

Medicare Financial Management Manual

Chapter 12 – Instructions for Medicare Credit Balance Report Activities

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10 - Instructions to Fiscal Intermediaries (FIs) for the Medicare Credit Balance Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

General

In accordance with section §1815(a) and §1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, §1866(a) (1) (C) of the Act requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. In accordance with these provisions, providers are to complete a Medicare Credit Balance Report (CMS-838) to ensure that monies owed to Medicare are repaid in a timely manner.

Fiscal intermediaries (FIs) are responsible for monitoring and ensuring provider compliance with the credit balance reporting process. This responsibility includes the following activities: ensure that providers submit properly completed CMS-838 reports on time, claims adjustments to Medicare credit balances are properly made, payments to providers are suspended for untimely submission of CMS-838 reports, demand letters are appropriately issued to providers that have not repaid their Medicare credit balances, and outstanding Medicare credit balances are included in Medicare financial reports.

10.1 - Medicare Credit Balance Report (CMS-838)

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. They determine the number and amount of these balances for refunding the Medicare program. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a “credit.” However, Medicare credit balances include money due to the program regardless of its classification in a provider’s accounting records. For example, if a provider maintains credit balance accounts for a stipulated period such as 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies from these credit balance accounts to the Medicare program.

The current version of the Medicare Credit Balance Report (Certification Page and Detail Page) and instructions for its completion are available at www.cms.hhs.gov/forms. This report is identified as CMS Form 838 on the CMS Web site, and a replica of this form is in section 20 of this chapter.

FIs are charged with the responsibility for performing all necessary activities to implement these instructions.

Providers must pay all amounts owed (column 9 of the Detail Page) at the time the credit balance report is submitted. Payment must be submitted with the report and may be made by check or adjustment bill.

- *Submission of the completed Detail Page by itself does not constitute a claim adjustment. The claim adjustment (i.e., adjustment bill) must be submitted separately, either*

electronically or by hard copy (e.g., UB-92). The instructions for column 11 of the Detail Page reflect the type of payment made.

- *If the credit balances are repaid by check, the provider must still submit adjustment bills for any individual credit balances. (The FI will ensure that the monies for these balances are not collected twice.)*

10.1.1 - FI Internal Controls

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

The FI's Chief Financial Officer for Medicare Operations shall ensure that all FI credit balance reporting related processes and activities are completed timely and accurately.

10.1.2 - Minimum Requirements for Internal Controls

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. A designated centralized area to receive Medicare credit balance reports.

B. FIs shall have all CMS-838 reports and accompanying documents retained in the centralized area. The sole exceptions are the originals of the accompanying check and/or accompanying claim adjustment bill.

- *A copy of any accompanying check or accompanying claim adjustment bills must be retained with the other original documents.*
- *All other documents must be copied if the information they contain is needed by another area for the resolution of any matter involving provider credit balance reports.*
- *The envelopes shall be retained or copied to substantiate the date of receipt of the CMS-838 report.*

NOTE: *FIs may convert these materials into image files (e.g., PDF files) for electronic storage and archival purposes.*

C. Faxed credit balance reports that are within 30 calendar days of the close of each calendar quarter should be accepted as timely.

- *Retain the coversheet to substantiate the date of receipt of the CMS-838 report.*

NOTE: *When the FI accepts faxes, the FI shall ensure that these faxes are received over electronically secure transmission lines, and placed in a limited access work area.*

D. The FI shall designate a point of contact for receipt and the resolution of credit balance reporting related issues. This individual is to verify that all FI activities related to credit balance reporting are completed timely and accurately in all areas of the FI.

E. The FI shall have a listing of all providers required for submitting the CMS-838. FIs shall have written procedures to ensure this listing is reviewed and updated each calendar year quarter.

F. Written policies and procedures for monitoring and validating receipt of timely, accurate, and complete CMS-838s from all providers.

For example:

- Is the name and title of the certifying officer or administrator of the provider on the Certification Page, and are all data fields completed for Medicare credit balances on the Detail Page? Did the Detail Page come with an accompanying check and/or appropriate hard copy or electronic adjustment bills?*
- Were the monies for the reported credit balances timely recouped to the Medicare Trust Fund?*

G. FIs shall have appropriate tracking and/or reports for provider credit balances reporting related activities.

For example:

- Such as related claims adjustments, Suspension Warning Letters and suspensions, verification of low Medicare utilization providers with claims data, demand letters, financial reporting, credit balance summary reports, etc., that have been performed with respect to credit balance reports due or received for a given calendar year quarter.*

H. The FI shall have internal controls in place to ensure the accurate and timely processing and reporting of credit balances.

- The time frame for processing claims adjustments for Medicare credit balances from start to finish is 90 days from the receipt date of acceptable credit balance reports. (Contact your RO if you need additional time.)*

I. A desk guide or manual with published internal control policies and standard operating procedures for implementing the credit balance reporting process.

10.1.3 - Processing CMS-838 Claims Adjustments

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. The FI shall review the reported credit balances to ensure that the claims were paid by Medicare and the amounts listed appear to be appropriate.

- The FI shall accept electronic or hard copy adjustment bills for repayment of Medicare credit balances from providers.*
- Based on the FI's review of the credit balance, the FI should decide to do an adjustment or perform a canceled claim in FISS/HIGLAS to recoup the monies owed.*

For example:

- 1. Canceling-out the claim if the claim is entirely incorrect, a duplicate payment, a wrong HIC number, or if the Medicare credit balance resulted from an outpatient claim; or*

2. *Establish a claims adjustment if part of the claim needs modification and the remainder of the claim is correct; or*
3. *Perform a claims recoupment by withholding claim amounts from future Medicare claims. These withheld amounts are to be included in remittance advices to providers.*

B. *Establish and maintain control of all adjustments and adjustment bills from the time you receive them.*

10.2 - Checks Submitted by Providers

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

If a check is submitted by a provider for repayment of Medicare credit balances, the provider must also submit a complete CMS-838 report (Detail and Certification Pages) with hardcopy UB-92's.

- *A check is necessary when a provider has terminated from the program and is no longer submitting claims.*
- *When checks are deposited and adjustment bills are processed, the FI shall ensure that monies for these credit balances are not collected from the provider twice.*

10.3 - Suspension Warning Letter (FI Action if a Credit Balance Report is not Submitted)

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. *The FI shall issue a Suspension Warning Letter if it does not receive a credit balance report from a provider by the 15th calendar day after 30 calendar days from the end of each calendar year quarter (45 calendar days from the end of each calendar year quarter).*

- *The Suspension Warning Letter shall state that the FI will suspend all claims payments at 100% in 15 calendar days from the date of issuance of this letter if the credit balance report is not received during this time period.*
- *This suspension will continue until the FI receives a credit balance report.*
- *The FI shall ensure that any necessary suspensions are implemented timely and maintained, as appropriate. (Refer to Pub. 100-06, Chapter 4, §§40 - 40.2). In addition, Federal regulations at 42 CFR §405.372 require that the provider be notified of the intention to suspend payment and the reasons for the suspension.*

B. *The FI shall have the responsibility to ensure that if providers change from submitting a low utilization cost report to a full cost report, then they shall comply with all credit balance reporting requirements.*

NOTE: *A provider with extremely low Medicare utilization does not have to submit the CMS-838 form. A low utilization provider is defined as a facility that files a low utilization Medicare cost report or files less than 25 Medicare claims per year.*

10.3.1 - Sample Suspension Warning Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

This is a sample suspension warning letter, which the FIs may use to notify the provider.

(Optional)

Exhibit 1 - Sample Suspension Warning Letter

Date:

*[Name], [Job Title]
[Company Name], [Provider Number]
[Address]
[City], [State] [Zip]*

***RE: Past Due Quarterly Credit Balance Report
Suspension Warning Letter
Quarter Ended: _____***

Dear [Title] [Last Name]:

The Medicare Credit Balance Report, CMS-838, for the quarter ending _____ was due on _____. Our records show the Medicare Credit Balance Report for the quarter is overdue.

Since we have not received your report, this letter is notification that, fifteen (15) days from the above date of this correspondence, Medicare will implement a 100% withholding of your payments until the Credit Balance Report is received.

If you have any questions regarding this matter, please contact _____ at (____) _____.

Sincerely,

*[Name]
[Title]*

10.4 - Issuance of a Notification/Rejection Letter to Providers Regarding Non-Payment of Medicare Credit Balances or Missing/Inaccurate Information on the CMS-838 Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. The FI shall have a process in place to resolve non-payment of Medicare credit balances or missing/ inaccurate information on received CMS-838 reports.

For example:

- *Review each credit balance entry individually on the CMS-838 report to determine whether it is missing information such as: is it being repaid by check or hardcopy adjustment bill?*
- *Contacting the provider via telephone, to obtain missing information on the CMS-838 report. (Phone calls should be documented).*
- *If the FI is successful at reaching the provider, the provider may fax over the requested information at the FI's discretion.*

B. *If the FI is unsuccessful in reaching the provider within 30 calendar days from the due date of the CMS-838 report, the FI should issue a letter on the thirtieth-day after the due date of the CMS-838 report.*

- *This letter shall state that the FI will place the provider on 100% withhold up to the total amount owed if the provider does not send a check or adjustment bills for these balances in 15 calendar days from the date of this letter.*
- *After the Notification/Rejection letter has been sent and the provider is placed on 100% withhold up to the total amount owed and a balance remains outstanding 60 days after the due date of the CMS-838, the FI must issue a demand letter to the provider. Refer to Section 10.6 - FI Issuance of a Credit Balance Demand Letter.*

10.4.1 - Sample Notification/Rejection Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

This is a sample notification letter, which FIs may use to notify the provider.

(Optional)

Exhibit 2 – Notification/Rejection Letter

Date:

*[Name], [Job]
[Company Name], [Provider Number]
[Address]
[City], [State], [Zip]*

RE: Notification/Rejection Letter

Quarter Ended: _____

Dear [Title], [Last Name]:

During our review of your submitted Medicare Credit Balance Report (CMS-838) Detail Page for the quarter ending _____, we noted that _____ was not included with your report.

In accordance with published Centers for Medicare and Medicaid Services (CMS) manual instructions, your office must include an adjustment bill for each reported credit balance listed in column 9 of the Detail Page. You should refer to your Provider Instructions for a detailed description of the published guidelines, or visit us on our Web site, www._____.com.

We must receive \$_____ for your payment of reported credit balances within fifteen (15) days from the date of this letter. If we do not receive a check and/or hard copy adjustment bills (UB-92 claim form) or electronic adjustment bills for these balances within 15 days from the date of this letter, your facility will be placed on one-hundred percent (100%) withhold up to the total amount owed to recoup the above liability on day 16.

Make sure to include your Medicare Provider Number on your check. Your check should be mailed to the following address: _____

If you have any questions related to this letter, please call me at (999) 123-4567.

Sincerely,

[Name]

[Title]

10.5 - FI Recovery of Non-MSP/MSP Accounts Receivables and Claims Accounts Receivables

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. Non-MSP Accounts Receivables (A/R) –

- When the credit balance adjustments are entered in the FI's claims processing system, they will remain in the system until the amounts for these adjustments are recouped.*
- These adjustments are normally recovered through the recoupment of future claims, and they are included in remittance advices to providers. If the credit balance has not been recovered, the balance remains outstanding in the FI's financial reporting system and appears in the CMS-751 report.*

NOTE: Refer to Pub. 100-06, chapter 4, §40

B. Non-MSP Claims AR's

The established A/R is included in the FI's balances of new receivables for Medicare credit balances, and these balances appear in Line 2a of the CMS-751. (Pub. 100-06, Chapter 5, §270.2)

NOTE: Follow your existing instructions for recovering MSP A/R's.

10.6 - FI Issuance of a Credit Balance Demand Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

When a Medicare credit balance is not fully recovered to the Medicare Trust Fund through the adjustment bill process (or through check submission) and this balance remains outstanding 60 days after the due date of the CMS-838, the FI shall issue a demand letter to the provider.

- *The FI shall issue demand letters within 60 calendar days from the due date of the CMS-838 report.*
- *If a full payment is not received 15 days after the date of the first demand letter, the FI shall start the 100% withholding of claims payment up to the total amount owed on day 16, (if they haven't already placed providers on 100% from their 1st Notification/Rejection letter)*

Refer to Pub. 100-06, Chapter 4, §§40 and 40.1.

- *If no response is received from the provider within 30 days after the date of the first demand letter, follow the existing instructions in Pub. 100-06, Chapter 4, §§10 and 20.*
- *If the provider believes that prompt repayment of the amount owed Medicare is so large that it will cause financial hardship, the provider may complete a request for an extended repayment schedule in accordance with Pub. 100-06, Chapter 4, §50.*
- *Contact your Regional Office (RO) for guidance on specific provider issues as needed.*

Refer to Pub. 100-06, Chapter 3, §40.2 for sample Demand Letter for Claims Accounts Receivables. For MSP, refer to Pub. 100-05, Chapter 7, §60.10.1 "Intent to Refer" letter.

10.7 - Interest Assessment for Non-MSP and MSP Medicare Credit Balances (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Calculation of Interest on Medicare Credit Balances

Effective October 1, 2004, 42 CFR § 405.378 and 411.24 (m) (l) was amended to change how interest is calculated on Non-MSP/MSP recoveries. Section 1862(b)(2)(B)(i) of the Act provides express authority to assess interest on MSP debts. Under this new rule, interest is assessed for each full 30-day period that payment is not made on time. This change applies to debts established on or after October 1, 2004.

A. Assessment of Interest on Non-MSP Credit Balances

Interest on Non-MSP debts established prior to October 1, 2004 will continue to be assessed under the former method, until the debt is recovered in full.

NOTE: Refer to Pub. 100-06, Chapter 4, §30.3 – Non-MSP (Debt Collection).

B. Assessment of Interest on MSP Credit Balances

Refer to Pub. 100-05, Chapter 7, revised §30.1.5- "Interest on MSP Recovery Claims" for information on the calculation of interest.

For MSP recovery demand letters involving credit balances, there is an exception to the general rule that interest accrues from the date of the recovery demand letter. Federal regulations at 42

CFR 489.20(h) state that if the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, the provider has 60 days to make repayment to Medicare. For MSP credit balances, interest accrues from the later of either the date of the demand letter for the credit balance due or 60 days from the date the provider received the credit balance. If the provider does not specify the date of receipt of the MSP credit balance, accrue interest from the date of the demand letter.

10.8 - Extended Repayment Schedule

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

If, at the time of submitting the CMS-838 report, the provider believes that the repayment of the amount owed Medicare is so large that it will cause financial hardship, a request can be made for an extended repayment schedule in accordance with Pub. 100-06, Chapter 4, §50.

10.9 - Credit Balance Reporting Completion Standard and Backlog Issues

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

All FIs shall notify their RO regarding whether or not they are current with respect to their credit balance reporting workload. “Current” is defined as meeting the specific time frames set forth in these instructions, and the completion of all activities associated with credit balance reporting for a given calendar year quarter which is 90 calendar year days after the receipt date of acceptable CMS-838s for that quarter.

- *FIs are responsible for documenting the “current status” of their credit balance workloads for all quarters from January 1, 1999 to date.*
- *Those FIs who do not have “current” credit balance workloads must submit a plan to their RO for bringing their workloads into compliance within 30 days of the issuance of this manual instruction.*

10.10 - Medicare Credit Balance Summary Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

- *FIs shall prepare their summary reports in Excel (an electronic file of this report is available from Central Office (CO) by e-mail to: CMS_SCBR@cms.hhs.gov), and to include their five digit FI number in the file name (i.e., CBSFI#####.xls). In addition, FIs shall complete the “Prepared/Approved by:” section at the bottom of their reports.*
- *See Exhibit 3 below for a sample Medicare Credit Balance Summary Report.*
- *FIs shall submit their Medicare credit balance summary reports to CO via e-mail (CMS_SCBR@cms.hhs.gov) no later than 45 days after provider credit balance reports are due.*

10.10.1 - Instructions for Completing the Medicare Credit Balance Summary Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Below are FI instructions for completion of the Medicare Credit Balance Summary Report.

Credit Balance Activities by Type of Provider for This Quarter

No. of Providers Required to Submit CMS Form 838 for This Quarter -- Show the total number of providers, by type of provider, which were required to submit a credit balance report for the reporting quarter. Do not include low utilization providers or any other providers that were not required to submit a credit balance report.

No. of Providers With Submission of CMS Form 838 for This Quarter -- Show the total number of providers, by type of provider, that submitted a credit balance report for the reporting quarter.

Number of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter - Count the number of identified Medicare credit balance amounts that were reported, by type of provider, from column 9 of the provider's CMS-838 Detail Page for this quarter.

Amount of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter - Show the total amount of identified Medicare credit balances that were reported, by type of provider, from column 9 of the provider's CMS-838 Detail Page for this quarter.

Total - Sum all columns.

10.11 - Exhibit 3: MEDICARE CREDIT BALANCE SUMMARY REPORT
 (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Fiscal Intermediary: (Name and Number)

Quarter Ended: _____

Credit Balance Activities by Type of Provider for This Quarter

<u>Type of Provider</u>	<u>No. of Providers Required to Submit CMS Form 838 For This Quarter</u>	<u>No. of Providers That Submitted CMS Form 838 For This Quarter</u>	<u>Number of Identified Medicare Credit Balances on CMS Form 838 For This Quarter</u>	<u>Amount of Identified Medicare Credit Balances on CMS Form 838 For This Quarter</u>
Hospital	-----	-----	-----	\$-----
SNF	-----	-----	-----	-----
HHA	-----	-----	-----	-----
ESRD	-----	-----	-----	-----
Other	-----	-----	-----	-----
TOTAL	=====	=====	=====	\$=====

NOTE: See the next page for a sample of a completed summary report.

Prepared by: _____

Date Prepared: _____

Approved by: _____

Date Approved: _____

SAMPLE REPORT

MEDICARE CREDIT BALANCE SUMMARY REPORT

Fiscal Intermediary: Blue Cross Blue Shield of XXXXXXX 00xxx
Quarter Ended: 9/30/2004

Credit Balance Activities by Type of Provider for this Quarter:

<i>Type of Provider</i>	<i>No. of Providers Required to Submit CMS Form 838 For This Quarter</i>	<i>No. of Providers That Submitted a CMS Form 838 For This Quarter</i>	<i>Number of Identified Medicare Credit Balances on CMS Form 838 For This Quarter</i>	<i>Amount of Identified Medicare Credit Balances on CMS Form 838 For This Quarter</i>
<i>Hospital</i>	300	257	1,348	\$643,278
<i>SNF</i>	278	215	288	86,441
<i>HHA</i>	0	0	0	0
<i>ESRD</i>	21	21	0	0
<i>Other</i>	34	33	15	3,065
TOTAL	<u>633</u>	<u>526</u>	<u>1,651</u>	<u>\$732,784</u>

Prepared by: _____ **Date Prepared:** _____

Approved by: _____ **Date Approved:** _____

20 - Provider Instructions for Medicare Credit Balance Report
(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

General

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses the information. In accordance with sections 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, all providers participating in the Medicare program are to complete a Medicare Credit Balance Report (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" due to Medicare. A credit balance is an improper or excess payment made to a provider as the result

of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due to Medicare.

Only Medicare credit balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the applicable provider manual that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

20.1 - Submitting the CMS-838 (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Submit a completed CMS-838 to your fiscal intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

20.2 - Completing the CMS-838 (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the

reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from the CMS web site (e.g., www.cms.hhs.gov/forms) or your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. This page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you have reported. An electronic file (or hard copy) of the detail page is also available from the CMS Web site or your FI.

You may submit the detail page(s) on a diskette/CD or by secure electronic transmission to your FI as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE: Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;
- The facility's provider number (if there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number);
- The month, day and year of the reporting quarter, e.g., 12/31/02;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3);and
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1 - The last name and first initial of the Medicare Beneficiary, (e.g., Doe, J.)

Column 2 - The Medicare Health Insurance Claim Number (HICN) of the Medicare Beneficiary.

Column 3 - The multiple-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

- Column 4 - The 3-digit number explaining the type of bill, e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the section(s) for the Uniform Billing instructions in the applicable provider manual.)
- Columns 5/6 - The month, day and year the beneficiary was admitted and discharged, if an inpatient claim; or "From" and "Through" dates (date service(s) were rendered), if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 1/1/02).
- Column 7 - The month, day and year (e.g., 1/1/02) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure the paid date and ICN number correspond to the most recent payment.
- Column 8 - An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)
- Column 9 - The amount of the Medicare credit balance that was determined from your patient/accounting records.
- Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the CMS-838 to your FI.)
- Column 11 - Choose one of the following:
A "C" when you submit a check with the CMS-838 to repay the credit balance amount shown in column 9;
An "A" if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the CMS-838;
A "Z" if payment is being made by a combination of check and hard copy adjustment bill with the CMS-838; or
An "X" if an adjustment bill has already been submitted electronically or by hard copy.
- Column 12 - The amount of the Medicare credit balance that remains outstanding (column 9 minus column 10). Show a zero ("0") if you made full payment with the CMS-838 or a claim adjustment has been submitted and has been fully processed to recoup the Credit Balance.
- Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer or a "3" for "other reasons". Provide an explanation on the detail page for each credit balance with a "3".
- Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter the code applicable to the payer with the largest liability. For

code description, see the section(s) in the applicable provider manual for the listed codes.)

- 12 - Working Aged
- 13 - End Stage Renal Disease
- 14 - Auto No Fault
- 15 - Workers' Compensation
- 16 - Other Government Program
- 41 - Black Lung
- 42 - Department of Veterans Affairs (VA)
- 43 - Disability
- 44 - Conditional Payment
- 47 - Liability

Column 15 - The name and billing address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report.

20.3 - Payments of Amounts Owed Medicare (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Providers must pay all amounts owed (column 9 of report) at the time the credit balance report is submitted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a **separate** adjustment bill for all individual credit balances. The FI will ensure that the monies are not collected twice.
- Submission of credit balance information on the CMS-838 detail page will not be accepted by the FI as a substitute for adjustment bills.
- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).
- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that “if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare...” the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.
- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, you may contact your FI regarding an extended repayment schedule.

20.4 - Records Supporting CMS-838 Data (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Develop and maintain documentation that shows that **each patient record with a credit balance** (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether the patient is an eligible Medicare beneficiary;
- Identify other liable insurers and the primary payer;
- Adhere to applicable Medicare payment rules; and
- Ensure that the credit balance is due and refundable to Medicare.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

20.5 - Provider-Based Home Health Agencies (HHAs) (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Provider based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it may be different from the FI servicing the parent facility.

20.6 - Exception for Low Utilization Providers (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, section 2414.4.B, or files less than 25 Medicare claims per year.

20.7 - Compliance with MSP Regulations (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Federal regulations at 42 CFR 489.20(h) requires you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of the CMS-838 and adherence to CMS's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it on the CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to the expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.

20.8 - Exhibit I: Medicare Credit Balance Report Certification Page
(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0600

MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of Sections 1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITTS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by

Provider Name

Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

(Sign)

Officer or Administrator of Provider

(Print)

Name and Title

(Print)

Date

CHECK ONE:

- Qualify as a Low Utilization Provider.
 The Credit Balance Report Detail Page(s) is attached.
 There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached.)

Contact Person

Telephone Number

Form CMS-838 (10/03)
838

INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT – PROVIDER INSTRUCTIONS, FORM CMS-

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R99FM	06/30/2006	Initial Issuance of Chapter Instruction for Medicare Credit Balance Reporting Activities	10/02/2006	5084

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