




Recoupment Request Guide: Letter



This guide will answer questions you may have related to the Iowa Total Care payclass review project. Please contact your Iowa Total Care Provider Relations Specialist with any questions or concerns.

 **iowa total care.**
  P.O. BOX 8030
FARMINGTON, MO 63640

February 23, 2020

Billed Amount: \$782.75
Project ID: PROJ-11654725-4

PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP

Dear Provider:

Please submit a copy of this letter with any correspondence.

A recent review of our records indicated that an overpayment of claims was made to your account. The reason for the overpayment by Iowa Total Care to your facility was attributed to the Iowa Total Care payclass review project. Please see the attached listing outlining the claim detail for each overpayment. Please refund the amount on the attached spreadsheet, payable to:

Iowa Total Care
Attention: Claims Recovery Unit
P.O. Box 958092
St. Louis, MO 63195-8092

Iowa Total Care is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit a request to:

Iowa Total Care
Attention: Grievance and Appeal Department
P.O. Box 8030 Farmington, MO 63640-
8030

This dispute request must include the following information:

1. Name, address and phone number of the provider of service.
2. Provider's Iowa Total Care National Provider Identification (NPI) number, and Tax Identification Number.
3. A complete and accurate explanation of the issue.
4. Supporting documentation including copies of claims (if applicable), claim numbers, medical records or supporting documentation to challenge the initial adverse determination.

Iowa Total Care will process your dispute request within 30 calendar days. If you do not contest this overpayment determination within 30 working days, Iowa Total Care will offset the overpayment amount against future claims. If a claims payment is not available or applicable for the **Automatic Debit/Recoupment**, the refund must be sent to Iowa Total Care within 60 calendar days.

Your prompt attention and cooperation in this matter is greatly appreciated. If you have questions please contact our provider Service line at 1-833-404-1061.

Sincerely,
Iowa Total Care
Claims Recovery Unit

Billed Amount refers to the billed amount for the claim(s) and does not include the amount paid by Iowa Total Care.

Project ID refers to the ID number needed for reprocessing. This ID is necessary in order Iowa Total Care to review your recoupment information.

Location where to send refunds. Checks should be made payable to Iowa Total Care.

Where to send provider disputes. Remember, disputes must be submitted within 30 business days.

Information that must be included in the dispute request.

Recoupment Request Guide: Claim Detail



An important element of the Iowa Total Care payclass review project is the claim detail report that will be included with your letter. To help you navigate the report, please refer to table below for terminology and definitions included on the report, as well as an example.

| CLAIM | LINE | MEMBER NAME | MEMB NBR | PT CTRL NBR | BIRTH DATE | TIN | DOS | DIAG | PROC | BILLED AMT | PAID AMT | PAID DATE | ADD AMT DUE |
|-------|------|-------------|----------|-------------|------------|-----|----------|-------|-------|-------------|-----------|-----------|-------------|
| | 01 | | | | | | 7/1/2019 | Z7689 | T2031 | \$ 782.75 | \$ 372.00 | 1/3/2020 | \$ (234.83) |
| | 02 | | | | | | 7/1/2019 | Z7689 | S5125 | \$ 84.00 | \$ 84.00 | 12/6/2019 | \$ (25.20) |
| | 03 | | | | | | 7/1/2019 | Z7689 | S5161 | \$ 34.20 | \$ 34.20 | 1/3/2020 | \$ (10.26) |
| | 04 | | | | | | 7/1/2019 | Z7689 | S5170 | \$ 175.15 | \$ 175.15 | 1/3/2020 | \$ (52.55) |
| | 05 | | | | | | 7/1/2019 | Z7689 | S5170 | \$ 175.15 | \$ 175.15 | 1/3/2020 | \$ (52.55) |
| | | | | | | | | | | \$ 1,251.25 | | | \$ (375.39) |

| Terminology | Definition |
|-------------|--|
| CLAIM | Iowa Total Care's claim number |
| LINE | Service line found on claim |
| MEMBER NAME | Member name |
| MEMB NBR | Member number assigned by Health Plan |
| PT CTRL NBR | Member's State Medicaid ID Number |
| BIRTH DATE | Member's date of birth |
| TIN | Provider's tax identification number |
| DOS | From and through date of service |
| DIAG | Diagnosis code assigned by provider |
| PROC | CPT, HCPCS or revenue codes billed |
| BILLED AMT | The amount billed for the procedure or service |
| PAID AMT | The contracted amount allowed for the procedure or service |
| PAID DATE | Date claim or service line was paid |
| ADD AMT DUE | Recoupment offset amount (could be full or partial) until balance is fully satisfied |

EXAMPLE:

| CLAIM | LINE | MEMBER NAME | MEMB NBR | PT CTRL NBR | BIRTH DATE | TIN | DOS | DIAG | PROC | BILLED AMT | PAID AMT | PAID DATE | ADD AMT DUE |
|-------|------|-------------|----------|-------------|------------|-----|----------|-------|-------|-------------|-----------|-----------|-------------|
| | 01 | | | | | | 7/1/2019 | Z7689 | T2031 | \$ 782.75 | \$ 372.00 | 1/3/2020 | \$ (234.83) |
| | 02 | | | | | | 7/1/2019 | Z7689 | S5125 | \$ 84.00 | \$ 84.00 | 12/6/2019 | \$ (25.20) |
| | 03 | | | | | | 7/1/2019 | Z7689 | S5161 | \$ 34.20 | \$ 34.20 | 1/3/2020 | \$ (10.26) |
| | 04 | | | | | | 7/1/2019 | Z7689 | S5170 | \$ 175.15 | \$ 175.15 | 1/3/2020 | \$ (52.55) |
| | 05 | | | | | | 7/1/2019 | Z7689 | S5170 | \$ 175.15 | \$ 175.15 | 1/3/2020 | \$ (52.55) |
| | | | | | | | | | | \$ 1,251.25 | | | \$ (375.39) |

\$782.75 Billed Amount
 - \$372.00 Paid Amount
 = \$234.83 Recoupment Amount Due

\$234.83 Recoupment Amount Due
 - \$372.00 Paid Amount
 = \$137.17 New Claim Amount