Medicare Financial Management
Chapter 4 - Debt Collection

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(Rev. 202, 07-29-11)

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NOTE: Revision 4 includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - Requirements for Collecting Overpayments - Fiscal Intermediaries
(Rev. 29, 01-02-04)

The following collection activities are the minimum requirements of the Fiscal Intermediary for all overpayments, claim based or cost report based. However, see Chapter 3, §40 for additional instructions for claim accounts receivables.

- Once an overpayment is discovered and a final determination is made a first demand letter should be sent. This first demand letter shall meet the requirements set forth in §20.

- Once a final determination is made, an accounts receivable shall be created and the overpayment shall be posted onto the POR System. (Cost report receivables only)

- If a full payment is not received 15 days after the date of the first demand letter the FI shall start recoupment on day 16. (See Chapter 4, §40) (Cost report receivables only)

- If no response is received from the provider 30 days after the date of the first demand letter, a second demand letter shall be sent on day 31. (See Chapter 4, §20.)

- If the overpayment is not paid in full by day 30 interest shall begin to accrue on day 31. (See Chapter 4, §30.)

- If by day 45 there has been no response or no contact with the provider the FI shall attempt to contact the provider by telephone. Attempted contact shall be completed at various times of the day until contact is made. The FI may cease attempting to contact the provider if the debt is referred to the Department of Treasury, if the provider files for bankruptcy, or under the guidance of CMS. At a minimum FIs shall attempt to call the delinquent provider weekly until contact is made (A voicemail message is not considered contact.). If contact is made, the FI shall determine how the provider plans to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed.

- If no response is received from the provider 30 days after the date of the second demand letter, a third demand letter shall be sent on day 61. If the debt is eligible for referral to the Department of Treasury, the third demand letter shall include language indicating an intent to refer the debt to the Department of Treasury if necessary. (See §20.)

- If the provider submits an application for an extended repayment plan the FI shall follow the instruction in §50. (An ERP application may be submitted at any time during the collection process.)

- If the FI cannot reach the provider by telephone or the FI receives any demand letter back as undeliverable the FI shall attempt to locate the provider through other means. Overpayment departments shall refer to provider enrollment applications, Medical Review staff, and Fraud and Abuse staff for further ideas concerning the debtor's whereabouts. Overpayment departments shall attempt to find out if the provider is bankrupt and the names of the owner, partners, or the corporation officers. If the FI has

access to an Internet search site, such as Lexis-Nexis® or a similar program, in the Overpayment department or another department this shall also be utilized. If the FI does not have access to a search program the servicing regional office shall be contacted to see if they could be of assistance. All attempts to find the provider shall be documented in the case file.

- If the FI believes the debt may be recovered in litigation, consult with the servicing regional office before referring the debt to the Department of Treasury.

- After 60 days, if there is no response to the intent to refer letter, the FI shall input the debt into the Debt Collection System for referral to the Department of Treasury for cross servicing and offset. Until the Department of Treasury accepts the debt, the collection of the debt is still the responsibility of the FI. Therefore, collection activities shall not cease until the acceptance from the Department of the Treasury is received. This acceptance shall be noted on the contractor's internal system as well as in the case file. Recoupment by means of withhold will continue by the FI until the debt is collected in full.

- Throughout all stages of the overpayment FIs shall keep records of all collection activity. These records can be in the overpayment case file or can be stored electronically or a combination of both. Regardless of which storage method is used all records must be retrievable. This includes all correspondence, all collection forms, all checks, and any other piece of the case file that was kept in hardcopy or electronically. This record is in addition to the internal accounting system and the Provider Overpayment Reporting (POR) System. This record shall be detailed and include all conversations and correspondence with the provider. An outside individual shall be able to see a complete audit trail. Hard copy files shall be available immediately upon request. Electronic files must be available within 48 hours of request. Files that have been converted to microfilm must be available within 48 hours of request. Files that have been stored offsite must be available within 72 hours of request. (See Ch. 5 §200 for additional information.)

The FIs shall input all cost report overpayments on the POR System within 10 days of the determination date. Unfiled and as filed cost report overpayments shall be input within 17 days of the due date of the cost report. (This allows 7 days for mail time. The determination date for an unfiled cost report and an as filed cost report is the day after the due date of the cost report. This date should be utilized even if the as filed is received after the due date. Contractors will not be penalized for late entry into the POR System as long as the case file indicates when the cost report was received.) In addition, all changes, updates and recoupments shall be posted onto the POR System within 10 days. FIs shall attempt to use the most current status code. Once the status of the overpayment changes, the status code shall be updated within 10 days. FIs shall attempt to use the most current status code that accurately reflects the overpayment's current situation. FIs shall remember that certain codes such as bankruptcy, debt referral and Currently Not Collectible supercede all other codes. If the FI cannot determine the appropriate status code, the servicing regional office shall be contacted for assistance.

20 – Cost Report Overpayment Demand Letters

(Rev. 29, 01-02-04)

The purpose of an overpayment demand letter is to notify the provider of the existence and amount of an overpayment, and to request repayment. Every demand letter, regardless of the cause of the overpayment or the status of the provider shall meet certain requirements as to form and content. Each demand letter is:

- Sent to the provider. (For institutional providers, the FI will not address the letter to the facility only, but to the person(s) it identified as responsible for any debts incurred by the provider.

- Sent by certified mail, return receipt requested (FIRST REQUEST ONLY);

- Labeled either - FIRST REQUEST, SECOND REQUEST, or THIRD REQUEST;

- For a first request, mail within 7 calendar days of discovery or determination of the overpayment. In the case of the second or third request, mailed 30 days after the most recent demand letter;

- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined. (Does not apply in situations involving overdue cost reports)

- The demand letter shall offer the provider the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be analyzed using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter. (Does not apply in situations involving overdue cost reports.)

- The demand letter constitutes a request to the provider to refund the overpaid amount. The FI provides a brief description of the methods of repayment (or, where applicable, it requests the provider to submit the overdue cost report).

  The demand letter informs providers that continue to participate and have filed the cost report, that the FI will adjust (reduce or withhold) interim payments if it does not receive repayment, or a request for a repayment plan along with the first month's payment within 15 days of the demand letter. In the situation of an unfiled cost report or an as filed cost report overpayment, the cost report reminder letter serves as sufficient notice that interim payments will be suspended if the overpayment is not received on or before its due date.

- The FI shall not recoup interim payments before the 16th day after the date of notification.

Exception: If the provider has provided the FI with a written request or written authorization to begin recoupment before the 16th day, the FI shall comply with the provider's request.

- The demand letter also points out that, where a cost report has not been filed timely and the provider continues to participate, interim payments were adjusted (reduced or suspended) on the seventh (7th) calendar day following the due date of the cost report.

NOTE: The cost report reminder letter (see Chapter 3, §30) serves as sufficient notice to the provider that interim payments will be suspended if the overpayment is not received on or before its due date.

Providers in bankruptcy proceedings. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.

20.1 - Number of Demand Letters
(Rev. 29, 01-02-04)

In general the FI shall send **three** overpayment demand letters to a provider. These must be in the case file. The FI shall keep copies of all demand letters. Where one or two demand letters have been sent and returned undeliverable the FI shall attempt to locate the provider. If the FI is unable to locate the provider and the overpayment is eligible for referral to the Department of Treasury, the FI shall immediately send the third demand letter which shall include the intent to refer language.

Where a repayment plan has been established (either through refund or setoff against interim payments) after the first or second demand letters have been sent **and** the provider defaults on the repayment plan, the FI counts the demand letters sent prior to the acceptance of the repayment plan toward the total of three letters normally sent to an overpaid provider.

20.2 - Content of Demand Letters – FI Serviced Providers
(Rev. 61, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Exhibit l contains a detailed list of the requirements (this Exhibit is not all inclusive) for each of the three basic demand letters for use in various overpayment situations. Certain items may be combined; for example, the Notice of Program Reimbursement may be attached to the first demand letter. Since some cases may become very complex, some sample letters have been included.

Exhibit 1: Contents of a Demand Letter

Exhibit 2: Sample Overpayment Demand Letter – Cost Report Filed -First Request

Exhibit 3: Sample Overpayment Demand Letter – Cost Report Filed - Second Request (30 days after the date of the first demand letter)

Exhibit 4: Sample Overpayment Demand Letter – Cost Report Filed - Third Request (30 days after the date of the second demand letter)

Exhibit 5: Sample Overpayment Demand Letter--Unfiled Cost Report- First Request

Exhibit 6: Sample Overpayment Demand Letter--Unfiled Cost Report- Second Request

Exhibit 7: Sample Modified Intent Letter for Unfiled Cost Reports Only-Third Request

EXHIBIT 1: CONTENTS OF A DEMAND LETTER
(Rev. 41, 04-30-04)

Key: Overpayment Situations

A - an overpayment due to pattern of excessive or noncovered services
B - cost report overdue- (all payments are considered an overpayment) participating and terminated providers
C - cost report filed and an overpayment is due- participating and terminated providers

	First Demand				**Second Demand**				**Third Demand**		
	A	**B**	**C**		**A**	**B**	**C**		**A**	**B**	**C**
Send letter by certified mail	X		X								
Mail letter to provider with 7 days of the determination of the overpayment	X		X								
Mail letter to provider on the 7th day after the due date or extended due date of the cost report, if not received.		X									
Include explanation of the overpayment determination and the amount due or Notice of Program Reimbursement	X		X								
As applicable, request provider to submit cost report, make a refund, or arrange repayment	X	X	X		X	X	X		X	X	X
An adjustment (reduction or suspension) of interim payments has been imposed (indicate percentage of withhold)		X			X	X	X		X	X	X
Notify provider it has 15 days to work out a repayment plan or to pay balance in full before adjustment (reduction or suspension) of interim payments is begun	X		X								
If payment in full is not received within 30 days, interest will be charged	X		X								
Notify provider it has 15 days to submit a statement of explanation before suspension of interim payments begins	X		X								
DCIA Intent Language for referral to the Treasury Department for cross servicing									X	X	X
Mail letter to provider 30 days after the date of the first demand letter					X	X	X				
Mail letter to provider 30 days after the date of the second demand letter									X	X	X

EXHIBIT 2- OVERPAYMENT DEMAND LETTER- COST REPORT FILED- FIRST REQUEST
(Rev. 41, 04-30-04)

FIRST REQUEST

Certified Mail #

Mr. Joe Smith, President
Provider Name
Anytown, State ZIP Code

Date

Dear Mr. Smith:

Contractors shall use the appropriate paragraph for the cost report situation:

(NPR Issued)

On July 26, 20xx, we received your cost report for the fiscal year ending June 30, xxxx. We have fully reviewed this report, and the results of our review have been incorporated in the enclosed copy of your Notice of Amount of Program Reimbursement (dated August 21, 20xx. As explained in the Notice, we find that the Valley Convalescent Center has been overpaid $_____ for the past fiscal year.

(Tentative Settlement)

On July 26, 20xx we accepted your cost report for the fiscal year ending June 30, xxxx. We have completed a preliminary review of this report and have determined that the Valley Convalescent Center has been overpaid $ _____ for this fiscal year.

(As Filed Cost Report)

On July 26, 20xx we received your cost report for the fiscal year ending June 30, xxxx, and on _____, the cost report was determined acceptable. The cost report, as filed, reflects an overpayment $_____ for this fiscal year. The Provider Reimbursement Manual (PRM) Part 1, Chapter 24, Section 2409.A(2) states that when a cost report is filed indicating an overpayment, a full refund should accompany the cost report submission.

(Home Office Cost Report is Unfiled)

We have not received the home office cost report from _____. According to our records _____ serves as the home office for your facility. Since the home office cost report remains unfiled the amount stated on your filed cost report for the fiscal year ending _____ for home

office costs has been disallowed. This disallowance will continue until the home office submits the home office cost report.

The total of $_____ should immediately be refunded in full. Your facility's check should include your provider number and be made payable to _____.

PLEASE MAIL TO:

If payment in full is not received by, (specify a date 15 days from the date of the notification), payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur on _____ you must notify <contractor> before ___. We will review your documentation, but will not delay recoupment. This is not an appeal of the overpayment determination. The appeal process is detailed in the NPR. In addition, in accordance with 42 CFR 447.30, if we do not receive payment in full or an extended repayment request from you within 15 days from the date of this letter we may initiate a request that your Federal share of Title XIX (Medicaid) be withheld, if applicable. If this withholding is initiated it will not be removed until payment in full is received or an acceptable extended repayment request is received and approved.

In accordance with 42 CFR 405.378 simple interest at the rate of __ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made in full. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged and will continue to be assessed for full 30-day periods on any portion that remains outstanding until the debt is paid in full. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ .

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure for details.) Any repayment plan (where one is approved) would run from the date of this letter. If we do not hear from you, your interim payments will be withheld starting on the 16th day from the date of this letter, and applied towards the outstanding overpayment balance. Any amount withheld will not be refunded.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Should you have any questions please contact _____ at _____.

We expect to hear from you shortly.

Sincerely,

(name and title)

Enclosure

EXHIBIT 3- OVERPAYMENT DEMAND LETTER- COST REPORT FILED - SECOND REQUEST

(Rev. 41, 04-30-04)

SECOND REQUEST

Date (30 days after the date of the first demand letter)

Mr. Joe Smith, President
Valley Convalescent Center
Anytown, State ZIP Code

RE: MEDICARE OVERPAYMENT FOR <contractor name>
FISCAL YEAR ENDED _____
PROVIDER NUMBER _____

Dear Mr. Smith:

On July 26, 20xx, we sent you a request for an overpayment that resulted from FY 20xx. We have not yet received payment or an application for an extended repayment plan. The outstanding amount due for this overpayment is $_____ which includes a principal amount of $_____ and interest assessed in the amount of $_____. This amount must immediately be refunded in full.

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received or an acceptable extended repayment plan is approved.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is repaid in installments or recouped by withholding your facility's interim payments, each payment will first be applied to accrued interest and then to principal. Interest will be assessed for each 30-day period that payment is delayed. The interest rate set by

the Secretary of the Treasury for overpayment determinations made on or after _____ is _____percent.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure in initial demand letter) Any repayment plan (where one is approved) would run from the date of the first demand letter.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly.

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this withholding is initiated it will not be removed until payment in full is received or an acceptable extended repayment request is received and approved.

Should you have any questions please contact _____ at _____. We expect to hear from you shortly.

EXHIBIT 4- OVERPAYMENT DEMAND LETTER- COST REPORT FILED -THIRD REQUEST

(Rev. 41, 04-30-04)

SECOND REQUEST

Date (30 days after the date of the first demand letter)

Mr. Joe Smith, President
Valley Convalescent Center
Anytown, State ZIP Code
RE: MEDICARE OVERPAYMENT FOR <contractor name>
FISCAL YEAR ENDED _____
PROVIDER NUMBER _____

Dear Mr. Smith:

On July 26, 20xx, we sent you a request for an overpayment that resulted from FY 20xx. We have not yet received payment or an application for an extended repayment plan. The outstanding amount due for this overpayment is $_____ which includes a principal amount of $_____ and interest assessed in the amount of $_____. This amount must immediately be refunded in full.

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received or an acceptable extended repayment plan is approved.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is repaid in installments or recouped by withholding your facility's interim payments, each payment will first be applied to accrued interest and then to principal. Interest will be assessed for each 30-day period that payment is delayed. The interest rate set by the Secretary of the Treasury for overpayment determinations made on or after _____ is _____percent.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure in initial demand letter) Any repayment plan (where one is approved) would run from the date of the first demand letter.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly.

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this withholding is initiated it will not be removed until payment in full is received or an acceptable extended repayment request is received and approved.

Should you have any questions please contact _____ at _____. We expect to hear from you shortly.

EXHIBIT 5: OVERPAYMENT DEMAND LETTER – UNFILED COST REPORT- FIRST REQUEST

(Rev. 41, 04-30-04)

(Mailed 7 calendar days after cost report was due)

Date:

FIRST DEMAND LETTER

{Provider name}
{Mail to Name}
{Mail to Address 1}
{Mail to Address 2}
{City} {State} {Zip}

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

RE: **Late Medicare Cost Report**
Provider Name: {DBA Name}
Provider Number: {xxxxxxxx}
Fiscal Year End: {Month, Day, Year}
Taxpayer Identification Number: {xxxxxx}

Dear {Title} {Last Name}

We have not received the cost report for {DBA Name}, provider number {xxxxxxx} for the period ending {month/day/year}. Under Title 42 Code of Federal Regulations (CFR), Section 413.24, cost reports are due by the last day of the fifth month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS &R) reports from the contractor, whichever is later. Your report is now late as it was due {month/day/year}.

Deemed Overpayment: Title 42 CFR 405.378 (c) (1) (v)
As a cost report has not been received from your facility, all interim and lump sum payments made for the fiscal period noted above are deemed an overpayment. The principal amount of the overpayment related to this fiscal period is {$ xxxxxx.xx} . If you do not submit a cost report please be advised that this letter constitutes Federal Claims Collection Standards (FCCS) notification that this amount is now due and must be remitted to us within thirty (30) days from the date of this letter. Interest will be assessed on any portion of this amount that is not paid timely.

If full payment is not received or arrangements made for an extended repayment plan, we will take all action(s) necessary to recover the full amount. (See enclosure for extended repayment plan details.)

Suspension:
<u>As your cost report has not been received timely, all payments to your facility have now been suspended under the authority of Title 42 CFR Section 405.371(c).</u> Payments will not be resumed until an acceptable cost report is received by us.

Interest Charges:
Interest is assessed on late cost reports and late payments under Title 42 CFR 405.378 (c) (1) (v):

1. Cost reports reflecting an amount due to the Medicare program must include the full amount owed (including interest) from the day following the date the cost report was due to the date that the cost report is filed.

2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not included with the cost report, interest will continue to accrue on the overpayment until it is paid in full.

3. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settlement or NPR, interest will be assessed on the overpayment from the day following the date the cost report was due to the date the cost report is filed. If the subsequent overpayment is not paid within thirty (30) days of the date of the first demand letter, additional interest will be assessed from the date of the subsequent determination until the overpayment is paid in full. If the full amount is not paid, any partial payments will be applied first to accrued interest and then to principal. After each partial payment, interest will continue to accrue on the remaining principal balance.

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report.
Under Title 42 CFR Section 405.378 (b) (2), interest charges are assessed in thirty days periods. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be assessed and for each full 30-day period until the debt is paid in full.

Cost Report Submission:
Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with any amounts due (principal and interest), (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty days of the date of this letter, or (3) A request for a repayment plan of all interim payments, the deemed overpayment, within fifteen (15) days of the date of this letter. Checks are to be made payable to {Contractor}. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

{Prime Contractor}
{Division or Group}
{Routing, Room Number}
{Mail To Address 1}
{Mail To Address 2}
{City, State, Zip}

As you are aware, cost reports are subject to further review. There could be additional adjustments required after completion of a review. Therefore, the records supporting this report are to be retained for at least three (3) years from the date of the NPR.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare and Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Medicaid Offset:

If this matter is not resolved within fifteen (15) days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, Section 447.30(g). These recoveries will be in addition to any recoupments from other Medicare funds due you until the full amount owed to Medicare is recovered.

Termination of Medicare Provider Agreement:
Be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the required cost report may result in the termination of your Medicare provider agreement.

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions concerning this letter, do not hesitate to call {Title} {Insert full name} at {(xxx) xxx-xxxx}.

Sincerely,

{Title} {Name}
{Position Title}

Exhibit 6- OVERPAYMENT DEMAND LETTER- UNFILED COST REPORT- SECOND REQUEST

(Rev. 41, 04-30-04)

Date:

SECOND DEMAND LETTER

{Provider Name}
{Mail to Name}
{Mail to Address 1}
{Mail to Address 2}
{City} {State} {Zip}

RE: **Late Medicare Cost Report**
Provider Name: {DAB Name}
Provider Number: {xxxxxxxx}
Fiscal Year End: {Month, Day, Year}
Taxpayer Identification Number: {xxxxxx}

Dear {Title} {Last Name}

This is our second letter to you noting that we have not received the cost report for {DBA Name}, provider number {xxxxxxx} for the period ending {month/day/year}. Under Title 42

Code of Federal Regulations (CFR), Section 413.24, cost reports are due by the last day of the fifth month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS & R) reports from the contractor, whichever is later. Your report continues to be late as it was due {month/day/year}.

Deemed Overpayment:
As neither cost report or payment for the deemed overpayment has been received from your facility, all interim and lump sum payments made for the fiscal period noted above continue to be deemed an overpayment and are now delinquent. The amount owed is {$ xxxxx.xx}. This amount is overdue and must be remitted to us within thirty (30) days from the date of this letter. Interest will be assessed on any portion of this amount that is not paid timely. If full payment is not received, we will take all action(s) necessary to recover the full amount owed.

Suspension:
<u>As your cost report has not been received timely, all payments to your facility continue to be suspended under the authority of Title 42 CFR Section 405.371(c).</u> Payments will not be resumed until an acceptable cost report is received by us.

Interest Charges:
Interest is assessed on late cost reports and late payments under Title 42 CFR 405.378(c)(1)(v):

1. Cost reports reflecting an amount due the Medicare program must include the amount owed (including interest) from the day following the due date of the cost report to the date that the cost report is filed.

2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not included with the cost report, interest will continue to accrue on the overpayment until it is paid in full.

3. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settlement or NPR) interest will be assessed on the overpayment from the day following the date the cost report was due to the date the overpayment is paid. If the full amount is not paid, any partial payments will be applied first to accrued interest and then to principal. After each partial payment, interest will continue to accrue on the remaining principal balance.

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report. Under Title 42 CFR Section 405.378, interest charges are assessed in thirty days periods. Interest charges for a thirty (30) day period are calculated by multiplying the principal amount due by the interest rate and then dividing by twelve (12). A debt that is paid thirty-one (31) days late is assessed one (1) full thirty-day period.

Cost Report Submission:

Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with any amounts due (principal and interest), (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty days of the date of this letter. Checks are to be made payable to {Contractor}. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

{Prime Contractor}
{Division or Group}
{Routing, Room Number}
{Mail To Address 1}
{Mail To Address 2}
{City, State, Zip}

As you are aware, cost reports are subject to further review. There could be additional adjustments required after completion of a review. Therefore, the records supporting this report are to be retained for at least three (3) years.

As we informed you previously, If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare and Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the required cost report may result in the termination of your Medicare provider agreement. However, termination of a provider agreement in no way abrogates the responsibility of the facility to file a cost report, repay an overpayment, or to comply with the Medicare law, regulations, and instructions applicable to the period when the facility was participating.

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions concerning this letter, please call _____ at _____.

Sincerely,

Name and title

Exhibit 7- MODIFIED INTENT LETTER FOR UNFILED COST REPORTS ONLY - THIRD REQUEST

(Rev. 61, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Subject in Bold: **Notice of Intent to Refer Unfiled Cost Report Debts to the Department of Treasury's Debt Collection Center for Cross Servicing and Offset of Federal Payments**

Insert contractor opening paragraphs concerning the reason for the overpayment, date of determination and amount due. Refer to previous demand letters or other forms of contact regarding the debt.

Your **unfiled cost report debt** to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt **may** be referred to the Department of Treasury's **Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments.** Your debt **may** be referred under the provisions of Federal law, title 31 of the United States Code, Section 3720A and the authority of the Debt Collection Improvement Act of 1996.

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debt to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross servicing and/or the Treasury Offset Program. Under the offset program, delinquent Federal debt is collected through offset of other Federal agency payments you may be entitled to, including the offset of your income tax return through the Internal Revenue Service (IRS).

The DCC may use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it **may** be reported to the IRS as potential taxable income.

For Individual Debtors Filing a Joint Federal Income Tax Return

The Treasury Offset Program automatically refers debt to the IRS for offset. Your Federal income tax refund is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which **may** be payable to the non-debtor spouse.

Federal Salary Offset

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) **may** be offset if you are or become a federal employee.

Medicaid Offset

As authorized in 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS **may** instruct the State Medicaid Agency to offset the Federal share of any Medicaid payments due to you, your agency and/or related facilities. At that time, the offset **shall** remain in effect until the Medicare overpayment is paid in full.

Read the following instructions carefully to determine what action you should take to avoid referral for cross servicing/offset.

Due Process

You have the right to request an opportunity to inspect and copy records relating to the **unfiled cost report debt**. This request must be submitted in writing to the address listed below. You have the right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter. You must submit any evidence that the debt is not owed or legally enforceable within **60 calendar** days of the date of this letter. If, after sixty calendar days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, **may** be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset. **NOTE: Unfiled Cost Report debts (including new ones) may be transferred to Treasury for cross servicing/offset, upon approval from CMS central/ regional offices.**

Repayment

Your unfiled cost report debt(s) **shall not** be referred to the Department of Treasury if you submit the cost report or make the **payment in full**; otherwise you will remain legally responsible for any amount not satisfied through the collection efforts.

Your check or money order for the amount due should be made payable to:

Medicare
Contractor Address
000 Street
Anywhere USA 00000-0000.

Include a copy of this letter with your payment.

If you cannot make the payment in full, you **may** be allowed to enter into an **extended repayment agreement**. If you are interested in an extended repayment agreement, please contact this office.

Bankruptcy

If you have filed for bankruptcy and an automatic stay is in effect, you are not subject to offset while the automatic stay is in effect. Documentation supporting your bankruptcy status, along with a copy of this notice, must be forwarded to this office at the above address.

If you have any questions concerning this debt, please contact_____ at_____.

Sincerely,

_____
Signature of Certifying Official

30 - Interest Assessment/Payment on Overpayments and Underpayments

(Rev. 29, 01-02-04)

The CMS regulations, in accordance with the Federal Claims Collection Act, as amended, the Social Security Act, and common law establish specific rules for the payment of interest on Medicare overpayments and underpayments (42 CFR 405.378). As a general rule, interest shall be assessed at the prevailing rate specified by the Secretary of the Treasury unless the overpayment is recouped or the underpayment is paid within 30 days of a "final determination."

Interest shall be assessed on overpayments, and shall be paid on underpayments, to providers and suppliers of services (including physicians and other practitioners), if the overpayment or the underpayment is not liquidated within 30 days from the date of the final determination.

The provisions of this section may not apply to FI overpayments or underpayments determined as a result of interim rate and periodic interim payment (PIP) adjustments (See Chapter 3, §60) or utilization reviews. The basic rules for assessing interest are:

30.1 - Final Determination

(Rev. 29, 01-02-04)

For purposes of this chapter:
A final determination is deemed to occur upon final settlement of a cost report when both an NPR and a written demand for payment of an overpayment or a written determination of an underpayment is transmitted to a provider based upon:

- An audited final settlement;
- Final settlement without audit; or
- Reopening for any reason.

In cases in which an NPR is not used as a notice of determination, one of the following determinations is issued:

- A written determination that an overpayment exists and a written determination for payment;
- A written determination of an underpayment;
- An Administrative Law Judge (ALJ) or hearing officer’s decision that reduces the amount of an overpayment below the amount that CMS has already collected. A final determination is deemed to have occurred only when the amount of the overpayment/underpayment has been calculated. This may be at the decision time and it may be at a later time if recalculations are necessary.

- A written determination that an As Filed Cost Report has been received without payment;

- A written determination that an accelerated payment or advanced payment has occurred and has now been deemed an overpayment.

A final determination is deemed to occur upon the due date of a timely filed cost report which indicates an overpayment is due CMS and is not accompanied by payment in full.

A final determination is deemed to occur with respect to a cost report that is not filed on time, from the date due until such time as the cost report is filed.

30.2 - Rates of Interest - FIs and Carriers
(Rev. 30, 01-28-04)

The interest rates on overpayments and underpayments is determined in accordance with regulations promulgated by the Secretary of the Treasury and is the higher of the private consumer rate or the current value of funds rate prevailing on the date of final determination. Interest accrues from the date of the initial request for refund and is assessed for each 30-day period, or portion thereof, that payment is delayed after the initial refund request.

The private consumer rate, historically higher than the current value of funds rate, is subject to quarterly revision. The Department of the Treasury certifies the revised rate to the Department of Health and Human Services on a quarterly basis. Medicare contractors will be receiving subsequent quarterly updates of the new interest rate for Medicare overpayments and underpayments through a recurring update notification. Interest assessed for both late payments and installment payments is computed as simple interest using a 360-day year. Simple interest is interest that is paid on the original principal balance and after each payment interest accrues on the remaining unpaid principal balance. Interest charges will not be prorated on a daily basis for overdue payments received during the month (e.g., 10, 15, or 20 days late). Interest is assessed for the full 30-day period. The interest rate on each of the final determinations will be the rate in effect on the date the determination is made.

If periodic but unscheduled payments or credits are made in different calendar quarters, the quarterly rate prevailing at the time of the final determination is charged and remains the same until the debt is liquidated. Interest must be recalculated based on the outstanding balance at 30-day intervals from the date of final determination.

The interest rate charged on overpayments repaid through an approved extended repayment schedule is the rate that is in effect for the quarter in which the determination was made. The rate remains constant unless the provider defaults (i.e., misses two consecutive installment payments) on an extended repayment agreement. When the provider defaults on such an agreement, interest on the balance of the debt may be changed to the prevailing rate in effect on the date of the default if that rate is higher than the rate specified in the agreement.

30.3 - Interest Accruals
(Rev. 41, 04-30-04)

NOTE: Effective October 1, 2004, 42 CFR 405.378 was amended to change how interest is calculated on Medicare overpayments and underpayments to providers, suppliers, and other health care entities. This change also applies to Medicare Secondary Payer (MSP) recoveries. Under the new rule, interest is assessed for each full 30-day period that payment is not made on time. This change applies to Medicare overpayments and underpayments determined (and MSP debts established) on or after October 1, 2004 (the effective date of the final rule). Unliquidated debts determined prior to October 1, 2004 will continue to use the former interest calculation method (a period of less than 30 days is considered to be a full 30-day period) until paid in full.

Reminder: The date of the demand letter (not the day after) is the first day of the first 30-day period.

A. Accrual of Interest; Timely filed Cost Report/Part B Overpayment Determination

Interest will accrue from the date of the final determination and will either be charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that complete liquidation is delayed.

Generally, interest charges on an overpayment begin to accrue on the date the FI issued an NPR and/or the date the FI or carrier issued a notice of final determination of an overpayment, along with a written demand for payment. If the overpayment is paid in full within 30 days from the date of determination the interest accruals are normally waived.

NOTE: The standard systems generally post interest on a monthly basis. Interest is assessed at the end of 30-day periods. If the payment is postmarked on or before the 30th day any interest accrual is waived or zero-balanced in the system.

Cost Report Overpayment-Example of Interest Accrual- The provider with a FYE 08/31/04 submits a cost report on 01/28/05, showing $10,000 due the program, payment in full accompanies the cost report. On 02/15/05, the intermediary completes the desk review and determines an additional $25,000 overpayment. On 02/15/05 the first demand letter is sent. The provider does not pay the $25,000 additional overpayment until 04/03/05 (45 days after the date of the initial demand letter). Interest, therefore, accrues on the $25,000 for one full 30-day period.

Physician/Supplier Overpayment-Example of Interest Accrual- The carrier discovers that an overpayment for $795.45 exists and sends a demand letter on 12/01/04. The physician/supplier does not remit payment on the overpayment until 01/15/05 (45 days after the date of the initial demand letter). Therefore, interest accrues on the $795.45 for one full 30-day period.

Physician/Supplier Overpayment – Example of Interest Accrual Prior to 10/01/2004 –

The carrier discovers that an overpayment for $795.45 exists and sends a demand letter on 09/30/04. (The determination date of this overpayment is prior to the effective date of the revision to 42 CFR 405.378). The provider does not remit payment on the overpayment until

11/14/2004 (45 days after the date of the initial demand letter). Therefore, interest accrues on the $795.45 for two full 30-day periods.

Example of Waiver of Interest- Overpayment Paid in Full within 30 days from the date of determination- The FI/carrier determines and demands an overpayment on 11/03/04 for $1500.00. The provider remits payment of $1500.00. The postmark date on the payment is 11/30/04. Any interest accrual is waived since the overpayment was paid in full within 30 days of the date of determination.

B. Accrual of Interest; Untimely Filed Cost Reports, Regarding Final Determinations at §30.1.

Interest always accrues for any overpayment on a late filed cost report for the period of delinquency when an overpayment is declared or determined by CMS. The overpayment may appear on the cost report, or may be determined later (including increases to overpayment, see example 2 below) through desk review or audit. Interest accrues during the period a cost report remains unfiled beyond the due date. Interest is assessed for the period of time the cost report was unfiled even if the overpayment is satisfied at the time of the delayed filing of the cost report. This interest assessment is due and payable following the notice of a final determination. The interest rate will be the rate in effect as of the day following the due date of the cost report.

On any subsequent determination that increases the overpayment on a cost report filed untimely, the additional overpayment is also subject to accrued interest charges for the period the cost report was due until the date filed. The interest rate will be the rate in effect as of the day following the due date of the cost report.

Where desk review, audit or reopening determinations increase the originally filed and declared overpayment, the revised overpayment also is subject to the general provisions governing interest on overpayments from the date of the new or revised notice of final determination. These interest charges will be in addition to the interest charges due for the period of time the cost report remained unfiled.

Examples of Application when cost report not filed on time

1. The provider submits its cost report 70 days late and pays the declared overpayment of $50,000 when filing. Interest at the prevailing rate accrues from the due date until the date filed, or, in this case, two 30-day periods as only two full 30-day periods have passed. Interest is assessed during the period of delinquency whether or not payment accompanies the cost report.

The intermediary performs a desk review and determines an additional overpayment of $12,000. Interest, at the prevailing rate at the time the cost report became overdue is assessed on the $12,000 for the two 30-day periods of delinquency. In addition, interest accrues at the current prevailing rate on the $12,000 if payment is not made within 30 days of the date of the initial demand letter.

2. A provider with FYE 6/30/04 has a cost report that is due on 11/30/04. The cost report became overdue on 12/01/04. On 01/15/05 the cost report was submitted indicating an amount due the program; payment did not accompany the report. Due to the late submission of the cost report, interest is assessed for one 30-day period. The interest rate assessed is the rate in effect on the day the cost report became overdue, 12/01/04. In addition interest, at the rate in effect on the day the cost report became overdue, will accrue on the declared overpayment from the date the cost report is filed to the date the amount due is paid.

On 03/12/05, the intermediary completes a desk review and determines an additional overpayment, issuing a NPR and demand letter. Interest will be assessed on this additional amount at the rate in effect on 3/12/05. In addition interest will be assessed for the period of delinquency at the rate in effect on the day the cost report became overdue, 12/01/04.

C. Accrual of Interest; Rejected Cost Report

In terms of interest accrual, a rejected cost report is treated like an unfiled cost report. If a cost report is officially rejected by the contractor, (see Audit and Reimbursement section to determine when to reject a cost report) interest accrues on the determined overpayment amount from the date the cost report is due until the date the cost report is resubmitted with payment in full. The determined overpayment amount is the amount due the program on the accepted cost report. If a cost report is submitted with payment in full and is later rejected the accrual of interest depends on the determined overpayment amount on the accepted cost report. If the determined overpayment amount on the accepted cost report was paid in full by the original submission, no interest accrues. If the determined overpayment amount is different than the overpayment amount listed on the original rejected cost report, interest will accrue on the difference.

Example of Interest Accrual When the Cost Report is Rejected

1. A provider submits the cost report with payment in full before the due date. Upon review the contractor rejects the cost report. The provider corrects the cost report and resubmits it. The contractor accepts the revised cost report. The amount due the program on the revised cost report is equal to the check that accompanied the original cost report. Since the check fulfilled the determined overpayment on/ before the due date, there is no interest accrual.

2. A provider submits the cost report with payment in full before the due date. Upon review the contractor rejects the cost report. The provider corrects the cost report and resubmits it. The contractor accepts the revised cost report. The amount due the program on the revised cost report is different than the amount of the check that was submitted with the original cost report. The provider sent in a check for the additional amount with the revised cost report. Since the check with the original cost report was not the determined overpayment amount, interest accrues on the difference between the check and the overpayment listed on the revised cost report. The interest rate is the rate that was in effect on the day the cost report was due.

D. Underpayments

Generally interest charges on an underpayment begin to accrue upon the FI's or carrier's issuance of:

- An NPR (FI only) and a notice of final determination of an underpayment under §30.1.

- A notice of final determination of an underpayment under §30.1 when an NPR is not issued.

- An administrative law judge (ALJ) or hearing officer's decision that reduces the amount of an overpayment below the amount that CMS has already collected. Interest begins to accrue once the underpayment amount has been determined. This may be at the decision time if the ALJ reverses the entire overpayment amount or the ALJ states a principal amount to be paid upon which interest may be calculated. However, if the ALJ does not specify the overpayment amount and recalculations are necessary (not including a full reversal of the overpayment amount) interest will begin to accrue at the time of the recalculations. If the FI/carrier is unsure when interest should accrue for a particular case, the servicing regional office should be contacted.

- An Intermediary Hearing or a Provider Reimbursement Review Board (PRRB) decision that reduces the amount of an overpayment below the amount that CMS has already collected.

However, no interest will be due and payable to a provider if the FI or carrier pays the underpayment within 30 days from the date of notice of final determination of the underpayment. Interest will accrue each 30-day period on the underpayment balance that has not been satisfied.

30.4 - Procedures for Applying Interest During Overpayment Recoupment
(Rev. 41, 04-30-04)

A. General

If a provider is unable to satisfy the overpayment within 30 days from the date of final determination and demand for repayment (§30.1), interest accrues on the unpaid principal balance and is due and payable for each full 30-day period that an overpayment balance is outstanding. The contractor first applies any payments received to the accrued interest charges and then to the overpayment principal. If the provider has more than one overpayment outstanding and a payment is received, the contractor credits the payment to the oldest overpayment first, unless the provider designates otherwise.

B. Recoupment Through Installment Payments

A provider is expected to repay any overpayment as quickly as possible. If a provider cannot refund the total amount of the overpayment within 30 days after receiving the first demand letter,

it should immediately request an extended repayment plan. (See Chapter 4, §50 for extended repayment procedures.)

The interest rate to assess on overpayments repaid through an approved extended repayment plan is the rate in effect for the quarter in which the final determination is issued to the provider.

Interest rates remain constant based upon the initial rate assessed unless the provider defaults, i.e., **misses two consecutive installment payments** of an extended repayment agreement. Interest on the principal balance of the debt may be changed to the current prevailing rate if (a) the provider is delinquent on its installment payments and (b) the current prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement. (For FISS and APASS users only.) Each payment is applied first to accrued interest and then to principal. After each payment interest will accrue on the remaining unpaid principal balance.

C. Proof of Receipt

The U.S. Postal Service postmark date is controlling in determining the timely receipt of a cost report or payment of an overpayment. Therefore, the contractor should retain all envelopes in order to have proof of receipt. If a due date for any payment falls on a holiday or a weekend, the next working day is considered the official due date for the purpose of applying accrued interest. (FISS and APASS users only.) CMS does not accept dates imprinted by a provider's meter postage machine as confirmation of the postmark date. In these cases the FI/carrier should use the date the cost report or payment was received and date stamped. If a provider utilizes a commercial delivery service the date constituting a timely receipt is the date the commercial delivery service signs and accepts the package. The date the cost report or payment is received by the FI/carrier controls if any other mailing service was used.

30.5 - Notification to Providers Regarding Interest Assessment
(Rev. 41, 04-30-04)

A. Cost Report Reminder Letters

The FI is required to issue reminder letters to a provider of the time limitation for filing the cost report when the institutional provider fails to file by the last day of the fourth month following the end of the cost report period. In addition to the requirements outlined in Chapter 3, §30 and Chapter 4, §20 the FI must include the following in a cost report reminder letter:

1. Late Filing Interest- If a cost report is not filed on time and indicates an amount is due CMS, or if it is subsequently determined that an additional overpayment exists, such as when an NPR is issued, interest will be assessed on the overpayment from the due date of the cost report to the date the cost report was filed. This interest assessment is made regardless of whether the overpayment is liquidated within 30 days.

2. Assessed Interest- If a cost report is filed on time and indicates an amount is due CMS, interest will accrue on that overpayment from the date the cost report is due, unless full

payment accompanies the report or the provider and the contractor agree in writing, in advance, to recoup the amount of the overpayment from interim payments over the next 30-day period.

B. Notice of Program Reimbursement (NPR)

In addition to the requirements outlined in audit instructions, all NPRs issued after September 3, 1982, must include the following:

> "In accordance with the procedures of 42 CFR 405.378ff interest will be assessed on the amount due CMS unless full payment is made within 30 days from the date of the Notice. Interest will be assessed for each full 30-day period that payment is delayed."

C. Overpayment Demand Letters

In addition to the requirements of Chapter 4, §20 and §90 the FI and Carrier's written demand for repayment must contain a notice that in accordance with 42 CFR 405.378, interest shall be assessed on all overpayments at the prevailing rate specified by the Secretary of the Treasury unless repayment is made within 30 days. Interest shall be assessed for each full 30-day period that payment is delayed and shall accrue from the date of the final determination. The demand letter shall include the appropriate interest rate that will be assessed if payment in full is not received within 30 days.

30.6 - Waiver and Adjustment of Interest Charges
(Rev. 41, 04-30-04)

A. Waiver of Interest Charges

Interest charges shall be waived if the overpayment is completely liquidated within 30 days from the date of final determination, or if the contractor or the RO determines that the administrative cost of collection would exceed the amount of interest.

For institutional providers serviced by FIs, interest shall not be waived for the period of time during which the cost report was due but remained unfiled as specified in Chapter 4, §30.1. Also, interest shall not be waived where a cost report is timely filed indicating an amount due CMS and is not accompanied by payment in full as specified in Chapter 4, §30.1 unless the provider and the FI agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30-day period.

For bankrupt providers and interest see Chapter 3, §140.

B. Adjustment of Interest Charges

1. Reopenings-FI

When the FI reopens a final settlement pursuant to 42 CFR 405.1885 - 1887(a) and such reopening reverses some or all adjustments, whereby the previous overpayment is reduced or eliminated, it makes an appropriate adjustment to previously assessed and recovered interest to reflect the proper interest chargeable under 42 CFR 405.378 and the policies set forth.

Should the reopening action establish or increase an overpayment, the rate of interest on the additional or new overpayment is the rate in effect as of the date of the new notice of final determination.

If the original cost report was not submitted timely, any reopening action, which results in an adjustment to the previously determined overpayment, shall also include an appropriate adjustment to the late filing interest assessment.

2. FI and Provider Reimbursement Review Board Hearings - Institutional Providers Serviced by FIs

If an overpayment or underpayment determination is reversed administratively by the FI or by the PRRB, and the reversal is the final decision in the case, it is necessary to recalculate the correct amount of interest to be assessed. If any excess interest or principal has been collected, the FI refunds it to the debtor. No interest accrues on the refunded amount unless payment is not made within 30 days from the date of notification of the corrected overpayment or underpayment amount.

If the hearing results in an additional overpayment, the FI assesses interest on the additional amount at the rate in effect on the date of the revised final determination. **Interest does not accrue until the FI notifies the provider of the revised overpayment or underpayment amount.**

Example of Application
On 07/18/05, the intermediary completes a final settlement and issues a NPR and a written demand showing an amount due the program of $16,000. On 09/15/05, the provider pays the $16,000 overpayment plus one 30-day period of accrued interest.

As a result of a hearing on 12/l0/05, the PRRB reverses the intermediary's findings and determines that the correct amount due the program was $4,000. The excess $12,000 in principal and the accrued interest on $12000 that was assessed and collected must be returned to the provider.

3. Judicial Review

The policies and procedures of this section do not apply to the time period for which interest is payable under 42 CFR 413.64(j) because the provider seeks judicial review of an adverse decision by the PRRB or the decision of the Administrator. Section 1878(f) of the Social Security Act authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court’s decision. The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the

intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis. The interest rate assessed is the rate on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. This rate of interest can be found at http://cms.hhs.gov/statistics/trust-fund-interest-rates/. If the FI withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider. However, if the Medicare program had recovered any of the amount in controversy interest would be payable from the time of recovery through the date of payment.)

40 – Withholds and Suspensions

(Rev. 29, 01-02-04)

In accordance with regulations (42 CFR §405.370), recoupment and suspension are defined as:

Recoupment- The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Suspension of Payment- The withholding of payment by an intermediary or carrier from a provider of an approved Medicare payment amount before a determination of the amount of the overpayment exists.

40.1 – Recoupment by Withholding Payments

(Rev. 29, 01-02-04)

A. General

In accordance with regulations (42 CFR §§405.371-372), payments determined to be payable to providers can be withheld to protect the Medicare program against financial loss if the intermediary has determined that the provider to whom payments are to be made has been overpaid.

The withholding of interim payments may be partial (for example, a percentage of payments withheld or a set amount) or complete.

B. Requirements for Withhold

Comply with the following conditions to withhold interim payments:

- Notify the provider in writing through the demand letter or in other correspondence of your intention to withhold payments, in whole or in part; and
- Give the provider an opportunity to submit a statement (including any evidence) as to why the withhold shall not be put into effect. Inform the provider it has l5 days following the date of the notification to submit such a statement.

C. Cost Report Overpayments Percentage of Withhold

Some percentage of withhold shall begin 15 days after the date of the first demand letter (day 16) if the overpayment has not yet been liquidated or an extended repayment plan has not been requested. The matrix below shall be utilized to determine the percentage of withhold for an overpayment determined from a cost report that has been filed (as filed cost report, tentative settlement, or final settlement), a PIP review, or an interim rate review. See Chapter 3, §30.1 when a cost report remains unfiled.

Day 16	**No word from provider**	**100 % withhold**
Day 16	Provider has submitted ERP application	No withhold as long as provider submitted a first payment along with ERP application. Payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If payment is not received with the application request, withhold shall be initiated at 30%.
Day 16	Provider has submitted ERP application but it is incomplete	No withhold as long as provider submitted a first payment along with ERP application. If payment is not received with the application request, withhold shall be initiated at 30%. Once a completed application is submitted payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If completed information is not received within an allotted amount of time (rarely more than 30 days) withhold shall be initiated at 100%.
Day 16	Provider has said that it is planning to submit an ERP application	30% withhold- when ERP application is received, cease withhold if the first payment accompanies the application request; maintain 30% withhold if payment does not accompany application
Day 30	**Still no word from provider**	**Remain at 100%**
Day 30+	ERP application is being reviewed by RO or CO	No withhold as long as provider continues to submit appropriate payments on a monthly basis under the terms of the application request. If provider did not submit a first payment or does not submit subsequent payments withhold shall be 30% unless RO or CO gives alternative instructions
Day 30	Provider said an ERP application was	Increase withhold to 100% If provider calls with an acceptable reason for

	forthcoming but has not been received to date	the delay, make a judgment call to leave at 30% until day 45
Day 45+	No ERP application and no payment by provider	100%

NOTE: A set amount of withhold may be proposed instead of a percentage. The amount shall not be less than the appropriate percentage unless specific instructions are received from RO or CO.

D. Physician/Supplier Overpayments- Withhold of Payments

Withhold of all payments shall begin 40 days (41st day) after sending the initial overpayment demand letter unless payment in full has been received or an ERP application has been received. If an ERP application has been received and is currently being reviewed by the Carrier or CMS RO or CO and the first payment was sent in by the provider with the application no withhold shall occur. If the first payment did not accompany the ERP application a 30% withhold shall be initiated.

NOTE: Additional Information for Both FIs and Carriers

If extenuating circumstances exist and the FI/carrier believe that a higher or lower percentage of withhold is necessary to protect the Medicare Trust Fund, the FI/carrier shall contact the servicing regional office for guidance and/or approval. Some examples include knowledge that the provider may file bankruptcy, a history of non-payment of overpayments, or evidence that the withhold percentage would cause irreparable harm.
The payment submitted with the ERP application shall be one month's payment based on the amortization schedule submitted with the ERP application. The amortization schedule shall not exceed 60 months, shall include principal and interest and the minimum monthly payment shall not be less than 1/60th of the overpayment. If the provider requests an ERP in excess of 60 months the payment submitted shall be 1/60th of the overpayment. If the payment submitted is not 1/60th of the overpayment, the FI/carrier shall contact the provider (in writing or a documented telephone call with the appropriate personnel at the provider's place of business) requesting additional funds. If the provider does not submit additional funds within 15 days of the date of the request, the FI/carrier shall initiate a 30% withhold.

Until a final decision is made regarding the ERP the provider should submit monthly payments based on the amortization schedule. If the provider does not continue to submit monthly payments, the FI/carrier shall contact the provider requesting the payment. If the provider does not submit the monthly payment within 15 days of the date of the request, the FI/carrier shall initiated a 30% withhold.

E. Disposition of Withheld Funds

All funds withheld shall be applied towards the outstanding overpayment. The funds shall be applied to the outstanding interest first and then to the outstanding principal balance.

F. Duration of Withhold

The withhold shall remain in effect until:

- The overpayment is liquidated;
- You enter into an agreement with the provider for liquidation of the overpayment; or
- On the basis of subsequently acquired evidence, or otherwise, you determine that there is no overpayment.

40.2 – Suspension of Payment (See Program Integrity Manual)
(Rev. 29, 01-02-04)

Medicare authority to withhold payment in whole or in part for claims otherwise determined to be payable is found in federal regulations at 42 CFR 405.370-377, which provides for the suspension of payments.

Suspension may be used when the contractor possesses reliable information that:

- Fraud or willful misrepresentation exists;
- An overpayment exists but the amount of the overpayment is not yet determined;
- The payments to be made may not be correct; or
- The provider fails to furnish records and other requested information. (Some examples include cost reports, credit balance reports, and form CMS-91.)

50 - Establishing Extended Repayment
(Rev. 29, 01-02-04)

Where the debtor does not comply with the first demand letter requesting that full refund of the overpayment be made, but acknowledges the existence of an overpayment, it may contact the FI or carrier to arrange for a repayment plan.

A debtor is expected to repay any overpayment as quickly as possible. If it cannot refund the total overpayment within 30 days after receiving the first demand letter, it should request an extended repayment plan immediately. However, an ERP request may be received and shall be reviewed at any time the overpayment is outstanding. The provider must explain and document its need for an extended (beyond 30 days) repayment plan.

A repayment plan may be established to recover all or part of an overpayment. Following the withhold guidelines in Chapter 4, §40 the FI or carrier shall offset any money owed to the

provider prior to establishing a repayment plan. Some examples of monies owed to the provider include underpayments money held by suspension or money withheld from the provider based on Chapter 4, §40. When a repayment plan is used to recover part of an overpayment, the FI/carrier recovers the remainder of the overpayment by withholding interim payments (See Chapter 4, §40), setoff of monies due the debtor, or from a lump-sum payment by the provider. Any approved ERP will run from the date of the initial demand letter.

NOTE: Once an ERP is established, the offset of an underpayment against the ERP is not automatic. If a Medicare underpayment is determined subsequent to an established ERP, the FI shall notify the provider in writing of the underpayment. The FI will permit the provider 15 calendar days following the date of notification to submit a statement (including any pertinent evidence) as to why the underpayment should not be offset.
If the provider does not respond in the required time, the FI shall offset the underpayment against the ERP. If the provider responds timely, the FI shall not take action to offset until it has completed its review of the documentation. Based on its review, the FI will make a determination as to whether the facts justify offsetting the underpayment. If the FI determines that offset is appropriate, in whole or in part, written notice will be sent to the provider. Such notice shall contain specific findings on the conditions upon which the offset was based, and an explanation for the final decision.

50.1 – Documentation Required in an ERP Application--Physician is a Sole Proprietor – Carrier Only
(Rev. 29, 01-02-04)

The carrier shall request the physician to complete and return a Form CMS-379, Financial Statement of Debtor and a copy of the physician's income tax filing for the most recent calendar year. A request for an extended repayment of 12 months or more must also be accompanied with at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.

50.2 - Documentation Supporting a Request for Extended Repayment – Provider is an Entity Other Than a Sole Proprietor
(Rev. 29, 01-02-04)

The FI/carrier shall request the provider to furnish the following:

- **Amortization Schedule**- this schedule shall contain the proposed repayment schedule, including length of schedule, dates of payment, and payment amount broken down between principal and interest for the life of the schedule

- **Balance sheets** - the most current balance sheet and the one for the last complete Medicare cost reporting period or the most recent fiscal year (preferably prepared and certified by the provider's accountant).

NOTE: If the time period between the two balance sheets is less than 6 months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last two complete Medicare reporting periods (providers that file a cost report) or last two complete fiscal years.

- **Income statements** - related to the balance sheets (preferably prepared by the provider's accountant).

The CMS suggests that both the balance sheets and income statements include the following statements:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.
>
> CERTIFICATION BY OFFICER OF ADMINISTRATOR
> OF PROVIDER(S)

(For physicians/suppliers, "CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by _____and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed
Officer or Administrator of
Provider(s)
Title

Date

(For physicians/suppliers:
Signed
Officer or Owner of
Debtor(s)
Title)

- **Statement of Sources and Application of Funds** - for the periods covered by the income statements (see Exhibit 2 for recommended format).

- **Cash flow statements** - for the periods covered by the balance sheets (see Exhibit 3 for recommended format). If the date of the request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than 3 months after that of the most recent balance sheet, a projected cash flow statement should be included for the 6 months following the date of the request.

- **Projected cash flow statement -** covering the remainder of the current fiscal year. If fewer than 6 months remain, a projected cash flow statement for the following year should be included. (See Exhibit 3 for recommended format.)

- **List of restricted cash funds -** by amount as of the date of request and the purpose for which each fund is to be used.

- **List of investments -** by type (stock, bond, etc.), amount, and current market value as of the date of the report.

- **List of notes and mortgages payable -** by amounts as of the date of the report, and their due dates.

- **Schedule showing amounts -** due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet--such as Accounts Receivable, Notes Receivable, etc

- **Schedule showing types -** and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

- **Loan Applications -** Requests for extended repayment of 12 months or more. Have the debtor include at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.

- **FIs Only - The percentage of occupancy -** by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods covered by the income statements; and

All financial records must be for the business participating in the program. They should not be for the owner if the business is a partnership or a corporation. If the financial aspects of the business are managed by an outside facility, the provider's individual financial records must still be submitted as well as the financial records of the outside facility.

If a debtor is unable to furnish some of the documentation, it should fully explain why it is unable to. Where the debtor's explanation is reasonable and the documentation is otherwise acceptable, the FI/carrier shall forward the request for extended repayment to the RO with its recommendation. It shall comply with Chapter 4, §40 regarding recoupment of the overpayments pending receipt of the documentation and a decision on the extended repayment request.

50.3- Approval Process

(Rev. 29, 01-02-04)

Below is a chart detailing the requirements of a Medicare contractor for an extended repayment plan. Once the FI/carrier completes these requirements a decision regarding approval must be made. If the FI/carrier determines that the provider does not meet the requirements for an extended repayment plan the provider shall be notified in writing. If the FI/carrier determines that the provider does meet the requirements for an extended repayment plan the following criteria shall be followed:

- If the ERP request is for 12 months or less the FI/carrier shall notify the provider immediately in writing of the approval.

- If the ERP request is greater than 12 months the FI/carrier must send the entire ERP package including the documentation prepared by the FI/carrier to the servicing RO for approval.

The FI/carrier has the option of altering the length of time when approving an ERP request. For example, if a provider requests 24 months, but the FI/carrier feels that 12 months is sufficient the FI/carrier can deny the 24 month request and extend an offer of a 12 month repayment plan. If the FI/carrier recommends approval of an ERP that is over 12 months in length, the recommendation must be forwarded to the RO for approval.

The FI/carrier may request additional financial information from the provider as well as financial information from the owner if the owner is requesting to submit personal capital to help repay the Medicare debt.

The FI/carrier shall attempt to review and approve or deny or recommend approval to CMS within 20 days of receipt of the completed ERP application.

Requirements to be Completed before approval or denial	**ERP request 12 months or less**	**ERP request greater than 12 months**	**ERP request asking for an unconventional payment arrangement**
ERP Protocol (See Exhibit 1)	**X**	**X**	**X**
Analysis of financial statements	**X**	**X**	**X**
Review of Last 12 months of claim history	**X**	**X**	**X**
Payments on the claim floor	**X**	**X**	**X**
Outstanding Advance/Accelerated Payments (Accelerated Payments are FI only)	**X**	**X**	**X**
FI- Outstanding	**X**	**X**	**X**

settlements			
Outstanding Fraud Investigations	**X**	**X**	**X**
Send to RO for additional approval		**X**	**X**

Exhibit 1 - Protocol for Reviewing Extended Repayment Plan (ERP) - Provider/Physician Medicare Overpayments

Protocol for Reviewing Extended Repayment Plan (ERP)

Provider_____
Provider Number _____

(FIs Only) Cost Report FYE _____

(Carriers Only) Date(s) Overpaid _____

Overpayment Amount $_____

Date of Demand Letter_____ No. of Months Requested for ERP_____

Date ERP Approved/Not Approved (12 mos. or less) _____No. of Mos. Approved

Date Referred to RO for Consideration _____

Name of FI/carrier

Reviewed By_____ Date _____

FI/carrier Analyst

Supervisor Review_____ Date _____

FI/carrier Official

1. Summarize the major reasons why the overpayment occurred.

2. FI/carrier reviews the documentation sent by the debtor for completeness. (Refer to §70.2 for required documentation.) It analyzes the financial data submitted to determine the availability of cash, marketable securities, accounts receivable, restricted and unrestricted endowment funds, or special funds. It considers whether these funds could be used for partial or full payment of the overpayment.

3. FI/carrier performs the following calculations by using the most current financial data submitted by the provider to determine if it qualifies for an ERP.

a. Current Ratio

The current ratio relates the dollar value of current assets to the dollar value of current liabilities in order to evaluate an organization's ability to pay its current debt. Derived as:

$$\frac{\text{CURRENT ASSETS}}{\text{CURRENT LIABILITIES}} = _____$$

This ratio defines the number of dollars held in current assets per dollar of current liabilities (e.g., it relates current assets to current liabilities). Multiple coverage of liabilities is desirable. Generally, high values for the current ratio imply a good ability to pay short-term obligations and thus a low probability of technical insolvency.

Normally, the FI/carrier considers a current ratio of 2 to 1 adequate to meet current liabilities. However, a debtor with a current ratio (2 to 1 or greater) may have short-term payment problems if its current assets are not expected to be in liquid form (cash or short-term investments) in time to meet the expected payment dates of the current liabilities.

b. Quick Ratio

A liquidity ratio which measures the number of dollars of liquid assets (cash plus marketable securities plus accounts receivable) that are available per dollar of current liabilities. Derived as:

$$\frac{\text{CASH + MARKETABLE SECURITIES + ACCOUNTS RECEIVABLE}}{\text{CURRENT LIABILITIES}} = _____$$

This is a more stringent measure of liquidity than the current ratio. The FI/carrier uses it to determine the adequacy of cash, accounts receivable, and marketable securities to pay current liabilities.

Normally, the FI/carrier considers a quick ratio of 1.5 to 1 adequate to meet current liabilities. However, a debtor with a high quick ratio may have short-term payment problems if there are excessive amounts of slow-paying or doubtful accounts receivable which may not be turned into cash soon enough to meet maturing current liabilities. Conversely, a low quick ratio may not imply a future liquidity crisis if current liabilities include terms that will not require payment from existing current assets.

4. The FI, for institutional debtors, determines if there are any settlements (interim rate adjustments or cost report) in process which could be used to offset the outstanding overpayment.

5. Based upon the previous steps, the FI/carrier summarizes whether or not a repayment plan should be approved or denied. If approval is recommended, it indicates the number of months, how it calculated the monthly payment and the reason(s) for the approval. If denial is recommended, it indicates the reason(s).

Exhibit 2 - Statement of Source and Application of Funds Period Covered

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Provided by:

Operations - Net income for the period	$XXXX	
Add: Charges not affecting working capital (depreciation, amortization, etc.)	XXXX	
	$XXXX	
Less: Operating revenues not affecting working capital	XXXX	
Total fund provided by Operation		$XXXX
Long term loans	XXXX	
Unrestricted cash donations		XXXX
Other (identify)		XXXX
Total Funds Provided		$XXXX

Exhibit 2 (Cont.)

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Applied to:

Retirement of long-term obligations (mortgages, notes, bonds, etc.)		$XXXX
Purchase of equipment		XXXX
Purchase of land	XXXX	
Dividends to stockholders		XXXX
Other (identify)		XXXX
Total Funds Applied		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	

Working Capital* (end of period) (date)		XXXX
Less: Working Capital* (beginning of period) (date)		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	

*Current Assets less Current Liabilities

Exhibit 3, Cash Flow Statement Period Covered

CASH FLOW STATEMENT
FOR THE PERIOD

Cash provided by:

Operations (net) (Schedule A) (See Exhibit 4)	$XXXX
Cash donations (unrestricted)	XXXX
Long-term borrowing	XXXX
Investment earnings (cash dividends, interest)	XXXX
Sale of long-term investments	XXXX
Sale of equipment	XXXX
Issuance of bonds	XXXX
Decrease in current assets – other than Accounts Receivable, Prepaid Expenses, and Inventory	XXXX
Increase in current liabilities – other than Accounts Receivable, Prepaid Expense, and Inventory	XXXX
Others	XXXX
Total Cash Provided $XXXX	

Exhibit 3 (Cont.)

CASH FLOW STATEMENT
FOR THE PERIOD

Cash applied to:

Purchase of equipment		$XXXX	
Payment of long-term debt		XXXX	
Payment of bond redemption fund		XXXX	
Purchase of long-term investments	XXXX		
Payment of dividends		XXXX	
Purchase of land and/or building (purchase price less mortgage, capital stock and non-cash assets given toward purchase)	XXXX		
Increases in current assets - other than Accounts Receivable, Prepaid Expenses, and Inventory			XXXX
Decreases in current liabilities – other than Accounts Payable and Prepaid Income			XXXX
Other			XXXX
		Total Cash Applied	XXXX

Increase (Decrease) in Cash $XXXX

- - - -

PROJECTED CASH FLOW
CASH FROM OPERATIONS (SCHEDULE A)

Net Income (or Net Loss)			$XXXX
Increases:	Depreciation expense	$XXXX	
	Loss from sale of equipment	XXXX	
	Decrease in net Accounts Receivable	XXXX	
	Decrease in Prepaid Expense	XXXX	
	Decrease in Inventory	XXXX	
	Increase in Accounts Payable	XXXX	
	Increase in Prepaid Income	XXXX	
	Others	XXXX	XXXX
	Gross Cash from Operations	$XXXX	
Decreases:	Gain from sale of equipment	$XXXX	
	Increase in net Accounts Receivable	XXXX	
	Increase in Prepaid Expense	XXXX	
	Increase in Inventory	XXXX	
	Decrease in Accounts Payable	XXXX	
	Decrease in Prepaid Income	XXXX	
	Others	XXXX	XXXX
	Net Cash from Operations		$XXXX

50.4 – Sending the ERP Request to the Regional Office
(Rev. 29, 01-02-04)

After the FI/carrier has reviewed the documentation submitted in support of the ERP request, it sends its recommendation to the RO for approval if the ERP request is over 12 months in length. It submits the following:

- All information submitted by the provider. (See § 50.l.);

- The date of the initial contact between the FI/carrier and the provider concerning the overpayment;

- Copies of all correspondence (including demand letters) about the overpayment and the request for the ERP (including telephone conversations, if applicable);

- FI-The amount of the overpayment; cost report year in which it occurred; dates and amounts of any repayments; dates and amounts of payments (interim or retroactive) held in account.

- Carrier-The amount of the overpayment, claim paid date, dates and amounts of any repayment

- FI-The cost reports in which the overpayments appeared or were found. The FI furnishes any information it has on the financial status of related organizations, as determined through audits and other sources such as mercantile reports;

- The provider's proposed repayment plan and rationale;

- The FI/carrier's recommendation and supporting rationale including a completed extended repayment plan protocol (See Exhibit 1) and the last twelve months claim history; and

- The FI/carrier's opinion, based on experience, as to the reliability of the financial data.

50.5 - Monitoring An Approved Extended Repayment Plan
(Rev. 29, 01-02-04)

After an extended repayment plan has been approved, the FI/carrier shall continue to monitor the case to ascertain whether recoupment is being effectuated as contemplated. If it becomes apparent that the repayment plan will not result in a liquidation of the indebtedness within the time period contemplated, it shall take further action, preferably the renegotiation of the amount of installment payments so that the overpayment will be recouped within the time period originally agreed upon. The FI/carrier reports to the RO any significant changes in the provider's financial condition or any indication that the provider misstated or failed to disclose pertinent facts that may raise a question of its ability to refund the overpayment. The FI/carrier shall notify the RO immediately by telephone and send a detailed written statement of the problem.

50.6 - Requests from Terminated Providers or Debts that are Pending Referral to Department of Treasury
(Rev. 29, 01-02-04)

When approving/denying an ERP request the FI/carrier is making a subjective decision concerning the provider/supplier's ability to repay. All complete ERP requests shall be

reviewed. This includes ERP requests from terminated providers and requests received for debts where an Intent to Refer has already been sent. If the provider is still actively participating in the Medicare Program and claims are being submitted on a regular basis (no more than a 20% drop off during the last twelve month period) the FI/carrier shall attempt to work with the provider to approve an ERP request. If denying an ERP request will result in the immediate referral of the active provider to the Department of Treasury the RO shall be contacted to determine if an alternative exists. If at all possible the referral of an active provider, who has requested a legitimate repayment plan, to the Department of Treasury should be avoided. (The requirements set forth in the Debt Collection Improvement Act of 1996 still apply.)

60 - Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments

(Rev. 29, 01-02-04)

Institutions and persons furnish health care services under both the Medicare and Medicaid programs, and are reimbursed according to the rules applicable to each program. Overpayments may occur in either program; at times resulting in a situation where an institution or person that provides services owes a repayment to one program while being reimbursed from the other.

60.1 - Withholding the Federal Share of Medicaid Payments to Recover Medicare Overpayments

(Rev. 29, 01-02-04)

Section 1914 of title XIX and 42 CFR §447.30 provide for CMS to withhold the Federal share of Medicaid payments with respect to Medicaid providers that have, or previously had, a Medicare provider agreement under §1866, and for physicians when:

- They have received an overpayment of title XVIII funds, and efforts to collect it have been unsuccessful; or

- Efforts to secure from the provider, the necessary data and information to determine the amount, if any, of the overpayment have been unsuccessful (i.e., a deemed overpayment because the provider failed to file a cost report); and

- For physicians or suppliers, they have previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act, and during the 12 month period preceding the quarter in which CMS proposes to withhold the Federal share of Medicaid payments for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of the overpayment.

The CMS may order the State to withhold the Federal share of Medicaid payments of a provider to recover Medicare overpayments plus accrued interest.

The FI/carrier shall establish whether or not a provider is subject to these procedures. The FI/carrier must be sure the provider is participating in title XIX program prior to referring the case to the RO for withholding. It shall refer only those cases that it is unable to collect through

established procedures. The RO resolves questions with respect to the provider's status in the Medicaid program.

Section 1914(a) of the Act permits, rather than requires, the Secretary to withhold the Federal share of Medicaid payments to recover Medicare overpayments. To allow flexibility in the administration of this provision, the ROs routinely determine whether it would be cost effective to withhold the Federal share. If they determine that it is not feasible, they notify the FI/carrier, citing the reason for not processing the collection request.

The provider may appeal the FI/carrier's overpayment determination. The appeal procedures, however, do not delay the withholding of the Federal share of payments due the Medicaid provider or physician.

If a provider is subject to the procedures for withholding the Federal share of Medicaid payments to recover the Medicare overpayment and it has not met the conditions in the second demand letter, the FI/carrier shall contact the RO with a recommendation to initiate withholding action.

If the RO determines that withholding the provider's federal share of Medicaid payments would be cost effective, the RO may request copies of the case file, which may include cost reports, demand letters, and copies of all correspondence and contact with the provider.

To implement the withholding action, the RO notifies the provider and the State Agency (SA) responsible for the State's title XIX expenditures. The withholding of Federal payments under title XIX remains in effect until notice is received by the title XIX SA through the RO that:

- The overpayment has been refunded,
- Satisfactory arrangements have been made for repayment, or
- There is no overpayment based upon new evidence or a subsequent audit.

When the withholding of Federal payments under title XIX is no longer necessary, it will be lifted and the provider again receives Federal title XIX payments for Medicaid services rendered.

The FI/carrier shall notify the RO immediately if the provider submits an acceptable cost report or makes satisfactory arrangements for the repayment of the overpayment. It includes the date the delinquent cost report was filed or satisfactory arrangements for the repayment were made. Because the withholding process is a lengthy one, the RO may revoke a withholding before its effective date if the provider submits a satisfactory cost report or if it makes satisfactory arrangements for repayment.

The RO monitors the collection and advises the FI/carrier when the overpayment is recovered. If an excess amount is withheld, it advises the FI/carrier to restore any excess.

60.2 - Withholding Medicare Payments to Recover Medicaid Overpayments

(Rev. 29, 01-02-04)

Section 1885 of title XVIII of the Act and 42 CFR §405.375 provide for CMS to withhold Medicare payments under both Part A and B to recover Medicaid overpayments that a Medicaid agency has been unable to collect.

The RO determines if withholding the Medicare payments due the overpaid Medicaid institution is appropriate. Where it determines that withholding the Medicare payments is proper, it advises the FI/carrier to withhold the Medicare payments to the institution by the lesser of:

- The amount of the Medicare payments to which the institution would otherwise be entitled;
- The total Medicaid overpayment.

The FI/carrier shall terminate the withholding action if the Medicaid overpayment is recovered or the RO advises it to do so.

It shall submit to the RO, at least monthly until the overpayment is recovered, the amount of Medicare payments withheld. If no claims are received in any month, it informs the RO that no payments were withheld.

The Medicaid agency establishes procedures to assure the return to the institution or person amounts withheld that are ultimately determined to be in excess of the Medicaid overpayments. The FI/carrier shall establish internal procedures to account for the Medicare amounts withheld under this section.

70 - Non-Medicare Secondary Payer (Non-MSP) Debt Referral Instructions and Debt Collection Improvement Act of 1996 (DCIA) Activities

(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

(MSP Debt Referral Instructions are contained in the Medicare Secondary Payer Manual, Publication 100-05, Chapter 5, Section 60.)

70.1 - Background

(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

The Debt Collection Improvement Act of 1996 (DCIA) facilitates collections by the Federal Government and encourages the streamlining of procedures within and among Federal agencies. The DCIA requires Federal agencies to refer eligible delinquent debt to the Department of Treasury (Treasury) or a Treasury designated Debt Collection Center (DCC) for cross servicing and/or offset through the Treasury Offset Program (TOP).

70.2 - Cross Servicing

(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

Cross servicing is a process whereby Federal agencies refer eligible delinquent debt to Treasury for collection. The agency referring the debt retains responsibility for reporting the debt on the

Treasury Report on Receivables Due from the Public. The agency is also responsible for removing accounts from its receivables when Treasury directs it to write off the debt. To effectively collect the debt that agencies refer, Treasury issues demand letters, conducts telephone follow-up, initiates skip tracing, refers debt for administrative offset, and refers debt to a private collection agency (PCA). Other collection tools may include Federal salary offset and administrative wage garnishment. The PCA shall attempt collection of the debt, using collection tools such as skip tracing, credit report search, demand letters and telephone calls.

70.3 - Treasury Offset Program (TOP)

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

The TOP is a program that compares Federal payments and eligible state payments with Federal debt. When a match occurs, the payment is offset to collect the debt. When the Taxpayer Identification Number (TIN) and name of the debtor match the TIN and name of a payee, the payment to the payee is offset and monies that would have gone to the payee are sent to the creditor agency to satisfy the debt. A debt may remain in TOP for offset up to ten years from date of determination. Types of payments that can be offset may include tax refunds, vendor payments, benefit payments with certain restrictions, and eligible state payments.

70.4 Definition of Delinquent Debt

(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

Per DCIA referral criteria, “delinquent” is defined as debt: (1) that has not been paid (in full) by the date specified in the agency’s initial written notification (i.e., the agency’s first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement.

70.5 - Referral Requirements

(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

The Centers for Medicare & Medicaid Services (CMS) is mandated to refer all eligible debt, 180 days delinquent, for cross servicing and/or TOP. Additionally, the CMS has the option of referring such debt before it is 180 days delinquent.

70.6 - Debt Ineligible for Referral

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Non-MSP debt ineligible for referral include those: (1) in bankruptcy status, (2) in an appeal status (pending at any level), (3) at the Department of Justice, (4) where the debtor is deceased, (5) Federal entity debt where the debtor is a Federal agency, (6) where the principal balance is less than $25, or (7) debt under fraud and abuse investigation where the investigating unit has provided the contractor with specific instructions not to attempt collection.

Treasury has also approved a waiver for the mandatory referral of unfiled cost report debt for cross servicing and/or TOP and for debts less than $100 that do not have a TIN.

Medicare contractors shall monitor debt previously ineligible for referral that become eligible for referral. If the status of the debt changes to an eligible status, Medicare contractors shall determine whether an IRL has been sent. If the IRL has been sent, and at least 60 days have passed since the date of the IRL (unless the IRL was returned undeliverable), Medicare contractors shall input the debt to the Debt Collection System (DCS) within ten calendar days of the status change making the debt eligible for referral. If the IRL has not been sent, Medicare contractors shall send the IRL within ten calendar days of the status change making the debt eligible for referral, and follow the normal debt referral process.

70.7 - Intent to Refer Letter

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

To comply with the DCIA requirements to provide specific notice to debtors before referring a debt for cross servicing and/or TOP, Medicare contractors shall send an "Intent to Refer" letter (IRL) as their final demand letter for all eligible delinquent debt. The "final demand letter" is defined as the last letter routinely sent to debtors to request payment, and shall be sent when or before the debt is 90 days delinquent (120 days from the determination date). This letter may be sent before the debt is 90 days delinquent; however, the letter should not be sent until the contractor has placed the debtor on recoupment status for at least 30 days. A sample "Intent to Refer" letter is included in Exhibit 1 of this section.

The IRL shall be sent regardless of previous collections on the debt, unless there is an approved current extended repayment agreement in effect.

When appropriate, the IRL shall include the amount of interest due, along with the date of the last interest accrual. Medicare contractors may add additional wording to this letter that shall provide additional instructions or clarification regarding the recoupment of the overpayment.

Medicare contractors should use their own language in the opening paragraphs to explain the reason for the overpayment and the current balance, including interest accrued and the interest rate.

The IRL shall be signed by the Medicare contractor official who routinely signs the demand letters.

The IRL may be sent for debt currently ineligible for referral based on the status if the contractor believes the debt shall become eligible for referral in the future. The language in the IRL shall include a sentence that says: "If, after sixty calendar days from the date of this letter we have not received such evidence, your debt, if it is still outstanding and eligible for referral, shall be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset." The IRL shall not be sent if the debt is in a status that excludes it from receiving demand letters.

70.8 - Response to Intent to Refer Letter

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors shall respond to any inquiries received as a result of the IRL within 15 calendar days of receipt. If the status of the debt changes based on the communications with the debtor, Medicare contractors shall update all appropriate systems timely.

The IRL provides debtors with 60 calendar days to respond. If, by day 61 the debtor has not responded, Medicare contractors shall input the debt to DCS. The debt shall be entered to the DCS no later than 70 calendar days from the date of the IRL. Debt for which less than full payment was received, or there is a current repayment agreement that is in default, are eligible for referral for cross servicing and/or TOP. Where there has been a partial recoupment or collection, but the collection is not the result of a current extended repayment agreement, the balance (if principal balance is greater than or equal to $25) shall still be referred for cross servicing and/or TOP. Debts that are ineligible for referral or exempt from referral to cross servicing and/or TOP shall not be entered to the DCS.

Before inputting a debt to DCS for cross servicing, Medicare contractors shall first determine if the debt should be referred to the Regional Office (RO) for litigation rather than referral to Treasury for cross servicing. If it is determined that the debt should be litigated, contact the RO for further action.

If the IRL is returned as undeliverable, Medicare contractors shall follow established procedures to locate a better address. (See Chapter 4, Sections 10 and 80.) If a better address is obtained, the IRL shall be sent to that address with a new re-issued date. If the IRL is returned as undeliverable and a better address cannot be located, Medicare contractors shall input the debt to DCS within 10 calendar days of return of the letter.

70.9 - Debt Collection System

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

The DCS is a CMS developed system used for debt referral to Treasury or a designated Debt Collection Center (DCC) in order to comply with the provisions of the DCIA. This system is comprised of a Data Entry Screen, which houses detailed information regarding the debt, a Comments screen for users to add comments regarding the particulars of a debt, and Collection screens for posting collections to a debt once it has been transmitted to Treasury for cross servicing/TOP.

Medicare contractors shall enter debts to the DCS for referral to Treasury. Detailed user instructions are included in Exhibit 4.

The CMS developed reports are produced from this system; however, the system does not have user adhoc reporting capabilities.

70.10 - Cross Servicing Collection Efforts

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors, at the time of input to DCS, shall determine IF the Non-MSP debt is currently being recouped through Medicare (claims payments/withhold), and if the anticipated

recoupments shall collect the debt in full within three years. If the contractor anticipates that the debt shall be collected in full within three years of delinquency by Medicare recoupment, the debt shall not be referred to a PCA as part of the cross servicing collection process. A specific debt type has been established in the DCS for this purpose. The debt type shall alert Treasury that the debt is being recouped through Medicare and should not be forwarded to a PCA. This determination shall eliminate many duplicate collections. Specific instructions are found in the DCS User Guide, Exhibit 4 of this section.

70.11 - Actions Subsequent To DCS Input

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Once the debt is referred for cross servicing, active collection efforts by the Medicare contractors and/or CMS shall cease. However, debt referred for cross servicing and/or TOP shall still be maintained in the Medicare contractors' internal systems for financial reporting, interest accrual, and possible internal recoupment. Medicare contractors shall be responsible for updating all the applicable systems, including the DCS for the change of the status and the balance of the debt.

70.12 - Transmission of Debt

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

When CMS transmits debt, CMS shall generate a report of the debt transmitted that week (Transmission Report) and send the report to the Medicare contractors. The Medicare contractors shall review the report to ensure that debts transmitted remain valid and amounts are accurate. Interest amounts listed on the report are the amounts that were entered in the DCS and shall not be updated in the DCS for any interest accruals since input. The Medicare contractors shall verify the report, annotating any changes to the information on the report and updating the DCS, as appropriate. Changes for additional interest accruals are not required.

The report shall be signed by the Chief Financial Officer (CFO), or his/her designee, and returned to CO via fax within 10 calendar days of the date of the report.

70.13 - Update to DCS after Transmission

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Once a debt has been referred for cross servicing and/or TOP:

If the Medicare contractors discover an error, collect (by check or recoupment), or receive information establishing that the debt is ineligible for cross servicing (i.e., bankruptcy, appeal), the Medicare contractors are responsible for updating the DCS, within ten days of the notification of the change to the debt. The CMS CO shall notify Treasury and recall the debt due to a change of status code or a full collection or shall report partial collection information. The updates in the DCS made by Medicare contractors shall be automatically transmitted to Treasury.

If Treasury or the PCA discovers an error, collects on the debt, or receives information, that would render the debt ineligible for cross servicing, Treasury shall notify CO who, in turn, shall notify the Medicare contractors via the Treasury Cross-Servicing Dispute Resolution Form or the

Collection/Refund Spreadsheet. Medicare contractors are responsible for updating their internal records, and the DCS, as appropriate. The Treasury Cross-Servicing Dispute Resolution Form or Collection/Refund Spreadsheet shall be returned to CMS within established timeframes.

If Treasury or the PCA receives a dispute from the debtor or obtains additional information regarding the debt that requires CMS or Medicare contractor intervention, a Treasury Cross-Servicing Dispute Resolution Form shall be sent to CMS. The CMS shall maintain a report of all debt in dispute and forward the information to the Medicare contractors for review and decision. Central Office, upon receipt of the Treasury Cross-Servicing Dispute Resolution Form, shall update the DCS status code to "XX" for all Non-MSP disputed cases (or status code "XO" if the DCS is updated systematically), and CMS CO shall track these codes for timely disposition by the Medicare contractors. The Medicare contractors shall have 30 calendar days to respond to Treasury and update DCS, their internal systems if applicable, and shall copy CMS RO and CO on their response. If Medicare contractor determines the disputed debt shall be recalled from Treasury, the appropriate status code shall be entered to the DCS. If the Medicare contractor determines that the debt shall remain at Treasury for collection, the status code shall be changed from "XX" (or "XO") to "UX" to indicate the dispute was resolved and the debt is still valid. (See instructions in the DCS User Guide, Exhibit 4.)

If Treasury does not receive the response to the dispute timely, the debt may be returned to agency (RTA) with the reason "dispute timer expired." In this case, even if the contractor responded to the dispute and changed the debt status in DCS back to UJ or changed the status code to UX, the contractor will be required to enter the debt as a new debt in DCS. Once a debt is RTA, it cannot be updated in DCS. A new entry is required.

70.14 - Collections
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

70.14.1 - Background
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Collections from the Department of the Treasury (Treasury) as a result of cross servicing efforts are received by CMS central office (CO) through the Intra-governmental Payment and Collection (IPAC) system. Collections may be received as a result of collection efforts by Treasury's Servicing Center or by a Treasury contracted Private Collection Agency (PCA) including installment payments on Treasury approved extended repayment schedules or from offsets from the TOP. Treasury provides the CMS CO with a collection report generated from the IPAC system through the Program Support Center (PSC) of the Department of Health & Human Service (HHS) on a monthly basis.

70.14.2 - Intra-governmental Payment and Collection (IPAC) System
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

The collection report generated from the IPAC system includes a break out of principal and interest collected on individual debts; however, the report does not show the balance and the status of the debt after the collection. Due to system limitations, interest on the CMS debts that have been referred to Treasury and its PCAs does not continue to accrue on Treasury/PCA

records during the entire collection process. Therefore, the amount of interest collected by Treasury or its PCAs may not equal the amount of interest shown as accrued by the Medicare contractors.

70.14.3 - Collections Posted to the Debt Collection System
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

The CMS CO shall update the DCS for collection activity received from the IPAC collections reports. The principal balance reported in the DCS should reflect the principal balance being pursued by Treasury and its PCAs and should be the principal balance reflected in Medicare contractors' internal systems after posting the collection.

NOTE: If the principal balance in Medicare contractors' system does not agree with the principal balance reported in the DCS, Medicare contractors shall research the discrepancy by querying the DCS collection screen to compare collection/adjustment entries to their internal systems/records to determine the difference. Any differences shall be reconciled and the appropriate systems shall be updated.

70.14.4 - Collection/Refund Spreadsheet
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors will receive Treasury collection information from CMS CO via the Collection/Refund Spreadsheet (Exhibits 3A and 3B). The Collection/Refund Spreadsheet, initially prepared by CMS CO, shall be forwarded electronically to Medicare contractors within 15 calendar days of receipt of the IPAC collections. However, no Collection/Refund Spreadsheet shall be forwarded to Medicare contractors with less than 15 calendar days remaining in the quarter.

For each debt listed on the Collection/Refund Spreadsheet, Medicare contractors shall apply the collection to principal and interest amounts as indicated. For collection of interest only, Medicare contractors shall post the interest as shown on the Collection/Refund Spreadsheet. No interest adjustment is required prior to posting the collection. For collection of principal and interest, Medicare contractors shall manually adjust the amount of interest accrued to the amount of interest collected as listed on the Collection/Refund Spreadsheet. This will make the amount of the accrued interest equal to the amount of interest collected and listed on the Collection/Refund Spreadsheet. Medicare contractors shall then post the collection. If a principal balance remains after posting the collection, interest, if appropriate, shall continue to accrue on the remaining principal balance. Medicare contractors shall use the current date as the date of collection to post the Treasury collections to their systems.

Medicare contractors shall complete and return the Collection/Refund Spreadsheet within 15 calendar days of receipt.

Note: Any principal balance that remains in Medicare contractors' systems, after posting the collection activity, will be carried forward. Medicare contractors shall continue to accrue interest, if applicable, on any outstanding principal balance until notified by CMS CO that the debt is paid in full or compromised.

70.14.5 - Debt Paid in Full
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

If the principal balance of the debt in DCS after the IPAC collection is posted is zero, the status code of the debt will not be systematically changed to a paid in full status code. Sometimes a debt has been collected by Treasury and the collection received in one IPAC, but a reversal of the collection occurs in a subsequent IPAC. Medicare contractors shall not initiate any case "close out" activity on the debt when the collection is posted. CMS will provide separate instructions on debts returned by Treasury as paid in full or closed.

NOTE: If Medicare contractors' system does not reflect a zero principal balance after posting the collection, Medicare contractors shall research the discrepancy by querying the DCS collection screen to compare collection/adjustment entries to their internal systems/records, and update all the applicable systems to reflect the appropriate adjustment.

70.14.6 - Extended Repayment Schedule (ERS)
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Treasury and its PCAs have authority to approve extended repayment schedules (ERS) up to 60 months without requesting CMS approval. The ERS requests in excess of 60 months shall be referred to CMS CO for consideration.

When Treasury notifies CMS CO of an approved ERS, CMS CO shall update the DCS with the DCS status code of UR. The periodic payments on the approved ERS received by Treasury or its PCAs will be forwarded to CMS CO on an IPAC collections report. When CMS CO receives the IPAC collections on the approved ERS, CMS CO shall indicate the ERS status on the Collection/Refund Spreadsheet to notify Medicare contractors of such status. Upon receipt of the collection on the approved ERS on the Collection/Refund Spreadsheet from CMS CO, Medicare contractors shall remove the debt from any internal withhold/recoupment status.

Medicare contractors shall apply each collection to principal and interest based on the breakout as indicated on the Collection/Refund Spreadsheet and follow Collection/Refund Spreadsheet instructions as outlined in section 70.14.3.4. Medicare contractors shall continue to accrue interest, if applicable, on any outstanding principal balance until notified by CMS CO that the debt is paid in full.

Debts that are in a Treasury approved ERS shall be reported as current on the Form CMS H 751. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent on the Form CMS C 751. For those Medicare contractors who have transitioned to HIGLAS, debts that are in a Treasury approved ERS shall be reported as current unless they are already classified as CNC. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent.

70.14.7 - Excess Collections
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Amounts collected may exceed the amount of the debt that was referred for cross servicing/TOP. As an example, an excess collection may result from Treasury and its PCAs receiving a collection and Medicare contractors recouping the same debt by internal withhold.

Excess collections are identified on the Collection/Refund Spreadsheet by showing a negative principal balance in the DCS Principal Balance column.

70.14.8 - Applying Excess Collections
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors shall apply the portion of the collection to the debt listed on the Collection/Refund Spreadsheet in order to bring the balance to zero. Medicare contractors shall then determine if the debtor has any other outstanding debts including interest to which the excess collection may be applied.

70.14.8.1 - If the Debtor Has Other Outstanding Debt
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

If the debtor has other outstanding debt, the excess collection shall then be applied to the oldest debt first (then next oldest), in accordance with established procedures for applying excess collections against a debtor's overpayments. The breakout of principal and interest on the Collection/Refund Spreadsheet does not apply when the excess collection is applied to another outstanding debt. Medicare contractors shall indicate on the Collection/Refund Spreadsheet the action taken and the way the collection was allocated to principal and interest on the other debt, and return the completed spreadsheet to CMS CO. If the collection is applied to other debts, the Medicare contractors shall first update the DCS with the DCS Collection Type Code of AD to zero the negative balance of the debt where the excess collection is identified. If the excess collection is applied to another debt currently at Treasury, Medicare contractor shall use AD to post the excess collection to the other debts.

70.14.8.2 - If the Debtor Has No Other Outstanding Debt
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

If there are no other outstanding debts, the excess portion of the collection, after bringing the debt listed on the spreadsheet to a zero balance, shall be refunded. The amount of the refund shall be annotated on the Collection/Refund Spreadsheet. If the refund cannot be processed within the timeframe allotted for returning the Collection/Refund Spreadsheet, Medicare contractor shall annotate the spreadsheet as partially complete and return to CMS CO timely. An additional 15 days shall be allowed for processing refunds. Once the refunds are processed, the completed Collection/Refund Spreadsheet shall be forwarded to CMS. A copy of the spreadsheet, with the appropriate annotations regarding the refund, shall be kept in the debtor file for audit trail purposes. The contractor shall make appropriate adjustments in DCS, as well as internal systems to reflect the refund activity. The DCS shall be updated to reflect the refund and bring the principal balance of the debt to zero. Instructions are found in Exhibit 4, DCS User Guide, of this section.

70.15 - Financial Reporting for Debt Referred
(Rev. 77, Issued: 09-16-05, Effective: 10-17-05, Implementation: 10-17-05)

70.15.1 - Financial Reporting for Non-MSP Debt
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors shall continue to report the debt at their location for financial reporting purposes. Debt referred to Treasury for cross servicing shall not be transferred out on the Form CMS 751 (Status of Accounts Receivable). See Chapter 5 for Financial Reporting instructions.

Medicare contractors shall continue to accrue and report interest in internal systems as well as the POR, if applicable, on a debt after the debt has been referred for cross servicing. The DCS shall not reflect this additional interest unless/until DCS is updated with a collection.

Medicare contractors shall follow the instructions outlined in Chapter 5, Section 270. Medicare contractor shall report and post all activities related to these debts according to CMS guidelines and instructions.

70.15.2 - Financial Reporting for Intermediary Claims Accounts Receivable A/R
(Rev. 72, Issued: 07-29-05; Effective: 01-01-06; Implementation: 01-03-06)

Intermediaries shall be able to identify and separate the claims A/R that have been demanded from those claims A/R that have not been demanded. The date of the initial demand letter shall become the new determination date for aging purposes and the financial reporting of the receivable in Line 2a. New Receivables on the H751, Status of Accounts Receivable, report. The date of the initial demand letter shall be the determination date for interest accrual, delinquency determination and referral to Treasury. The demanded claims A/R shall be reported as delinquent in Section B, Delinquent Receivables, if payment is not received within 30 days after the date of the initial demand letter. These claims A/R shall age and the aging shall be reported in Section B, Delinquent Receivables. The demanded claims A/R shall be eligible for currently not collectible (CNC) reclassification request in accordance with CNC instructions as outlined in chapter 5. The accrual of interest shall begin on the 31st day, and shall be charged from the date of the initial demand letter.

The balance of all Claims A/R (demanded and not demanded), shall be recorded on CMS Form H750 on the line "Claims Accounts Receivable."

The balance of Claims A/R established during the fiscal year that have not been demanded shall continue to be reported on Form CMS-751, Line 2a, New Receivables. These receivables should not be aged. The outstanding balance of Claims A/R not demanded shall be reported in the Not Delinquent category of Section B, Form CMS-751. Claims A/R that have been demanded shall be reported in the appropriate aging category of Section B, Form CMS-751. These demanded Claims A/R shall accrue interest and age consistent with the intermediaries' other types of overpayments.

70.15.3 - Financial Reporting for Collections Received on Debts from Cross Servicing

(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Medicare contractors shall follow the instructions outlined in Chapter 5, Section 270. Medicare contractor shall report and post all activities related to these debts according to CMS guidelines and instructions.

Collections posted to the debts listed on the Collection/Refund Spreadsheet shall be reported in Section A, Line 4C, Collections Deposited at Other Location, and Section C, Line 4C, Collections Deposited at Another Location, of Forms CMS H 751. If the debt is in a Currently Not Collectible (CNC) status, the amounts collected shall be reported in Section A, Line 4A, Re-established as Active A/R, and Section C, Collections on CNC Debt, of the Forms CMS C 751 and in Section A, Line 6B, Transfers In From CNC, and Line 4C, Collections Deposited at Other Location on Forms CMS H 751.

The amount of accrued interest that is adjusted in order to equal the amount of interest collected and posted to the debt shall be reported on Line 5A, Adjusted Amounts, Internal Adjustments, of Forms CMS H 751 or Line 4E, Other, of Forms CMS C 751, if the debt is in CNC status. Medicare contractors shall separately track interest adjustment amounts reported on the "Adjusted Amounts" line on Forms CMS H 751 or reported on the "Other" line on the Forms CMS C 751. The interest adjustment amounts shall be reported in the "Remarks" section of the Forms CMS 751.

For Medicare contractors who have transitioned to the Healthcare Integrated General Ledger Accounting System (HIGLAS), collections reported and posted to the debts on the Collection/Refund Spreadsheet shall be reported on the Treasury Report on Receivables and Debt Collection Activities Report (TROR), Part I, Section A, Line (4)(D), Collections by Treasury through Offset and Cross-Servicing and in Part II, Section C, Line (1)(G), By Treasury/Designated Debt Collection Center Cross-Servicing. If the debt is in a Currently Not Collectible (CNC) status, the amounts collected shall be reported in Part I, Section A, on Line (4) (D), Collections by Treasury Through Offset and Cross-Servicing, and Line (5) (E), Written-Off Debts Reinstated for Collections and also in Part II, Section C, Line (1) (G), By Treasury/Designated Debt Collection Center Cross-Servicing.

70.15.4 - Financial Reporting for Debts Returned to Agency (RTA)

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Debts RTA shall be reported in the appropriate line of the CMS Form 751 and the Treasury Report of Receivables and Debt Collection Activities (TROR) Reports. Details regarding debts RTA are outlined in Section 70.17 herein.

70.15.4.1 - Debts RTA for Bankruptcy

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Debts RTA for Bankruptcy shall be reported in Bankruptcy status as soon as Medicare contractor has bankruptcy documentation to support the bankruptcy status.

C751 Reporting
Section D
(B)(1) In Bankruptcy

H751 Reporting
Section B
(4)(B)(1) In Bankruptcy

TROR Reporting
Section B
(1)(D)

70.15.4.2 - Debts RTA, Pending Final Disposition

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Debts RTA for the following reasons: uncollectible, out of business, miscellaneous dispute, dispute timer expired, recall approved, manual RTA, shall be reported as follows:

C751 Reporting
Section D
(B)(9) Pending Request Waiver/Compromise – for those debts waiting write off approval.
Section D
(B)(11) Other Exclusions – for those debts not yet eligible for write off due to age or past collections.
Section A
Line 4.D. Written-Off Closed – for those debts approved for Write off Closed.

H751Reporting
Section B
4(B)(9) Pending Request Waiver/Compromise – for those debts waiting write off approval.
Section B
(4)(B)(11) Other Exclusions – for those debts not yet eligible for write off due to age or past collections.
Section A
Line 6.A. Amounts Written-Off (Bad Debts) – for those debts approved for Write off Closed.

TROR Reporting
Section B
Line (3)(G) Debt Returned from Cross-Servicing – for those debts waiting write off approval AND for those debts not yet eligible for write off due to age or past collections.

The HIGLAS Accounts Receivable status code DR-RTN-CS (Debts Returned from Cross-Servicing) is mapped to line (3)(G). The receivable balance detail extract can be used to validate the detail of debts reported to this line.
Section A,
Line (6) (B) Written Off and Closed Out – for those debts approved for Write off Closed that are not in CNC Status. For debts approved for write off closed already in CNC status:
Section D
Line (2) CNC Debts Closed Out During the Current FY

70.15.4.3 - Debts RTA Because Dispute Timer Expired

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Debts to be re-referred to Treasury shall be reported as Referred to Treasury.

C751 Reporting
Section D
(A) Referred for Cross Servicing OR
Section D
(B)(1)-(11)As appropriate.

H751Reporting
Section B
4(A) Referred for Cross Servicing OR
Section B
(4)(B)(1)- (11) As appropriate.

TROR Reporting
Section B
Line (3) (J) Debt Referred to Treasury or a Designated Debt Collection Center for Cross-Servicing – for those debts resubmitted to Treasury. OR
Debts ineligible for referral shall be reported in the appropriate line as an exclusion to debt referral.

70.15.4.4 - Debts RTA Paid in Full or Satisfied Payment Agreement or Satisfied Compromise

(Rev. 143; Issued: 10-24-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Debts in these status codes with other than a zero balance shall be reported as follows until further instructions are issued:

C751 Reporting
Section D
(B)(11) Other Exclusions

H751Reporting

Section B
(4)(B)(11) Other Exclusions.

TROR Reporting
Section B
Line (3)(G) Debt Returned from Cross-Servicing. The HIGLAS Accounts Receivable status code DR-RTN-CS (Debts Returned from Cross-Servicing) is mapped to line (3)(G). The receivable balance detail extract can be used to validate the detail of debts reported to this line.

70.16 - Intermediary Claims Accounts Receivable (A/R)
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Intermediary claims A/R arises from adjustments in the intermediary's claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). The adjustments may be the result of duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, or for any reason an intermediary adjusts a claim payment. These adjustments are usually recovered through recoupment and the recovered amounts are included in the remittance advices to the providers. If the overpayment has not been recouped, the balance remains outstanding and is reported on the intermediary's financial records.

The CMS has determined that these types of debt are eligible for referral for cross servicing/Treasury Offset Program (TOP). The following outlines procedures for referral/collection/termination of collection action and write-off closed of these debts. Intermediaries shall use these procedures to:

- Address the current inventory of intermediary claims A/R.
- Demand and refer delinquent intermediary claims A/R as part of their on-going debt collection procedures.

To identify and address the current inventory of outstanding intermediary claims A/R and to identify, on an ongoing basis, claims A/R to be demanded or recommended for termination of collection action and write-off closed, intermediaries' shared system shall be able to separately identify the following:

- Claims A/R, of any amount, regardless of age, that cannot be validated.
- Claims A/R, for an individual provider, totaling less than $25 for the aggregated principal balance, where no adjustment/recoupment has occurred in the past 60 days.
- Claims A/R for an individual provider, greater than 10 years old, regardless of amount.

- Claims A/R, for an individual provider, with an aggregate principal balance greater than or equal to $25, which is less than 10 years old, and no adjustment/recoupment has occurred in the past 60 days.

After these separations are made, the following procedures shall be followed:

For Recommendation of Write-Off (Termination of Collection Action):
When recommending write-off (termination of collection action), intermediaries shall follow instructions as outlined in the overpayment section of this manual, which begins at Section 100, or contact their regional office (RO) for guidance.

- Claims A/R for an individual provider, totaling less than $25 for the aggregated principal balance, where no recoupment has occurred in the past 60 days, should be recommended for termination of collection action and write-off closed. A listing should be forwarded to the RO which contains the following information:

    - Provider number;
    - Provider name;
    - Amount of claims A/R being requested for termination of collection action and write-off closed;
    - Date of claims A/R;
    - Date of last activity; and
    - Reason for requesting/recommending termination of collection action and write-off closed.

- Claims A/R, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and write-off closed. This could include claims A/R received as a result of a Medicare contractor transition where no remittance advices are available, and other claims A/R where no remittance advice is available to support the balances. The intermediary shall make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R shall be forwarded to the RO for approval. The list should contain the same information as above, with the reason for termination of collection action and write-off recommendation that provides reasonable evidence to substantiate that the claim is no longer available.

- Claims A/R for an individual provider greater than 10 years old, regardless of amount, shall be recommended and submitted to the RO for termination of collection action and write-off closed.

Intermediaries shall submit, at least quarterly, recommendations for write-off and termination of collection action of outstanding claims A/R meeting the above criteria. Requests shall be submitted to the RO no later than 30 days after the end of each calendar quarter. ROs shall have 30 days after receipt of the request to respond, except for cases exceeding the RO's delegated authority. For those cases exceeding the RO authority, the RO shall forward the

case to CO with the RO's recommendation, within 30 days of receipt of the contractor's request.

For issuing an initial demand letter:

This instruction supercedes any other instructions for issuing demand letters for claims A/R, including those found in FMM Section 130. These instructions, however, do not apply to medical review and fraud overpayments. Claims A/R that are demanded shall age and accrue interest and the aging and interest accrual shall be reported in accordance with chapter 5, section 200.

Claims A/R for an individual provider with an aggregate principal balance greater than or equal to $25 and less than 10 years old, and where no recoupment has occurred in the past 60 days, shall be validated and intermediaries shall send an initial demand letter for the outstanding amount claim A/R balance. The demand letter shall have a determination date equal to the date of the demand letter. In accordance with the intermediary's established demand process, the provider shall have 15 days to respond to the demand letter. In addition, the demand letter shall contain the following:

- The letter shall explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest shall begin to accrue if the debt is not paid in full within 30 days. The letter shall provide the debtor with appeal rights and contain all provisions of a standard initial demand letter. The letter shall also contain language that explains how the overpayment was determined and that the claims A/R have been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries shall include the date(s) of the remittance advice and original amount(s) of the claims A/R.

- If the initial demand letter is returned as undeliverable, the intermediary shall attempt to locate a valid address. If a valid address is found, or it is determined that there was a change of ownership, the intermediary shall send the demand letter to the valid address/owner.

- If a current address cannot be located, the intermediary shall send the Debt Collection Improvement Act of 1996 (DCIA) intent to refer letter (IRL), and follow established debt referral procedures.

- If the initial demand letter is not returned undeliverable, the intermediary shall follow established debt collection procedures similar to other accounts receivable overpayments as outlined in chapter 3, sections 20 and 40, with the exception that withhold does not stop for claims A/R for fifteen days from the initial demand letter. The claims A/R debt collection process shall include sending the DCIA IRL if the overpayment is not recouped. The DCIA IRL shall be sent no later than 120 days from the date of the initial demand letter.

- Each demanded claim A/R shall be considered a separate identifiable debt and shall not be aggregated with other demanded claim A/R.

- The contractors' shared system must be able to properly report these claims A/R in accordance with financial reporting requirements outlined in Pub. 100-6, Chapter 5, Sections 200 through 400.

Exception to above procedures for issuing the initial demand letter:

If the intermediary has knowledge that the letter to a debtor shall be returned undeliverable, based on prior attempts to contact the debtor, and where the intermediary cannot obtain a current address, the initial demand letter may be expanded to include the DCIA IRL language. The intermediary shall send the initial demand letter with the DCIA IRL language and follow established debt referral procedures. The date of the initial demand letter shall be the determination date for aging, interest accrual and DCIA referral purposes.

Claims A/R that are outstanding, but have not yet been demanded because they have not met the timeframe for issuing an initial demand letter or do not meet the dollar threshold for being demanded should be considered in cost report settlements if collection by withhold from interim payments or through the claims accounts receivable demand process is doubtful. Claims A/R that have been demanded, in accordance with these instructions, shall not be included in the cost report settlement process, as these are now considered as separate receivables.

If the intermediary determines that the provider has filed bankruptcy, established procedures regarding bankruptcy in Chapter 3, Section 140 shall be followed, including administrative freezes on recoupment, exemption to DCIA, and issuance of letters regarding the overpayment. This instruction does not change any of the procedures to be followed for bankrupt providers.

70.17 - Debts Returned to Agency (RTA) by the United States Department of the Treasury (Treasury)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

During the collection process, Treasury either collects debts or makes a final determination as to the status of the debts. The Treasury returns to agency (RTA) debts to the Centers for Medicare & Medicaid Services (CMS) using the following reasons:

In Bankruptcy
Uncollectible
Out of Business
Dispute Timer Expired
Miscellaneous Dispute
Manual Return to Agency
Recall Approved
Complaint
Paid in Full
Satisfied through Payment Agreement

Satisfied through Compromise

The CMS will send monthly reports of these debts to the Medicare contractors (contractors) for final resolution. The reports will state the reasons Treasury RTA the debts.

The CMS has developed new status codes in the Debt Collection System (DCS) for each of the reasons the debts were RTA. The RTA reports, prepared by CMS Central Office (CO), will reflect the new status codes. If Treasury returns debts and the DCS already shows the debts in a recall status, the system will not update the status code. However, the RTA reports will include the debts showing the existing DCS recall status codes and the reason for the Treasury RTA.

The RTA reports are sent out in Excel format so the contractors may sort them as appropriate. The contractors shall address all debts on the RTA reports and forward the completed report to CMS CO within 30 days after receipt.

The following sections will give a detailed description of the new status codes in DCS for debts RTA by Treasury:

70.17.1 - Debts RTA by Treasury due to Bankruptcy (RB)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

Debts in bankruptcy status are ineligible for cross servicing. If debts, RTA by Treasury due to bankruptcy are already status code 2B (Bankruptcy) in DCS; the debts will still appear on the RTA report but the status code will not change. The CMS changes the status code of debts, RTA by Treasury, in DCS to RB (RTA – Bankruptcy). The RB status code indicates that these debts were RTA by Treasury due to bankruptcy. The contractor shall not make any further updates to the debts in DCS. The RTA debts, which appear on the monthly report, will remain in RB status in DCS. The contractors are responsible for obtaining bankruptcy documentation to support the bankruptcy status code listed on the RTA report. Once the contractors obtain the documentation, they shall update their internal records to reflect the appropriate code for bankruptcy. The contractors shall follow established procedures regarding debts in bankruptcy status. The contractors shall properly report the status of these debts in their quarterly financial reports to CMS CO. (See Pub. 100-06, chapter 3, section 140.)

The Treasury no longer routinely sends bankruptcy documents to creditor agencies. Therefore, contractors shall follow established procedures, including contacting the CMS Regional Office (RO), to obtain bankruptcy documentation. It is the contractor's responsibility to obtain the bankruptcy documentation. If the contractors cannot obtain bankruptcy documentation through established procedures, including asking the RO for assistance, the contractors may contact Treasury to obtain documentation for RTA debts in bankruptcy. If the contractors are unable to obtain bankruptcy documentation through established procedures or through the assistance of the RO, they shall request bankruptcy documentation from Treasury via email to CrossServicing.Questions@fms.treas.gov. The subject line of the email request shall be entitled, "Request for Bankruptcy Information". If the contractors do not receive a confirmation from Treasury within 2 business days of the request, the contractor shall re-send the email or make another request to Treasury via fax number 205-912-6353. The contractors shall include the

following information; the FedDebt number, debtor name and the contractor's contact information on each request via email or fax.

If the CMS Regional Office of General Counsel (OGC) advises the contractor that debts are not discharged in bankruptcy and are still eligible for referral, the contractor shall submit a new referral to Treasury. The contractors shall change the status code from RB to 2R (RTA Debt Re-entered into DCS) and re-enter the debts into DCS as a new referral to Treasury. (See-Exhibit 4 of this section, the DCS User Guide, Section 2.1) The contractors **shall not** change the status code of a debt in RB status back to status code UJ (Sent to PSC for Cross-Servicing). The contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

70.17.2 - Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

If debts are RTA for one of the above reasons, CMS will update the DCS with the new codes unless the DCS is already showing the debts in a recall status. The RTA report will reflect the recall status along with the reason for the RTA by Treasury.

The contractors shall use the RTA report to research the debts in order to determine the current status or final disposition. The debts already in a recalled status are included so that the contractors will know that Treasury considers the debts uncollectible or out of business.

The contractors shall determine whether collection by litigation is a viable option for debts showing a status code of RU (RTA – Uncollectible) or RN (RTA – Out of Business). If so, follow established procedures for referring the debts for litigation (See CMS Pub. 100-06, chapter 3, section 120).

The contractors shall also consider whether all other appropriate actions to collect debts have been taken before recommending debts for Write-Off Closed (WOC), including the criteria listed below

1. Have there been any collections or payments on this debt in the last year? If so, and the contractor believes further collections are possible, the contractor shall not recommend the debt for WOC, but shall continue collection efforts for MSP and Non-MSP debts.

2. Has the debtor submitted any Medicare claims in the last 6 months? If so, and the contractor believes further collections are possible, the contractor shall not recommend the debt for WOC, but shall continue collections efforts.

3. Is the debtor receiving Medicaid funds? If so, the contractor shall not recommend the debt for WOC. The contractor shall instead contact the CMS RO to institute an offset, and shall continue collection efforts.

4. If applicable, did the debtor undergo a Change of Ownership (CHOW) (a new owner who opts to receive automatic assignment of the old owner's provider agreement)?

   If so, the contractor shall determine if collection efforts were pursued from the new owner.

   (a) If so, the contractor shall recommend for WOC
   (b) If not, the contractor shall follow the normal policies and procedures for debts collection.

5. If applicable, did the debtor file any cost reports that the contractor has not yet settled?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await settlement of the cost report to determine whether it results in an underpayment. If it does result in an underpayment, the contractor shall apply any funds due to the provider to any outstanding debts first, before releasing any funds to the debtor

6. If applicable, does the debtor have any outstanding unfiled cost reports less than 1 year overdue?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await filing and settlement of the cost report to determine whether it results in an underpayment. If it does result in an underpayment, the contractor shall apply any funds due to outstanding debts first, before releasing any funds.

7. If applicable, does the debtor have any funds in suspense due to an unfiled cost report? If so, and the provider has been terminated from the Medicare Program, the contractor shall apply the funds in suspense to recover the debt or any other outstanding debts for the provider.

8. If applicable, does the debtor have any claims or cost reports subject to re-opening?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall wait until the expiration of the reopening period. If a cost report reopening during this period results in an underpayment, the contractor shall apply the underpayment to recover the debt or any other outstanding debts for the debtor, before releasing any funds.

9. Does the debtor have any open appeal(s)? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await the final determination on the appeal(s), and apply any funds due from a favorable decision to any outstanding debts first, before releasing any funds.

10. Does the debtor have an active fraud case? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall forward the debt to the appropriate Program Safeguard Contractor (PSC) or the Zone Program Integrity Contractor (ZPIC) or CMS Centers for Program Integrity that has the open fraud case.

If the contractors have considered all of the above criteria above and are recommending the debts for WOC, the contractors shall submit a request to the CMS RO for approval. The contractor shall submit two separate reports for debts in RU status: 1) Debts in RU status with a principal balance of $500,000 or less and 2) Debts in RU status with a principal balance greater than $500,000.

The contractor shall also submit two separate reports to the CMS RO for debts in RN status: 1) Debts in RN status with a principal balance of $100,000 or less and 2) Debts in RN status with a principal balance greater than $100,000.

The CMS RO will review the contractor's recommendation and proceed as follows: 1) All debts with a principal balance greater than $25,000 must have the concurrence of the CMS RO OGC before approval for WOC by the RO is granted and 2) All debts with a principal balance less than $25,000 maybe approved by the RO; these debts do not require OGC concurrence to WOC.

The above criteria allow the contractors to confirm that all appropriate methods of collection were completed before recommending debts for WOC. The contractors may use the suggested format or choose a similar format of their own to submit WOC information. Any format used shall include the Contractor Validation statement below with each submission:

Contractor Validation:
We recommend these debts for termination of collection action, close out and write-off-closed. We considered all criteria in section 70.17.2 in making this recommendation.
Total debts recommend for Write-Off-Closed:
Number of Debts: _____ Principal Balance: _____ Interest Balance: _____

Signature of Medicare Contractor CFO: _____ Date: _____

The Debts recommended for WOC that do not meet the above criteria shall remain open until the criteria for WOC has been met. The contractors shall report these debts on the appropriate line of the CMS Forms 751 or the Treasury Report on Receivables (TROR) to indicate Treasury has RTA the debts but the WOC process has not been completed. (See CMS Pub 100-06, chapter 4, section 70.15.4) The contractors shall submit a report of the debts recommended for WOC to the CMS RO using established procedures for recommending debts for WOC.

Once CMS approves the debts for WOC, the contractors shall complete the WOC process and make all appropriate adjustments on CMS Form 751 or the TROR. The contractors shall update debts approved for WOC to status code 2W (Non-MSP WOC) in DCS. The contractors shall add a comment on the DCS comment screen reflecting the date of the RTA report in which the WOC debts appear on and the financial statement reporting quarter in which the debts were closed.

70.17.3 - Debts RTA by Treasury as Dispute Response not Received Timely (RX)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

The Treasury returns debts with this status code because the dispute response was not received timely. The debts in this status will update to RX (RTA - Dispute Timer Expired) in DCS, if the debt was still in a dispute status code or was updated to UJ or UX (Dispute Resolved, Debt Returned for Cross-Servicing). The contractor shall research and resolve the debts in RX status in order to determine the current status of the debts. No further action is necessary if the debts are already in a recalled status. The contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

If the debts are still valid and eligible for referral to Treasury, the contractors shall re-enter debts as new entries in DCS, even if a response to the disputes were previously submitted to Treasury. The contractors shall not issue a second Intent to Refer letter (IRL). However, the contractors shall change the status code of the original debt in DCS from RX to 2R (See Exhibit 4 of this section, the DCS User Guide, Section 2.1). If the final determination indicates that the debts should be in recall status, the contractors shall update the original debts in DCS from RX to the appropriate recall status code.

70.17.4 - Debts RTA by Treasury as a Miscellaneous Dispute, a Manual RTA, Complaint or as Recall Approved (RD)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

The CMS updates the DCS to status code RD if the debts are not already in a recalled status. The contractors shall research and resolve debts in status code RD and update the DCS with the final disposition of the debts. If any debts are still valid and eligible for referral to Treasury, the contractors shall change the status code of the debts from RD to 2R and re-enter the debts as new entries in the DCS to be resubmitted to Treasury. The contractors shall not issue a second Intent to Refer letter (IRL) for the debts. (See Exhibit 4 of this section, the DCS User Guide, Section 2.1). Lastly, the contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

70.17.5 - Debts RTA by Treasury as Paid in Full (RP), Satisfied Payment Agreement (RP) or Satisfied Compromise (RC)

(Rev. 198, Issued: 10-27-11, Effective: 11-01-11, Implementation: 11-28-11)

The CMS updates debts in the DCS to the above status codes unless the debts are already in a paid in full status. If the principal balance of the debts in DCS and in the contractor's internal systems are $100 or less, the contractors shall update the DCS status code from RP to 2Q (Cross-Servicing Collection – Paid-in-Full) or RC to 2C (Cross Servicing Collection – System Compromise) as applicable. The contractors shall close out the debts in their internal systems and any balance shall be adjusted to zero.

If the principal balance of the debts in the DCS and the contractors' internal systems has a negative balance, the contractors shall update the DCS using the codes listed above. The contractors shall analyze the payments received and determine if a refund should be issued (See CMS Pub. 100-06, chapter 4, section 70.14.8). If it is determined a refund is valid, the contractors shall follow procedures for applying excess collections and update their internal systems as well as the DCS to reflect any refund given (See CMS Pub. 100-06, chapter 4, section 70.14.8).

If the principal balance of the debts in DCS and in the contractors' internal system is greater than $100, these debts shall remain in status codes RP or RC in DCS. The CMS will issue additional instructions regarding the debts for this workload in the future.

The contractor shall consider these debts as paid in full and shall annotate their internal systems accordingly so that no additional collections are applied to these debts. The contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

Exhibit 1
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Intent to Refer Letter

Background

The DCIA requires Federal agencies to refer debt that is 180 days delinquent to the Department of Treasury or a Treasury designated Debt Collection Center for cross servicing.

Prior to debt transfer, the DCIA requires agencies to inform the debtor of the agency's intent to refer the debt, and to provide debtor information regarding the referral process.

Attached are specific paragraphs that explain the process and debtor rights. These paragraphs shall be included in the intent to refer letter sent to the debtor.

Medicare contractors should use their own language in the opening paragraphs to explain the reason for the overpayment and the current balance, including interest accrued and the interest rate.

Subject in Bold: **Notice of Intent to Refer Debt to the Department of Treasury's Debt Collection Center for Cross Servicing and Offset of Federal Payments and Certain Eligible State Payments**

Contractor opening paragraphs concerning the reason for the overpayment, date of determination and amount due. May refer to previous demand letters or other forms of contact regarding the debt.

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt will be referred to the Department of Treasury's Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments. Your debt will be referred under provisions of Federal law, title 31 of the United States Code, Section 3720A and the authority of the Debt Collection Improvement Act of 1996.

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debts to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross servicing and/or the Treasury Offset Program. Under the offset program, delinquent Federal debts are collected through offset of other Federal agency payments you may be entitled to, including the offset of your income tax return through the Internal Revenue Service (IRS). The TOP offsets can also be taken from eligible state payments to which you are entitled.

The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it may be reported to the IRS as potential taxable income.

During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

<u>For Individual Debtors Filing a Joint Federal Income Tax Return</u>

The Treasury Offset Program automatically refers debts to the IRS for offset. Your Federal income tax refund is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

<u>Federal Salary Offset</u>

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become a federal employee.

<u>Medicaid Offset</u>

As authorized at 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to offset the Federal share of any Medicaid payment due you, your agency and/or related facilities. At that time, the offset will remain in effect until the Medicare overpayment is paid in full.

Please read the following instructions carefully to determine what action you may take to avoid referral for cross servicing/offset.

Due Process

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. If, after sixty days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, will be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset.

Repayment

Your debt will not be referred to the Department of Treasury if you make payment in full. The past due amount of $_____owed to the Medicare Program as of _____ includes interest accrued through _____. **(Note: Medicare contractors may alter this sentence to read: The past due amount owed to the Medicare Program as of the date of this letter includes current accrued interest. This sentence may be omitted for debts that do not accrue interest.)** Interest is accrued monthly and is added to the balance of the debt.

Your check or money order for the amount due should be made payable to:

Medicare
Contractor Address
000 Street
Anywhere, USA 00000-0000.

Include a copy of this letter with your payment.

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement. If you are interested in an extended repayment agreement, please contact this office.

Bankruptcy

If you have filed for bankruptcy and an automatic stay is in effect, you are not subject to offset while the automatic stay is in effect. Documentation supporting your bankruptcy status, along with a copy of this notice, must be forwarded to this office at the above address.

If you have any questions concerning this debt, please contact_____
at_____.

Sincerely,

_____
Signature of Certifying Official

Official Position

Exhibit 3 A - Collection/Refund Spreadsheet (Part A)
(Rev. 124, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

Click here to review Exhibit 3 A – Collection/Refund Spreadsheet (Part A)

Exhibit 3 B - Collection/Refund Spreadsheet (Part B)
(Rev. 124, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

Click here to review Exhibit 3 B – Collection/Refund Spreadsheet (Part A)

SECTION ONE:

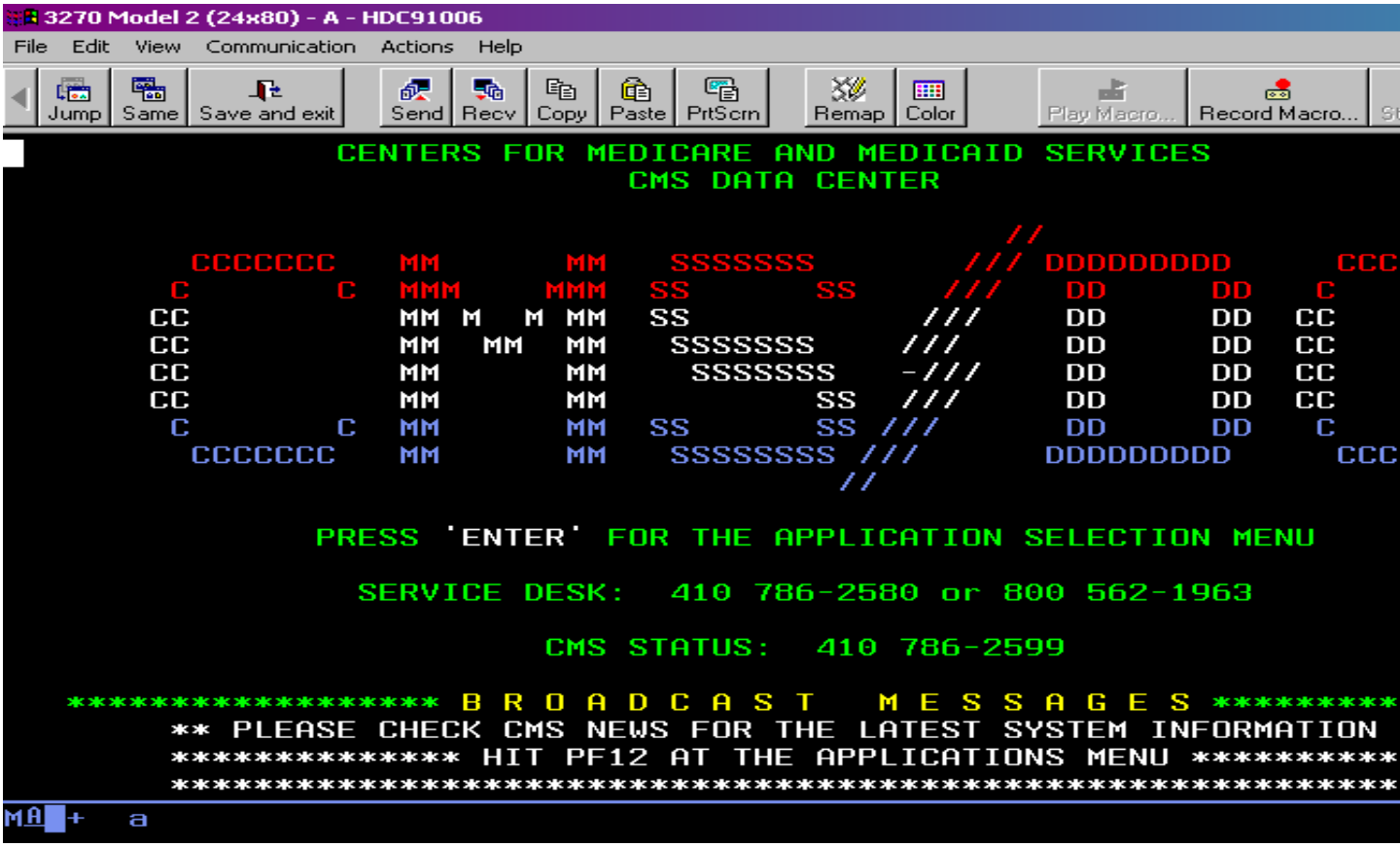
ACCESSING DCS

USER INSTRUCTIONS FOR DEBT COLLECTION SYSTEM (DCS)

TO ACCESS DCS

1. The DCS is housed within the Customer Information Control System (CICS) region of the CMS Data Center. Users must have a CMS User ID for system access. For additional information, contact your system administrator.

2. The CMS Data Center screen will appear. From this screen Hit Enter.



3. The next screen will be the application menu. From this screen Type “3" and Hit Enter.

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3270 Model 2 (24x80) - A - HDC91368
File  Edit  View  Communication  Actions  Help
Jump  Same  Exit  Send  Recv  Copy  Paste  PrtScrn  Remap  Color  Play Macro...  Record Macro...  Stop Macro  Pause Macro  Run Ap

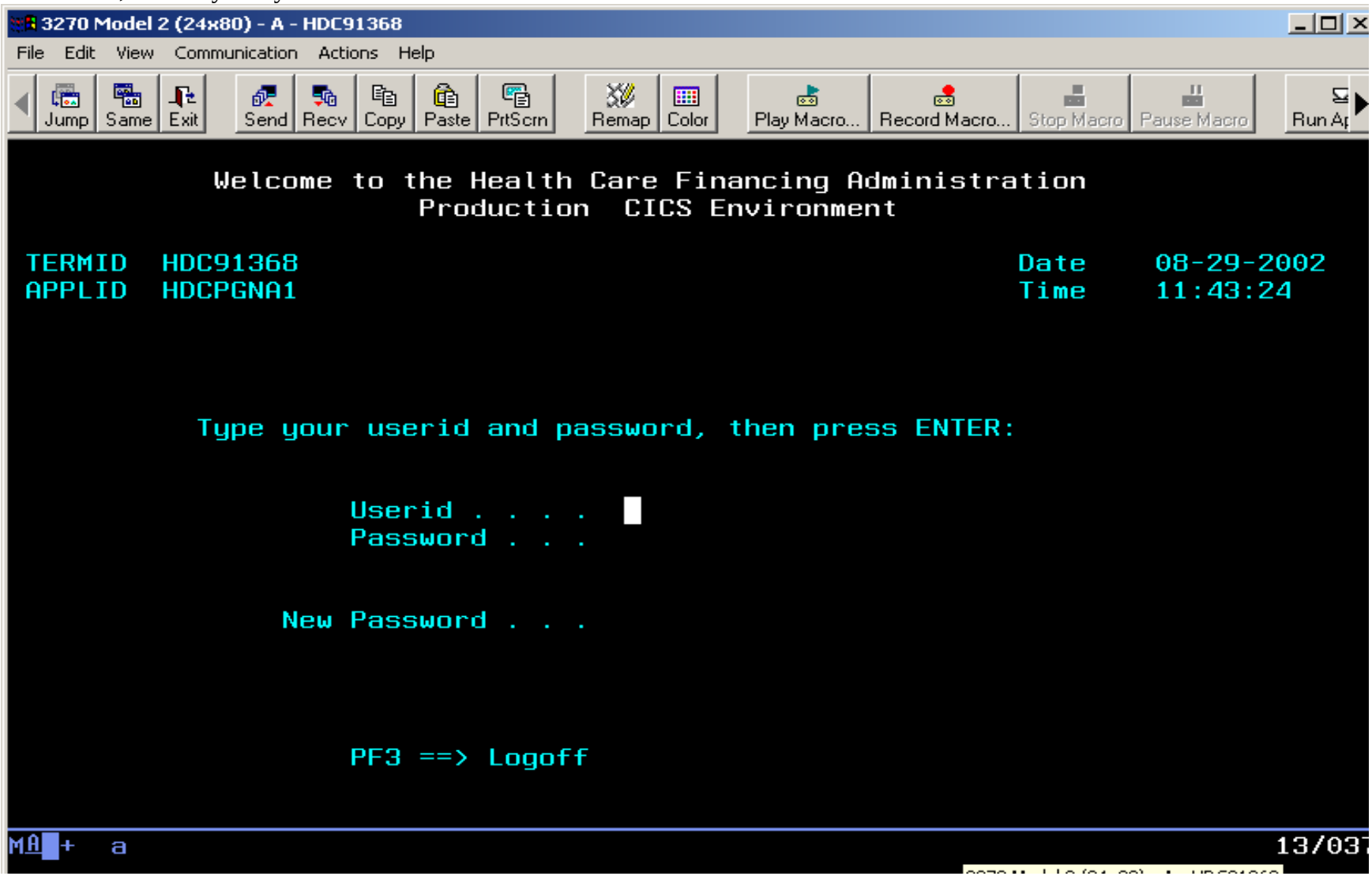
PAGE 1 of 3 ......... A P P L I C A T I O N    M E N U .......................
08/29/02 11:38                                                TERMINAL - HDC91368

        ** PLEASE CHECK CMS NEWS FOR THE LATEST SYSTEM INFORMATION ***
        *************** HIT PF12 AT THE APPLICATIONS MENU *************
        ***********************************************************************
.......................................................................................

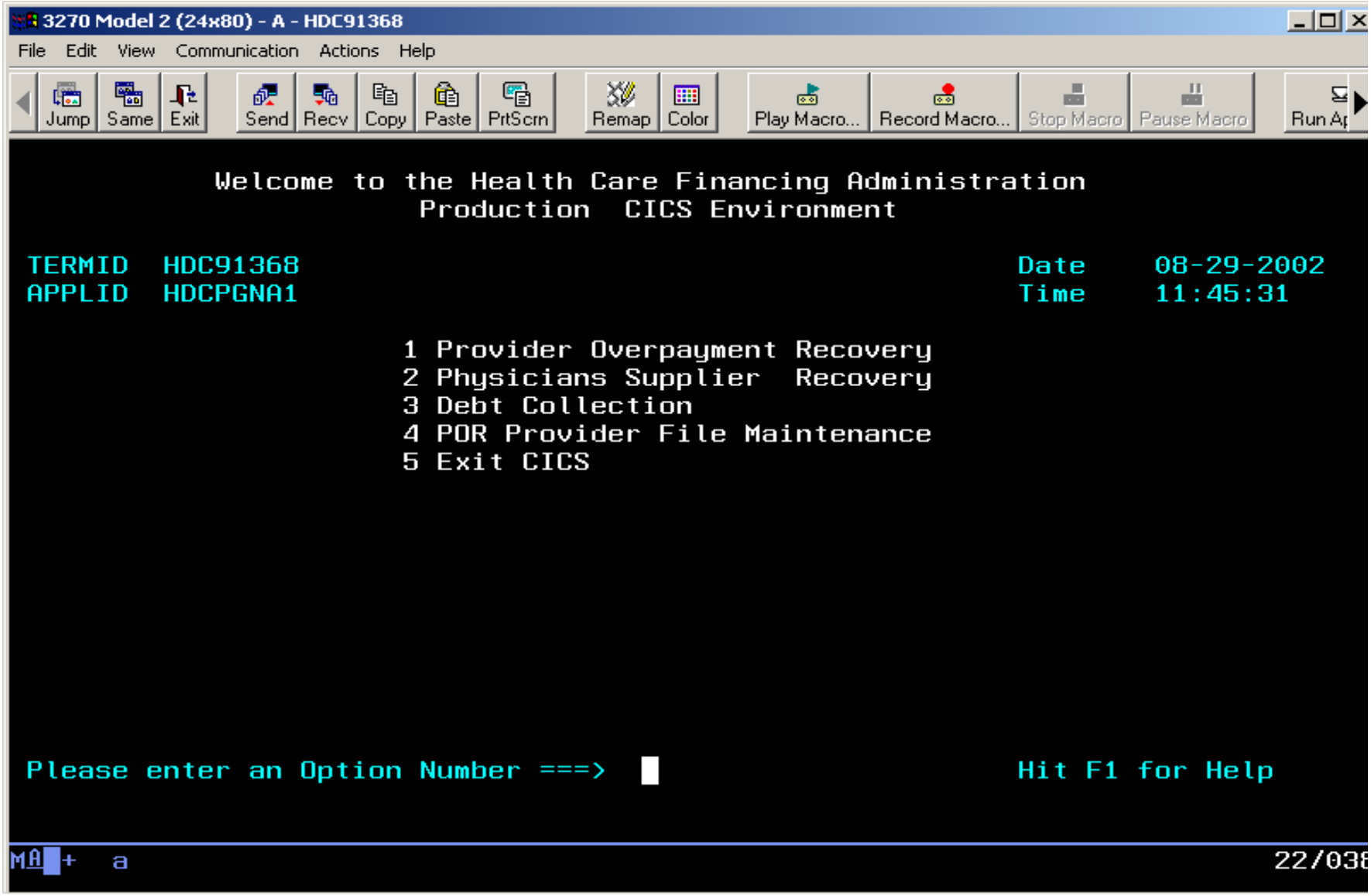
                 1   TSO        ACTIVE     Application Development
                 2   RESERVED   INACTIVE   Future CICS System
                 3   CICS41     ACTIVE     CICS41 System
                 4   M204PRD1   ACTIVE     MODEL204 Production Region
                 5   M204PRD2   ACTIVE     MODEL204 Version 2 Production
                 6   WYLBUR     ACTIVE     WYLBUR Online System
                 7   IDMSTEST   ACTIVE     IDMS/CV100 Database System
                 8   NIHTITAN   ACTIVE     NIH Application Menu
                 9   M204PRD3   ACTIVE     Oscar/Cafm/Casr/Crowd/Clia

                Select application ==>
                                                                  more . . .
.......................................................................................
 PFK  1   H E L P            PFK 12   ** HDC NEWS**      PFK  3   HDC LOGO
 PFK  7   PAGE BACK                                      PFK  8   PAGE FORWARD
 PFK  2   APPLICATION INFO                               PFK 11   UTILITIES
MA  +   a                                                                19/046
158.73.207.36:7723
```

4. Next will be the HCFA Production CICS Environment screen. Type in your CMS User ID and Password. For additional information, contact your system administrator.



5. Next will be a menu option screen. Type in the corresponding number for Debt Collection and Hit Enter.

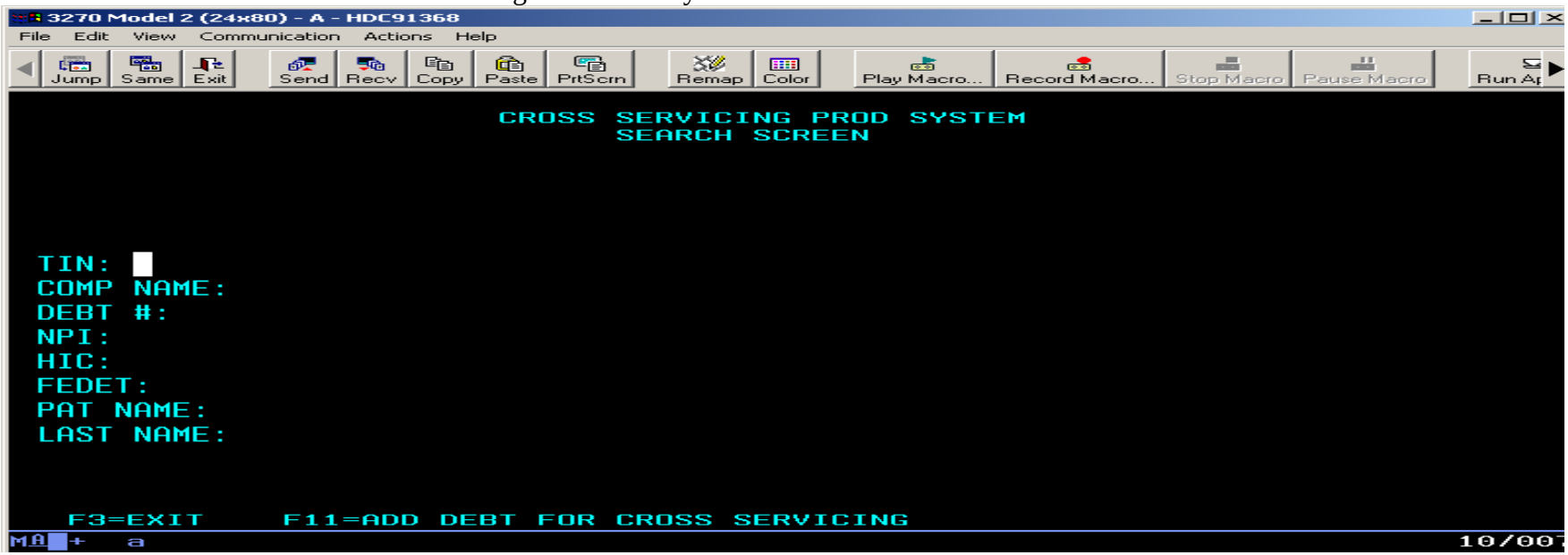


SECTION TWO:

ENTERING DEBTS INTO DCS

TO ENTER A DEBT INTO DCS

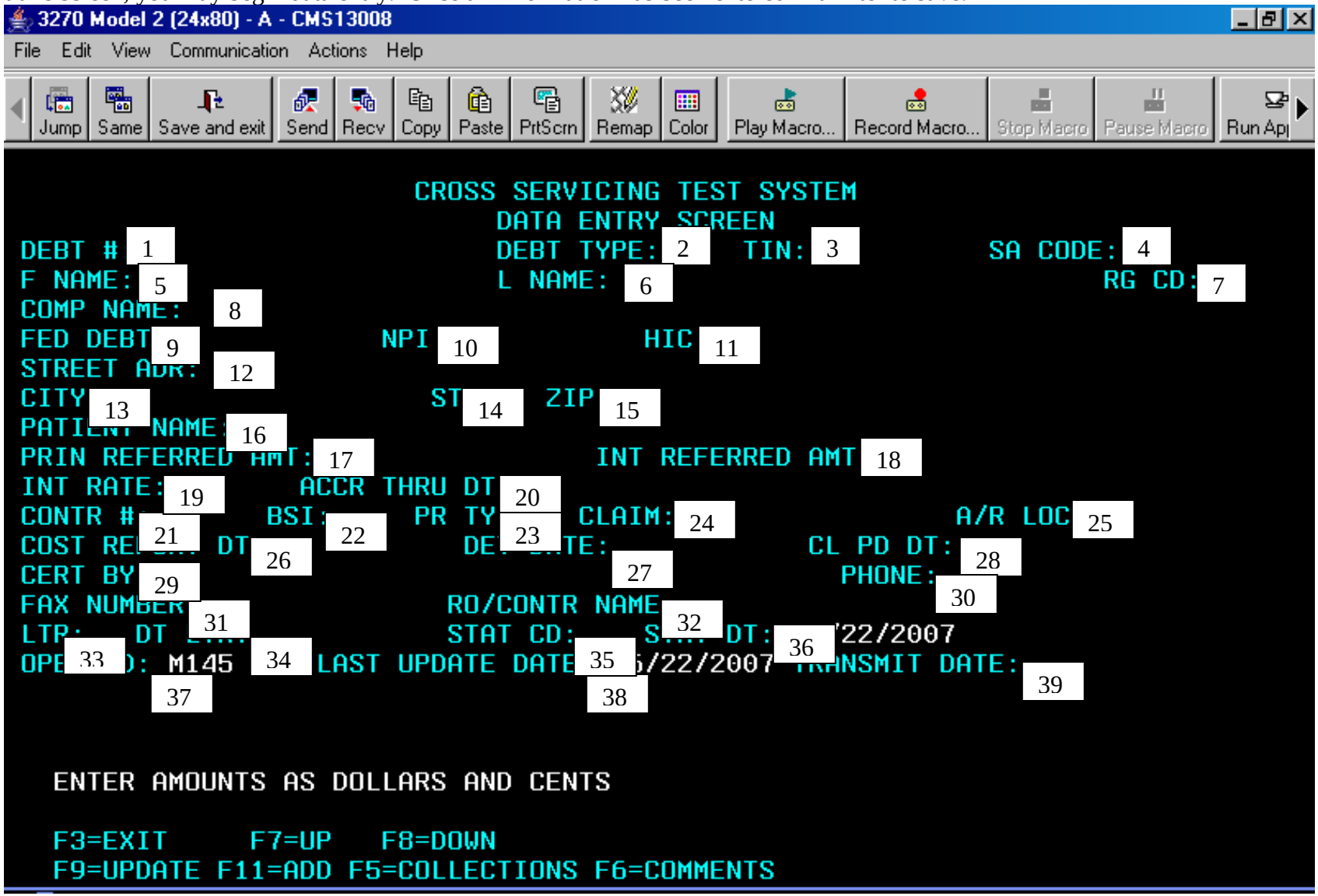
1. The next screen will be the Cross Servicing Production System Search Screen.



From this screen you may query a particular debt by entering data into any of the fields listed. If you do not have the complete TIN (Taxpayer Identification Number), the system will allow you to enter a minimum of five characters. If you do not have the complete COMP NAME (Company Name), the system will allow you to enter a minimum of six characters. If you do not have the complete Debt #, the system will allow you to enter a minimum of four characters. If you do not have the complete NPI (National Provider Identifier), the system will allow you to enter a minimum of six characters. If you do not have the complete HIC (Health Insurance Claim) Number, the system will allow you to enter a minimum of four characters. If you do not have the complete FEDET (FedDebt Number), the system will allow you to enter a minimum of five characters. If you do not have the complete PAT NAME (Patient Name), the system will allow you to enter a minimum of six characters. If you do not have the complete LAST NAME, the system will allow you to enter a minimum of four characters. The system will then bring up all debts related to the information provided. You may then select the correct debt by using the F8 key to scroll forward through the debts.

IMPORTANT: This query shall be used before entering a debt into the system so that you can check for a duplicate entry. Once you have determined that the debt is not currently in the system, Hit F11 to insert a new debt.

2. If you chose F11 to insert a new debt, the next screen to appear will be the Cross Servicing Production System Data Entry Screen. At this screen, you may begin data entry. Once all information has been entered Hit Enter to save.



FIELD SPECIFIC INSTRUCTIONS FOR DATA ENTRY SCREEN

Field #	Description/Instruction
1.	DEBT NUMBER - Enter the associated debtor number. This number will be to provide updates to the debt or to query the debt. For Part B debt types use the Physician/Supplier number. For Part A debt types use the Provider number. For MSP debt type use the report ID for a data match case or HIC number for a non-data match case. For all other debts, use a specific identifying debtor number. When entering this number, enter from left to right, DO NOT use spaces and DO NOT use dashes.
2.	DEBT TYPE - Enter the appropriate debt type. Debt types are as follows: PTA (Part A, includes referral to a Private Collection Agency (PCA) and the Treasury Offset Program (TOP)); PTB (Part B, includes referral to PCA and TOP); TPA (Part A, includes referral to TOP only, will not be referred to a PCA); TPB (Part B, includes referral to TOP only, will not be referred to a PCA); MSP (Medicare Secondary Payer); HMO; FOI (Freedom of Information Act); RRB (Railroad Retirement Board); OTH (other); PUB (Public Invoices); LTC (Long Term Care); OIG (Office of the Inspector General); CBC (Centers for Beneficiary Choice) ; CLA (Intermediary Claims A/R); HAT (Part A HIGLAS, includes referral to a PCA and TOP); HBT (Part B HIGLAS, includes referral to PCA and TOP); HMS (HIGLAS Medicare Secondary Payer); HPA (Part A HIGLAS, includes referral to TOP only, will not be referred to a PCA); HPB (Part B HIGLAS, includes referral to TOP only, will not be referred to a PCA) Debt types PUB, OIG and CBC are used by Central Office only. *It is important that the appropriate debt type be used. If the debt is expected to be recouped in full within three years through internal offset, the debt should not be referred to a PCA.
3.	TIN (Taxpayer Identification Number) - Enter the TIN (Social Security Number (SSN) or Employer Identification Number (EIN). Do not use dashes between numbers. This field is required for all Non MSP debts and must be entered on MSP debts if available. For MSP debts, use the beneficiary SSN as the TIN when the beneficiary is the debtor. Use the EIN for company debt. Do not enter a pseudo TIN.
4.	SA CODE - Enter IND for an individual or COR for a corporate debtor or a partnership. This code is used for TOP referral. The debt will be rejected if the SA Code and name of the debtor are not in agreement.
5.	F NAME (First Name) - Enter the first name of the debtor. This field should not be used for corporate debtors.
6.	L NAME (Last Name) - Enter the last name of the debtor. This field is required when the SA Code is IND. This

field should not be used for corporate debtors.

7. RG CD (Regional Code) - Enter the Regional Office number (i.e. 01).

8. COMP NAME (Company Name) - Enter the corporate name of the debtor. For debt type LTC this will be the name on the provider agreement. This field is required when the SA Code is COR.

9. FED DEBT - This field will be entered by Central Office. It will contain the FedDebt number once it is supplied by the Department of Treasury.

10. NPI – Enter the National Provider Identifier (NPI) number for the debt. This is a 10 character alpha numeric field.

11. HIC – Enter the Health Insurance Claim (HIC) number for the debt. This field is for MSP debt only. This is a 14 character alpha numeric field.

12. STREET ADR (Street Address) - Enter the street address of the debtor.

13. CITY - Enter the city of the debtor.

14. ST (State) - Enter the state of the debtor.

15. ZIP - Enter the five numeric digit zip code of the debtor. DO NOT MAKE THIS FIELD ALL ZEROS.

16. PATIENT NAME - This field is ONLY for MSP debts. Enter the beneficiary's first and last name.

17. PRIN REFERRED AMT (Principal Referred Amount) - Enter the amount of the principal that is outstanding and is to be referred. This will be the principal amount due as stated in the intent letter minus any adjustments, reductions due to a valid documented defense, partial payments, etc which are made before the debt is referred. If this is an interest only MSP debt, enter 1.01. This figure must be entered in as dollars and cents (xxx.xx).

18. INT REFERRED AMT (Interest Referred Amount) - Enter the amount of interest due as of the date entered into field 19 (interest accrued thru date). This figure must be entered in as dollars and cents (xxx.xx). If there is no interest due at the time of referral enter .01 in this field.

19. INT RATE (Interest Rate) - Enter the interest rate for the debt. It must be entered as a whole number and be three decimal places (13 1/2% would be 13.500). This field is required if there is an interest referred amount. If the debt will not accrue interest this field must be 00.000.

20. ACCR THRU DT (Interest Accrued Thru Date) - Enter the date the interest is accrued through. This must be entered as MM/DD/YYYY (slashes must be included). This can not be a future date.

21. CONTR # (Contractor Number) - Enter the Medicare contractor number. This field must be five numeric digits.

22. BSI – This is to be used for the future implementation of the Business Segment Identifier.

23. PR TY (Provider Type) - Enter the appropriate provider type for the debt. This field is required for debt types PTA/TPA/MSP/CLA/TAO/PAO. For MSP debt this field will correlate to the type of MSP case being entered into the system. MSP case codes are as follows: 12 (Working Aged); 13 (ESRD – End Stage Renal Disease); 14 (Auto / No Fault); 15 (Workers' Compensation); 41 (Black Lung); 42 (VA – Veterans); 43 (Disability); 47 (Liability). This is a two digit numeric field (i.e. 10).

24. CLAIM (Claim Number) - Enter the fifteen-digit claim number or document control number. This field is required for debt types PTB/TPB/TBO/PBO/CLA. This is not required for MSP. This field is fifteen digits entered from left to right. For debt type LTC, this will be the twelve digit LTC number.

25. A/R LOC (Accounts Receivable Location) - Enter the appropriate location of the receivable. H - Central Office, R – Regional Office or C - Contractor. This field represents the reporting responsibility for financial statements (Form CMS-751).

26. COST REPORT DT (Cost Report Date) - This field is required for Part A debts. For MSP debts enter the date of the intent letter. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.

27. DET DATE (Determination Date) - Enter the overpayment determination date for the debt. If it is an MSP debt, enter the date of the demand letter to the identified debtor. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.

28. CL PD DT (Claim Paid Date) - This field is required for debt types PTB/TPB/TBO/PBO. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date. This is not required for MSP.

29. CERT BY (Certified By) - Enter the name of the contact person certifying the debt as valid and legally enforceable.

30. PHONE - Enter the phone number of the certifying/contact person. If possible, please use direct line numbers.

31. FAX NUMBER - Enter the fax number of the certifying/contact person.

32. RO/CONTR NAME (Regional Office/Contractor Name) - Enter the location of the certifying office of the debt prior to referral. This will be the Regional Office (i.e. Dallas Regional Office) or the Contractor name (i.e. Trailblazers). For HIGLAS contractors this will be: transaction number – workload number – customer number

33. LTR (Letter) - Enter Y to indicate that the intent to refer letter containing the DCIA language has been sent.

34. DT LTR (Date of Letter) - Enter the date the intent to refer letter was sent. This date is used to calculate the 60 days' notice the debtor is given prior to referral. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.

35. STAT CD (Status Code) - Enter UU to indicate initial input. If the intent to refer letter was returned undeliverable use the status code UN instead of UU. When the debt is sent to Treasury, the status code will be changed by Central Office to UJ to indicate that the debt was referred for cross servicing.

36. STAT DT (Status Date) - This is a system-generated field. It will update each time the status code changes.

37. OPER-ID (Operator ID) - This field is system generated and shows the User ID.

38. LAST UPDATE DATE - This field is system generated and shows the date of the last change made to the data entry screen of the debt

39. TRANSMIT DATE - This field is system generated when the debt is transferred to Treasury.

SECTION 2.1

RESUBMITTING A RECALLED/RETURNED DEBT

This section explains the process for sending a debt back to Treasury that has previously been Returned to Agency (RTA) by Treasury or recalled. A separate function key will be used for this process.

To begin this process, the original debt to be re-submitted to Treasury must be in a recalled or RTA status code. At the Data Entry Screen of the original debt, depress the F10 function key. A new Data Entry Screen will appear, and most fields from the original debt will be pre-filled on the new screen. You will be prompted to enter fields highlighted in red. These fields are: Debt Type, Principal Referred, Interest Referred, Interest Accrued Through Date, Certified By Name, Phone and Fax numbers, and Status Code. Enter status code "UU." After entering these fields, hit the Enter key to accept the new record. The following comment will automatically be posted to the Comment Screen: "RTA RESUBMITTED TO TREASURY." The "RO/Contractor Name" field will be automatically deleted from the original debt and transferred to the new debt in order to allow contractors on HIGLAS to continue sending updates to the debt. This field on the original debt will be automatically filled with an internal "timestamp."

If the debt to be resubmitted is not in a recalled or RTA status code or the Transmit Date field is blank, the user will receive the following error message: "NO TRANSMIT DATE OR STATCD = X OR U."

SECTION THREE:

UPDATING A DEBT

UPDATING A DEBT

Updates to a debt are made on the Data Entry Screen. Debts already added to DCS cannot be deleted. However, the system will allow users to update/edit information.

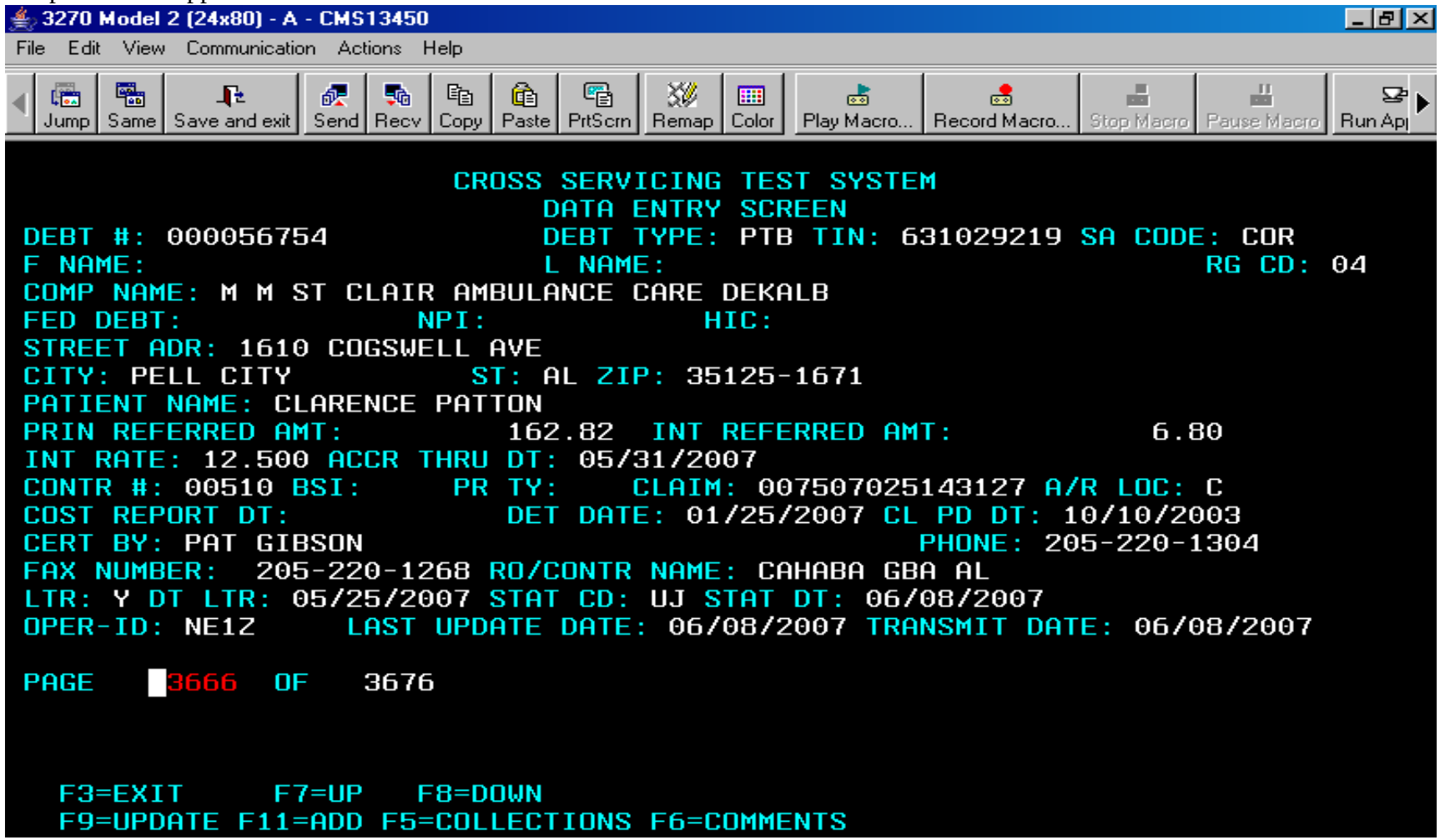
The status code for Non MSP debts that require a status change prior to being transferred to Treasury begin with the number “1”. The status code for Non MSP debts that require a status change after being transferred begin with the number “2”. The status code for MSP debts that require a status change prior to being transferred to Treasury begin with the number “3". The status code for MSP debts that require a status change after being transferred begin with the number “4".

For debts transmitted to Treasury, **do not update principal and interest amounts on the data entry screen.** Medicare Contractors should post all changes on the collection screen. Be advised that the amounts on the data entry screen will not change once these updates are made. These fields must stay in their original amounts so that Central Office can keep track of the dollar amount of debt referred to Treasury. To see the balance of the debt, press F5 to go to the collection screen.

The Contractor may make any necessary changes to the Data Entry Screen as long as the status code is UU, UN, or UJ and the transmit date field is blank. If an error is discovered in one of these fields after the status code is UJ and the transmit date field is filled, the Contractor will need to recall the debt with the incorrect information and re-enter a new debt with the corrected information. Only the status code field should be changed on the data entry screen after the debt has been transmitted. If the principal or interest referred amounts need to be adjusted downward, make the necessary changes on the collection screen. If the principal or interest referred amounts need to be adjusted upward, these debts shall be recalled and re-entered with the correct information.

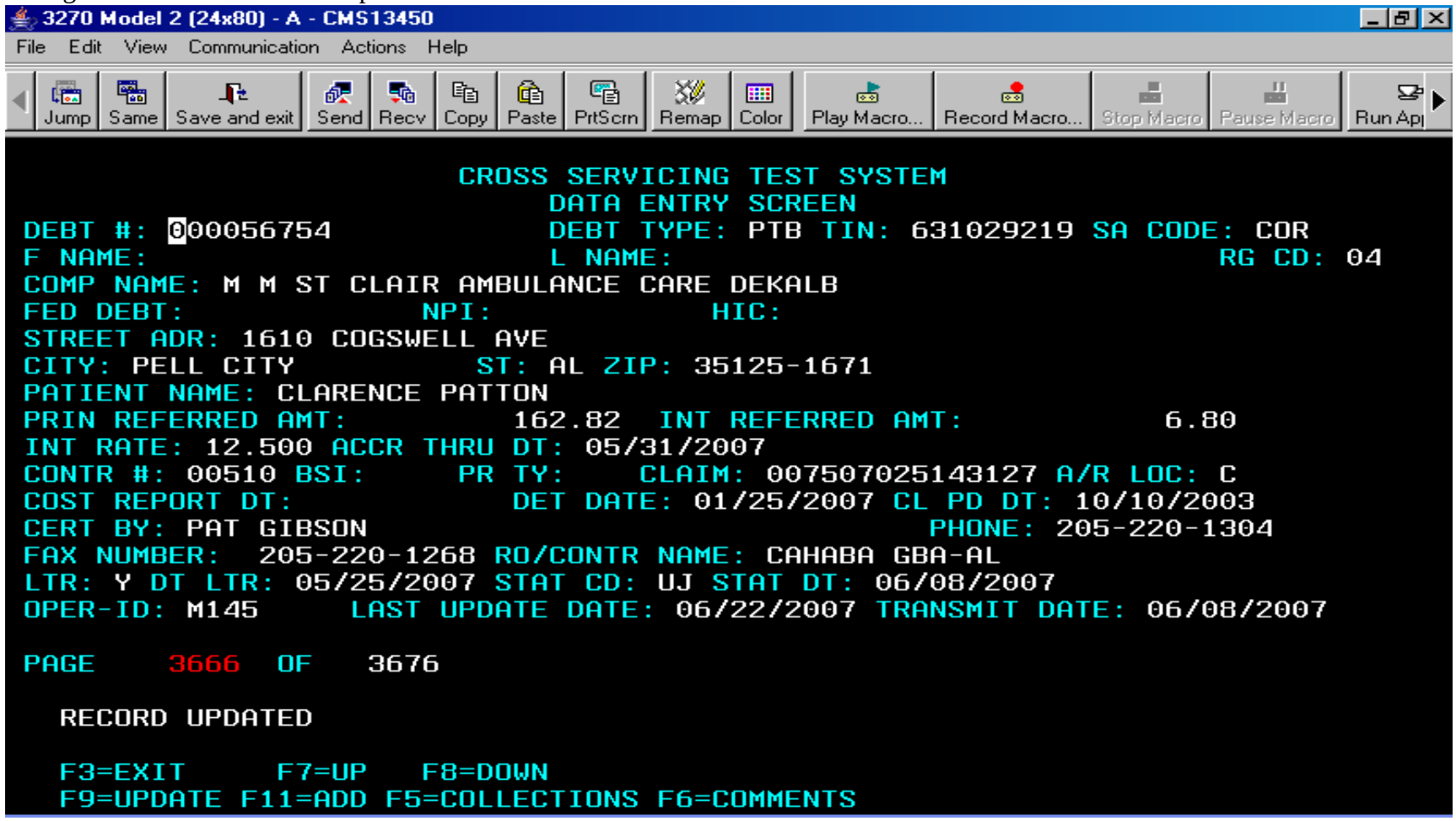
Once a debt has been recalled using a 2 or 4 code it shall not be updated back to UJ. If the debt needs to go back to Treasury it must be entered and referred as a new debt.

To change information for a debt, you must first query the debt and be at the Data Entry Screen. If there is more than one debt for the queried information, use F8 to scroll to the correct debt. Once on the Data Entry Screen, Hit F9. At this point all information that can be updated will appear in red.



NOTE: Any changes to this screen after transmission other than a status code change will not be sent to Treasury. Therefore, the debt must be recalled and re-entered with the correct information for it to be sent to Treasury.

If the debt has not yet been transmitted to Treasury, and a change to one or several fields is necessary, tab to the field to be updated and insert the correct information. Once all corrections have been made, hit Enter. A message will appear at the bottom of the screen stating that the record has been updated.



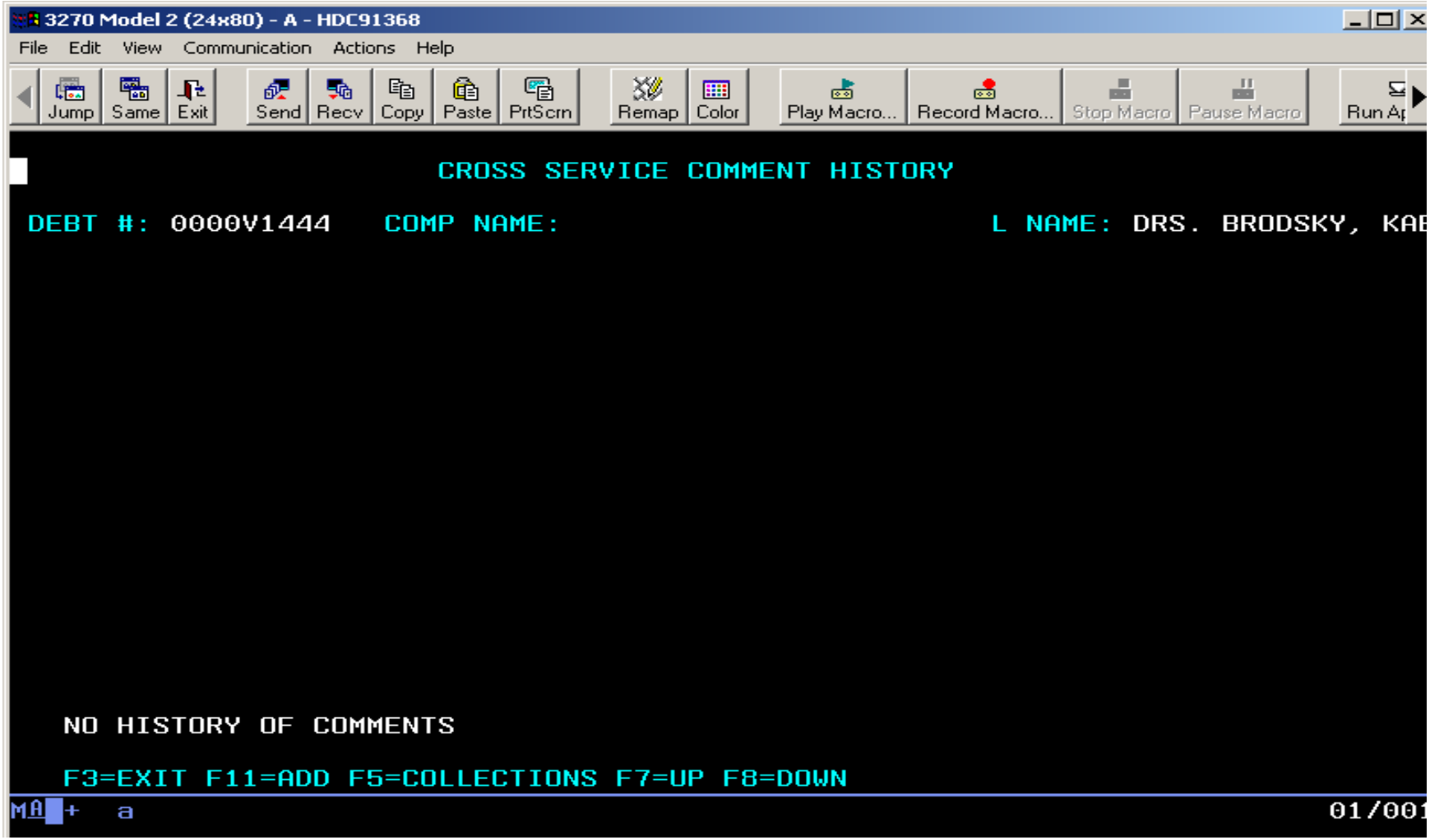
NOTE: A change to one field may require changes to other fields, based on system edits. For example, changing the Debt Type from PTA to PTB will require changes to fields required for Part B debts. The Status Date, Operator ID, Last Update Date, and Transmit Date fields are system protected and cannot be updated.

SECTION FOUR:

COMMENTS SCREEN

COMMENTS SCREEN

When F6 is chosen for comments, this is the screen that will appear if there are no current comments for that debt.



When F6 is chosen for comments, this is the screen that will appear if there are previous comments for that debt.

3270 Model 2 (24x80) - A - HDC91368

File Edit View Communication Actions Help

Jump Same Exit Send Recv Copy Paste PrtScrn Remap Color Play Macro... Record Macro... Stop Macro Pause Macro Run Ap

```
                    CROSS SERVICE COMMENT HISTORY

DEBT #: 000033443   COMP NAME: FAMILY PLUS MEDICAL CE L NAME: LAZO


DATE:    05/29/2002 PREV STAT CD:            UU
USERID:  GDS6       PREV STAT DT:            05/23/2002



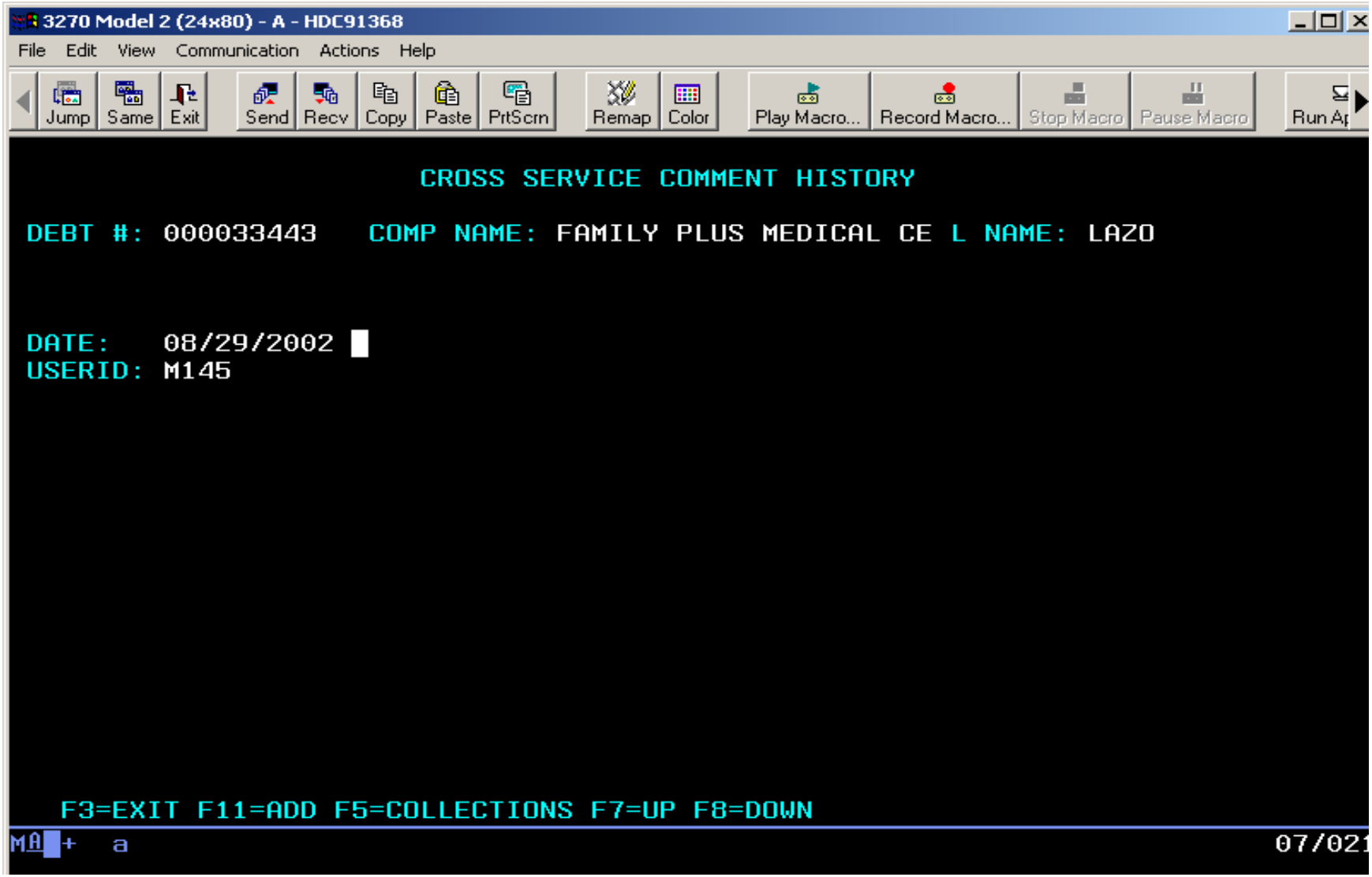
DATE:    05/23/2002 PREV COMP NAME:          FAMILY PLUS MEDICAL CETNE
USERID:  GDS6



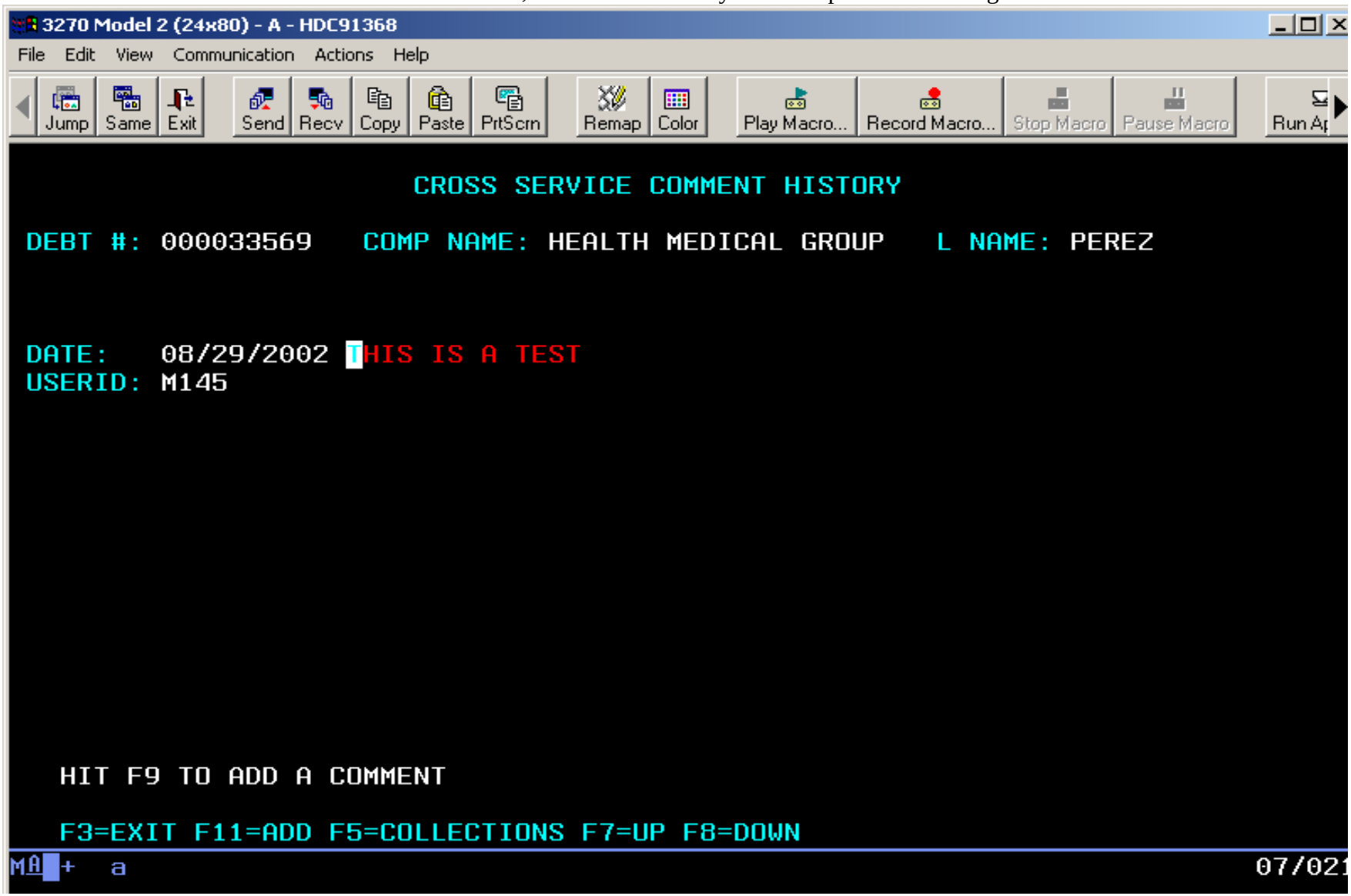
PAGE     1   OF      2


  F3=EXIT F11=ADD F5=COLLECTIONS F7=UP F8=DOWN
MA+   a                                                          20/009
```

When F11 is chosen to add a new comment, the comment screen will appear as below. (NOTE: The new comment screen will only allow for four lines of text. Also, the text does not wrap from line to line. Once you near the end of the text line you must hit tab to proceed to the next line.)



Once all new comment information has been entered, Press Enter. The system will provide a message to Hit F9 to add the comment.



Hit F9 and the message “Record Inserted” will appear.

3270 Model 2 (24x80) - A - HDC91368

File Edit View Communication Actions Help

Jump Same Exit Send Recv Copy Paste PrtScrn Remap Color Play Macro... Record Macro... Stop Macro Pause Macro Run Ap

```
                    CROSS SERVICE COMMENT HISTORY

DEBT #: 000033569   COMP NAME: HEALTH MEDICAL GROUP   L NAME: PEREZ


DATE:   08/29/2002 THIS IS A TEST
USERID: M145



DATE:   04/17/2001 IT'S CLOSED IN PSOR BY ROA WITH STATUS CODE N ON
USERID: AS41       05/29/97.



PAGE    1   OF      2

  RECORD INSERTED

  F3=EXIT F11=ADD F5=COLLECTIONS F7=UP F8=DOWN
MA  +   a                                                    20/009
```

The comments section may be used for two purposes.

First, the comments area is used as an update log. Each time the debt is updated a system generated entry is made in the comments screen. The entry will show the date of the change, user ID of the person making the change and the previous information that has now been updated. (NOTE: To have a history of all changes made to a debt, limit them to four at a time. This is because the system will only note the first four updates made on a record.)

Second, it can be used to enter important information that may clarify issues concerning the debt. Some examples of this type of information could include items not on the data entry screen, changes in company ownership, contractor transitions or dispute resolution.

NOTE: All users must enter a comment whenever there is an update or additional information on a debt.

SECTION FIVE:

COLLECTIONS SCREEN

General Collections Information:

Central Office staff, Regions and Contractors will use the Collection Screen to enter all types of collections and offsets applied to a debt.

The status code of a debt may or may not change, based on a collection. If a debt is offset at the contractor location, but is not paid in full, and that debt is already at Treasury, the debt will remain there for further collection and the status code will remain UJ or UX. If a debt is collected in full the status code should be changed to the appropriate code. Treasury will be notified of this reduction in the amount to be collected by an electronic file sent by CO.

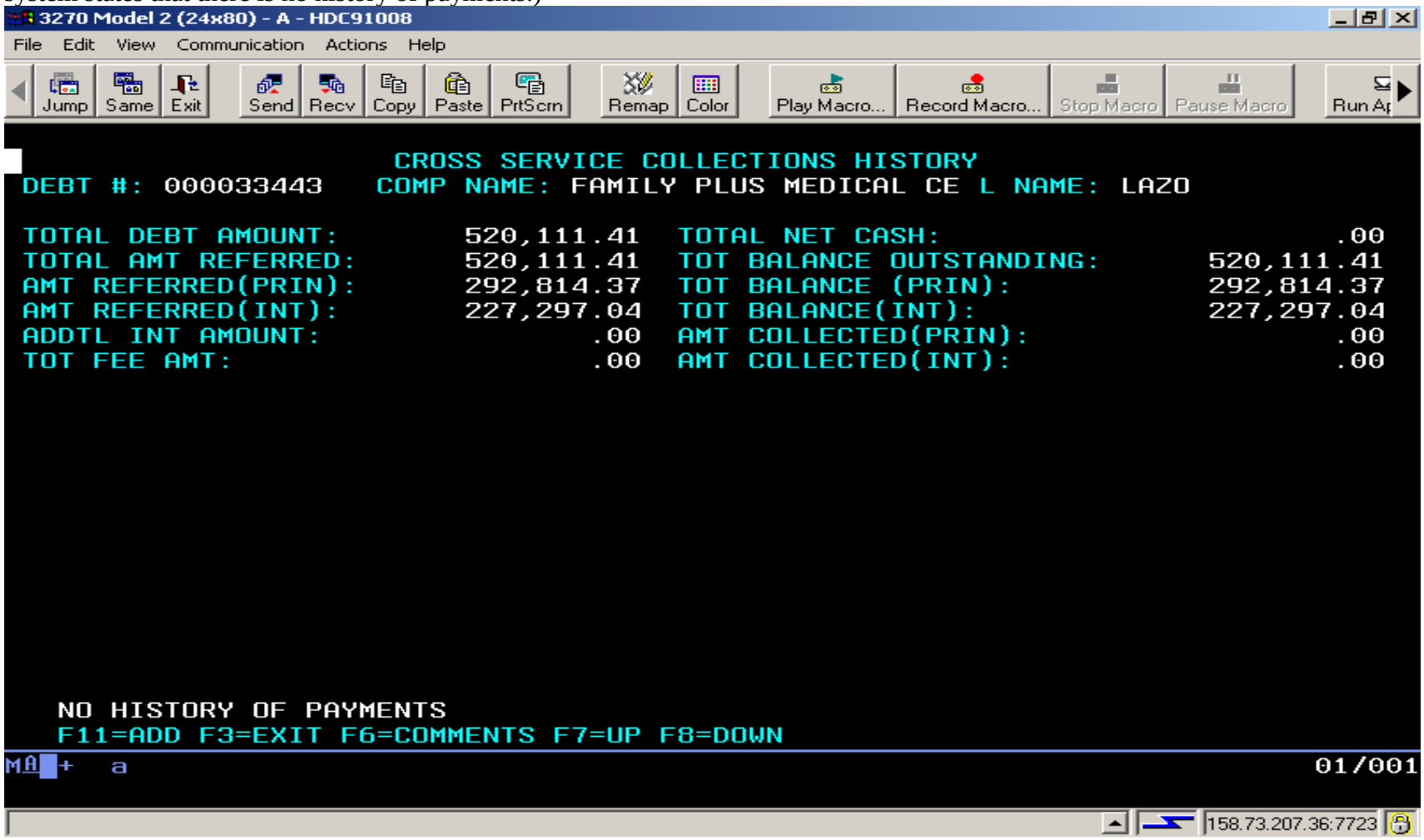
Central Office, Regional Offices, and Contractors will use the Comments Screen in conjunction with the Collections Screen to add any particular information regarding the collection.

If a debt has a negative balance that is being refunded, use collection type RF to adjust DCS to a zero balance. If a debt has a negative balance that is being applied to another debt, use collection type AD to adjust the negative balance to zero and to post the collection to another debt.

The only updates that are transmitted to Treasury are status code changes, collections, and adjustments.

COLLECTIONS SCREEN

When F5 is chosen for Collections, this is the screen that will appear if there is no current payment history for that debt. (Note: The system states that there is no history of payments.)



When F5 is chosen for Collections, this is the screen that will appear if there are previous payments for that debt.

3270 Model 2 (24x80) - A - HDC91008

File Edit View Communication Actions Help

Jump Same Exit Send Recv Copy Paste PrtScrn Remap Color Play Macro... Record Macro... Stop Macro Pause Macro Run Ap

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                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 0000V1841   COMP NAME: DIAGNOSTIC CARDIOLINE   L NAME: TURTURO

TOTAL DEBT AMOUNT:      1,616,932.00  TOTAL NET CASH:                 99,733.00
TOTAL AMT REFERRED:     1,616,932.00  TOT BALANCE OUTSTANDING:    1,517,199.00
AMT REFERRED(PRIN):     1,616,932.00  TOT BALANCE (PRIN):         1,517,199.00
AMT REFERRED(INT):               .00  TOT BALANCE(INT):                    .00
ADDTL INT AMOUNT:                .00  AMT COLLECTED(PRIN):           99,733.00
TOT FEE AMT:                     .00  AMT COLLECTED(INT):                  .00

DATE:       04/17/2001               AMT COLLECTED(PRIN):          99,733.00
USERID:     AS41                     AMT COLLECTED(INT):                .00
COLL TYP:   AD                       FEE AMT:                           .00
ACCT DATE:  04/17/2001               NET CASH RECEIVED:            99,733.00



PAGE    1   OF      1

  F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA+   a                                                              21/009
```
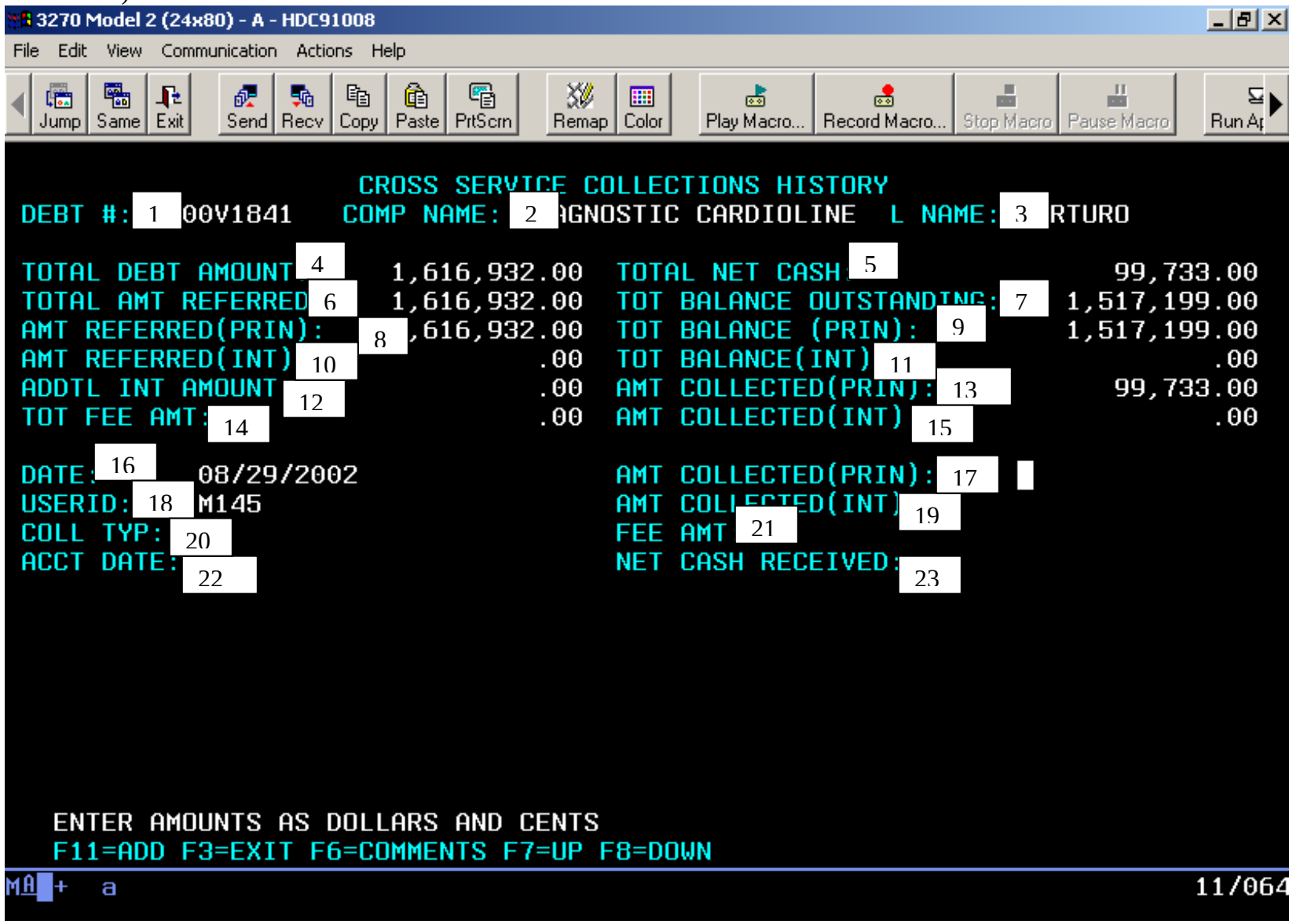

158.73.207.36:7723

When F11 is chosen to add a payment entry, this is how the screen will appear. (See attached collection screen field specific instructions)



After all collection information has been added, Hit Enter. The system will provide a message to Hit F9 to add the collection.

3270 Model 2 (24x80) - A - HDC91008

File Edit View Communication Actions Help

Jump Same Exit Send Recv Copy Paste PrtScrn Remap Color Play Macro... Record Macro... Stop Macro Pause Macro Run Ap

```
                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 000000718   COMP NAME: GALITZ WEISS & ASSOC.   L NAME: GALITZ

TOTAL DEBT AMOUNT:            979.00  TOTAL NET CASH:                     .00
TOTAL AMT REFERRED:           979.00  TOT BALANCE OUTSTANDING:         979.00
AMT REFERRED(PRIN):           979.00  TOT BALANCE (PRIN):              979.00
AMT REFERRED(INT):               .00  TOT BALANCE(INT):                   .00
ADDTL INT AMOUNT:                .00  AMT COLLECTED(PRIN):                .00
TOT FEE AMT:                     .00  AMT COLLECTED(INT):                 .00

DATE:       08/29/2002               AMT COLLECTED(PRIN):            103.35
USERID:     M145                     AMT COLLECTED(INT):              21.79
COLL TYP:   CO                       FEE AMT:                           .00
ACCT DATE:  05/21/2002               NET CASH RECEIVED:

  HIT F9 TO ADD A PAYMENT
  F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA+  a                                                              11/064
```

Depress F9 and the message “Record Inserted” will appear.

3270 Model 2 (24x80) - A - HDC91008

File Edit View Communication Actions Help

Jump Same Exit Send Recv Copy Paste PrtScrn Remap Color Play Macro... Record Macro... Stop Macro Pause Macro Run Ap

```
                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 000000718   COMP NAME: GALITZ WEISS & ASSOC.   L NAME: GALITZ

TOTAL DEBT AMOUNT:          1,000.79  TOTAL NET CASH:                  125.14
TOTAL AMT REFERRED:           979.00  TOT BALANCE OUTSTANDING:         875.65
AMT REFERRED(PRIN):           979.00  TOT BALANCE (PRIN):              875.65
AMT REFERRED(INT):               .00  TOT BALANCE(INT):                   .00
ADDTL INT AMOUNT:              21.79  AMT COLLECTED(PRIN):             103.35
TOT FEE AMT:                     .00  AMT COLLECTED(INT):               21.79

DATE:       08/29/2002               AMT COLLECTED(PRIN):            103.35
USERID:     M145                     AMT COLLECTED(INT):              21.79
COLL TYP:   CO                       FEE AMT:                           .00
ACCT DATE:  05/21/2002               NET CASH RECEIVED:              125.14

PAGE   1   OF      1

  RECORD INSERTED
  F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA+  a                                                              21/009
```

FIELD SPECIFIC INSTRUCTIONS FOR COLLECTION SCREEN

Field #	Description/Instruction
1.	DEBT # (Debt Number) - This field is carried over from the Data Entry Screen.
2.	COMP NAME (Company Name) - This field is carried over from the Data Entry Screen
3.	L NAME (Last Name) - This field is carried over from the Data Entry Screen. For MSP this field will be blank.
4.	TOTAL DEBT AMOUNT - This is a system calculated field and is principal referred + interest referred + any additional interest.
5.	TOTAL NET CASH - This is a system calculated field and is total principal collected + total interest collected - total fees collected.
6.	TOTAL AMT REFERRED (Total Amount Referred) - This is a system calculated field and is principal referred + interest referred.
7.	TOT BALANCE OUTSTANDING (Total Balance Outstanding) - This is a system calculated field and is principal balance + interest balance.
8.	AMT REFERRED PRIN (Principal Amount Referred) - This field is carried over from the Data Entry Screen and is the principal amount referred to PSC/Treasury.
9.	TOT BALANCE PRIN (Total Principal Balance) - This is a system calculated field and is the remaining unpaid principal after posted collections and adjustments. (Amount Referred Principal - Total Principal Collected)
10.	AMT REFERRED INT (Interest Amount Referred) - This field is carried over from the Data Entry Screen and is the interest amount referred to PSC/Treasury.
11.	TOT BALANCE INT (Total Interest Balance) - This is a system calculated field and is the remaining unpaid

interest referred after posted collections and adjustments.

12. ADDTL INT AMOUNT (Additional Interest Amount) - This is a system calculated field and is for any additional interest collected or adjusted over the initial referred interest amount.

13. AMT COLLECTED PRIN (Principal Amount Collected) - This is a system calculated field and is the total principal amounts that have been collected or adjusted to date.

14. TOT FEE AMT (Total Fee Amount) - This is a system calculated field and is the total fee amounts that have been paid to PSC/Treasury to date.

15. AMT COLLECTED INT (Interest Amount Collected) - This is a system calculated field and is the total interest amounts that have been collected or adjusted to date.

16. DATE - This field is system generated and shows the date of the entry.

17. AMT COLLECTED PRIN (Principal Amount Collected) - This is a data entry field. Enter the amount of the collection received that is being applied to principal. This figure must be entered as dollars and cents (xxx.xx). If the amount is a negative, the minus sign must be entered after the amount (100.00-).

18. USER ID - This field is system generated and shows the User ID of the user posting the collection.

19. AMT COLLECTED INT (Interest Amount Collected) - This is a data entry field. Enter the amount of the collection received that is being applied to interest. This figure must be entered as dollars and cents (xxx.xx). If the amount is a negative, the minus sign must be entered after the amount (100.00-). If the collected interest amount is greater than the interest referred amount, the system will calculate the difference and apply it to the additional interest field.

20. COLL TYP (Collection Type) - This is a data entry field. Enter the appropriate collection type code for the payment that was received. Collection type codes will be used for recording all collections and adjustments including reversals for previous collections or refunds. For MSP, the contractor could use any one of these codes but CC, AD, or PC will be used in most instances. (Refer to the end of this section for collection type codes.)

21. FEE AMT (Fee Amount) - This is a data entry field based on the IPAC. Enter the fee charged by PSC or Treasury

to process the debt. This amount will be stated on the Intergovernmental Online Payment and Collection (IPAC) Report. This field is used by Central Office only.

22. ACCT DATE (Accounting Date) - This is a data entry field. Enter the date the collection was received. For MSP Contractor collections by check, use the date of the postmark on the envelope if available or the date of the check if the envelope is not available. (Contractors should routinely retain the envelope for all checks.)

23. NET CASH RECEIVED - This is a system generated field. This amount is principal collected plus interest collected minus any fees that apply.

Rules for Edits:

If Collection Type = TO, TC, PC, JC, AO, SS, then the Fee Amount must be Greater than Zero.

If Collection Type = CO, CC, CU, RC, HC, MO, AD, XT, XP, XC, XR, XH, RF then the Fee Amount must be blank.

COLLECTION TYPES

AD	Adjustments
AO	HHS Administrative Offset
CC	Contractor Collection
CO	Contractor Offset
CU	Contractor Underpayment (Underpayment Applied to Overpayment)
HC	Central Office Collection
JC	Dept of Justice Collection
MO	Medicaid Offset
PC	PSC Collection (includes collections by any entity under contract to the PSC)
RC	Regional Office Collection
RF	Refund
SS	SSA Offset
TC	Treasury Collection
TO	TOP Offset
XH	Central Office Compromise
XP	PSC Compromise
XR	Region Compromise
XT	Treasury Compromise

Certain fields on the Collection Screen are automatically system generated. When the debt is entered into the Data Entry Screen and the Amount Referred Principal and Amount Referred Interest fields are completed, this will automatically fill in on the collection screen and the system will automatically total the amount of the debt being referred. Total Amount Referred, Total Debt Amount, Total Balance Outstanding, Total Principal Balance and Total Interest Balance fields are system generated.

When the contractor enters a collection the following fields on the Collection Screen must be entered:

- the amount collected principal
- the amount collected interest
- the collection type status code
- and the accounting date

When reviewing a debt for a current balance, always check the total balance principal, total balance interest and total balance outstanding fields on the collection screen. (NOTE: Interest balance will not reflect actual current accrued interest as reflected in the contractor's system.)

Examples:

1) If a contractor receives a partial payment or documentation such as a valid documented defense to reduce the debt prior to entering it into DCS, the contractor must make these adjustments before entering it into the system. Where there is partial payment, the contractor must adjust the interest amount and the principal amount to reflect the amount of payment applied to interest and principal. The remaining balance is the amount entered into DCS. The contractor must also annotate the Comments Screen. The annotation must show: how much the debt was prior to the reduction and/or partial payment, the amount of any payment or the amount of reduction and the basis of any reduction. These figures must reflect the principal amount and interest amount separately.

2) If the debt has been referred to the PSC and the contractor receives a check (full or partial payment), this information must be entered onto the DCS Collection Screen. In addition, the contractor will note this on the DCS Comments Screen. If the collection is for a partial recovery the DCS status code on the data entry screen stays as a UJ or UX. If the collection is for a full recovery the DCS status code on the data entry screen must be changed to the appropriate code.

3) If the contractor receives documentation which will reduce the amount due Medicare and/or close the case after it has been referred to PSC, this information should be entered onto the DCS Collection Screen. If the documentation closes the case, update the Collection screen with an AD status code and update the DCS data entry screen with the appropriate status code. If the documentation reduces the amount due Medicare leaving a balance on the case, update the Collection Screen with a status code of AD but do not change the status code on the data entry screen.

4) If the contractor receives notification that the debtor is in bankruptcy, appeals, etc, and the debt has already been sent to PSC, enter the appropriate DCS status code on the data entry screen in order to pull back (recall) the debt from PSC.

5) If the contractor receives a collection on a debt in the DCS, which has a status code of UU or UJ with no transmission date, update the data entry screen with the new principal referred amount and interest referred amount (old amount – collection = new amount that is entered into the DCS). In this situation, the collection would not need to be posted to the Collection Screen. A comment should be added to the comment screen.

6) If the contractor reduces a debt for part of the debt and a check for all or part of the remaining debt that has already been sent to the PSC, the information would be entered on the collection screen as follows:

1st the reduction amount and appropriate collection code.

2nd the collections/check received and/or fee amt if applicable with the appropriate collection code.

If the debt is paid in full, update the data entry screen with the appropriate status code. . If there is a remaining balance, the status code on the data entry screen would stay UJ or UX so PSC can continue recovery of the debt.

7) If the contractor has a Non MSP debt with a negative principal balance, the debt will require your research to determine if it has been over collected. If there is another debt that the excess collection can be applied to, adjust the negative balance on the over collected debt by using the collection type of AD. (Reminder: the negative sign always goes after the dollar amount). If the debt the excess collection is being applied to is also in the DCS, post this collection using the collection type of AD. If a refund will be issued, post the refund to the DCS using the collection type of RF. Remember to post a comment to the comments screen explaining your adjustment or refund.

SECTION SIX:

REPORTS

REPORTS

The Central Office will be responsible for generating reports and sending them to the Regional Offices. Non MSP reports will be sent to Regional Offices and Contractors. MSP reports will be sent to the Regional Offices or the Central Office MSP Project Officer and it will be their responsibility to forward these reports to the appropriate Contractors.

Last Debts Transmitted to PSC - This report lists all debts that were sent to PSC during the last transmittal. Each Region and Contractor will receive reports for their area. There are a total of 12 transmittal reports: two are for Non MSP Part A Non HIGLAS debts, two are for Non MSP Part B Non HIGLAS debts, one is for Claims A/R debts, one is for MSP Non HIGLAS debts, two are for Non MSP Part A HIGLAS debts, two are for Non MSP Part B HIGLAS debts, one is for MSP HIGLAS debts, and one is for Long Term Care.

MSP/DCS Snapshot – This is a MSP report only. It lists all referred MSP debts in DCS by Contractor. It is used by the MSP Contractors to reconcile their internal systems with DCS.

Dispute Report – This report lists all debts with an "X" status code, which represents an outstanding dispute. It is sent to the Regional Offices and Central Office MSP Project Officer to use as a monitoring tool for all disputes that have not been answered in a timely manner.

TT Report – This report lists all debts with a TT status, which represents a transmittal hold. A transmittal hold is the result of a debt not meeting referral standards. These debts should be corrected in order to be transmitted on the following weeks report. This report is sent out on a weekly basis to the regional offices whose contractors have debts listed on the report.

SECTION SEVEN:

CODES/FUNCTION COMMANDS

DCS STATUS CODES - Non MSP

UN - Undeliverable Letter
UU - Initial Entry
UJ - Sent to PSC for Cross Servicing
UR - Extended Repayment Plan
XX – Dispute
UX – Dispute resolved, debt to stay at Treasury

RF - Refund Issued by CO
RT - Returned from Treasury

RETURNED TO AGENCY BY TREASURY

RB – In Bankruptcy
RU - Uncollectible
RN – Out of Business
RX – Dispute Timer Expired
RD – Miscellaneous Dispute or
- Manual RTA, or
- Complaint, or
- Recall Approved

RP – Paid in Full, or
- Satisfied Payment Agreement

RC - Compromise

NOT TRANSFERRED TO DCC

1A	Appeal
1B	Bankruptcy
1C	Compromise
1D	Deceased
1E	Error
1F	Cost Report Filed
1G	Fraud
1L	Litigation
1O	Contractor Offset
1P	Voluntary Payment
1R	Repayment Agreement
1T	Under $600
1W	Write Off

RECALLED FROM DCC

2A	Appeal
2B	Bankruptcy
2C	Compromise
2D	Deceased
2E	Error
2F	Cost Report Filed
2G	Fraud
2L	Litigation
2O	Contractor Offset/Paid in Full
2P	Voluntary Payment
2Q	Cross Servicing Collection/Paid in Full
2R	Reconciliation Issue or RTA-Debt Re-entered to DCS
2T	Treasury Offset / Paid in Full
2W	Write Off

DCS STATUS CODES - MSP

UN	Undeliverable Letter
UU	Initial Entry
UJ	Sent to PSC for Cross Servicing
UR	Extended Repayment Plan
XA	Dispute/Amount of Debt
XP	Dispute/Paid in Full (excludes Treasury/PSC/PCA Collections)
XG	Dispute/Part of Global Settlement
RT	Returned from Treasury
XV	Dispute/Valid Defense
XB	Dispute/Bankruptcy
XW	Dispute/Wrong debtor
XD	Dispute/Additional documentation requested
XS	Dispute/Statue of Limitations
XO	Dispute/Other
RF	Refund Issued by CO
UX	Dispute resolved, debt to stay at Treasury

NOT TRANSFERRED TO DCC

3A	Appeal
3B	Bankruptcy
3C	Compromise
3D	Deceased
3E	Error
3F	Full Valid Documented Defense
3L	Litigation/Negotiation
3O	Contractor Offset/Paid in Full
3P	Voluntary Payment
3R	Repayment Agreement
3W	Write Off - Closed

RECALLED FROM DCC

4A	Appeal
4B	Bankruptcy
4C	Compromise
4D	Deceased
4E	Error
4F	Full Valid Documented Defense
4L	Litigation/Negotiation
4O	Contractor Offset/Paid in Full
4P	Voluntary Payment
4Q	Cross Servicing Collection/Paid in Full
4R	Repayment Agreement
4V	1870 Waiver of Recovery
4W	Write Off-Closed
4X	Closed Backlog Collections
4Z	Valid Defense & Check/Paid in Full

FUNCTION KEY COMMANDS

F3 Exit - If you are in one of the DCS screens, this will exit you out of the current screen and take you back to the previous screen. If you are at the search screen, it will exit you completely out of the system.

F5 Collections - This will take you to the Collections screen.

F6 Comments - This will take you to the comments screen.

F7 Up - This will allow you to scroll backwards through the screens when there is more than one page to a debt or more than one debt.

F8 Down - This will allow you to scroll forward through the screens when there is more than one page to a debt or more than one debt.

F9 Update - This will allow you to make changes to debt information on the data entry screen.

F9 Add - This confirms the addition of a comment or collection when in the comments or collection screens.

F10 Resubmit – This function key duplicates certain fields from the original debt to a new Data Entry Screen so the debt may be resubmitted to Treasury. This function is activated only for debts in a recalled or RTA status code. Specific instructions are outlined in Section 2.1 of this User Guide.

F11 Add - This will allow you to add a new blank entry screen to a debt.

SECTION EIGHT:

NON MSP GENERAL HELP INFORMATION

NON MSP GENERAL HELP INFORMATION

Treasury Requests/Debtor Disputes
All debts are transmitted through the Program Support Center (PSC) and are forwarded to the Department of Treasury for cross servicing. All debts with a TIN are sent to the Treasury Offset Program.

Based on the debt type entered into DCS, Treasury forwards debts to Private Collection Agencies (PCA) as part of their cross servicing procedures. As the PCA works the debts and contacts the debtors, questions arise or additional information may be needed.

Treasury sends a "Debt Management Services Action Form" to Central Office, which requests additional information and/or requires some type of action on the part of CMS. To maintain control over these requests, Central Office will update the debt in DCS with a status code of "XX" or ("XO" if the dispute is systematically updated in DCS). These status codes will be used as "Suspense" codes meaning "Treasury Request – Needs Action". Central Office then forwards these forms to the individual who certified the debt. A report will be generated on debts with these status codes and used for follow up action. Contractors shall update the DCS appropriately when the dispute is resolved. (Status Code "UX" shall be used when the dispute has been resolved and the debt should remain at Treasury for collection.)

General Information

The debt will reflect a DCS status code of UU or UN when the debt is initially entered. If a debt has been transmitted to Treasury the status code will be UJ (Debt sent for cross servicing) or UX (Dispute resolved, debt to remain at Treasury). The Contractor may make any necessary changes to the Data Entry Screen as long as the status code is UU, UN, UJ or UX and the transmit date field is blank. If an error is discovered in one of these fields after the status code is UJ or UX and the transmit date field is filled, the Contractor will need to recall the debt with the incorrect information and re-enter a new debt with the corrected information. If the principal or interest referred amounts need to be adjusted downward, make the necessary changes on the collection screen. If the principal or interest referred amounts need to be adjusted upward, these debts shall be recalled and re-entered with the correct information.

If a change to a debt is a result of a partial or full payment, this must be documented by the contractor on the collection screen. Do not change the principal and interest amounts on the data entry screen. These shall stay at their original amounts so that Central Office can track amounts referred to Treasury. If the change is because of a valid documented defense, bankruptcy, appeal, etc., the contractor shall also make the appropriate changes to the DCS as part of the required activity to recall the debt.

Note: Contractors shall be aware of the current status code of a debt on the DCS before entering collections, adjustments, etc. The status code is important in identifying exactly where a debt is in the process of referral and/or collection. Knowing the status of a debt is critical in making a determination regarding what the next step will be.

Debts are transmitted weekly to PSC by Central Office.

Explanation of Debt Types

PTA – is used for intermediary Part A debts where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

PTB – is used for carrier Part B debts where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a physician/supplier who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

TPA – is used for intermediary Part A debts where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

TPB – is used for carrier Part B debts where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

CLA - is used for intermediary Claims A/R debts where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

HAT – is used for intermediary Part A debts on HIGLAS where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider

who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

HBT – is used for carrier Part B debts on HIGLAS where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a physician/supplier who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

HPA – is used for intermediary Part A debts on HIGLAS where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

HPB – is used for carrier Part B debts on HIGLAS where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

LTC – is used for Long Term Care debts on the Civil Monetary Penalties Tracking System where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.

The following debt types are no longer used, but are included here for reference purposes only.

PAO - is used for intermediary other Part A debts where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

PBO - is used for carrier other Part B debts where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.
If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a physician/supplier who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

TAO - is used for intermediary other Part A debts where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

TBO - is used for carrier other Part B debts where cross servicing will not include referral to a PCA though they will continue to be referred to TOP.
If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

SECTION NINE:

RECALLS / ADJUSTMENTS

RECALLS / ADJUSTMENTS

Recall/Adjustment Process

1. The Contractor will update DCS with the appropriate recall codes & information.
2. Central Office will send a weekly report to PSC of all recalls, collections and adjustments.
3. PSC will then recall the debt.

RULES FOR RECALLS OR ADJUSTMENTS

Example 1: If a debt was incorrectly transmitted at $1000 but should have been $100, do an adjustment for this debt.

Example 2: If a debt was incorrectly transmitted at $100 but should have been $1000, do a recall for this debt. (This is because Treasury will not allow the upward adjustment of debts.)

SECTION TEN:

MSP GENERAL HELP INFORMATION

MSP General Information

The debt will reflect a DCS status code of UU or UN when the debt is initially entered. If a debt has been transmitted to Treasury the status code will be UJ (Debt sent for cross servicing) or UX (Dispute resolved, debt to remain at Treasury). The Contractor may make any necessary changes to the Data Entry Screen as long as the status code is UU, UN, or UJ and the transmit date field is blank. If an error is discovered in one of these fields after the status code is UJ or UX and the transmit date field is filled, the Contractor will need to recall the debt with the incorrect information and re-enter a new debt with the corrected information. If the principal or interest referred amounts need to be adjusted downward, make the necessary changes on the collection screen. If the principal or interest referred amounts need to be adjusted upward, these debts shall be recalled and re-entered with the correct information.

If a change to a debt is a result of a partial or full payment, this shall be documented by the contractor on the collection screen. Do not change the principal and interest amounts on the data entry screen. These must stay at their original amounts so that Central Office can track amounts referred to Treasury. If the change is because of a valid documented defense, bankruptcy, appeal, etc., the contractor shall also make the appropriate changes to the DCS as part of the required activity to recall the debt.

Note: Contractors shall be aware of the current status code of a debt on the DCS before entering collections, adjustments, etc. The status code is important in identifying exactly where a debt is in the process of referral and/or collection. Knowing the status of a debt is critical in making a determination regarding what the next step will be.

Debts are transmitted weekly to PSC by Central Office. Debts to be transmitted are set to a UJ status on the data entry screen on Monday morning of each week. These debts are then transmitted to the PSC on Friday morning of the same week.

Contractors must use the appropriate interest rate as of the date of the original demand letter. This interest rate will not change for the life of the debt.

If the intent to refer letter was returned undeliverable and the contractor has been unsuccessful in identifying a more appropriate address, the contractor should immediately enter the debt into DCS with a status code of “UN”.

MSP STATUS CODES

Upon initial DCS entry, Contractors will, with one exception use the status code UU, which means initial entry. If any subsequent activity occurs on the debt, the status code must be updated. Where the intent letter is returned undeliverable, the contractor will proceed with the normal MSP research to obtain a better address in order to resend the intent letter. If no additional information is found or the intent letter is returned a second time after being issued with a new mailing address, enter the debt into the DCS with a status code of UN (undeliverable). Both UU and UN allow the debt to be transmitted to Treasury.

Status Codes Defined:

There are two lists of DCS status codes: codes beginning with 3 are used for debts entered into DCS but not transmitted due to information received prior to Central Office transmission of the debt (debts can not be deleted from DCS) and codes beginning with 4 are for debts recalled from Treasury due to subsequent activity or information. In most cases Contractors will use the recall codes that begin with 4.

4E - Error: Duplicate, entered incorrectly or by mistake

4F - Full valid documented defense

4L - Litigation/Negotiation: Debt which was referred is in litigation/negotiations with CMS

4O - Contractor offset/Paid in full: This can mean two things: contractor offset has resulted in a payment in full or payment in full by check to the contractor from the debtor has occurred.

4Q - Cross Servicing Collection (PSC) / Paid in Full: Contractors will use this code when PSC has received full recovery on a debt.

4P - Voluntary Payment: This is a voluntary payment from the debtor

4W - Write Off: CMS has decided to write off the debt as write off closed, no longer pursing debtor.

4X – Closed Backlog Collections – This is a CMS Central Office status code used to indicate the debt shall be closed due to Treasury collections.

4Z - Valid Defense & Check/Paid in Full: The contractor receives both a valid documented defense and a check that covers full payment of the debt.

SECTION ELEVEN:

HIGLAS GENERAL HELP INFORMATION

HIGLAS LOAD TO DCS

The process for transmitting data from HIGLAS to the Debt Collection System (DCS) is as follows:

1) Each contractor sends a file to Central Office through their data center via the Network Data Mover (NDM).

2) Each business day CMS checks to see if files were received from one of the HIGLAS contractors. If a file is received it is verified for proper format. A duplicate check is run for the file to be loaded by checking the first and last record in the file. If a duplicate exists the file is rejected and not loaded to DCS. A duplicate check is also run for each individual new debt in the file. If the first 20 characters of the HIGLAS A/R Reference Number (in DCS this is the RO/CONTR NAME field) of an individual debt matches one already in DCS or in the file to be loaded, the individual debt is rejected and not loaded to DCS.

3) A job is run to process the file and update DCS.

4) An NDM file is sent back to the contractor's data center. This file includes all debts accepted into DCS. It also includes all debts rejected and the reason for rejection. Debts rejected need to be verified by the contractor for validity and to ensure that they are not duplicates. If the debt is not a duplicate it will need to be manually entered into DCS. It is the contractor's responsibility to check that the file is returned from CMS.

DEBTS SYSTEMATICALLY LOADED TO DCS

Contractors need to verify the following:

• Manually enter ACCR THRU DT if it does not load with the debt (this is the last debit memo applied to the debt).
• Manually enter PATIENT NAME for MSP if it does not load with the debt.
• If the debt is under $100 and has no TIN, update the status code (1E for Non MSP or 3E for MSP) so that the debt does not transmit.
• If the debt is NON MSP and the principal is under $25, update the status code so that the debt does not transmit.
• If the debt is MSP and the principal plus interest is under $25, update the status code so that the debt does not transmit.
• All HIGLAS debts load as SA CODE COR. If it is an individual debtor, change the SA CODE to IND and update all appropriate fields based on system edits.
• If the debt is NON MSP Part A and the debt should only go to the Treasury Offset Program (TOP), update the debt type from HAT to HPA.
• If the debt is NON MSP Part B and the debt should only go to TOP, update the debt type from HBT to HPB.
•Generally, recalls and collections are posted systematically to DCS from HIGLAS. If they are not, then they must be entered manually. An example of where this may occur is if there is only one debt in HIGLAS but two duplicate debts in DCS. Under these circumstances, one of the duplicate debts must be manually recalled from DCS in order to prevent over collection from Treasury.

MANUAL ENTRY OF HIGLAS DEBT TO DCS

• Contractors should follow the same process as manual entry for non HIGLAS debt (see Section Two: Entering Debts Into DCS).
• Be sure to use HIGLAS debt types (HAT, HBT, HPA, HPB, HMS).
• Use the enter key to go through fields, the debt type will prompt for the required fields.

Exhibit 5
(Rev. 136; Issued: 02-15-08; Effective/Implementation Date: 03-17-08)

Treasury Cross-Servicing Dispute Resolution

DMS Request Date: Total Number of Pages: _____
SBU
FedDebt Case ID.: Principal Amt: $
Creditor Agency Debt ID: PCA Code:
Debtor:

Program: For CMS Use Only:
Creditor Agency Contact Name: HIC:
Creditor Agency Contact Phone: Beneficiary Name:
Creditor Agency Facsimile:

Dispute Number:
Dispute request reason: Miscellaneous Dispute
Additional comments:

If you have any questions regarding the dispute, please call Valencia Thompson at 205-912-6327. Creditor Agency must return response to Bosch Stanley via facsimile 205-912-6374 with 60 days of request date.

Creditor Agency (CA) Dispute Resolution Section:
Please indicate a response by checking one of the following reasons: Please attach supporting documentation.

DAIC ___ CA agrees. Debt amount is incorrect. Requires financial adjustment.
DACC ___ CA disagrees. Debt amount is correct. Continue collection efforts.

MDAA ___ CA agrees. Miscellaneous dispute, stop collection activity.
MDFF ___ CA agrees. Miscellaneous dispute. Requires financial adjustment, continue collection efforts.
MDDD ___ CA disagrees. Miscellaneous dispute. Continue collection efforts.

VDWD ___ CA agrees. Wrong debtor, stop collection activity.
VDRD ___ CA disagrees. This is not the wrong debtor, continue collection efforts.

VDPP ___ CA agrees. Previously paid, stop collection activity.
VDNP ___ CA disagrees. Not previously paid, continue collection efforts.

VDPR ___ CA agrees. Previously resolved, stop collection activity.
VDNR ___ CA disagrees. Not previously resolved, continue collection efforts.

Financial Adjustment Information (To Be Completed By Creditor Agency):
Principal Amount $_____
Interest Amount $_____
Penalty Amount $_____
Admin Cost Amount $_____
Total Balance Owed $_____

Please check one of the following:
□ Adjustment reflects the total balance currently owed by the debtor, and has been made by our Agency.
□ Adjustment has not been made in FedDebt by the Agency, and should be made by DMS.
Creditor Agency Response Date: _____ Creditor Agency Response Contact: _____
Additional Comments By Creditor Agency:
_____
_____
_____
_____

80 – Requirements for Collecting Overpayments-Carriers
(Rev. 29, 01-02-04)

When a carrier determines an overpayment resulting from a Part B service the Carrier, in most cases, shall attempt recovery from the physician, supplier or beneficiary that was overpaid.

80.1 – Overpayment Recovery from the Beneficiary
(Rev. 29, 01-02-04)

See chapter 3, §§100 and 110ff

80.2 – Overpayment Recovery from the Physician/Supplier
(Rev. 29, 01-02-04)

The following collection activities are the minimum requirements of the Carrier for all overpayments:

- Once an overpayment is discovered and a final determination is made a first demand letter shall be sent. This first demand letter shall meet the requirements set forth in Chapter 4, §90.

- If the overpayment is not paid in full by day 30 interest shall begin to accrue on day 31(See Chapter 4, §30)

- If a full payment is not received 40 days after the date of the first demand letter the Carrier shall start recoupment on day 41. (See Chapter 4, §90)

- If no response is received from the physician/supplier 30 days after the date of the first demand letter, a second demand letter shall be sent between day 31 and day 45 (See Chapter 4, §90)

- If by day 60 there has been no response or no contact with the physician/supplier the Carrier shall attempt to contact the physician/supplier by telephone. The carrier may cease attempting to contact the physician/supplier if the debt is

referred to the Department of Treasury, if the physician/supplier files for bankruptcy, or under the guidance of CMS. At a minimum Carriers shall attempt to call the delinquent physician/supplier weekly until contact is made (A voicemail message is not considered contact.). If contact is made, the Carrier shall attempt to determine how the physician/supplier plans to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed. Document each attempted contact, as well as any discussions with the physician/supplier. If the Carrier is unable to contact the provider by telephone because of a disconnected number or a number not in service the Carrier shall attempt to locate the provider through other means. (See Chapter 4, §90)

- If the debt becomes 90 days delinquent and is eligible for referral to the Department of Treasury, a third demand letter shall be sent. (Normally 120 days from the determination date.) This letter shall include the DCIA Intent to Refer language. (See CR 1683 or Chapter 4, §70)

- If the physician/supplier submits an application for an extended repayment plan the Carrier shall follow the instruction in Chapter 4, §50. (An ERP application may be submitted at any time during the collection process.)

- If the Carrier cannot reach the physician/supplier by telephone or the Carrier receives any demand letter back as undeliverable the Carrier shall attempt to locate the physician/supplier through other means. Some examples of other sources include state and local medical societies, the American Medical Association, telephone directories, driver's license records, state insurance boards, Secretaries of State and the Carrier's own Medicare beneficiary records. Overpayment departments shall refer to physician/supplier enrollment applications, Medical Review staff, and Fraud and Abuse staff for further ideas concerning the debtor's whereabouts. Overpayment departments shall attempt to find out if the physician/supplier is bankrupt and the names of the owner, partners, or the corporation officers. If the Carrier has access to an Internet search site, such as Lexis-Nexis® or a similar program, in the Overpayment department or another department this shall also be utilized. If the Carrier does not have access to a search program the servicing regional office shall be contacted to see if they could be of assistance. All attempts to find the physician/supplier shall be documented in the case file.

- If you believe this debt may be recovered in litigation, consult with the servicing regional office before referring the debt to the Department of Treasury.

- If the debt is still delinquent 60 days after sending the third demand letter, the debt shall be input into the Debt Collection System for referral to the Department of Treasury for cross servicing and offset. Until the Department of Treasury accepts the debt, the collection of the debt is still the responsibility of the Carrier. Therefore, collection activities shall not cease until the acceptance from the Department of the Treasury is received. This acceptance shall be noted on the

Carrier's internal system as well as in the case file. Recoupment by means of withhold will continue by the Carrier until the debt is collected in full or an acceptable extended repayment plan is approved. (See CR 1683 or Chapter 4, §70)

- Throughout all stages of the overpayment Carriers shall keep a record of all collection activity and attempted collection activity. This record can be in the overpayment case file or can be stored electronically or a combination of both. If electronic, the entire case file shall be retrievable. This record is in addition to the internal accounting system and the Physician/Supplier Overpayment Reporting (PSOR) System. This record shall be detailed and include all conversations and correspondence with the physician/supplier. An outside individual shall be able to make a complete audit trail with the case file. Hard copy files shall be available immediately upon request. Electronic files shall be available within 48 hours of request. Files that have been converted to microfilm shall be available within 48 hours of request. Files that have been store offsite shall be available within 72 hours of request. (See Ch. 5 §200 for additional information.)

- Carriers shall input all overpayments (except summary entries) on the PSOR System within 10 days. In addition, all changes, updates and recoupments shall be posted onto the PSOR System within 10 days. Carriers shall attempt to use the most current status code. Once the status of the overpayment changes, the status code shall be updated within 10 days. Medicare Carriers shall attempt to use the most current status code that accurately reflects the overpayment's current situation. Carriers shall remember that certain codes such as bankruptcy, debt referral and Currently Not Collectible supercede all other codes. If the carrier cannot determine the appropriate status code, the servicing regional office shall be contacted for assistance.

90 – Physician/Supplier Overpayment Demand Letters - Carrier
(Rev. 29, 01-02-04)

When a carrier determines an overpayment for a Part B service the carrier issues a demand letter to the physician, supplier or beneficiary.

90.1 – Part B Overpayment Demand Letters to Beneficiaries
(Rev. 29, 01-02-04)

See chapter 3, §§100 and110ff

90.2- Part B Overpayment Demand Letters to Physicians/Suppliers
(Rev. 75, Issued: 08-12-05, Effective: 09-06-05, Implementation: 09-06-05)

When a physician/supplier is liable for an overpayment of $10 or more, the carrier shall attempt recovery through the following procedures.

It shall recover an overpayment made to a physician/supplier as an individual or to a professional corporation (following the procedures described below) only from the party to whom the overpayment was made. It shall make no attempt to recover an overpayment made to an individual physician/supplier from a professional corporation with which they may be associated as an employee or stockholder. Conversely, it shall not attempt recovery from an individual physician/supplier where the overpayment was made to a professional corporation with which they are, or were, associated.

Overpayment Amount Is At Least $10

When the carrier determines an overpayment it shall issue a demand letter that requests the physician/supplier to pay the debt in full within 30 days, or the amount owed and any assessed interest will be collected by offset.

Overpayment Demand Letter

The purpose of an overpayment demand letter is to notify the physician/supplier of the existence and amount of an overpayment, and to request repayment. The demand letter shall be written in such a manner as to fully explain the nature of the overpayment and the amount determined. Each demand letter shall be:

- Sent to the physician/supplier by first class mail; and

- Determined within forty-five (45) calendar days of the discovery of the overpayment and mailed within seven (7) calendar days of the creation of the accounts receivable and generation of the demand letter. Longer amounts of time in between discovery and determination must be supported by additional documentation. In the case of the second request, the letter must be mailed within 45 days but no earlier than 30 days after the date of the first demand letter.

Content of Demand Letters

- Sent to the physician/supplier.

- For a first request, mail within seven (7) calendar days of determination of the overpayment.

- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined.

- The demand letter shall offer the physician/supplier the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be approved using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter.

- The demand letter constitutes a request to the physician/supplier to refund the overpaid amount.

- The demand letter informs physicians/suppliers that the carrier will recover the overpayment through the recoupment of current payments due or from future claims submitted unless the carrier receives repayment or the physician/supplier provides a statement within 15 days of the date of the letter of why this action should not take place. The demand letter shall also inform physicians/suppliers that this recoupment will begin on the 41st day from the date of the letter.

- The demand letter informs physicians/suppliers that interest will accrue on the overpayment if payment in full is not received by the 31st day from the date of the letter. The demand letter shall also inform physicians/suppliers of the applicable interest rate that will accrue if payment in full is not received by the 31st day from the date of the letter.

- The demand letter informs physicians/suppliers that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) A review is available for disputed overpayments of any amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least $100.

- Bankrupt providers. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.

The carrier shall refer to Exhibits I through VI for the standard formats for each demand and voluntary refund letters to be used in various overpayment situations.

Recovery by Recoupment

If, within 15 days of the date of the initial demand letter, the physician/supplier submits a statement and/or evidence as to why offset should not be effectuated, the carrier shall promptly evaluate the material. This is different from a request for appeal (see subparagraph F) in that you are deciding only whether there is a basis to not effectuate an offset. Any correspondence dealing with the basis of the overpayment does not affect your decision concerning offset. If the carrier determines that offset shall begin, it shall notify the physician/supplier in writing of its determination. It shall give specific reasons for its decision.

If no such statement is received or an extended repayment plan has not been requested, the carrier shall initiate recovery by recoupment 40 days after the date of the initial demand letter (day 41), unless the physician/supplier refunds the overpaid amount in full. The carrier shall apply any amounts payable to the physician/supplier by reason of

assignment on behalf of **any** beneficiary to recoup the overpayment. It shall apply any amount recouped first to the accrued interest and then to the principal.

If it is not possible to make an immediate recoupment, the carrier shall annotate the physician's account so that the overpayment can be recouped from future Medicare benefits payable. When recoupment is used, the carrier sends the regular Medicare Summary Notice (MSN) to the beneficiary. However, it includes with the physician's/supplier's MSN an explanation that the benefits (or a specified amount of the benefit) are being applied to the overpayment and that the physician may not request the beneficiary to pay the amount applied to the overpayment.

The carrier shall discontinue recoupment only when the overpayment, plus all accrued interest, is recovered, it is determined on appeal that the physician/supplier was not overpaid or an acceptable extended repayment plan request is received (See Chapter 4, §50). After a favorable appeal decision, the carrier shall refund any excess amount withheld through recoupment. Also, it shall refund any interest that was collected.

Follow-up Request

If the initial demand letter for an overpayment of $10 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

Physician Appeals Within 30 Days of Notification of the Intent to Recoup

If, within 30 days after the date of the initial demand letter informing the physician/supplier of the intention to recoup, the physician/supplier submits a request for a review or hearing or otherwise protests the recovery, the carrier shall make every effort to conclude the appeal procedure expediently. However, it shall begin recoupment 40 days after the initial demand, if payment has not been made, regardless of the status of any appeal request. (See subparagraph D.)

Demand Letter to Physician Returned as Undeliverable

Where a refund letter is returned as undeliverable, the carrier shall attempt to locate the physician/supplier using such sources as telephone directories, city directories, postmasters, driver's license records, automobile title records, State and local medical societies, the American Medical Association or its own Medicare beneficiary records. (See Chapter 4, §80.)

Direct Contact with Physician

If attempted recoupment of the overpayment is unsuccessful for 30 days, the carrier shall contact the physician/supplier by telephone. (See Chapter 4, §80.)

Third Demand Letter

If the overpayment has not been recouped and the debt is eligible for referral to the Department of Treasury an intent to refer letter shall be sent once the overpayment becomes 90 days delinquent. (See CR 1683 or Chapter 4, §70)

EXHIBIT 1- SAMPLE DEMAND LETTERS

Exhibits I through VI include: the initial demand letter with optional opening paragraphs and the follow-up letter. It also includes a limited set of optional paragraphs to be used in specific situations, e.g., medical necessity denials, and installment payments. The carrier shall follow these formats, with the optional paragraphs, when preparing demand letters.

This section also includes standard letters to be used when the physician/supplier voluntarily submits a check to the carrier. These letters are optional if the carrier uses the remittance advice to inform physicians/suppliers of receipt of their refund checks.

EXHIBIT 1 - INITIAL DEMAND LETTER TO PHYSICIANS/SUPPLIERS
(Rev. 87, Issued: 12-30-05; Effective: 01-01-06; Implementation: 01-03-06)

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Date

Dear Dr. Smith:

Contractors should use the appropriate paragraph:

"This is to let you know that you have received Medicare payment in error which has resulted in an overpayment to you of $_____ for services dated _____ . The following explains how this happened."

or

"We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention."

or

"We have received your check in the amount of $_____. We thank you for bringing this overpayment to our attention. While we appreciate you submitting payment to us, our review found that the overpaid amount was $_____. Please remit the additional $_____."

How this overpayment was determined:

NOTE: This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.

Why you are responsible:

NOTE: For medical necessity determinations, the carrier shall insert appropriate paragraphs. It shall be sure to give an 1879 determination for each claim as well as the regulatory and statutory references for the 1879 determination.

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below. (Applicable Authorities: Section 1870(b) of the Social Security Act; §§ 405.350 - 405.359 of Title 42, §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.)

What you should do:

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

Carrier Address

If you do not refund in 30 days:

In accordance with 42 CFR 405.378 simple interest at the rate of __ will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ .

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. (See enclosure for details.) Any repayment plan (where one is approved) would run from the date of this letter.

If payment in full is not received by, (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is

received. If you have reason to believe that the withhold should not occur on _____ you must notify <contractor> before ___. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

If you wish to appeal this decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

Address of Redetermination Department

If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Should you have any questions please do not hesitate to contact _____ at _____.

If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.

Sincerely,

(name and title)

Enclosure

EXHIBIT 2 - FOLLOW UP DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Dear (Name of Physician/Supplier):

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the initial letter sent to you which explains how the overpayment was determined and why you are responsible. As of today, we have not heard from you, either to request an overpayment appeal or to make payment. The overpaid amount is _____ (principal plus interest) for your claim that paid on _____. $_____ has been recovered.

As stated in our initial letter, offset of the overpayment amount, plus interest, will be made against any pending and future assigned Medicare claims.

If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact us at _____.

Sincerely,

(Name of individual)

Enclosure

EXHIBIT 3- INTENT TO REFER LETTER

When an eligible physician/supplier overpayment remains delinquent for 90 or more days, the carrier shall send an intent to refer letter. (See CR 1683 and Chapter 4, §70 for more information.)

EXHIBIT 4 - OPTIONAL OVERPAYMENT CUSTOMIZING PARAGRAPHS

A1 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."

Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because...(i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community).
(Applicable Authorities: Section 1879 of the Social Security Act; §§411.404 and 411.406 of Title 42 of the United States Code of Federal Regulations.)

NOTE: The carrier shall be sure to include the applicable authorities at the end of the §1879 language as it appears here.

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary.

This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge.

The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

B2 - The carrier shall include one of the appropriate paragraphs below in all overpayment letters that involve duplicate payments.

- The overpayment resulted from excess payments caused by multiple processing of the same charge.

- The overpayment resulted from Medicare payment on an assigned claim for which the beneficiary also received payment on an itemized bill and turned his payment over to you. Therefore, you are liable for $_____ which represents that portion of the total amount paid in excess of the fee schedule amount.

- You have mistakenly received duplicate primary payment from both Medicare and another entity (Specific payer). (Specific payer) is the appropriate payer. As such, you are liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer.

- This overpayment resulted from duplicate Medicare payments to you for services you provided to (**named beneficiary**).

NOTE: The above paragraphs are not all-inclusive.

EXHIBIT 5 - SAMPLE LETTER - CHECK INCLUDED FOR CORRECT AMOUNT

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention, thereby protecting the integrity and resources of the Medicare program.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check in the amount of $_____ and applied it to the overpayment.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

EXHIBIT 6 - SAMPLE LETTER - CHECK INCLUDED BUT WRONG AMOUNT (TOO MUCH)

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid in error. We thank you for bringing this overpayment to our attention.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check for $_____. You will notice that the amount of your check exceeds the overpayment amount. We will send you a check shortly for the excess amount.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

Enclosure

90.3 - Notification to the Beneficiary When Recovery Is Sought from the Provider or Physician

(Rev. 70, Issued: 05-27-05; Effective and Implementation dates: 06-27-05)

When a claim adjustment creates an overpayment the beneficiary who received the services will normally receive a Medicare Summary Notice (MSN) notifying the beneficiary about the specifics of the adjustment and the beneficiary's appropriate appeal rights. The MSN uses codes with accompanying descriptions to update the beneficiary. Through a MSN code, the MSN can also be used to inform the beneficiary that the provider may be requested to repay the difference in the amount paid and the adjustment to Medicare.

In situations where the claim adjustment creates an overpayment and a MSN is generated, a separate notice to the beneficiary is **not** required whenever recovery is sought from the provider.

However, if a MSN is not generated a separate notice to the beneficiary is required whenever recovery is sought from the provider. Some reasons a MSN may not generate include, but are not limited to, if the claim has been purged from the system or if the overpayment is because of a mass adjustment. In these situations a separate notice to the beneficiary is required whenever recovery is sought from the provider. (See Chapter 3, §§100 & 110ff when recovering from the beneficiary.)

The following instructions apply if a separate notice to the beneficiary is required.

The contractor shall include in the notification to the beneficiary a copy of the letter sent to the provider unless the letter to the provider mentions more than one beneficiary or deals with overpayments which do not concern the particular being notified. In such cases, a copy of the initial demand letter sent to the provider should **not** be attached to the beneficiary notice.

Where overpayments to a provider have been determined by means of a sample study, the Contractor shall send a notice only to the beneficiaries identified in the overpayment notice sent to the provider as individuals on whose behalf the provider was overpaid a specified amount. It shall not send the notice to the beneficiaries until it has been established that recovery action will be taken.

In all cases the notice to the beneficiary should contain the following:

- The name and address of the provider and dates of service for which the overpayment was made.
- A clear explanation of why the payment was incorrect.
- A statement that the provider has been requested to refund the overpayment and, if the provider is liable for medically unnecessary services or (FIs only) custodial care, the following additional information, as applicable:

- If the error is discovered subsequent to the third calendar year after the year the payment was approved, and the other conditions described in Chapter 3, §80 apply, the Contractor shall advise the beneficiary that the provider is prohibited, by law, from requesting payment for the services; or

- If the beneficiary is determined to be without fault, the Contractor shall state that if the beneficiary pays for the services, the beneficiary may request that the Contractor indemnify the beneficiary for such payment. Any indemnification paid to the beneficiary will be recovered from the provider. (See Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.)

- In all other cases, Medicare law does not prohibit the provider from requesting the beneficiary to pay.

An explanation of the beneficiary's appeal rights. (See Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions.) In the notice to the beneficiary, however, the Contractor shall not mention waiver since there is no provision for waiver when the physician is liable for the overpayment.

90.4 - Sample Letter to Beneficiary Where Recovery Is Sought From Provider

(Rev. 70, Issued: 05-27-05; Effective and Implementation dates: 06-27-05)

A notice to the beneficiary is required whenever a provider is requested to repay Medicare because of an overpayment determined as a result of services provided to the beneficiary. If a MSN is generated the appropriate notice codes shall be utilized informing the beneficiary that the provider may be requested to repay Medicare. If this occurs no further action needs to be taken. However, if a MSN is not generated notice shall be sent to the beneficiary. Below is a sample letter to a beneficiary where recovery is sought from the provider.

Dear _____:

In (**month and year**), we made a payment to (**provider or physician name and location**) on your behalf for services provided to you (insert dates).

We have reviewed the payment and determined that the services were not covered under the Medicare program.

(The Contractor shall explain as clearly as possible the reason why all, or part, of the payment was erroneous.)

It shall use either paragraphs A, B or C below as appropriate:

A - Provider Liable for Medically Unnecessary or Custodial Care Services (Physician Liable for Medically Unnecessary Services)

(See Medicare Claims Processing, Chapter 30, Financial Liability Protections.)

We have found that you (the beneficiary) did not know or have any way of knowing that the services you (he/she) received during (**dates of services for which beneficiary's liability has been waived**) would not be considered to be reasonable and necessary by Medicare. However, the records show that (physician's name) should have known that such services would be considered noncovered. When this situation occurs, the law requires that the liability for these noncovered services be transferred to the physician.

Therefore, you (the beneficiary) are (is) not responsible for the charges billed by (**provider's name**) except for any charges for services or items never covered by Medicare. If you (the beneficiary) have (has) paid (**provider's name**) for these services, you may be entitled to a refund. To obtain this refund, please advise this office and enclose the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt from (provider's name), your cancelled check, or any other evidence showing that you (the beneficiary) have (has) already paid (provider's name) for the services at issue.

You should file your written request for payment within 6 months of the date of this notice.

B. Provider at Fault and Beneficiary Not at Fault for Medically Unnecessary or Custodial Services and the Overpayment was Discovered Subsequent to the Third Calendar Year After Year Payment Was Approved

(**Provider's name**) has been requested to refund this overpayment. Under the Medicare law, (**provider's name**) is prohibited from billing you, or any other source, for these noncovered services. If (**provider's name**) sends you a bill for these services, send it to us with a copy of this letter.

C. All Other Cases

(**Provider's name**) has been requested to refund the overpayment. Since the above services are not covered by Medicare, (**Provider's name**) may ask you to pay for them. However, if you are billed, this is a matter between you and (**Provider's name**) and will not affect your entitlement to future Medicare benefits in any way.

NOTE: The notification of appeal rights should be in accordance with the reopening rules in Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.

100 – Affiliated Contractor and PSC Interaction with the Non-MSP Recovery Audit Contractors

(Rev. 68, Issued: 05-20-05; Effective and Implementation Dates: 06-20-05)

100.1 – Recovery Audit Contractors (RACs)

(Rev. 139; Issued: 07-11-08; Effective/Implementation: 08-11-08)

Section 302 of the Tax Relief and Health Care Act of 2006 requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize RACs under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

In calendar year 2008, CMS will be expanding the use of RACs nationwide. All states will be impacted by January 1, 2010. A current RAC expansion map can be found at the following link www.cms.hhs.gov/RAC.

The RACs will be responsible for identifying improper payments. Adjustments of these claims will occur by the Medicare Contractors responsible for claims processing.

100.2 - Communication with the RACs

(Rev. 168; Issued: 04-30-10; Effective/Implementation Date: 06-01-10)

A. RAC Staff:

When Contractors and MACs have questions regarding the RAC National Program or their interaction with a RAC, they should contact the CMS RAC Project Officer or applicable RAC contact.

B. RAC Points of Contact (POC):

All contractors and MACs shall provide the CMS RAC Project Officer with the name, phone number, address, fax number, and email address of a primary point of contact (POC) and an alternate POC. The point of contact or alternate will be responsible for all communications with the CMS Project Officer and/or RAC. The POC will be contacted to handle overpayment issues such as offsets, status of overpayment collections, and referrals to the Department of Treasury and other questions involving suppression cases, provider address information, status of claim adjustments and status of appeals. In addition, the contractor shall provide the CMS RAC Project Officer with the name, phone numbers, addresses, fax number and email address of a vulnerability POC to handle such issues as local edits, prepay claim reviews, provider education and LCD's and other corrective actions.

C. Applications to Assist Communication:

An online Data Warehouse has been developed to track Non-MSP overpayments and underpayments identified by the RAC. For access to the RAC Data Warehouse, email the Central Office contact at rac@cms.hhs.gov.

D. RAC/AC Communication:

All Contractors and MACs shall work with the RAC to develop a communication process. This process shall be flexible and shall be reached by a mutual agreement. CMS has several items to assist in the communication efforts:

- RAC Data Warehouse
- Indicator code for RAC identified overpayments; and
- System generated flat file of all A/R transactions on a daily basis.
- Mass adjustment process for FISS
- CMS Secure Email

NOTE: Unless prior approval has been given by CMS, Personal Health Information (PHI) shall not be transferred over the internet, (this includes email**).** PHI may be transmitted via fax, telephone, mail pager, or CMS secure e-mail.

E. Joint Operating Agreement (JOA):

All Contractors and MACs shall develop a JOA with each RAC in their jurisdiction. The JOA shall be approved by all contractors, by the RAC, and by CMS prior to its effective date. The JOA shall cover all requirements in Pub.100-06, Chapter 4, 100, but may expand upon those requirements and may provide alternative time frames. The JOA shall include communication processes and time frames for adjustments, recoupments, appeals, inquires and receipt of provider names and addresses.

F. Provider Information:

All Contractors and MACs shall provide the RAC with a provider listing of all provider numbers, names, addresses and tax identification numbers. This listing shall be placed on a CD or DVD and shall be retrieved from the AC's internal system. If available, the RAC and Contractor may utilize the MDCN lines to transfer the file. At a minimum, the contractor shall update the list every 6 months. The method of transfer and the number of transfers per year shall be included in the JOA.

100.3 - Overview of the RAC Process

(Rev. 148; Issued: 03-06-09; Effective Date: 03-13-09; Implementation Date: 03-13-09)

The RACs will receive a data file from CMS containing National Claims History (NCH) data about claims that have been processed by the claims processing contractors in the appropriate states based on the RAC contract. The RACs will receive a data file updating the NCH data on a monthly or quarterly basis. RACs will enter individual claim

information into the RAC Data Warehouse for each claim that contains an overpayment or potential overpayment. Assuming a provider or claim(s) has not been suppressed because of an ongoing post payment medical review investigation, an ongoing fraud or benefit integrity investigation or a potential criminal investigation, or inclusion in the CERT sample, the RAC will continue with the identification and recoupment process.

100.4 – Inputting Suppression and Exclusion Cases to the RAC Data Warehouse

(Rev. 168; Issued: 04-30-10; Effective/Implementation Date: 06-01-10)

The AC and the CERT Review Contractor will input all cases requiring suppression and/or enter claims requiring exclusion into the RAC Data Warehouse. The AC can permanently exclude an individual claim or a series of claims, or suppress a provider's entire claim submission or claim type for a period of time not to exceed one calendar year. The following cases require suppression or exclusion:

- A post payment medical review is in progress; or was already completed (exclusion)
- Claims subjected to complex prepayment medical review; (exclusion)
- A fraud/benefits integrity review is in progress, or (suppression)
- The AC has been instructed by an outside agency (law enforcement, OIG, DOJ) that an investigation is ongoing. (suppression)
- Claims originally denied and later paid by an appeal entity (exclusions)

The ACs shall not suppress or exclude claims that do not meet the above criteria. Claims that the AC is conducting education on should not be suppressed.

All contractors and MACs shall enter suppression and/or exclusion records immediately after the need for these actions are identified. After the initial data input, contractors shall consistently monitor the RAC Data Warehouse and update on an as needed basis.

All contractors and MACs must keep documentation on file that supports the information they added to the RAC Data Warehouse.

NOTE: Suppression or Exclusion of an entire provider will require CMS approval.

100.4.1 - Providing Suppressed Cases to the RAC Data Warehouse

(Rev. 169, Issued: 04-30-10, Effective: 06-01-10, Implementation: 06-01-10)

Refer to the Medicare Program Integrity Manual, Publication 100-08, Chapter 4- Benefit Integrity, Section 4.33- Recovery Audit Contractors (RACs). The updated manual

changes references RAC Data Warehouse Suppression information for all applicable contractors.

100.5 - Adjusting the Claim

(Rev. 202; Issued: 01-06-12, Effective Date: 01-01-12; Implementation Date: 01-03-12)

The CMS may grant the Recovery Auditor read only access to the CWF (and any other systems at the CMS's sole discretion) to obtain additional information pertaining to potential improper payments. The Recovery Auditor shall submit claim adjustments directly to the Enterprise Data Centers (EDCs) via the file-based mass adjustment processes; manual adjustments via the MAC/Contractor shall be limited to those that cannot be accommodated through more automated means. The MAC/Contractor shall identify the origin of any manual adjustments by assigning Recovery Auditor adjustment reason and/or discovery codes as appropriate. The MAC/Contractor shall establish receivables and issue all demand letters for any Recovery Auditor identified overpayment, following the same process as for any other payment recoupment. All demand letters shall include the initiating Recovery Auditor name and contact information. The MAC/Contractor shall be responsible for fielding any administrative concerns, such as the issuance of demand letters and timeframes for recoupment and the appeals process. The Recovery Auditor shall remain responsible for any audit specific communications, such as reviewer rationale inquiries.

The Recovery Auditor is required to routinely enter the RAC Data Warehouse and provide updates on the claim review process, although reporting adjustment outcomes and subsequent transactions is the exclusive domain of the MAC/Contractor. The MAC/Contractor shall forward HIGLAS outcome/transaction files to the Recovery Auditor, if applicable, and shall ensure that the EDCs return the appropriate FISS/MCS/VMS files directly; the MAC/Contractor shall also upload both sets of files to the RAC Data Warehouse until that system is able to obtain them directly.

The MAC*/Contractor* shall not make overpayment/underpayment adjustments on zero dollar claims unless the MACs*/Contractors* are contacting the providers to notify them of a new denial reason.

100.6 - Handling Overpayment and Underpayments Resulting from the RAC Findings

(Rev. 162, Issued: 10-30-09, Effective: 12-15-09, Implementation: 12-15-09)

The administrative processing of a RAC determined overpayment will not be any different than an overpayment determined by the AC or MAC. The RAC determined overpayment will be sent to the AC or MAC for processing. It will be the responsibility of the AC and MAC to update the RAC Data Warehouse with a transaction file that includes any recoupments received either through offset or by check. It will also be the responsibility of the AC and MAC to report the overpayment on the appropriate CMS financial statement.

100.6.1 - Underpayments
(Rev. 184, Issued: 02-25-11, Effective: 03-28-11, Implementation: 03-28-11)

All underpayments shall be processed by the AC or MAC, instructed to utilize the mass adjustment process whenever possible. The AC or MAC shall upload a transaction file into the RAC Data Warehouse that includes the required information on the underpayment reimbursement to the provider. The AC or MAC will only be accountable for determining claim validity if so established in the joint operating agreement.

100.6.2 - Setting up an Accounts Receivable
(Rev. 162, Issued: 10-30-09, Effective: 12-15-09, Implementation: 12-15-09)

Once the AC or MAC has made the appropriate claim adjustment and forwarded this information to the RAC, the AC or MAC shall create an Accounts Receivable. The AC and MAC shall NOT issue a demand letter, however the AC and MAC shall initiate offset on the applicable day following the guidelines in the Medicare Financial Management Manual (MFMM), Chapter 4, §20 and §80.

In case of a PSC or ZPIC, it is the AC or MAC that shall handle overpayment/underpayment actions.

The AC and MAC shall obtain information about the reason for the overpayment/underpayment from the RAC. The AC and MAC may also obtain information about the improper payment from the RAC Data Warehouse. If additional information is required, the AC and MAC may contact the CMS RAC Project Officer. Once the RAC receives the overpayment amount from the claim adjustment the RAC shall issue the demand letter for the recoupment.

100.6.3 - Recoupments Received on a RAC Initiated Overpayment
(Rev. 162, Issued: 10-30-09, Effective: 12-15-09, Implementation: 12-15-09)

The RAC shall be required to follow the same procedures as the AC and MAC for sending a demand letter. If a demand letter is issued, the letter will instruct providers to send checks to the appropriate payment address of the AC or MAC.

The date of the initial demand letter shall be the determination date for interest accrual, delinquency determination and referral to Treasury. The accrual of interest will begin on the 31st day and will be charged from the date of the initial demand letter. The RAC shall upload a status record into the RAC Data Warehouse indicating the date of demand letter.

The AC and MAC shall upload a transaction file into the RAC Data Warehouse within 7 calendar days of applying the payment, be it by check or offset.

100.6.4 - Extended Repayment Requests Received on a RAC initiated Overpayment

(Rev. 162, Issued: 10-30-09, Effective: 12-15-09, Implementation: 12-15-09)

The RAC shall offer the provider the ability to repay the overpayment through an extended repayment plan (ERP). The provider has 12 months to repay the overpayment on an ERP. However, if the provider requests an ERP for a time period longer than 12 months, the RAC shall forward the request to the regional office. When reviewing all installment agreements, the RAC shall follow the guidelines in section 1893 (f) (1) of the Social Security Act as amended by 935 (a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

If the AC or MAC receives an Extended Repayment Plan (ERP) from a provider for a RAC initiated overpayment, the AC and MAC shall forward the ERP to the appropriate contact at the RAC. The point of contact information for the ERP at the RAC location will be given in a separate instruction. The RAC shall upload a status file into the RAC Data Warehouse for each payment collection received through the ERP. The AC and MAC shall upload a transaction file into the RAC Data Warehouse for each payment collection received through the ERP.

100.7 - Appeals Resulting from RAC Initiated Denials

(Rev. 180, Issued: 12-29-10, Effective: 01-28-11, Implementation: 01-28-11)

The ACs and MACs shall process any appeals stemming from a RAC initiated overpayment. (e.g., RAC decisions appealed by the providers or beneficiaries). The ACs and MACs shall not automatically uphold or reverse the RACs decision. Instead, the ACs and MACs shall ensure that the appeal is processed as any other appeal request.

Upon receiving an appeal request for a RAC identified overpayment the AC and MAC shall request the medical records and any other supporting documentation from the RAC. The timeframes regarding requesting medical records and receiving from the RAC shall be agreed upon in the JOA. Even if the AC or MAC believes they have enough documentation to make a determination on the appeal, the AC or MAC shall still request the medical records and any other supporting documentation (providers may submit different documentation to the RAC than to the AC or MAC upon appeal).

The ACs and MACs shall utilize the same approach in defining an appeal request (i.e, reopening or redetermination) as used with any other appeal request. RAC initiated adjustments that are appealed shall not have separate criteria. For more information on determining whether an appeal request should be processed as a reopening or redetermination please refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 34- Reopening and Revision of Claim Determinations and Decisions, Section 10- Reopenings and Revisions of Claim Determinations and Decisions- General.

100.8 – Referrals to the Department of Treasury

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

All overpayments identified by the RAC shall follow the normal referral to Treasury process. The AC and MAC shall issue the Intent to Refer letter following the normal process. The RAC shall transfer the case to the AC or MAC prior to the issuance of the Intent to Refer letter. The AC shall accept the transferred case and proceed with the referral to Treasury. The RAC shall continue to attempt to collect the overpayment until the referral to Treasury is complete. The AC and MAC shall update the RAC Data Warehouse with the referral to Treasury status code once referral is complete. If the AC or MAC receives a question or dispute after referral that cannot be answered through the case file the AC or MAC shall contact the RAC for assistance. The communication process for the transfer of debt shall be agreed upon in the JOA.

100.9 - Tracking Overpayments and Appeals

(Rev. 68, Issued: 05-20-05; Effective and Implementation Dates: 06-20-05)

100.9.1 - Tracking Overpayments

(Rev. 189, Issued: 05-06-11, Effective: 06-06-11, Implementation: 06-06-11)

The MAC/Contractor shall upload all applicable FISS, MCS, VMS, and HIGLAS adjustment outcome files into the RAC Data Warehouse on a daily(business day) basis; transaction files shall be uploaded on a weekly basis (or more frequently at contractor discretion). The MAC/Contractor shall also send or arrange for the Enterprise Data Center to send outcome/transaction files directly to the Recovery Auditor, as so mandated per JOA or alternate agreement. Any MACs/Contractors unable to meet such requirements in a timely fashion shall communicate with the CMS regarding the surrounding circumstance and the potential for alternate instruction.

100.9.2 - Tracking Appeals and Reopenings

(Rev. 200, Issued: 11-16-11, Effective: 09-27-11, Implementation: 09-27-11)

Appeals and reopenings requests received in response to a Recovery Auditor initiated improper payment shall be tracked. The status of any appeals shall be tracked through the redetermination level of the appeal process. The MAC/Contractor shall complete the supplied Excel spreadsheet when reporting monthly appeals and reopenings information. The MAC/Contractor shall submit a Monthly Recovery Auditor Appeals and Reopenings Report to its Contracting Officer's Technical Representative (COTR) or Contractor Manager by the 15th business day of each month. The report shall include the prior month’s information and a copy shall be provided to the appropriate Recovery Auditor and the COTR for the affected Recovery Audit region. Once the RAC Data Warehouse is capable of tracking appeals, the MAC/Contractor shall update that system instead within 7 calendar days of learning of a new request and/or update.

The MAC/Contractor shall include the additional tracking information supplied on the Excel monthly appeals and reopenings report. The MAC/Contactor shall record on the tracking report the rationale for the reversal. Reasons for Reversal Codes have been created and if one of the given codes is not appropriate, a narrative explanation shall be input.

100.10 - Reporting Administrative Costs Directly Associated with the RAC Program

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

Section 302 of the Tax Relief and Health Care Act of 2006 allows CMS to pay for all costs associated with conducting the RAC Program out of RAC collections. These costs are not attributed to a contractor's annual budget. These costs are only attributed to the RAC Program and are paid from RAC collections. To track these costs, separate activity codes will be utilized.

CMS has created two activity codes for the RAC Program. Contractors using activity codes involved in the RAC Program, shall use these codes for all activities related to the RAC National Program. Detailed descriptions of the activity codes and what may be included are below.

<u>Activity Code 11031- All RAC implementation and maintenance activities</u>

These duties include:

- Completion and maintenance of a JOA with the applicable RAC(s)
- Adjusting all claims identified by the RAC as containing an underpayment or an overpayment.
- Performing validation of overpayment identifications if requested by CMS
- Creating and maintaining accounts receivables for RAC identified overpayments
- Collecting and processing monies received for RAC identified overpayments
- Processing offset for RAC identified overpayments
- Performing necessary provider education relevant to the operation of the RAC program if requested by CMS
- Creating exclusion files for upload to the RAC Data Warehouse
- Creating monthly/daily reports for upload to the RAC Data Warehouse
- Creating monthly/daily reports for feedback to the RAC
- Communicating with RACs and CMS
- Handling RAC related inquires
- Handling activities associated with withdrawing an overpayment not resulting from an Appeal

<u>Activity Code 12031- All RAC initiated appeal activities</u>

- All cost associated with performing and adjudicating the redetermination
- All cost associated with reporting appeals statistics to the CMS RAC Project Officer or delegate.
- All cost associated with appeal inquiries from CMS regarding RAC identified overpayments
- All cost associated with meetings with the RAC and/or CMS Project Officer
- All cost of records, notes and documents regarding RAC & Provider appeals

- Processing and tracking all appeals for RAC identified overpayments and creating appeal reports for upload to the RAC Data Warehouse if requested by CMS
- Communicating with the RAC and CMS.
- Communicating with other appeal entities on RAC identified overpayment cases (QIC, ALJ, DAB)

All cost associated with adjusting the claim in response to an appeal decision.

100.11 - Potential Fraud

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

The RAC will refer any claims it determines to be potentially fraudulent to the appropriate CMS RAC Project Officer who will then forward this claim information to the CMS Division of Benefit Integrity Management Operations.

100.12 – AC and MAC Requirements Involving RAC Information Dissemination

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

When instructed by CMS, the ACs and MACs shall disseminate information concerning the RAC program to the provider community. Questions and correspondence received from the provider community regarding RAC initiated overpayments shall be referred to the RAC. The RAC is required to have knowledgeable customer service representatives to assist the provider community.

The AC and MAC shall notify the RAC when any community outreach and/or public education is taking place in the area. While not required, the RAC may decide to attend the function. The RAC may only address their function as recovery auditors. They may NOT address policy changes and/or provider education on other Medicare issues. The AC and MAC are only required to notify the RAC of the event. It is also up to the discretion of the AC and MAC to invite the RAC to speak at the event. It is also up to the RAC if it wants to attend the event. All information disseminated to the provider community concerning the RAC National Program shall be approved by the CMS Project Officer. Information shall be sent by email to the CMS Project Officer 30 calendar days before the event.

100.13 – Contacting Non-Responders

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

The AC, and MAC have no responsibility to contact providers who do not respond to the RACs' request for additional documentation. It is the RACs' responsibility to retrieve the medical records or to make an overpayment determination. However, the appeal entities may contact the provider to request additional documentation if it is needed to finalize the appeal request.

100.14 - Voluntary Refunds

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

If the AC and MAC receives a voluntary refund from a provider on a claim in the RAC Data Warehouse that has not yet been demanded by the RAC, the AC and MAC shall process the refund as they do all other voluntary refunds (i.e., in accordance with the Medicare program Integrity Manual, Pub. 100-08, Ch. 4, Section 4.16).

100.15 – Working with RAC Support Contractors

(Rev. 152; Issued: 06-12-09; Effective/Implementation Date: 07-13-09)

The AC and MAC shall work cooperatively with all RAC support Contractors by providing all requested data. This includes the Evaluation Contractor, the Data Warehouse Contractor, the Validation Contractor, and any other contractor supporting the RAC process.

100.16 – Receivables Initiated by the Recovery Auditor as Independent Audit Accessible Information

(Rev. 186, Issued: 03-18-11, Effective: 04-18-11, Implementation: 04-18-11)

As stated in Chapter 7, Section 20.1: CMS requires its contractors to perform risk assessments on an annual basis. Contractors requested to provide Recovery Auditor initiated information during the course of an independent audit are responsible for retrieving such documentation from the Recovery Auditor, (i.e.: the production of demand letters), and delivering it to the independent auditor performing the risk assessment for review. Contractors are obligated to produce any pertinent information stemming from Recovery Auditor receivables upon independent auditor request. While contractors must show good faith and diligent effort, Recovery Auditors shall supply all requested documentation in a timely fashion. Situations where documentation is not provided should be sent to CMS as soon as possible.

110 - Confirmed Identity Theft

(Rev. 199, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

For purposes of this instruction, a claim related to the confirmed identity theft shall be referred to as “affected claims”.

The Centers for Medicare and Medicaid Services (CMS) is addressing instances of Identity Theft confirmed by the Investigating Unit (IU). For purposes of this instruction, the IU may be the Program Safeguard Contractor (PSC), Zone Program Integrity Contractor (ZPIC), or the CMS Center for Program Integrity (CPI).

- The contractor shall stop collection efforts for all affected claims when it is notified by the IU of a confirmed case of Identity theft.

- The contractor shall update the standard systems and HIGLAS as appropriate, to reflect a fraud status for all affected claims within 5 business days from the confirmation receipt date.

- The contractor shall stop recoupment against the victim on all affected claims within 5 business days from the confirmation receipt date.

- The contractor shall discontinue sending demand letters to the victim for all affected claims within 5 business days from the confirmation receipt date.

- The contractor shall not refer any overpayments for affected claims to Treasury including overpayments already posted in the Debt Collection System (DCS).

- The contractor shall change the status code to (1I) for all overpayments posted in DCS related to the confirmed identity theft within 5 business days from the confirmation receipt date.

- The contractor shall recall any overpayments related to confirmed identity theft and change the status in DCS to (2I).

- The contractor shall not stop collection efforts if the case of identity theft is not confirmed by the IU in writing and does not include all the information required.

- The contractor shall request the missing information from the IU (PSC/ZPIC).

110.1 - IRS Form 1099 MISC

(Rev. 199, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

When the official investigation confirms a provider is the victim of identity theft these steps shall be taken.

- The contractor shall adjust the affected claims before sending the 1099, to ensure the affected claims are not included on the victim provider's IRS Form 1099 MISC.

- The contractor shall issue a revised (corrected) IRS Form 1099 MISC if the original IRS Form 1099 MISC issued to the victim contained amounts related to confirmed identity theft.

- The contractor shall keep debts open in a fraud status for possible collection until;

1. You receive notification from CPI that no future recovery is expected.

2. Any debts related to confirmed identity theft existing after 6 years shall be adjusted as closed and no future recovery is expected.

3. The contractor shall recommend these debts for termination of collection action and write-off closed.

110.2 - Seized Monies Received from Law Enforcement

(Rev. 199, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

The contractor shall apply any seized monies received (e.g., Treasury check) from the perpetrator of the identity theft to the fraudulent debt in accordance with the Medicare Financial Management Manual, Publication, 100-06, Chapter 5.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R202FM	01/06/2012	Recovery Audit Program MAC-issued Demand Letters	01/03/2012	7436
R200FM	11/16/2011	Recovery Audit Program Tracking Appeals and Reopenings	09/27/2011	7458
R199FM	11/04/2011	Instructions for Processing Physicians and Other Suppliers Debts that Have Been Confirmed as Identity Theft	12/05/2011	7419
R198FM	10/27/2011	Medicare Financial Management Manual, Chapter 4-Debts Returned to Agency (RTA) by Treasury	11/28/2011	7311
R193FM	08/26/2011	Recovery Audit Program Tracking Appeals and Reopenings – Rescinded and replaced by Transmittal 200	09/27/2011	7458
R192FM	07/29/2011	Recovery Audit Program MAC-issued Demand Letters – Rescinded and replaced by Transmittal 202	01/03/2012	7436
R189FM	05/06/2011	Recovery Audit Program Tracking Overpayments Instruction Alteration	06/06/2011	7403
R186FM	03/18/2011	Receivables Initiated by the Recovery Auditor as Independent Audit Accessible Information	04/18/2011	7336
R184FM	02/25/2011	Recovery Audit Program Underpayments Instruction Alteration	03/28/2011	7326
R180FM	12/29/2010	Updated Appeal Reporting Recovery Audit Contractors (RACs)	01/28/2011	7160
R169FM	04/30/2010	Recovery Audit Contractors (RACs)	06/01/2010	6951
R168FM	04/30/2010	Recovery Audit Contractors (RACs)	06/01/2010	6936
R167FM	03/23/2010	Recovery Audit Contractors (RACs)	05/24/2010	6871
R162FM	10/30/2009	Recovery Audit Contractors (RACs)	12/15/2009	6398
R156FM	08/07/2009	Recovery Audit Contractors	09/08/2009	6582
R152FM	06/12/2009	Recovery Audit Contractors (RACs)	07/13/2009	6384
R148FM	03/06/2009	Recovery Audit Contractors (RACs)	03/13/2009	6273
R145FM	01/09/2009	Recovery Audit Contractors (RACs) – Rescinded and replaced by Transmittal 148	03/13/2009	6273
R143FM	10/24/2008	Instruction for Monthly Processing of Non-Medicare Secondary Payer (Non-MSP) Debts Returned to Agency (RTA) from the Department of Treasury	01/05/2009	6083

Rev #	Issue Date	Subject	Impl Date	CR#
R139FM	07/11/2008	Interaction With Recovery Audit Contractors (RACs)	08/11/2008	6089
R137FM	02/29/2008	Reporting Costs Directly Associated with the RAC Program	03/31/2008	5789
R136FM	02/14/2008	Revisions to Debt Referral Instruction	03/17/2008	5875
R124FM	06/29/2007	Treasury Collection on Non-Medicare Secondary Payer (Non-MSP) Debts	07/30/2007	5631
R109FM	10/27/2006	Claims Accounts Receivable-Clarification to CR 3963	11/27/2006	5302
R104FM	08/11/2006	Updated Procedures for AC Communication with RAC	09/11/2006	5226
R87FM	12/30/2005	Update to Carrier Demand Letter Appeals Language	01/03/2006	4211
R77FM	09/16/2005	Non-Medicare Secondary Payer (Non-MSP) Debt Referral and Debt Collection Improvement Act of 1996 (DCIA) Activities	10/17/2005	3964
R75FM	08/12/2005	New Thresholds for 2nd Demand Letter for Physicians/Suppliers	09/06/2005	3932
R73FM	08/05/2005	New Thresholds for 2nd Demand Letter for Physicians/Suppliers - Replaced by Revision 75FM	09/06/2005	3932
R72FM	07/29/2005	Claims Accounts Receivable Update	01/03/2006	3963
R70FM	05/27/2005	Revision to the Beneficiary Notification Process when Recovery is Sought from the Provider	06/27/2005	3795
R69FM	05/27/2005	Update to Debt Collection System (DCS) User Guide	06/27/2005	3868
R68FM	05/20/2005	Instructions for Affiliated Contractors Involved in the Recovery Audit Contractor (RAC) Demonstrations	06/20/2005	3773
R61FM	12/10/2004	New Location Code ICC, Status Code AR and Modified Intent Letter for Unfiled Cost Reports Only	01/10/2005	3563
R53FM	08/27/2004	Change Request 3367, Debt Collection System (DCS), replaces Change Request 2952, Debt Collection System (DCS)	09/27/2004	3367
R41FM	04/30/2004	Calculated Interest on Medicare Overpayments and Underpayments	10/04/2004	3163
R30FM	01/28/2004	Notice of New Interest Rates for Medicare	02/04/2004	2829

Rev #	Issue Date	Subject	Impl Date	CR#
		Overpayments and Underpayments		
R29FM	01/02/2004	Revisions to Chapters 3 and 4	02/06/2004	2911
R19FM	07/25/2003	Intermediary Claims Accounts Receivable (A/R)	08/08/2003	2753
R13FM	02/03/2003	Termination of Debt Collection Activities	07/01/2003	2436
R04FM	08/30/2002	Initial Publication of Chapter	N/A	N/A

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