces the debt below the amount already recouped, the same policies would be followed with respect to the application of the recouped funds.

Proposed paragraph (h) would insulate a provider or supplier, invoking the limitation on recoupment under this section, from the operation of § 401.607(c)(2)(iv). This latter rule provides that missing one payment

under a 6 month extended repayment plan granted under the authority of § 401.607(c)(2) constitutes a default allowing CMS to accelerate the debt.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption ''Impact'' at the beginning of your comments.]

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We do not expect this proposed rule to have a substantial financial impact on beneficiaries, providers, or suppliers. We do anticipate that Federal costs to implement this proposed rule may be substantial, but we do not expect them to exceed the $100 million threshold in any 1 year.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, all providers and suppliers affected by this regulation are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 (proposed documents)/604 (Final documents) of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act. We are uncertain how many small entities would be affected by this proposed rule as this would depend in part upon voluntary actions on the part of the provider or supplier. The purpose of this proposed rule is to limit our ability to recoup against providers or suppliers who appeal an overpayment determination. In order to impact a provider or supplier, the provider or supplier must have received an erroneous payment; an overpayment must be determined and demanded; the provider or supplier must elect to appeal; and the provider or supplier may not satisfy the overpayment by making either a lump sum payment or requesting to repay the debt in installments. The only possible adverse impact upon a provider or supplier is that by deferring repayment of the overpayment until final action by the QIC, the provider would owe additional interest. However, the provider or supplier can avoid the additional interest exposure by electing to satisfy the debt by a lump sum payment or an installment payment while still pursuing the appeal. In addition, should the overpayment determination be reversed at a level above the QIC, the provider or supplier potentially will receive additional interest beyond what CMS would be obligated to pay under current regulations. Therefore, we expect the impact of this proposed rule to be positive although the extent to which it would benefit any one provider would depend upon specific facts and circumstances and voluntary choices made by that provider. The impact on small rural hospitals is expected to be similarly positive but unpredictable. Therefore, we are certifying that this proposed rule would not have a significant impact on a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule will not have this effect on State, local, or tribal governments, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This proposed rule would not have a substantial effect on State or local governments.

B. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this proposed rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

1. The authority citation for subpart C is revised to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, 1892 and 1893 of the Social Security Act (42 U.S.C. 1302, 1395g,

1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, 1395ccc and 1395ddd) and 31 U.S.C. 3711.

2. Section 405.370 is amended by:

A. Designating the existing text as paragraph (a);

B. Adding a new paragraph (b);

The additions read as follows:

§ 405.370 Definitions.

(a) * * *

(b) For purposes of sections 405.378 and 405.379, the following terms apply:

Appellant means the beneficiary, assignee or other person or entity that has filed and pursued an appeal concerning a particular initial determination. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Fiscal intermediary means an organization that has entered into a contract with CMS in accordance with section 1816 of the Act and is authorized to make determinations and payments for Part A of title XVIII of the Act, and Part B provider services as specified in § 421.5(c) of this chapter.

Medicare Appeals Council means the council within the Departmental Appeals Board of the U.S. Department of Health and Human Services.

Medicare contractor, unless the context otherwise requires, includes a fiscal intermediary, carrier, and Medicare administrative contractor.

Party means an individual or entity listed in § 405.906 that has standing to appeal an initial determination and/or a subsequent administrative appeal determination.

Qualified Independent Contractor (QIC) means an entity which contracts with the Secretary in accordance with section 1869 of the Act to perform reconsiderations under § 405.960 through § 405.978.

Remand means to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Vacate means to set aside a previous action.

3. In § 405.373, paragraph (e) introductory text is revised to read as follows:

§ 405.373 Proceeding for offset or recoupment.

* * * * *

(e) *Duration of recoupment or offset.* Except as provided in § 405.379, if a recoupment or offset is put into effect, it remains in effect until the earliest of the following:

* * * * *

4. Section 405.378 is amended by—

A. Revising paragraph (a);

B. Revising paragraph (b)(2);

C. Republishing paragraph (c)(1) introductory text;

D. Revising paragraph (c)(1)(ii) introductory text;

E. Removing ''or'' from (c)(1)(ii)(B);

F. Revising paragraph (c)(1)(ii)(C);

G. Adding paragraph (c)(1)(ii)(D);

H. Revising paragraph (c)(2);

I. Redesignating existing paragraph (h) as paragraph (i) and existing paragraph (i) as paragraph (h) respectively;

J. Adding paragraph (j).

§ 405.378 Interest charges on overpayment and underpayments to providers, suppliers and other entities.

(a) *Basis and purpose.* This section, which implements sections 1815(d), 1833(j) and 1893(f)(2)(B) of the Act and common law, and authority granted under the Federal Claims Collection Act, provides for the charging and payment of interest on overpayments and underpayments to Medicare providers, suppliers, HMOs, competitive medical plans (CMPs), and health care prepayment plans (HCPPs).

* * * * *

(b) Basic rules. * * *

(2) Except as provided in paragraph (j) of this section, interest accrues from the date of the final determination as defined in paragraph (c) of this section, and either is charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed.

(c) *Definition of final determination.* (1) For purposes of this section, any of the following constitutes a final determination:

* * * * *

(ii) In cases in which an NPR is not used as a notice of determination (that is, primarily under part B), one of the following constitutes a final determination—

* * * * *

(C) A written determination by a Medicare contractor that effectuates a redetermination which reversed in full or in part an overpayment determination and the written determination reduces the amount of the overpayment below the amount that CMS has already recovered by recoupment or otherwise; or

(D) A written determination by a Medicare contractor that effectuates a reconsideration by a Qualified Independent Contractor which reversed in full or in part an overpayment determination and the written determination reduces the amount of the overpayment below the amount that CMS has already recovered by recoupment or otherwise.

* * * * *

(2) Except as required by any subsequent administrative or judicial reversal and specifically as provided in paragraphs (i) and (j) of this section, interest accrues from the date of final determination as specified in this section.

* * * * *

(j) *Special rule for provider or supplier overpayments subject to § 405.379.* If an overpayment determination subject to the limitation on recoupment under § 405.379 is reversed in whole or in part by an Administrative Law Judge (ALJ) or at subsequent administrative or judicial levels of appeal and if funds have been recouped and retained by the Medicare contractor, interest will be paid to the provider or supplier as follows:

(1) The applicable rate of interest is that provided in paragraph (d) of this section.

(2) The interest rate in effect on the date the ALJ, the Medicare Appeals Council, the Federal district court or subsequent appellate court issues a decision reversing the overpayment determination in whole or in part is the rate used to calculate the interest due the provider or supplier.

(3) Interest will be calculated as follows:

(i) Interest will be paid on the principal amount recouped only.

(ii) Interest will be calculated on a simple rather than a compound basis.

(iii) Interest will be calculated in full 30-day periods and will not be payable on amounts recouped for any periods of less than 30 days in which the Medicare contractor had possession of the funds.

(iv) In calculating the period in which the amount was recouped, days in which the ALJ's adjudication period to conduct a hearing are tolled under 42 CFR 405.1014 shall not be counted.

(v) In calculating the period in which the amount was recouped, days in which the Medicare Appeals Council's adjudication period to conduct a review are tolled under 42 CFR 405.1106 shall not be counted.

(4) If the decision by the ALJ, Medicare Appeals Council, Federal district court or a subsequent Federal reviewing court, reverses the overpayment determination, as modified by prior levels of administrative or judicial review, in part, the Medicare contractor in effectuating the decision may allocate recouped monies to that part of the overpayment determination affirmed by the decision. Interest will be paid to the

provider or supplier on recouped amounts that remain after this allocation in accordance with this paragraph (j) of this section.

5. Section 405.379 is added to read as follows:

§ 405.379 Limitation on recoupment of provider and supplier overpayments.

(a) *Basis and purpose.* This section implements section 1893(f)(2)(A) of the Act which limits recoupment of Medicare overpayments if a provider of services or supplier appeals until a decision is rendered by a Qualified Independent Contractor (QIC).

(b) *Overpayments subject to limitation.*

(1) This section applies to overpayments that meet the following criteria:

(i) Is one of the following types of overpayments:

(A) Post-pay denial of claims for benefits under Medicare Part A which is determined and for which a written demand for payment has been made on or after November 24, 2003; or

(B) Post-pay denial of claims for benefits under Medicare Part B which is determined and for which a written demand for payment has been made on or after October 29, 2003; or

(C) Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand for payment was issued on or after October 10, 2003; or

(D) Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment and, if Part A, demanded on or after November 24, 2003, or, if Part B, demanded on or after October 29, 2003; and

(ii) The provider or supplier can appeal the overpayment as a revised initial determination under the Medicare claims appeal process at 42 CFR Parts 401 and 405 or as an initial determination for provider/supplier MSP duplicate primary payment recoveries.

(2) This section does not apply to all other overpayments including, but not limited to, the following:

(i) All Medicare Secondary Payer recoveries except those expressly identified in this paragraph (b)(1)(i)(C) and (D);

(ii) Beneficiary overpayments; and

(iii) Overpayments that arise from a cost report determination and are appealed under the provider reimbursement process of 42 CFR Part 405 Subpart R–Provider Reimbursement Determinations and Appeals.

(c) *Rules of construction.*

(1) For purposes of this section, what constitutes a valid and timely request for a redetermination is to be determined in accordance with § 405.940 and § 405.958.

(2) For purposes of this section, what constitutes a valid and timely request for a reconsideration is to be determined in accordance with § 405.974 through § 405.978.

(d) *General rules.*

(1) Upon receipt of a timely and valid request for a redetermination of an overpayment, the Medicare contractor shall cease recoupment of the overpayment in question. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment.

(2) If the redetermination decision is an affirmation in whole or in part of the overpayment determination, recoupment may be initiated or resumed in accordance with paragraph (e) of this section.

(3) Upon receipt of a timely and valid request for a reconsideration of an overpayment, the Medicare contractor shall cease recoupment of the overpayment in question. If the recoupment has not yet gone into effect, the contractor must not initiate recoupment.

(4) Following final action by the QIC on the reconsideration, the contractor may initiate or resume recoupment in accordance with paragraph (f) of this section.

(5) If the provider or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, recoupment remains in effect as provided in § 405.373(e).

(6) If an overpayment determination is appealed and recoupment stopped, the contractor may continue to recoup other overpayments owed by the provider or supplier in accordance with this section.

(7) Amounts recouped prior to a reconsideration decision may be retained by the Medicare contractor in accordance with paragraph (g) of this section.

(8) If either the redetermination or reconsideration decision is a full reversal of the overpayment determination or if the overpayment determination is reversed in whole or in part at subsequent levels of administrative or judicial appeal, adjustments shall be made with respect to the overpayment and the amount of interest charged.

(9) Interest accrues and is payable in accordance with the provisions of § 405.378.

(e) *Initiating or Resuming Recoupment After Redetermination Decision.*

(1) Recoupment that has been deferred or stopped may be initiated or resumed if the debt (remaining unpaid principal balance and interest) has not been satisfied in full and the provider or supplier has been afforded the opportunity for rebuttal in accordance with the requirements of § 405.373 through § 405.375. Recoupment may be resumed under any of the following circumstances:

(i) Immediately upon receipt by the Medicare contractor of the provider's or supplier's request for a withdrawal of a request for a redetermination in accordance with § 405.952(a).

(ii) On the 30th calendar day after the date of the notice of redetermination issued under § 405.956 if the redetermination decision is an affirmation in whole of the overpayment determination in question.

(iii) On the 30th calendar day after the date of the written notice to the provider or supplier of the revised overpayment amount if the redetermination decision is an affirmation in part which has the effect of reducing the amount of the overpayment.

(2) Notwithstanding paragraphs (e)(i), (ii) and (iii) of this section, recoupment must not be resumed, or if resumed, must cease upon receipt of a timely and valid request for a reconsideration by the QIC.

(f) *Initiating or resuming recoupment after final action by the QIC on the reconsideration request.*

(1) Recoupment may be initiated or resumed upon final action by the QIC subject to the following limitations:

(i) The provider or supplier has been afforded the opportunity for rebuttal in accordance with the requirements of § 405.373 through § 405.375; and

(ii) The debt (remaining unpaid principal balance and interest) has not been satisfied in full; and

(iii) If the final action by the QIC is the notice of the reconsideration, the reconsideration decision either affirms in whole or in part the overpayment determination, including the redetermination, in question.

(2) For purposes of this paragraph (f), final action by the QIC on the reconsideration request is the earliest to occur of the following:

(i) The QIC mails or otherwise transmits written notice of the dismissal of the reconsideration request in its entirety in accordance with § 405.972; or

(ii) The QIC receives a timely and valid request to withdraw the request

for the reconsideration in accordance with § 405.972; or

(iii) The QIC transmits written notice of the reconsideration in accordance with § 405.976; or

(iv) The QIC notifies the parties in writing that the reconsideration is being escalated to an ALJ in accordance with § 405.970.

(g) *Disposition of funds recouped.*

(1) If the Medicare contractor recouped funds before a timely and valid request for a redetermination was received, the amount recouped may be retained and applied first to accrued interest and then to reduce or eliminate the principal balance of the overpayment subject to the following:

(i) If the redetermination results in a reversal, the amount recouped may be applied to any other debt, including interest, owed by the provider or supplier before any excess is released to the provider.

(ii) If the redetermination results in a partial reversal and the decision reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to any other debt, including interest, owed by the provider or supplier before any excess is released to the provider or supplier.

(iii) If the redetermination results in an affirmation and the provider or supplier subsequently requests a reconsideration, the Medicare contractor may retain the amount recouped and apply the funds first to accrued interest and then to outstanding principal pending final action by the QIC on the reconsideration request.

(2) If the Medicare contractor also recouped funds in accordance with paragraph (e) of this section, the amount recouped may be retained by the Medicare contractor and applied first to accrued interest and then to reduce or eliminate the outstanding principal balance pending final action by the QIC on the reconsideration request.

(3) If the final action by the QIC is a dismissal, receipt of a withdrawal, a notice that the reconsideration is being escalated to an ALJ, or a reconsideration which affirms in whole the overpayment determination, including the redetermination, in question, the amount recouped is applied to interest first, then to reduce the outstanding principal balance and recoupment may be resumed as provided under paragraph (f) of this section.

(4) If the final action by the QIC is a reconsideration, which reverses in whole the overpayment determination, including the redetermination, in question, the amount recouped may be applied to any other debt, including interest, owed by the provider or supplier to CMS or to HHS before any excess is released to the provider or supplier.

(5) If the final action by the QIC is a reconsideration which results in a partial reversal and the decision reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to any other debt, including interest, owed by the provider or supplier to CMS or to HHS before any excess is released to the provider or supplier.

(h) *Relationship to Extended Repayment Schedules.*

If (1) a provider or supplier has been granted an extended repayment schedule (ERS) under § 401.607(c); (2) the overpayment for which the ERS has been granted is one to which this section is applicable; and (3) a valid and timely request for a redetermination has been received by the Medicare contractor, then notwithstanding the language of § 401.607(c)(2)(iv), the provider or supplier will not be deemed in default if recoupment is not put into effect or stopped in accordance with this section.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)
(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 15, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 12, 2006.

Michael O. Leavitt,

Secretary.

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