Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents
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Transmittals for Chapter 3

10 – Overpayments Determined by the Medicare Contractor
- 10.1 – Aggregate Overpayments
- 10.2 – Individual Overpayments

20 – Recovery of Cost Report Overpayments- Cost Report Filed
- 20.1 – Part A Provider is Participating in Medicare and Medicaid
- 20.2 – Provider is No Longer Participating in Medicare and Not Participating in Medicaid
- 20.3 – Provider is No Longer Participating in Medicare But is Participating in Medicaid

30 – Recovery of Cost Report Overpayments- Overdue Cost Report
- 30.1 - Part A Provider is Participating in Medicare and Medicaid
- 30.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid
- 30.3 - Provider is No Longer Participating in Medicare But is Participating in Medicaid: One or More Cost Reports Not Filed

40 – Recovery of Claims Accounts Receivables from the Provider- FI Only
- 40.1 – Demand Letter Contents
- 40.2- Sample Demand Letter for Claims Accounts Receivables

50 – Recovery of Overpayments When a Provider Changes its Contractor
- 50.1 – Action by Outgoing FI
- 50.2 – Action by Incoming Contractor

60 – Interim Rate Adjustments and Periodic Interim Payment Adjustments – Part A Only

70 – Determining Liability and Waiver of Recovery for Overpayments
- 70.1 – 1879 Determination – Limitation of Liability
- 70.2 – 1842(l) Determination
- 70.3 – 1870 Determination – Waiver of Recovery of an Overpayment

80 – Individual Overpayments Discovered Subsequent to the **Fifth** Year
- 80.1 – How to Determine the **Fifth** Calendar Year After the Year the Payment was Approved
- 80.**2**- Recovery of Overpayment Due to Overdue Cost Report

90 – Provider, Physician, or Other Supplier Liability
- 90.1 – Examples of Situations in Which Provider, Physician, or Other Supplier Is Liable
- 90.2 – Provider, Physician, or Other Supplier Protests Its Liability

100 – Beneficiary Liability

110 – Recovery Where the Beneficiary is Liable for the Overpayment
- 110.1 – Recovery Where the Beneficiary is Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental

110.2 – Recovery From the Beneficiary
110.3 - When to Suspend Efforts to Recover from the Beneficiary Following the Initial Demand Letter
110.4 – Content of Demand Letter to Beneficiary
110.5 – Sample Demand Letter to Beneficiary
110.6 – Optional Paragraphs for Inclusion in Demand Letters
110.7 – Recovery Where Beneficiary is Deceased
110.8 – Beneficiary Wishes to Refund in Installments
110.9 – Beneficiary Protests
110.10 – When the Contractor Does Not Take Recovery Action in Beneficiary Cases but Considers Whether Waiver of Recovery is Applicable
110.11 – Recording Overpayment Cases in Which the Provider is Not Liable- Part A
120 – Reserved for Future
130 – Change of Ownership (CHOW)
130.1 – Impact of Change of Ownership and Assignment of Medicare Provider Agreement on Overpayments and Underpayments
130.2 – The Contractors Contact Only the Owner of Record
130.3 – Effect of New Owner's Rejection of Assignment of the Medicare Provider Agreement
140 - Bankruptcy
140.1 - Bankruptcy Forms
140.2 - Basic Bankruptcy Terms and Definitions
140.2.1 - Bankruptcy is Litigation
140.2.2 - Types of Bankruptcies
140.2.3 - Filing Bankruptcy Draws a Line in the Sand
140.2.4 - Bankruptcy Affects Nearly All Medicare Operations
140.2.5 - Recoupment and Set-off *(see also §140.6.4)*
140.2.6 - Time is of the Essence
140.3 - Contractor*s* Establishment of Relationships to Ensure Effective Actions Regarding Providers *in* Bankruptcy
140.3.1 - Contractor Staff Must Establish Relationships to Ensure That the *CMS Office* and *CMS* Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action
140.3.2 - Contractors Must Recognize and Advise *CMS* Staff About Potential Provider Bankruptcies
140.3.3 - Contractor Staff Will Establish a Relationship *with* the *CMS Office* That has Jurisdiction Over the Bankruptcy
140.3.4 - *The CMS Office* Jurisdiction Generally Parallels the Bankruptcy Court Where Case Is Filed
140.3.5 - Contractor and *the CMS* Office Bankruptcy Point of Contact Staff Member
140.4 - Actions to Take When a Provider Files for Bankruptcy
140.4.1 - *Establish Effective Lines of Communications*
140.4.2 - Respond to *the CMS Office* Requests for Information
140.4.3 - Immediate Contractor Directives from the *CMS Office*

140.4.4 - Tracking Debts/*CMS* Communications
140.5 - Chain Bankruptcies
140.5.1 - *Chain* Providers
140.5.2 - Single Providers Serviced *b*y a *Contractor*
140.6 - Affirmative Recovery Actions
140.6.1 - Working with the *CMS Office* and Regional Counsel's Office
140.6.2 - Assumption of the *Medicare* Provider Agreement
140.6.3 - Settlement Agreements *or* Stipulations
140.6.4 - *Recoupment*
140.6.5 - Administrative *Freeze/Setoff*
140.7 - Preparing *and* Filing Proof of Claim
140.8 - *Reserved for Future Use*
140.8.1 - *Reserved for Future Use*
140.8.2 - Debt Located at *the Department of Treasury*
140.8.3 - Managing Bankruptcy Debt at the *Contractor*
140.8.4 - Closure of Bankruptcy Cases and Treatment of Overpayment Reporting Systems at End of Bankruptcy
150 – Accelerated Payments – FI Only
150.1 – Eligibility for Accelerated Payment
150.2 – Computation of the Accelerated Payment
150.3 – Recoupment of the Accelerated Payment
150.4 – Recoupment of the Accelerated Payment
Exhibit 1 – Sample Format for Provider Request for Accelerated Payment
160 – **Debt Close-Out**
160.1 – **Reserved for Future Use**
160.2 – **Reserved for Future Use**
170 – General Overpayment Provisions
170.1 – Offset of Overpayments Against Other Benefits Due- FI Only
170.2 – When the FI or Carrier Does Not Attempt Recovery Action
170.3 - Information and Help Obtainable from the Social Security Office (SSO)
170.4 – Recovery Where Physician or Other Individual Practitioner is Deceased- Carrier Only
170.5 – Provider Offers to Settle on Compromise Basis
170.6 – Unsolicited Overpayment Refunds
170.7 – Timely Deposit of Overpayment Refund Checks
170.8 – Informal Referral to RO
180 – Reserved
190 – Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment
200 - Section 935 of the Medicare Modernization Act (MMA) - Limitation on Recoupment Overpayments
200.1 - Limitation on Recoupment Section 935(f)(2) Eligibility

200.1.1 - Overpayments Subject to Limitation on Recoupment:
200.1.2 - Overpayments Not Subject to Limitation on Recoupment
200.1.3 - Adjustment of the Fee-For-Service Claims
200.1.4 – The Rebuttal Process and the Limitation on Recoupment
200.1.5- Extrapolated 935 Overpayments
200.1.6 – Medicare Secondary Payer (MSP) Provider Duplicate Primary Payment (DPP)
200.1.7 – Immediate Recoupment Requirements for 935 Overpayments
200.2 - Requirements for All Initial Demand Letters (Manual or Ecectronic)
200.2.1 – 935 Initial Demand Letter
200.2.2 - Recoupment After The Initial Demand: When Does it Begin?
200.2.3 - Payments Made Upon Notice of Demand or Through An Immediate Recoupment Request
200.2.4 – Payment Suspension Relating to Limitation on Recoupment
200.2.5 - Timeframe for Receiving, Validating and Flagging in the System to Stop Recoupment for all Redetermination Requests
200.2.6- Extended Repayment Schedules (ERS) with an Overpayment Subject to Limitation on Recoupment
200.3 - What to Do After the Validated Redetermination is Received
200.3.1 - Outcome From the Redetermination Decision
200.3.2 - Administrative Law Judge (ALJ) Third Level of Appeal
200.4 - What to Do After the Validated Reconsideration Request is Received
200.4.1 - Actions to Take Upon Receiving a Qualified Independent Contractor (QIC) Notification
200.4.2 - The Reconsideration Receipt Notice Example
200.4.3 - Actions to Take after the Reconsideration Decision
200.4.4 - Recoupment Timeframes and Reconsideration Notices after Decision
200.4.5 - Reconsideration Notice/Revised Demand Letter
200.4.6 - Recoupment on Dismissals
200.4.7 - QIC Remands on Dismissals
200.5 - Administrative Law Judge (ALJ) Third Level and Subsequent Levels of Appeals
200.5.1 - Actions on a Valid Notification for the ALJ or Subsequent Level Appeal Request
200.5.2 - Remanded back to the QIC from the ALJ
200.5.3 - Actions to Take After the ALJ or Subsequent Level Appeal Decision
200.5.4 – The Revised Overpayment Letter for ALJ and Subsequent Decisions
200.6 - Obligation to Pay Interest on Underpayments
200.6.1 - Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date
200.6.2 - Computing 935 Interest at the ALJ and Higher Levels
200.6.3 - How to Calculate 935 Interest:
200.6.4 - Obligation to Pay the Providers, Physicians, or Suppliers Late Payment Interest
200.7 - 935 Interest Calculation
200.7.1 - Assessment of 935 Interest
200.7.2 - Interest Rate and Calculation Periods on Recouped Funds for Purposes of Paying 935 Interest

200.7.3 - Calculations for Each 30-Day Period at the ALJ Decision or The Final Determination Date
200.7.4 - Timeframes When Calculating the 935 Interest
200.7.5 - Computing 935 Interest on Favorable Decisions at the ALJ and Subsequent Levels
200.8 - Tracking and Report on the 935 Interest payments

NOTE: Revision 3 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 - Overpayments Determined by the Medicare Contractor
(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Overpayments are Medicare payments to a provider, or beneficiary who received the amounts that are due and payable under the statute and regulations. Once a determination of an overpayment is made, the overpayment amount is a debt that the provider or beneficiary owes to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must try to collect Federal Government claims that arise out of the agency's activities.

The Contractor will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part. However once a contractor determines an overpayment has been made, it shall attempt to recover the overpayments in accordance with the Medicare regulations, in accordance with 42 CFR 405.371.

The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments.

These include:

.1) Requesting an Extended Repayment Schedule (ERS).

2) Establishing the ERS repayment schedules.

3) Suspending interim payments to institutional providers.

4) Effecting recoupment or setoff, where appropriate.

5) Attempting to locate the debtor, where necessary.

6) In addition, The Debt Collection Improvement Act of 1996 (31 USC 3711) requires Federal agencies to refer eligible delinquent debt to a Treasury-designated Debt Collection Center (DCC) for cross servicing and offset.

In all cases, the Contractor ensures that the Intent to Refer Letter (ITR) is sent in enough time to allow the debtor 60 days' notice prior to referral to Treasury. In accordance with provisions of the Debt Collection Improvement Act of 1996 (DCIA), eligible delinquent debts must be referred to Treasury by the 120th day of delinquency. (Refer to IOM Pub.100-06, chapter 4, §70 for further detail.)

* The Healthcare Integrated General Ledger Accounting System (HIGLAS) adds an additional 5 days after generating the intent to refer letter (ITR) to allow for interest accruals to appear on the ITR; therefore, the ITR will be generated on day 66.

Generally there are two types of Overpayments:

A. Aggregate overpayments involve a group or all of provider's claims, e.g.:

1) Overpayments determined when the Contractor settles the cost report.

2) Overpayments resulting from a pattern of improper application of Medicare coverage provisions;

3) Overpayments with a threshold of less than $25 to equal $25 or higher.

4) Overpayments resulting from adjusting periodic interim payments.

5) The provider failing to timely file a cost report.

6) Fraud, ID Theft, or program abuse.

7) Overpayments resulting from aggregated open uncollected balances for un-demanded claims overpayments (Part A Only).

8) Overpayments resulting from extrapolations of a sampled claim review applied to a claim universe.

9) Aggregate overpayments are described in §10.1, §20 and §30 of this chapter and Chapter 4, Debt Collection.

B. Individual overpayments refer to incorrect claims payment for services.

1) Individual overpayments are described in §10.2, §80 and Chapter 4, Debt Collection.

2) Medicare Secondary Payer (MSP) instructions can be found in the Medicare Secondary Payer Manual, CMS Publication 100-5.

10.1 - Aggregate Overpayments

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

A. Institutional (Part A) Providers Serviced By the Contractor

Aggregate overpayments to providers (overpayments arising in other than individual cases) may occur when:

- The Contractor determines the amounts due when the provider files a cost report, or during desk review, final settlement or reopening of the cost report.
- The Contractor made excess interim payments to the provider.
- The provider includes non-allowable or excessive costs in its cost report.
- The provider fails to file a cost report (Chapter 3, §30).
- The provider fails to repay an accelerated payment; or
- The provider has a pattern of furnishing and billing for excessive or noncovered services. Refer to the improper payment and not in compliance in the Program Integrity Manual Publication 100-08, Chapter 1).
- The Contractor made adjustments in the claim processing systems (Claims Accounts Receivables or carryover adjustment) (Refer to Chapter 4, §70.7.3).

1. The Provider initiates (Part A) the claim adjustment and after 60 days the amounts are aggregated to reach the $25 threshold.

10.2 - Individual Overpayments

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

An individual overpayment is an incorrect payment the Contractor makes to a provider, or a-beneficiary for services under title XVIII.

Examples of individual overpayment cases are when the Contractor:

- Pays the provider, or beneficiary for services rendered after the beneficiary's benefits have been exhausted, or where the individual was not an eligible beneficiary.

- Incorrectly applies the deductible or coinsurance.

- Pays for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.

- Pays based on a charge that exceeds the reasonable charge.
- Processes duplicate charges/claims.
- Pays a physician on a non-assigned claim, or pays a beneficiary on an assigned claim, (Payment made to wrong payee).

- Makes primary payment/s for items or services for which another entity is the primary payer.
- Pays for items or services rendered during a period when the beneficiary was not an eligible Medicare beneficiary.

20 - Recovery of Cost Report Overpayments- Cost Report Filed
(Rev. 29, 01-02-04)

Providers of services under Part A of the Medicare program are normally required to submit a cost report. A cost report must be submitted for each cost reporting year or upon termination of the Medicare agreement.

20.1 - Part A Provider is Participating in Medicare and Medicaid
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

When the provider files a cost report indicating an overpayment, a final determination is deemed to have occurred if the cost report is not accompanied by payment in full. Where the provider does not remit the overpayment in full, the Contractor sends the initial demand letter notifying the provider that it will reduce or suspend interim payments in 15 days if the provider does not make repayment arrangements.

If an overpayment is determined as a result of a tentative settlement, final settlement, interim rate adjustment, or reopening the Contractor sends the Initial demand letter within 7 calendar days. (See Chapter 4, §20)

When the Notice of Program Reimbursement (NPR), which is sent at the conclusion of an audit, results in an overpayment, the initial demand letter must also be sent.

- The NPR and the initial demand letter may be sent simultaneously, or
- The Initial demand letter may be sent as a separate document, or
- The Initial demand letter can be incorporated into the NPR.

If the issuance of the NPR changes the facts as stated in prior demand letters, the Contractor shall include in the NPR an explanation of the revised overpayment amount.

See Chapter 4, §40 to determine if the overpayment requires a withhold of payments.

If the provider does not respond within 60 days after the date of the Initial demand letter, the Contractor sends a ITR letter notifying the provider of the Contractors intent to recoup the overpayment from interim

payments. (If the current percentage of withhold is less than 100%, the demand letter shall state that interim payments will be withhold at 100% in 30 days if repayment arrangements are not made.)

- The ITR letter shall include notification of the intent to refer the entire debt to the Department of Treasury for additional collection action. (See Chapter 4, §20)

20.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

If the Contractor becomes aware that there is an imminent likelihood that a provider will be terminating from the Medicare program it shall contact the RO with regard to future collection efforts.

If the Contractor discovers an overpayment upon the filing of a cost report, or on determination of program reimbursement, with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund in a lump-sum, if it has not been made.

The Initial demand letter shall be sent, and all subsequent collection activities performed as specified in §20.1 and Chapter 4, §10-20.

If the terminated provider has sold the entity to a participating provider refer to Chapter 3, §130 for change of ownership instructions.

20.3 - Provider is No Longer Participating in Medicare But Is Participating in Medicaid

(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

If the Contractor discovers an overpayment upon the filing of a cost report, or on determination of the amount of program reimbursement for a former Medicare provider that is still participating in Medicaid, it shall immediately contact the provider to obtain a refund in a lump sum, if it has not been made.

The Initial demand letter shall be sent and all subsequent collection activities performed as specified in §20.1 and Chapter 4, §10-20.

The Initial demand letter must provide notice (See Chapter 4, §10-20 and §60) that action to withhold its Federal share of Medicaid payments will be requested if repayment arrangements are not made within 15 days of the date of this notice. The Contractor shall send the ITR letter 60 days from the date of the Initial demand letter if the provider has not responded, even though procedures for withholding the Federal share of payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury. If the terminated provider has sold the entity to a participating provider refer to Chapter 3, §130 for change of ownership instructions.

30 - Recovery of Cost Report Overpayments - Overdue Cost Report

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

When a provider fails to submit a cost report by the due date the Contractor shall take recovery action to notify the provider that submission of the cost report is required and that additional collection action will continue until an acceptable cost report is submitted.

30.1 - Provider is Participating in Medicare and Medicaid

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

A. General

For a participating provider, the cost report required for each cost report period is due on or before the last day of the fifth month following the end of that particular cost report period. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

If no cost report has been received by the seventh day after the due date (including extensions), the Contractor must send the Initial demand letter in Chapter 4, §20. (The seven-day timeframe allows for processing and mail time.) In addition, the Contractor must initiate 100% suspension of all Medicare payments on day seven if the cost report has not been received, an extension request has not been received and approved or a reduction in the rate of suspension has not been approved.

If the provider does not respond within 60 calendar days from the date of the Initial demand letter, the Contractor shall send the ITR letter. (See Chapter 4, §20)

Note: Contractors shall follow the instructions in Chapter 4, §10 on telephone contacts to the provider.

30.2.-.Provider is No Longer Participating in Medicare and Not Participating in Medicaid

30.3 - Provider is No Longer Participating in Medicare But is Participating in Medicaid: One or More Cost Reports Not Filed

(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Where a provider's agreement under title XVIII has terminated and one or more cost reports have not been submitted the Contractor shall send the Initial demand letter. Requirements for this letter are in Chapter 4, §20. Since this situation involves not only a terminated provider but a provider that has failed to meet the basic obligation (submission of a cost report) for the period when it did participate, the Initial demand letter provides notice that initiation of the procedure for withholding the Federal share of Medicaid payments will begin in 15 calendar days if the Contractor does not receive the cost report.

When the provider has not responded, even though the procedures for withholding the Federal share of Medicaid payments have been initiated, the Contractor shall send the Initial demand letter by the 30th calendar day, followed by the ITR letter by the 60th calendar day from the date of the Initial demand letter. This must be done so that if recoupment efforts and the withholding of Medicaid payments are not effective, the case will be ready for referral to the Department of Treasury.

40 – Recovery of Claims Accounts Receivables from the Provider - FI

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Part A claims A/R arises from adjustments in the Contractor's claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). Some of the reasons these adjustments occur include the duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, a determination by the Contractor that an adjustment was required, or an adjustment created from a credit balance report, CMS-838 in accordance to Chapter 12, Credit Balance Reporting. These adjustments are normally recovered through the recoupment of future claims and the recovered amounts are included in the remittance advices to the providers. For additional information see Chapter 4, §70.15.2.

40.1 – Demand Letter Contents

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

The Contractor will demand an overpayment resulting from a claims adjustment if the claims adjustment has had no recoupment in the past 60 days.

The demand letter shall include the following information:

- That an overpayment was made;
- That interest will begin to accrue if the overpayment is not paid in full within 30 days;
- The name and Patient Control Number (PCN) of the beneficiary involved will be included in the spreadsheet attachment;
- The dates and types of services for which the overpayment was made to include sufficient information for the provider to identify the overpayment;
- How the overpayment was calculated;
- Why it is liable for recovery of overpayment (i.e., the reasons for finding the provider at fault);
- That recoupment of the overpayment from all available payments will occur on day 16 from the date of the Demand Letter;
- Rebuttal language shall be included;
- A reference to the Appeals rights in the remittance advice.

40.2- Sample Demand Letter for Claims Accounts Receivables

(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Refer to Publication 100.06, Chapter 4, § 20.2, Sample Demand Letters for all Providers or Suppliers

50 - Recovery of Overpayments When a Provider Changes Its Contractor
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Where CMS approves a change of Contractor the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Medicare Claims Processing, Chapter 1,General Billing Requirements.)

50.1 Action By Outgoing Contractor
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

The outgoing Contractor is responsible for effectuating final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter to ensure the timely receipt of the cost report as well as any NPRs and demand letters. The outgoing Contractor is also responsible for assuring that the incoming Contractor is aware of the outstanding overpayment and that recoupment is initiated by the withholding of interim payments, if necessary.

If the overpayment remains uncollected, the outgoing Contractor is responsible for initiating the withholding of Title XIX payments (Medicaid) and for referring the overpayment to the Department of Treasury. The outgoing Contractor must copy the incoming Contractor on all correspondence with the provider to ensure a timely collection process.

A. Notification to Incoming Contractor

When the outgoing Contractor is notified by the RO that the provider's request for a change of Contractor has been approved, it shall notify the incoming Contractor in writing of all outstanding program overpayments.

It shall include:

- The cost reporting period,
- The date the overpayment was determined.
- Explanation of the type of overpayment, e.g., cost report overpayment - desk review, cost report overpayment - audit.
- The current status of collection action, including any withhold that is currently in place to recoup the overpayment,
- The original balance of the overpayment and the current principal and interest balance of the overpayment.
- The outgoing Contractor should also notify the incoming Contractor of future settlements that will be occurring and of any unfiled cost reports.

B. Notice of Intent to Suspend Interim Payments

If at the time of the change of Contractor, the outgoing Contractor is recouping an overpayment by the withholding of interim payments the incoming Contractor will continue the withhold. The outgoing Contractor must notify the provider that the withhold will be continued by the incoming Contractor until

the overpayment is liquidated or an acceptable ERS is approved. In addition, the outgoing Contractor must notify the incoming Contractor of the details of the withhold.

If after the change of Contractor occurs the outgoing Contractor determines that an overpayment exists, the outgoing Contractor must notify the provider in accordance with normal procedures. The current Contractor should receive a copy of all NPRs and demand letters. The outgoing Contractor must contact the current Contractor to make sure that recoupment begins when necessary.

50.2 – Action by Incoming Contractor

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

The incoming Contractor is responsible for effectuating final settlements for the cost report periods after the change of Contractor becomes effective. If the Contractor receives a cost report from a prior period it should forward it to the outgoing Contractor to make the final settlement. If the outgoing Contractor is no longer participating in the Medicare program, the incoming Contractor shall contact the RO for further instructions. After the outgoing Contractor has completed its review of the cost report, it notifies the incoming Contractor whether the cost report is acceptable, and the final settlement. The incoming Contractor in accordance with Ch. 4, §40, disposes of funds withheld during the suspension of interim payments (for an unfiled cost report) and initiates recoupment by the withhold of interim payments if necessary. While overpayments are outstanding at the outgoing Contractor, the incoming Contractor must keep the outgoing Contractor up to date regarding the provider's location and participation in the Medicare program. If the incoming Contractor learns of a provider's termination from the Medicare program, it must notify the outgoing Contractor so that it may act accordingly.

60 - Interim Rate Adjustments and Periodic Interim Payment Adjustments – Part A only

(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

The interest provisions of Chapter 4, §30 do not apply to Part A overpayments or underpayments determined as a result of interim rate and periodic interim payment (PIP) adjustments or utilization reviews. If necessary, an interim rate or periodic interim payment adjustment shall occur prior to the end of the cost reporting year. When this occurs, the interim rate or periodic interim rate is adjusted for the remainder of the cost reporting year in order to have aggregate payments approximate total allowable costs. This adjustment is based on any overpayment or underpayment determined as a result of the interim review. Since payments are adjusted, this overpayment or underpayment should not exist at the end of the cost reporting year.

If the review is completed after the end of the cost reporting year or after the cost report is filed, adjustments to the interim or periodic rate are not possible. In this case any determined overpayment or underpayment shall be considered in conjunction with the final settlement. By taking the overpayment or underpayment into consideration with the tentative or final settlement the Contractor will issue a tentative settlement payment, tentative settlement demand letter, or Notice of Program Reimbursement. When a demand letter is issued, interest will be assessed if necessary. The Notice of Program Reimbursement will begin the recoupment process in accordance to Chapter 4, § 10.

70 – Determining Liability and Waiver of Recovery for Overpayments

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

The Medicare law contains three provisions (§1870, §1879 and §1842(l)) dealing with liability for, and recovery of, individual overpayments. These provisions do not cover cost report overpayments. These provisions are reflected below and, for a more extensive treatment, in Medicare Claims Processing Manual, Publication 100-04, Chapter 31, Financial Liability Protections.

The Contractor shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most Contractor payments for provider services are made to providers on behalf of the beneficiaries who received the services. If payment is made directly to the beneficiary, liability always lies with the beneficiary unless recovery is waived under the limitation of liability provision. Where the provider or physician has been overpaid, it is liable for the overpayment unless the Contractor determines that it was without fault with respect to the overpayment. If the Contractor determines that an overpaid provider or physician was without fault and therefore not liable for the overpayment, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault. However, recovery from the beneficiary may be waived if you determine the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

70.1- 1879 Determination – Limitation of Liability

(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

§ 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, practitioners, and other suppliers who acted in good faith in accepting or providing services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision applies to all Part A/Part B claims decisions where claims are denied or reduced (pre-pay or post-pay) under §1862(a)(9) and §1879 (e) and (g) of the Act. Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary. (See Medicare Program Integrity Manual (PIM), Publication 100-08, Exhibits, §14.1)

A. Limitation on Liability – Indemnification Procedures for Claims Filed under Part B

§ 1879(b) of the Act provides that, when a physician/supplier is held liable for the payment of expenses incurred by a beneficiary for items or services determined to be excluded and such physician/supplier requests and received payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program will indemnify the beneficiary or other person(s) for any payments made to the liable physician/s supplier (including deductible and coinsurance payments). Further, any such indemnification payments are considered overpayments to the physician/supplier. (See PIM Exhibits, §14.1.)

B. Limitation on Liability Where Physician and Beneficiary Did Not Have Prior Knowledge With Respect to Services Found to be not Reasonable and Necessary Services (§1879 of Act)

When both the physician and the beneficiary did not have prior knowledge with respect to services found to be not reasonable and necessary, permit Medicare payment to be made under under the limitation on liability provision. (See Medicare Program Integrity Manual (PIM), Publication

100-08, Exhibits, §14.1) An overpayment does not exist if a determination is made that the limitation of liability provision applies. The claim decision must incorporate a limitation of liability determination.

70.2 - 1842(l) Determination
(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

For denials of non-assigned claims based on §1862(a)(1) involving physician services, the *Contractor* must make a determination under §1842(l) of the Act regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for post-payment denials. (See Medicare Program Integrity Manual (PIM), Publication 100-08, Exhibits, §14.3)

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment
(Rev.12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Once the Contractor has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a §1870(b) determination regarding whether the provider/beneficiary was without fault with respect to the overpayment. Once this determination has been made, then waiver of recovery of the overpayment from the provider/beneficiary should be considered per §1870(c). The Contractor makes a §1870 determination for all assigned and non- assigned claims, however, §1870 (b) or (c) of the Act, does not apply to the provider on non- assigned post-payment §1862(a)(1) denied claims. However, it can apply to the beneficiary meaning that the beneficiary was not at fault in causing he overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program, §1870 is not limited to claims denied under §1862(a)(1) of the Act for not being reasonable and necessary. §1870 is the framework for determining who is liable for the overpayment and whether the overpayment recovery can be waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived per 1870(c), the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. §1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim, and this is the basis for the overpayment.

Examples of §1870 determinations:

A. Overpaid Provider or Physician Not Liable Because It Was Without Fault 1870(b) of the Act.)

If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the fifth calendar year after the year of payment) it is not liable for the overpayment: therefore, it is not responsible for refunding the amount involved. The Contractor makes these determinations.

A. Beneficiary Liable for Overpayments to Provider That Was Without Fault With Respect to the Overpayment (§§1870(a) and (b) of the Act)

- If an overpaid provider was without fault or is deemed without fault and therefore not Liable for refund, liability shifts to the beneficiary.

- If the overpayment involves services that are not reasonable and necessary, you should have made a §1879 determination regarding the beneficiary's liability for the overpayment.

- If the overpayment does not involve medically necessary services, then limitation on liability does not apply.

B. Contractor Waiver of Recovery from Beneficiary (§1870(c) of the Act)

- If a beneficiary is liable for an incorrect payment, recovery may be waived if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where an overpayment is discovered subsequent to the fifth calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.)

- If §1879 of the Act is applicable, then §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was lack of knowledge by both the beneficiary and the provider.

80 – Individual Overpayments Discovered Subsequent to the Fifth Year

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

There are special rules that apply when an overpayment is discovered subsequent to the fifth year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary.

In the absence of evidence to the contrary, the Contractor will not demand and recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See Medicare Program Integrity Manual, Publication (PIM) 100-08, Chapter 3.)

> **EXAMPLE 1:** On May 9, 2016, Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On January 6, 2022, the Contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The Contractor–will not recover this overpayment if there is no evidence to the contrary because it was determined subsequent to the fifth year after notification of payment. (Any determination date on or after Jan. 1, 2022, will not be recovered.) (If evidence to the contrary existed, recoupment may be initiated. The PIM should be referenced and if necessary, the appropriate Benefits Integrity unit at the Contractor for guidance.)
>
> **EXAMPLE 2:** On May 9, 2016, Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On September 20, 2019, the Contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The Contractor will attempt recovery of the overpayment. (Any determination dates up to and including Dec. 31, 2021, will be recovered.)

80.1 – How to Determine the Fifth Calendar Year after the Year the Payment Was Approved

(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Only the year of the payment and the year it was found to be an overpayment enter into the determination of the 5-calendar year period. The day and the month are irrelevant. With respect to payments made in 2016, the fifth calendar year thereafter is 2021. For payments made in 2017, the fifth calendar year thereafter is 2022, etc. Thus, the rules apply to payments made in 2016 and discovered to be overpayments after 2021, to payments made in 2017 and discovered to be overpayments after 2022, etc.

Where an overpayment to a provider, or a physician assignee for medically unnecessary services or custodial care is discovered (i.e., demanded) subsequent to the fifth calendar year after the year in which the payment was approved, the provider or physician assignee is prohibited from charging the beneficiary or any other person for the services notwithstanding the fact that the provider or physician assignee has refunded the overpayment if:

• The provider or physician assignee was at fault with respect to the overpayment; and

• The beneficiary was without fault with respect to the overpayment. (Where the overpayment is discovered in, or before, the fifth calendar year, an "at fault" provider or physician assignee is not prohibited from charging the beneficiary for the overpayment if it has refunded it. However, a without fault beneficiary who pays an at fault provider's or physician assignee’s bill for medically unnecessary services or custodial care, can be indemnified in accordance with Medicare Claims Processing Manual, Publication 100-04, Chapter 30, Financial Liability Protections.

Reopenings (See Medicare Claims Processing Manual, Publication 100-04, Chapter 29 Appeals of Claims Decisions for additional information)

Your initial, or review determination or a decision by a Hearing Officer may be reopened under the following conditions:

Within 12 months after the date of the determination or decision it may be reopened for any reason;

After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or

At any time, if:

- Such initial or review determination was procured by fraud or similar fault of the beneficiary or some other person.

If an overpayment is determined based on a reopening outside of the above parameters, the Contractor will not recover the overpayment.

80.2 - Recovery of Overpayment Due to Overdue Cost Report
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

Where CMS approves a change of the Contractor, the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Pub 100-04, Medicare Claims Processing Manual, Publication 100-04, Chapter 1, General Billing Requirements.)

A. Reminder Letter

The outgoing Contractor is responsible for effecting final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter required under §30.1 to ensure the timely receipt of the cost report.

B. Initial Demand Letter

If no cost report has been filed by the first day after the due date of the cost report (including extensions), the outgoing Contractor sends the first demand letter. (See Medicare Financial Management Manual, Publication 100-06, Chapter 4, Debt Collection, §20.2, Exhibit l, Column B.) It sends copies of the reminder letter and the first demand letter to the RO and incoming Contractor. Upon receipt of its copy of the letter, the incoming Contractor suspends the interim payment.

C. Intent to Refer Letter

The Contractor shall issue a "modified Intent to Refer (ITR) Letter for Unfiled Cost Reports," if the provider has not filed the cost report and the overpayment balance has not been paid. (See Medicare Financial Management Manual, Publication 100-06, Chapter 4, §20.2 Exhibit 7 for a sample intent letter)

D. Receipt of Delinquent Cost Report

If the delinquent cost report is sent to the incoming Contractor, it sends the cost report to the outgoing Contractor to make the final settlement.

After the outgoing Contractor has completed its review of the delinquent cost report, it notifies the incoming Contractor whether the cost report is acceptable, and the final settlement. The incoming Contractor, in accordance with Medicare Financial Management Manual, Publication 100-06, Chapter 4, §40.1, disposes of funds withheld during the suspension of interim payments.

90 - Provider, Physician, or Other Supplier Liability
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

A provider, physician, or other supplier is liable for overpayments it received unless it is found to be without fault. The Contractor, as applicable, makes this determination.

- The Contractor considers a provider, physician, or other supplier without fault, if it exercised reasonable care in billing, and accepting the payment, i.e., it made full disclosure of all material facts; and
- Based on the information available, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the Contractor's attention.

Normally, it will be clear from the circumstances whether the provider, physician, or other supplier was without fault in causing the overpayment. Where it is not clear, the Contractor shall develop the issue.

90.1 - Examples of Situations in Which Provider, Physician, or Other Supplier Is Liable
(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

In accordance with §90 *above,* the following are examples of situations in which the provider, physician, or other supplier is liable for an overpayment it received.

A. The Provider, Physician, or Other Supplier Furnished Erroneous Information or Failed to Disclose Facts That It Knew or Should Have Known, Were Relevant to Payment of the Benefit.

This includes, among others, situations in which a provider, physician, or other supplier failed to report any additional payments he may have received from the beneficiary and situations in which a provider, physician, or other supplier failed to request applicable information from the beneficiary including, but not limited to, information needed by the *Contractor* to identify cases in which Medicare may be secondary payer, or if it did request such information, it failed to annotate the billing form.

Providers, physicians, or other suppliers are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help the *Contractor* identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan. (See Medicare Claims Processing, Chapter 28, Coordination With Medigap, Medicaid and Other Complementary Insurers).

EXAMPLE: A provider, physician, or other supplier submitted an assigned claim showing total fees of $600. The provider, physician, or other supplier did not indicate on the CMS-1500 that any portion of the bill had been paid. After the deductible and coinsurance, the *Contractor* determined the amount owed to the provider, physician, or other supplier was $480 on the assumption that the provider, physician, or other supplier received no other payment. The *Contractor* later learned the beneficiary paid the provider, physician, or other supplier $200 before the provider, physician, or other supplier submitted the claim. Thus, the payment should have been split, i.e., $400 should have been paid to the provider, physician, or other supplier and $80 to the beneficiary. The provider, physician, or other supplier was at fault in causing the $80 overpayment since s/he failed to inform the *Contractor* of the amount s/he received from the beneficiary.

B. Provider, Physician, or Other Supplier Receives Duplicate Payments.

This includes the following situations:

- Provider, physician, or other supplier is overpaid when the *Contractor* processed the claim more than once. If an overpayment to a provider, physician, or other supplier is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the provider, physician, or other supplier does not have a reasonable basis for assuming that the total payment received was correct and thus should have questioned it. The provider, physician, or other supplier is, therefore, at fault and liable for the overpayment.

- Provider, physician, or other supplier received payment from Medicare based on an assignment and the beneficiary received payment on an itemized bill and turned the payment over to the provider, physician, or other supplier.

- The provider, physician, or other supplier is liable for only the portion of the total amount paid in excess of the provider's, physicians, or other supplier's portion of the allowable amount.

- The beneficiary is liable for the balance of the overpayment. However, if the beneficiary paid any portion of the coinsurance to the provider, physician, or other supplier, the provider, physician, or other supplier is also liable for that amount. If the provider, physician, or other supplier protests recovery of the overpayment on the grounds that the provider, physician, or other supplier applied all or part of the check received from the beneficiary to amounts the beneficiary owed the provider, physician, or other supplier for other services, the beneficiary, rather than the provider, physician, or other supplier, is liable for refunding such amounts.

EXAMPLE: Dr. A and Mr. B each received duplicate payments of $300 based on reasonable charges of $375. Mr. B turned his $300 over to Dr. A. Thus, Dr. A received a total of $600. Mr. B did not owe money to Dr. A for other services. Dr. A is liable for $225, which is the amount he received in excess of the reasonable charge. Mr. B is liable for the remaining $75 of the duplicate payment. If Mr. B had previously paid Dr. A the $75 coinsurance, Dr. A is liable for the entire $300 overpayment.

- Provider, physician, or other supplier receives duplicate payments from Medicare and another insurer or plan (directly or through the beneficiary) which is the primary payer, i.e., an automobile medical or no-fault insurer, a liability insurer, a WC insurer, or, under certain circumstances, an EGHP. (See Medicare Claims Processing Manual, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers).

- The provider, physician, or other supplier is liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer. (See Medicare Claims Processing Manual, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers and/or Medicare Secondary Payer Manual). However, if the provider, physician, or other supplier turns the other insurance payment over to the beneficiary, the beneficiary is liable.

C. The Overpayment Resulted Through Misapplication of the Deductible or Coinsurance Requirement or Payment After Exhaustion of Benefits and the Provider, Physician, or Other Supplier Could Have Known from Its Own Records the Beneficiary's Utilization Status

Part A provider, physician, or other supplier is considered liable if it received a remittance record within the 60 days preceding billing indicating deductible and benefit status. This condition is considered met

where, within the 60-day period preceding the admission that gave rise to the overpayment, the beneficiary had been a patient in the same institution, or the provider, physician, or other supplier could have known the beneficiary's utilization status from its own records.

The provider, physician, or other supplier is expected to ask the beneficiary, or the person acting on the beneficiary's behalf, at the time of admission if the beneficiary received inpatient services in a hospital or SNF within the past 60 days and note the response on its records.

EXAMPLE: John Doe entered University Hospital on January 10, 2024. After using all of his benefit days, including lifetime reserve days, he returned home, but reentered the same hospital in fewer than 60 days and stayed an additional 30 days. University Hospital neglected to check its records and billed the *Contractor* for 30 days of inpatient hospital care. The *Contractor* made payment. Subsequently, the overpayment was discovered. Since the hospital should have known from its own records that Mr. Doe had exhausted his benefit days, the *Contractor* shall seek recovery from the hospital.

If the previous stay had been in a different hospital, or if more than 60 days had elapsed between the end of the first stay and the start of the second stay but the benefit period had remained unbroken because John had been in an SNF or a different hospital, the *Contractor* would consider University Hospital "without fault." In this latter situation, the hospital would not have been able to ascertain from its own records that benefit days had been exhausted. The *Contractor* would seek recovery from the beneficiary.

D. The Overpayment Was Due to a Mathematical or Clerical Error.

Examples:

- Error in calculation by the *Contractor* in calculating reimbursement.
- Error by the provider, physician, or other supplier in calculating charges, or
- Overlapping or duplicate bills.

Mathematical error does not include a failure to properly assess the coinsurance and/or deductible. The Contractor would determine the liability for coinsurance and deductible overpayments in accordance with D. above. Where payment to a provider, physician, or other supplier was based on a deductible amount, the provider, physician, or other supplier is without fault. Seek recovery from the beneficiary.

E. The Provider, Physician, or Other Supplier Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

F. The Provider, Physician, or Other Supplier Does Not Submit Documentation to Substantiate That It Performed the Services Billed to the Program Where There Is a Question as to Whether the Services Were Performed.

(See the Program Integrity Manual, which can be found at the following Internet address: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html if fraud is suspected.)

G. The Beneficiary Was Not Entitled to Part A Benefits and the Provider, Physician, or Other Supplier Had Reason to Believe That the Beneficiary Was Not Entitled to Such Benefits.

For example, the Medicare Office verified to the the hospital that the individual was not entitled to hospital insurance benefits.

H. The Provider, Physician, or Other Supplier Billed, or Medicare Paid the Provider, Physician, or Other Supplier for Services that the Provider, Physician, or Other Supplier Should Have Known Were Noncovered.

1. Services that were not Medically Unnecessary or Custodial Services, e.g., skilled physical therapy services furnished by a nonqualified physical therapist, or services rendered pursuant to an authorization from the VA. (See the Medicare Benefit Policy, Chapter 16, Exclusions
In general, the provider, physician, or other supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or other supplier manual or in Federal regulations.
- *Contractors* provided general notice to the medical community concerning the policy or rule.
- The *Contractor* gave written notice of the policy or rule to the particular provider.
- CMS, a CMS *Contractor,* or the OIG gave written notice of the policy or rule to the particular provider, physician, or other supplier.
- The provider, physician, or other supplier was previously investigated or audited as a result of not following the policy or rule.
- The provider, physician, or other supplier previously agreed to a *Medicare enrollment* Agreement as a result of not following the policy or rule.
- The provider, physician, or other supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements, which are related to the policy or rule; or
- The provider, physician, or other supplier previously received documented training/outreach from CMS or one of its *Contractors,* related to the same policy or rule.

Generally, a provider, physician, or other suppliers' allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met.

However, there may be other circumstances that justify a finding that the provider, physician, or other supplier was not at fault. The *Contractor s*hall consider all the circumstances, including such factors as whether and to what extent a coverage rule is spelled out in regulations, instructions, or in a CMS notice, and whether a *Contractor* misinformed the provider, physician, or other supplier about the rule; in deciding whether a provider, physician, or other supplier acted reasonably in billing for and accepting payment for noncovered services.

2. Medically Unnecessary or Custodial Services.

The *Contractor* shall apply the criteria in the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections in determining whether the provider, physician, or other supplier should have known that the services were not covered.

I. *For Part A,* the overpayment resulted from *payment for* services rendered in a nonparticipating portion of the facility *that is not certified for Medicare or for services to a beneficiary* in a bed *that Medicare* certified for a type of care other than *what the provider* furnished.

J. For Part B, the overpayment resulted with a payment to a physician on claim/s which did not accept the assignment. Since, the physician was paid but did not accept assignment, the physician is liable whether the beneficiary had also been paid.

K. Overpayment was for rental of durable medical equipment and the supplier billed under the one-time authorization procedure.

Pursuant to Medicare Claims Processing, Chapter 20, suppliers of durable medical equipment who have accepted assignment may be reimbursed for rental items based on a one-time authorization by the beneficiary, i.e., without the need to obtain the beneficiary's signature each month. A supplier using the procedure must have filed with the *Contractor*, a statement that it assumes unconditional responsibility for rental overpayments for periods after the beneficiary's death or while s/he was institutionalized or while s/he no longer needed or used the equipment.

L Items or Services Were Furnished by Practitioner or Supplier not Qualified for Medicare Reimbursement

Two examples of such services are:

- A laboratory test performed by a nonqualified independent laboratory, or
- Services rendered by a naturopath.

90.2 - Provider, Physician, or Other Supplier Protests Its Liability
(Rev. 12946, Issued:11-08-24; Effective: 12-10-24; Implementation:12-10-24)

A provider, physician, or other suppliers reply to a notification that the provider, physician, or other supplier is liable for an overpayment may indicate dissatisfaction with some aspect of the overpayment decision. Such a protest shall be considered a request for an appeal. In most instances, this will be a redetermination which is the first level of appeal for an overpayment determination. However, if the overpayment is identified during the course of the redetermination, the Contractor shall consider the provider, physician, or other suppliers protest as a request for reconsideration (second level of appeal) by the Qualified Independent Contractor (QIC). In conducting the appeal, the Contractor shall consider whether:

a. There was an overpayment.
b. Was the amount of the overpayment calculated correctly; and whether,
c. The provider, physician, or other supplier is liable for repayment.

100 - Beneficiary Liability
(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

A beneficiary is liable for:

- Overpayments made to a provider that was without fault except for overpayments for medically unnecessary services or custodial care where the beneficiary, as well as the provider, was without fault. (See Medicare Claims Processing, Chapter 30, Limitation on Liability.)

- Situations in which Medicare pays a provider, and a Workers' Compensation (WC) carrier, automobile medical, or no-fault insurer or any liability insurer; or EGHP pays primary benefits to the beneficiary for the same services. (See Medicare Secondary Payer Manual)

- Overpayments made to the beneficiary.

110 - Recovery Where the Beneficiary Is Liable for the Overpayment

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

When the contractor has determined the beneficiary to be liable for the overpayment, it shall initiate recovery efforts in accordance with the following sections, as appropriate. The chart below is meant to be a guide. The actual sections shall be reviewed for additional guidance.

	MEDICARE BENEFICIARY NON-MSP OVERPAYMENTS		
O/P Amount	**Overpayment Notice**	**Level of Pursuit**	**Waiver Requests**
$0-$49.99	No- refer to Ch. 3 §110.2	None	N/A
$50-$999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. If case is in offset status for one year with no collection activity, refer case to RO with a recommendation to terminate collection action.	Review all waiver requests and decide to approve or deny the waiver based on Ch. 3 §70.
$1000-$19999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and decide to approve or deny the waiver based on Ch. 3 §70.
$20000 and over	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and recommend approving or denying the waiver based on Ch. 3 §70. If the recommendation is for approval, refer the waiver request to the Regional Office for concurrence.

110.1 - Recovery Where the Beneficiary Is Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

When the contractor determines the beneficiary is liable, and the beneficiary carries supplemental health insurance or is covered by another Government health benefits program such as Medicaid, TRICARE, CHAMPVA, or the Federal Employees Health Benefits Program, it may be possible to recover the overpayment from the other plan or program. Payments of deductible or coinsurance amounts and payment for services rendered persons who are not entitled to Medicare are the payments most likely to be recoverable.

If, based on the circumstances of the overpayment the contractor has knowledge of the other plan or program and the contractor believes there is a possibility that the other plan or program will refund the overpayment, it shall attempt to recover from the other plan or program. In this connection, it may be necessary to ask the beneficiary for their policy number or other information concerning their non-Medicare coverage. (See Medicare Claims Processing, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers, for procedures to follow where the overpayment is for services that should have been paid for by a WC carrier.)

To facilitate recovery of the Medicare overpayments to the extent possible, where another plan or program is involved, the contractor shall attempt to work out mutually satisfactory arrangements with the other carrier(s). In negotiations with Medicaid agencies or carriers, it may be helpful for the contractor to point out that Medicare will refund directly to Medicaid agencies overpayments for services reimbursed on a charge basis.

The methods listed below have been used successfully. The contractor shall use any one or a combination, as it finds appropriate. The most desirable method in each situation depends upon the individual circumstances and the provisions of the other plan or program.

- The contractor shall arrange with the other plan or program for direct refund of overpayments. If the contractor is also the carrier under the other plan or program, a transfer of funds is the most convenient method of recovering. If another insurance carrier is involved, the contractor shall send the other insurance carrier a letter requesting refund of the overpayment. The letter should explain how the overpayment occurred and how it was calculated. The contractor shall follow up in 30 days with another letter or a phone call if payment or a letter of explanation has not been received. If this does not bring a meaningful response, it shall write to the President or Chief Administrative Officer of the other carrier.

- If the contractor does not use the above method for provider overpayments, it shall arrange with the other plan or program to make payment to overpaid provider upon the contractor's request, (even though the provider has not billed the other plan or program) and to notify the contractor of the payment. Upon receiving such a notice, the contractor shall recover the Medicare overpayment from the provider.

- Where neither of the above methods is possible, the contractor shall ask the provider if it would be willing to refund the overpayment and to bill the other plan or program, with the understanding that if it is unable to obtain payment, the contractor will refund the amount recovered to the provider. If the provider does not agree to refund the overpayment before collecting from the other plan or program, the contractor shall ask it to bill the other plan or program and to use the payment to refund the overpayment. If the contractor receives notice that a provider (or a beneficiary) plans to file a claim with another plan or program, it shall suspend recovery efforts for a reasonable period.

If the contractor has questions concerning the proper approach in recovering from a welfare agency, or another insurance plan, it should contact its RO.

If efforts to recover the overpayment are not successful, or if the contractor is certain that the other plan or program will not refund a particular overpayment, it shall seek recovery from the beneficiary in accordance with §110.2 of this chapter. It shall explain in the notice to the beneficiary that the other plan or program will not make payment directly to it. However, if the beneficiary is a Medicaid recipient, the contractor shall not attempt recovery from the beneficiary.

110.2 - Recovery From the Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The term Medicare Beneficiary Identifier (MBI) is a general term describing a beneficiary's Medicare identification number.

To recover a non-MSP overpayment from a beneficiary, follow the recovery procedure below. If the beneficiary protests following the receipt of a notification of overpayment, handle the protest in accordance with §110.9 of this chapter.

A. Non-MSP Overpayment Is Less Than $50

Take no further recovery action. Do not send a recovery letter, or attempt recoupment. Also do not refer case to CMS for further collection efforts. See §160.2 of this chapter for termination of collection procedures.

B. Non-MSP Overpayment Amount Is $50 or More

Upon discovering an overpayment of $50 or more, send the beneficiary a recovery letter containing the information in §110.4 of this chapter.

If there is no response within 30 days after sending the initial recovery letter and none of the conditions in §110.3 of this chapter are present:

1. Send a follow-up letter to the beneficiary, and

2. Arrange to begin offset of the overpayment against any Medicare payments that become due the beneficiary on day 60.

C. Referral to SSA

To be considered for SSA referral the overpayment amount must be $1000 or more and the beneficiary must be in current pay status. If, within 90 days of sending the initial demand letter, the overpayment has not been recovered and the individual has not requested a reconsideration, hearing or waiver (see §110.9 of this chapter) Prepare the case for referral to SSA for possible recovery from the individual's social security benefits.

However, if the beneficiary is not entitled to monthly social security benefits, do not refer the case to SSA. Offset should be continued in the case of beneficiaries who is not entitled to monthly social security benefits. If appropriate, the instructions for termination of collection action should be followed (See 110.3D of this chapter for additional instructions.).

The contractor should not refer an overpayment to SSA if it has knowledge that the beneficiary is deceased.

When preparing the case for referral to SSA the following must be included in the case file:

- Referral Form- contains the address of the referring agency (The Centers for Medicare and Medicaid Services (CMS) Central Office, CMS Regional Office, or the Medicare Contractor and information pertaining to the case; and

- Return Notice- for SSA use in recording information for crediting the CMS Trust Fund; and

- Waiver Determination- if the Medicare Contractor or CMS RO determines the beneficiary was at fault for the overpayment.

NOTE: The contractor's file must contain all overpayment notification letters and correspondence from the beneficiary and/or representative. Contractors may retrieve copies of the relevant forms from the servicing regional office or by accessing SSA's Program Operations Manual System at http://policy.ssa.gov/poms.nsf/poms. Access the HI section for Health Insurance and then the section number HI 022 titled Medicare Overpayments. Then access HI 02201 - Methods of Recovery for Title XVIII Overpayments and finally HI 02201.015 titled Appeal Requests and Refunds. The Beneficiary Overpayment Referral Notice is Exhibit A.

When an individual or his/her authorized representative receives notice from SSA that a Medicare overpayment will be withheld from title II benefits and protests the withholding, the protest applies only to the deduction from his/her title II benefits. It does not apply to the Medicare overpayment because the Medicare contractor has determined that the overpayment must be recovered.

If SSA receives an appeal and/or waiver request, they must stop the process of recovery. If the Medicare Contractor, CMS RO, or the Administrative Law Judge has previously denied a waiver request, SSA will then process the overpayment in accordance with current operating procedures. If the individual has not requested a waiver with the contractor but files a waiver request with SSA, then SSA must return the overpayment package to the appropriate contractor for processing.

When an individual or his/her representative goes to SSA to request a waiver and/or an appeal of the Medicare Overpayment withholding, SSA must complete the following forms, depending on the request:

- Waiver- Form 632-BK (Request for Waiver of Overpayment and Recovery of Change in Repayment Rate)
- Appeal of Withholding – SSA-795 (Statement or Claimant or Other Person) since the rate of the withholding is not an initial determination, does not use the SSA-561 (Request for Reconsideration) or HA-501 (Request for Hearing).

NOTE: The referral of a non-MSP beneficiary debt to SSA occurs regardless of the classification of the debt for financial reporting. Thus, a referral to SSA should occur even if the debt has been reclassified to Currently Not Collectible (CNC).

D. Beneficiary "Write-Off" between $50- $999.99

If there has been "No Activity" (i.e. no recoupment) within a 12-month period of a beneficiary non-MSP overpayment that is between $50-$999.99, verify that no collections are being made on any other older debts for the same beneficiary before you make a recommendation for write-off to the Regional Office. At the end of each Quarter compile a list of all beneficiary non-MSP overpayments between $50-$999.99 to the Regional Office for Write-Off.
Submit this information, including the status of probate, if applicable, with an explanation for the beneficiary non-MSP overpayment Write-off.

Example:

Region #	*Contractor #*	*Medicare beneficiary identifier#*	Claim #
xx	xxxxx	xxxxxxxxxx	xxxxxxxxxxxx
Claim paid date	Demand letter date	Det. date.	$ amt.
xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxx

The RO will be responsible for approval or denial of all recommendations for "write-off", based on the information submitted by contractor.

NOTE: The write-off of a non-MSP beneficiary debt between $50-$999.99 occurs regardless of the classification of the debt for financial reporting. Thus, a request to write off non-MSP beneficiary debt between $50-$999.99 should occur even if the debt has been reclassified to Currently Not Collectible (CNC).

NOTE: Beneficiary overpayments that are greater than $1000 may be recommended for write-off following the above instructions if the Medicare contractor has verified from SSA that the beneficiary is not in a current pay status.

110.3 - When to Suspend Efforts to Recover From the Beneficiary Following the Initial Demand Letter

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Efforts to recover from the beneficiary should be suspended if any of the following conditions exist:

A. The Beneficiary Requests Administrative Appeal, or Questions the Overpayment Decision

The contractor shall make no further recovery efforts until it disposes of the appeal request. (See §110.9 of this chapter)

B. The Beneficiary Requests That Recovery be Waived or States Conditions that Might Qualify the Beneficiary for Waiver of Recovery

The contractor shall refer beneficiary waiver requests over $20,000 to their RO for waiver eligibility.

C. The Beneficiary Is Receiving Welfare Benefits

If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, the contractor shall ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. (See §110.1 of this chapter.) If the welfare agency does not refund the overpayment in full, the contractor shall not attempt recovery from the beneficiary, unless it is apparent that the beneficiary knew or should have known that the payment was incorrect.

NOTE: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

110.4 - Content of Demand Letter to Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment which is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the contractor's determination. Clarity is also important because the letter may eventually be used by CMS for further recovery attempts.

The following is the minimum information which shall be included in all overpayment refund letters sent to a beneficiary:

A. Name and address of physician, date and type of service, charges, date of check, amount of check, and name of payee.

B. A clear explanation of why the payment was not correct.

C. The amount of the overpayment and how it was calculated.

D. The beneficiary is required to refund the overpayment.

E. The refund should be by check or money order, and how it should be made out (enclose a pre-addressed envelope).

F. The refund can be made by installments. (See §110.8. of this chapter)

G. Unless a refund is made, the overpayment may be withheld from other Medicare benefits payable to the beneficiary and may be referred to the Social Security Administration for further recovery action.

H. Possible recovery from other insurance (if applicable).

I. An explanation of the beneficiary's right to a review or hearing as appropriate.

J. An explanation of the CMS/SSA waiver of recovery provisions. (See §170.3 of this chapter)

110.5 - Sample Demand Letter to Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The contractor may use or adapt the following model letter for requesting refunds of overpayments from beneficiaries:

"Dear Mr. _____:

A. Opening Paragraph:

"In (month and year) we paid (provider's, physician's, supplier's name and location) (you) $_____ more than was due for services furnished by _____ on _____ (from _____ through _____) (on _____). We have reviewed the payment and determined that it was incorrect. The correct payment should have been $_____."

The contractor shall include a clear and complete explanation of how the overpayment arose and how it was calculated.)

It shall add if applicable: "We have recovered $_____ from (specify source). Thus, the total remaining overpayment is $_____.

B. Liability of Beneficiary When Payment Made to Physician or Supplier

If payment was made to the physician, add the following:

"Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's, physician's, supplier's name) was not at fault. Therefore, you are liable for the $_____ incorrectly paid for the services you received."

C. Request for Refund

"Please send us a check or money order for $_____, within 30 days. Make the check or money order payable to (contractor name), and mail it in the enclosed self-addressed envelope."

D. Possible Offset

"If other Medicare benefits become payable to you and you have not refunded the incorrect payment, we will withhold the amount you owe from those benefits." (In the initial letter the contractor shall add: "beginning 60 days from the date of this letter.")

E. Possible Referral to Social Security Administration

If the overpayment is over $1000, add the following:

"If you do not repay this amount, this overpayment may be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action that, among other actions,

may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled."

F. Installment Payments

"If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of $_____each month for ___ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often."

G. Possible Recovery from Other Insurance

(The contractor shall not use this paragraph where it has determined that the private insurer will not pay.)

"If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider or physician) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office."

H. Notification of Appeal Rights

The notification of appeal rights must be in accordance with the reopening rules in Medicare Claims Processing, Chapter 29 – Appeals of Claims Decisions.

NOTE: If the overpayment was for medically unnecessary services or for custodial care, The contractor shall begin the first sentence of the appeals paragraph:

"If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services."

I. Notification of Waiver of Recovery Provision

"The law requires that you must repay an overpayment of Medicare benefits unless you meet both of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, and
- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses or would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination."

110.6 - Optional Paragraphs for Inclusion in Demand Letters

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The contractor should use or adapt the following paragraphs in explaining how the overpayment occurred.

A. Inpatient Hospital Deductible or Coinsurance Not Properly Assessed – Part A

1. General – Part A

"Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first $_____ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of $_____ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is $_____ per day coinsurance for each lifetime reserve day used.

2. Deductible Overpayment

"Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for ____ days in full. However, since these were the first inpatient hospital services furnished in this benefit period you are responsible for the deductible and the $_____ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus (provider's name) was overpaid by $_____."

3. Coinsurance Overpayment

"Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for ____ full days (less the $____ deductible). However, since you had previously been hospitalized for ____ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as ___ full days and ____ coinsurance days (and/or lifetime reserve days). Therefore (provider's name) has been overpaid on your behalf for _____ coinsurance days at $_____ per day and/or lifetime reserve days at $_____ per day) (less $_____ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is $_____."

B. Deductible Not Properly Assessed -Part B

"Under Part B of Medicare, no reimbursement may be made for the first $100 of approved charges incurred by a beneficiary in each calendar year." (If pertinent, add: "This is true even if you were covered under Medicare for only part of the year.") In these cases, explain the computation of the overpayment.

C. Payment Made Under Workers' Compensation Law

We paid $_____ in benefits for services furnished you by (provider's, physician's or supplier's name and location) on (dates). However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services that are covered under workers' compensation. Since (provider's, physician's, supplier's name) was not at fault in causing this overpayment, you are required to refund the $_____ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions."

D. Beneficiary Not Entitled to Medicare Benefits

"The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your Medicare Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (contractor name). Therefore, if you disagree with this decision, or

if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you."

110.7 - Recovery Where Beneficiary Is Deceased

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Where a beneficiary who is liable for an overpayment dies, the contractor shall attempt to recover from such sources as State welfare agencies, or private insurance plans (see §110.1 of this chapter), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative. (See 42 CFR 424.60)

If the entire overpayment cannot be recovered by the above methods, it shall send a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative if known, or to the last known address of the deceased. It shall include the basic information in §110.5 of this chapter but shall not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The contractor shall not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. It shall not recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

Model Refund Request to Estate of Deceased Beneficiary (contractor shall adapt to Fit the Situation)

Estate of (deceased beneficiary) (or, if known, "Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear M. _____ if estate representative's name is known).

On (date) we paid (provider's, physician's, or supplier's name and location) (deceased beneficiary, if applicable) $ _____ more than was due for services furnished by (_____) on _____ (from _____ through _____)."

(This paragraph should include a clear and complete explanation of how the overpayment

arose, the amount of the overpayment, how it was calculated, and why the payment was not correct.)

The contractor shall add if applicable:

"We have recovered $ _____ from (specify source). Thus, the total remaining overpayment is $_____.

"If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits.

If payment was made to the physician, add the following:

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the (provider, physician) was not at fault in causing the overpayment. In this case ((provider, physician) name) was not at fault. Therefore, the estate of (deceased beneficiary) is liable for the $_____ incorrectly paid to ((provider, physician) name) for the services it furnished (deceased beneficiary).

"Please send us a check or money order in the amount of $ _____ payable to (contractor name) in the enclosed, self-addressed envelope within 30 days.

NOTE: The contractor shall undertake notification of appeal rights in accordance with the reopening rules in Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.

"If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver."

110.8 - Beneficiary Wishes to Refund in Installments

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The term Medicare Beneficiary Identifier (MBI) is a general term describing a beneficiary's Medicare identification number.

A. General

If an overpaid beneficiary states that they are unable to refund the full amount of an overpayment at one time, regular monthly installment payments are acceptable. The amount and frequency of the installments should be in reasonable relationship to the amount of the overpayment.

Normally, the installments should be large enough to effectively recover within 3 years; however, the contractor shall allow a longer installment period if the beneficiary is willing to refund at least $50 per month. In notifying a beneficiary that they can refund an overpayment by installments, the contractor shall specify the amount (not less than $10) and the number of monthly installments necessary to recover the overpayment.

NOTE: These provisions for repayment in installments do not apply to overpayments for which providers are liable.

The contractor shall exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that they cannot afford an installment of at least $10 per month, or that they can afford installments of $10 to $50 per month but the overpayment is so large that recovery would take substantially more than 3 years, the contractor shall treat such statement as a request for waiver. (See §110.9 of this chapter)

B. Notification of Installment Schedule

When agreement is reached with a beneficiary for refund by installments, the contractor shall notify the beneficiary of the installment schedule. Request the beneficiary to sign an installment agreement such as the one in paragraph C below. It shall give one copy of the agreement to the beneficiary and retain the other.

C. Suggested Installment Agreement

_____ _____

Name of Overpaid Beneficiary Medicare Beneficiary Identifier

Beneficiary's Address

I hereby agree to repay my Medicare overpayment totaling $ _____ to (contractor's name), which will receive the payments on behalf of the Centers for Medicare and Medicaid Services. My payments will be made as follows:

DATE PAYMENT DUE (Month, Day, Year)	Amount of Payment

_____ _____

_____ _____

_____ _____

_____

Signature of Beneficiary

_____

Date

D. Beneficiary Fails to Remit Installments

If the beneficiary fails to remit two consecutive installments, or after remitting the overdue installments, fails to remit any subsequent installments, the contractor shall ask the beneficiary the reason for the lapse. If it does not receive a response within 30 days or is informed that the beneficiary is unable to continue paying any installments the statement should be treated as a waiver request. If the contractor learns that the beneficiary is deceased, see §110.7 of this chapter.

E. Beneficiary Can No Longer Afford Installment Amount but Can Afford a Lesser Amount

If the beneficiary notifies the contractor that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the contractor shall set up a new agreement, provided the new installment is at least $10 per month, and large enough to effect recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement.

110.9 - Beneficiary Protests

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

A beneficiary's reply to a notification of overpayment or request for refund may constitute a request for waiver, or request for appeal, i.e., reconsideration, review, contractor fair hearing, or ALJ hearing as applicable, or a request for both waiver and appeal.

A. Protests To Treat as Requests Administrative Appeal

The contractor shall consider a beneficiary's reply to a request for administrative appeal (Part A reconsideration, Part B review, Part B fair hearing, or ALJ hearing (both A & B), as applicable) if the beneficiary protests the existence of an overpayment, the amount of the overpayment, or if the nature of the protest is unclear. (See B below for which protests the contractor shall consider requests for waiver.) It shall take no further recovery action in such cases until the administrative appeal process is completed. (See Pub. 100-4, Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) The contractor shall tell the beneficiary that the request is being considered (or has been forwarded to the Office of Hearings and Appeals, if a hearing request) and that no action is necessary until further notice. If the overpayment case has been referred to SSA, the contractor shall inform SSA of the appeal so that recovery action by SSA may be suspended pending the results of the appeal.

If the appeal determination is that the beneficiary is liable for an overpayment, the contractor shall send the beneficiary another request for refund of the overpayment (including all information in §110.5 of this chapter), unless the beneficiary has also requested waiver. In that event, see B below.

B. Protests To Treat as Requests for Waiver

If an overpaid beneficiary protests on the grounds of hardship, or that recovery would be inequitable, the contractor shall treat the protest as a request for waiver even if it is filed on a form ordinarily used for requesting administrative appeal. Discontinue collection efforts and make a waiver determination if necessary. If the beneficiary offers evidence of financial condition, the contractor shall include it but shall not solicit such evidence. It shall tell the beneficiary that the overpayment case will be forwarded to the Social Security Administration and that no action is necessary until further notice.

NOTE: If the beneficiary has also requested appeal, the contractor shall conduct the appeal prior to the waiver determination.

110.10 - When the Contractor Does Not Take Recovery Action in Beneficiary Cases but Considers Whether Waiver of Recovery is Applicable

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The contractor shall consider whether waiver of recovery from the beneficiary is applicable. If the beneficiary is liable and the criteria for waiver of recovery from the beneficiary are likely to be met, i.e., it appears from the circumstances that the beneficiary was without fault and that recovery is against equity and good conscience or defeats the purpose of the Medicare program (i.e., would cause the individual financial hardship), the contractor makes a waiver determination.

The contractor shall first determine if the beneficiary was without fault see §70.3. If it appears that the beneficiary was without fault the contractor shall then determine if recovery would be against equity and good conscience or if recovery would defeat the purpose of title II or title XVIII of the Social Security Act.

- For recovery to be against equity and good conscience an individual must have changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that a payment would be made or because of the overpayment itself. (See 20 CFR §404.509)

- For recovery to defeat the purpose of title II or title XVIII of the Social Security Act the beneficiary must need all his or her current income to meet ordinary and necessary living expenses. (See 20 CFR §405.508)

The contractor shall make waiver of recovery determinations for individual non-MSP overpayments up to $20,000. If an individual non-MSP overpayment is greater than $20,000, and the contractor believes that the waiver of recovery is appropriate the contractor shall make a recommendation to the regional office for approval to waive the recovery. If there is a situation that involves several beneficiaries where the aggregate total of all waiver determinations exceeds $40,000, the regional office shall be notified. The regional office shall provide guidance as to who shall approve the waiver of recovery determinations.

If the **c**ontractor decides that the information available does not justify waiver, it proceeds with normal recovery efforts from the beneficiary.

NOTE: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

110.11 – Recording Overpayment Cases in Which the Provider is Not Liable— Part A

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

If a provider is relieved of liability for refunding an overpayment, and an adjustment bill is required in accordance with Medicare Bill Processing, Chapter 1, General Billing Requirements, the contractor shall treat the charges involved in the year-end cost report as though they were covered; i.e., make provision to assure that the overpaid amount is not recovered from the provider at the time of final cost settlement.

If the contractor has a system capable of preventing year-end recovery from the provider, where it was relieved of liability for refunding an overpayment, it need not maintain an additional record of the case.

120 - Reserved for Future

(Rev. 13235; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

130 – Impact of Change of Ownership (CHOW) on the Overpayments and Debt Referral Process

(Rev. 13235; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

When a provider undergoes a CHOW where the new provider accepts assignment of the previous owner's Medicare agreement, the responsibility for repaying any outstanding and future overpayments resides with the new owner. Exception: If any of the overpayments determined for a fiscal year when the previous owner had assignment were discovered due to fraud, the responsibility for the repayment of the overpayments does not shift to the new provider. It stays with the old provider. A sales agreement stipulating that the new owner is not liable for the overpayments made to the previous owner is not evidence enough for recovery from the new owner to not occur. Medicare was not a part of the sales agreement. That is a civil matter, and it would be up to the new owner to enforce the sales agreement. If the new owner assumes assignment of the Medicare agreement, Medicare will attempt to recover from the new/current owner regardless of the sales agreement. The Contractor attempts collection from the new owner. If this is not successful and the Contractor has reasonable evidence that the previous owner can repay the overpayment it should refer the case to the RO. The RO will confer with the Office of General Council (OGC) and decide if the case warrants collection from the previous owner. This action should be completed before the debt is transferred to the Department of Treasury.

The primary source for information on Change of Ownership (CHOW) is located in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM), Publication 100-07, Chapters 2 and 3. Please refer to that manual for any subsequent update on the information in this section.

When the owner of a Part A Medicare provider agreement transfers the provider rights to a new owner, (by sale, lease or other transaction), Medicare regulations state that the provider agreement is automatically assigned to the new owner. Refer to 42 C.F.R. § 489.18(c). Such a transfer is called a "Change of Ownership" (CHOW). A CHOW allows the provider's participation in the Medicare program to continue without any break in coverage.

However, if the new owner chooses to reject assignment of the provider agreement, the old owner's provider agreement terminates, and the new owner must apply to the CMS for certification as a new Medicare Provider. This is not a "CHOW." Just as any other new provider, this new provider is not eligible for payment for services that it provided to beneficiaries before the date on which the CMS approves its application to participate in Medicare. Refer to: 42 C.F.R. § 489.13(b).

For more information on payments during the CHOW processing period, refer to Program Integrity Manual, CMS Publication 100-08, Chapter 10, § 5.5.2.5.

130.1 – Impact of Change of Ownership and Assignment of Medicare Provider Agreement on Overpayments and Underpayments

(Rev. 13235; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

Assignment of Medicare Provider Agreement:

When an existing provider agreement is assigned to a new owner, the new owner is subject to all of the applicable statutes and regulations, terms and conditions under which the existing agreement was issued. One of these statutes requires the adjustment of ongoing payments to the provider to account for prior overpayments and underpayments. Under a CHOW, there is no change in the provider agreement; only the owner has changed. Therefore, when a new owner accepts assignment of the Medicare provider agreement, the Contractor continues to adjust any payments it makes to the provider.

A. The Contractor Collects All Overpayments from the New Owner

In a CHOW, the new owner that receives automatic assignment of the Medicare provider agreement also accepts responsibility for any overpayments that Medicare made to the old provider, whether those overpayments are currently outstanding or are determined after the CHOW. This rule applies even if the overpayments relate to a cost report or other time periods before the CHOW. Therefore, after the contractor receives the tie-in notice from CMS or the State Survey Agency (SA) confirming that CMS or the SA has approved the CHOW, the Contractor contacts only the new/current owner to collect any overpayments. It pursues all collection remedies against the new/current owner via (1) recoupment; (2) offset against Medicaid payments; (3) correspondence to the new/current owner; or (4) referral to the United States Department of the Treasury (Treasury).

B. The Contractors Recoup funds first on any outstanding Overpayments from any Underpayments before releasing the excess amounts back to the new provider.

After a CHOW, the Contractor issues any provider underpayments to the new owner, even if the underpayment relates to cost years or other periods before the CHOW. Such underpayments include, but are not limited to, underpayments which result from reimbursement appeals (regardless of whether they result from administrative or court decisions, from administrative resolutions or from court settlements). Contractors verify if there are any underpayments. If so, the Contractors shall recoup funds and apply to outstanding overpayments from any underpayments that are determined for the provider and refund any excess amounts.

C. Sales/Transfer Agreements between Owners are not Binding in Medicare Program

If the new owner does not reject automatic assignment of the previous owner's Medicare provider agreement, the assignment will occur automatically, consistent with Medicare regulations. Therefore, the Contractor shall recover overpayments from the new/current owner, regardless of the terms of any sales or other transfer agreement.

D. Overpayments Related to Fraud

A new owner that accepts assignment of the prior owner's Medicare provider agreement is responsible for any overpayments, regardless of the basis for the determination of the overpayment unless the overpayment is under fraud investigation. **In the case where the previous owner was under a fraud investigation the assignment of the overpayment would not pass to the new owner.**

130.2 – The Contractors Contact Only the Owner of Record
(Rev. 13235; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

Once the Contractor receives a tie-in notice from the CMS or SA, indicating that the CHOW processing is complete, the Contractor deals exclusively with the new owner on issues pertaining to the provider. If there are issues that the Contractor is unable to resolve, they may contact the Centers for Program Integrity (CPI), Provider Enrollment & Oversight Group (PEOG) and/or the Center for Clinical Standards & Quality (CCSQ), Survey & Operations Group (SOG). Where there has been more than one CHOW, the Contractor deals with the provider's current owner of record.

A. Overpayment/Demand Letters

The Contractors shall send demand letters or overpayment notification letters only to the provider's current owner. Refer to CMS Publication 100-06, Chapter 3, Section 40.1 & 40.2.

B. Refunds Based on Appeal Decisions

The Contractor sends payment/s resulting from a reimbursement appeal to the providers current owner. This includes, but is not limited to, payments that result from administrative or court decisions, from administrative resolutions or court settlements.

C. Civil Money Penalties (CMP) Imposed for Quality-of-Care Deficiencies

When the CMS asks the Contractor to reduce ongoing Medicare payments to recoup a CMP, the Contractor collects the CMP from ongoing payments to the current owner, regardless of the dates for which the CMS imposed the CMP.

130.3 – Effect of New Owner's Rejection of Assignment of the Medicare Provider Agreement
(Rev. 13235; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

Assignment of Medicare Provider Agreement:

If the new owner rejects the assignment of the provider agreement, there is a voluntary termination of the old owners provider agreement on the date of the sale or other transfer. There would be no CHOW of the Medicare agreement, and the previous owner would still be responsible for any outstanding overpayments. Contractors follow normal collection processes to recoup any outstanding debt from the previous owner.

If the new owner wants to participate in the Medicare Program, they must apply as a new provider, under a new Medicare Provider Agreement. The new provider will not be eligible to receive Medicare reimbursement for services rendered to beneficiaries before the date CMS approves the new application.

For providers which must undergo a compliance survey, that survey cannot take place until after the date on which the old owner terminates its Medicare participation and the new owner has begun providing services.
In the case of the rejection of the provider agreement, the new owner will not be able to participate in the Medicare Program until a valid provider agreement is issued from CMS. The Contractor seeks recovery of all overpayments and issues all underpayments to the last owner of record under the terminated provider agreement.

140 - Bankruptcy

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

This section *outlines the required* actions that *Contractors* must *implement* to safeguard the Medicare Trust Fund when a provider files for bankruptcy. *Although* the term "provider*" is used throughout this chapter for consistency, these* provisions *are equally applicable to suppliers and physicians.* However, use of the term "provider" does not *imply* that the Medicare program *classifies* suppliers and physicians *as providers under its definitions. The section* also explains how to *accurately* report the Centers for Medicare & Medicaid Services' (CMS) accounts receivable balances and support CMS's efforts *in* effectively *evaluating* and *managing* bankruptcy cases. *This section does not address bankruptcy issues related to debts arising under the Medicare Secondary Payer (MSP) provisions.*

This chapter will guide *Contractor* staff through the initial stages of a provider bankruptcy. It is not intended to be, and cannot *serve as*, a *step-by-step* process from beginning to end. **Bankruptcy is litigation.** Bankruptcy law and the bankruptcy court affect all the actions *CMS,* and its *Contractors* take concerning a bankrupt Medicare provider. Therefore, *Contractor* staff shall consult closely with the *servicing CMS Office or CMS Counsel.* In some cases, attorneys from the Department of Justice (DOJ) in Washington, D.C. or *the* United States Attorney's *Offices* will work directly with *CMS*. However, in most cases, *the servicing CMS Office* will be in contact with *the assigned CMS Counsel.*

140.1 - Bankruptcy Forms

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

Upon receipt of a bankruptcy notice, Contractors shall do the following:

1. *Upon receipt of a bankruptcy notice, Contractors shall send the bankruptcy notice to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov for review and place the provider in a bankruptcy status in the Health Integrated General Ledger Accounting System (HIGLAS).*
2. *The servicing CMS Office will review the bankruptcy notice and seek legal advice, if appropriate.*
3. *The CMS Office will contact the Contractor/s, via e-mail, that services the bankrupt provider/s and provide detailed instructions on the proper handling of the provider/s in the HIGLAS and the System for Tracking Audit & Reimbursement (STAR), if applicable.*
4. *The Contractor shall provide a Bankruptcy Referral Checklist for the bankrupt provider/s.*
5. *The Bankruptcy Referral Checklist is now divided into two (2) tiers, each designed to gather the bankruptcy information within a reasonable timeframe.*

    - *Tier I - Information shall be submitted to the CMS Office within ten (10) business days of receipt of the CMS instructions regarding the bankruptcy notification. If the CPI Fraud*

Check results have not been received within the ten (10) business days, the Contractor shall submit the Tier I checklist with all required information and indicate that the CPI Fraud Check results are pending. The Contractor shall forward the CPI Fraud Check results to the CMS Office immediately upon receipt.

- *Tier II - Information shall be submitted to the CMS Office upon request.*

Exhibit 1 provides the required information to be submitted for Tier 1 and Exhibit 2 provides examples of required information for Tier II.

Exhibit 1

Bankruptcy Referral Checklist Tier I

(Submit to the CMS Office as an Excel file, via e-mail, within ten business days from receipt of the CMS Office's instructions)

Description	***MAC Response***	***MAC Comments***
BNK Case Number		
Bankruptcy Court		
Petition Date		
Provider Name		
Provider Number (s)		
Provider Tax ID Number		
Any Claims Under Appeal (Y/N)?		
Any Overpayments in Appeal Status (Y/N)?		
Open Cost Reports (Y/N or N/A)? (Part A Only)		
Year & Status of Open Cost Reports? (Part A Only)		
Pending Cost Reporting Years in Appeal? (Part A Only)		
Pending Cost Report Reopening(s) (Y/N)? (Part A Only)		
Any Fraud Overpayments or Investigations (Y/N)? [1]		
Date of Fraud Cases, if applicable		
Evidence of a Recent or Pending CHOW (Y/N)?		

[1] **Fraud Check Report Request Instructions**

1. The *Contractor* shall email its fraud check request spreadsheet along with a completed CPI data request form (Attachment #1) to CPIFraudcheck-OFMDebt@cms.hhs.gov with the subject line "*Contractor*/Jurisdiction Fraud Check Request" (example – ABC/J2 Fraud Check Request).

2. The *Contractor* should expect to receive the fraud check report from CPI within one week of sending the fraud check request to CPI. The *Contractor* shall use the fraud check report to determine if the provider/supplier has an open fraud case.

The *Contractor* shall include a copy of CPI's completed fraud check report for the NPIs that are included in the Bankruptcy on the checklist spreadsheet Tier I that is sent to *CMS*.

*Note: The CPI Fraud check applies to bankrupt providers with NPI's. Bankrupt providers with no NPI's should follow the current process of checking for fraud.

Attachment #1 – Sample Fraud Check Request Form

Data Request Form

To request a fraud check report from CPI Unified Case Management (UCM) system, please complete and submit this form **one week before the desired delivery date** to CPIFraudcheck-OFMDebt@cms.hhs.gov.

Requestor Information			
Requester:		Component/Contractor	
Phone Number:		Date:	
Email Address:		Desired Date:	
Frequency :	*One time request*		

Data Request Information	
Summary	**Contractor is requesting fraud checks for the National Provider Identifiers that are included on the attached spreadsheet(s).**
Description	**Fraud checks are required for providers/suppliers who have Medicare debts that are being reviewed for potential termination of collection. If it is determined that the provider/supplier has an open fraud case, its debts will not be eligible for termination of collection.**
Business Need	**See description.**
Comments	

Exhibit 2

Bankruptcy Referral Checklist Tier II
(Submit to the CMS Office upon request, via email)

Examples:
Provider Participating in Medicaid program?
Provide copies of Demand Letters or Intent to Refer Letters
Provide copies of ERS approval or Denial Letters
Other Documents upon request such as provider agreements, surety bond letters, expected completion of cost report settlement, appeal outcomes, etc.

Referral Checklist Instructions for Tier I:

Category	Data Element	Instruction	Example
Tier I	Bankruptcy Case Number	Prescribed format for this field is Court Abbreviation + BNK Case Number	TNMBKE-19-12345
Tier I	Bankruptcy Court	Court State and Region (if applicable)	Tennessee Middle
Tier I	Petition Date	Date Petition Filed in US Bankruptcy Court	01/01/2019

Tier I	Provider Name		
Tier I	Provider Number (s)	HIGLAS Provider or Supplier Number	12-3456
Tier I	Provider Tax ID Number		12-3456789
Tier I	Any Claims Under Appeal (Y/N)		
Tier I	Any Overpayments in Appeal Status (Y/N)	If Yes, provide stage of Appeal (Ex: Reconsideration)	
Tier I	Open Cost Reports (Y/N or N/A)? (Part A Only)	If not Part A workload, list N/A	
Tier I	Year & Status of Open Cost Reports? (Part A Only)	If not Part A workload, list N/A	
Tier I	Cost Reporting Years in Appeal (Part A Only)	If not Part A workload, list N/A	
Tier I	Pending Cost Report Reopening(s) (Y/N)? (Part A Only)		
Tier I	Any Fraud Overpayments or Investigations (Y/N)?	CPI Fraud Check Request	
Tier I	Date of fraud cases, if applicable	CPI Fraud Check Request	
Tier I	Evidence of a Recent or Pending CHOW (Y/N)?	Recent = Within a year of the Petition Date	

140.2 - Basic Bankruptcy Terms and Definitions

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

The definitions below are generally accepted. Jurisdictional bankruptcy rules may impact the interpretation of these terms. CMS Counsel's guidance takes precedence over definitions listed below.

***Adversary Proceeding** is litigation in bankruptcy court to recover money or property; determine the validity, priority or ranking of an interest in property; get approval for selling an estate's property interest; revoke a discharge or an order of confirmation; and obtain declaratory judgments related to matters of the bankruptcy estate. Litigation against the CMS to turn over recouped monies is an example of an adversary proceeding.*

***Affirmative Recovery Actions** is the debtor's assumption of its executory contract (its provider agreement).*

***Automatic Stay** is an injunction that automatically springs into effect concurrently with the filing of the bankruptcy petition. The automatic stay protects the assets of the estate from lawsuits, foreclosures, garnishments, and any other collection activities that are not specifically exempt from the stay by statute or specifically approved by the bankruptcy court. The automatic stay applies to Medicare overpayment letters that demand repayment, assess interest or otherwise attempt to gain possession of property of the bankruptcy estate.*

***Bankruptcy Trustee** is a private individual or corporation appointed to represent the interests of the bankruptcy estate and the debtor's creditors.*

Bar Date *is the deadline for filing a proof of claim. In general, the bar date for government agencies such as the CMS is 180 days after the date of the order for relief (usually, the date the provider files for bankruptcy). In some bankruptcies, however, the court may set a different date.*

Claim *is the creditor's right to payment or equitable relief creating a right to payment from a debtor or the debtor's property whether that right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured or unsecured. The date a claim arises determines whether it is pre-petition or post-petition. In Medicare, the date of service is the date of the claim.*

Confirmation *is bankruptcy court approval of a plan of reorganization.*

Contingent Claim *is a claim that may be owed by the debtor under certain circumstances, for example, where the debtor is a co-signer on another person's loan and that person has not yet defaulted but may fail to pay.*

Creditor *is a person or a business to which the debtor owes money, or which claims to be owed money by the debtor.*

Debtor *is a person or business who has filed a bankruptcy petition.*

Discharge *is a release of a debtor from liability for certain dischargeable debts. It prevents the creditors that are owed those debts from taking any action to collect those debts from the debtor or the debtor's property. Prohibited actions include making telephone calls, sending letters, and having contact that is intended to induce the debtor to pay the debt.*

Dischargeable Debt *is a debt for which the Bankruptcy Code allows the debtor's personal liability to be eliminated.*

Dismiss *does not release a debtor from liability on any debts. It does not prevent creditors that are owed those debts from taking appropriate action to collect those debts from the debtor or the debtor's property. When a case is dismissed, it is as if the debtor never filed. Therefore, you may proceed with actions that include making telephone calls, sending demand letters, and having contact that is intended to induce the debtor to pay the debt.*

Estate *is the name for the Debtor's property interests overseen by the bankruptcy court. Filing a petition in bankruptcy creates an estate consisting of all legal and equitable interests the Debtor has. In general, a legal interest is direct ownership of property. In contrast, an equitable interest typically is indirect and may require court involvement to obtain control or exercise the property rights.*

Executory Contract *is a contract under which the parties to an agreement have duties remaining to be performed. A Medicare Part A provider agreement is treated as an executory contract.*

Exemption *is property that the Bankruptcy Code or applicable State law permits a debtor to keep from creditors.*

Fraudulent Transfer *is a known and fraudulent transfer or concealment of property by the debtor with the intent to defeat the provisions of the Bankruptcy Code.*

Lien *is a recorded claim upon specific property to secure payment of a specific debt or performance of an obligation. Medicare does not have a lien on overpayments.*

Liquidation *is the conversion of the debtor's property into cash with the proceeds to be used for the benefit of creditors.*

Liquidated Claim *is a creditor's claim for a fixed amount of money.*

Motion to Lift the Automatic Stay *is a request by a creditor to allow the creditor to take an action against a debtor or the debtor's property that would otherwise be prohibited by the automatic stay.*

Non-Dischargeable Debt *is a debt that cannot be eliminated in bankruptcy. Overpayments resulting from fraud are non-dischargeable. A complaint to determine discharge ability must be filed in the bankruptcy court. See Adversarial Proceeding, above.*

Plan of Reorganization *is a debtor's detailed description of how the debtor proposes to pay creditors' claims over a fixed period of time.*

Priority *is the Bankruptcy Code's statutory ranking of unsecured claims. It determines the order in which unsecured claims will be paid if there is not enough money to pay all unsecured claims in full.*

Priority Claim *is an unsecured claim that is entitled to be paid ahead of other unsecured claims that are not entitled to priority status. Administrative expenses for preserving the estate (e.g., certain accounting fees or post-petition Medicare overpayments) are considered priority claims.*

Secured Debt *is a debt backed by a mortgage, pledged collateral, or another lien. The creditor that has a secured debt has the right to pursue specific pledged property upon default. See lien above.*

Schedule *is a list submitted by the debtor along with the petition (or shortly thereafter) showing the debtor's assets, liabilities, and other financial information. (There are official forms a debtor must use.)*

Settlement Agreement *is an agreement settling a dispute between two or more parties.*

Stipulation *is an agreement between parties respecting the conduct of legal proceedings approved by the Bankruptcy Court. With appropriate approval, Medicare may enter into a stipulation agreement to facilitate a change of ownership or to resolve an overpayment earlier than could be expected by litigation.*

United States Trustee *is an officer of the Department of Justice responsible for supervising the administration of bankruptcy cases, estates, and trustees, monitoring plans and disclosure statements, monitoring creditors' committees, monitoring fee applications, and performing other statutory duties.*

Unsecured debt *is one that is not backed by property or collateral. Medicare claims are generally unsecured.*

140.2.1 - Bankruptcy is Litigation

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

An individual or company declares bankruptcy by filing a petition for bankruptcy in a United States Bankruptcy Court. The Bankruptcy Court then opens a bankruptcy case. The Bankruptcy Court closely monitors the affairs of the individual or company (the debtor) including the creditors' treatment of the debtor. Bankruptcy may appear to be "business as usual" for a debtor, **but it is not.** *Upon receipt of a bankruptcy notice, Contractors must place the provider in a bankruptcy status in HIGLAS and refer the case to the CMS Office. Contractors* should not take **any** *further action* against a debtor until *they* consult the *servicing CMS Office* who will consult with the *CMS Counsel assigned* the bankruptcy. Do not share any information about bankruptcy *strategies* or activities with the bankrupt provider.

140.2.2 - Types of Bankruptcies

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

Title 11 of the United States Code (the Bankruptcy Code) identifies four types of bankruptcies that may involve Medicare providers: Chapter 7, 9, 11 and 13. We briefly describe each type here to familiarize *the Contractor* with these types of bankruptcy. However, these general descriptions do not replace your attorney's specific advice in a particular bankruptcy case.

1. Chapter 7 - Debtors file Chapter 7 bankruptcies to obtain discharge of their debts. Companies that file under Chapter 7 generally close. A court-appointed trustee accumulates the assets of the debtor, sells them, and distributes the money among those whom the debtor owes (the creditors).

2. Chapter 9 - Chapter 9 bankruptcies involve municipalities, *including entities such as* hospital *districts. In a Chapter 9 case, the municipal entity itself – rather than the individual hospitals it operates – is eligible for bankruptcy relief. Chapter 9* provides for reorganization, much like Chapter 11.

3. Chapter 11 - Debtors file Chapter 11 to reorganize *a business or, in some cases, an individual's financial affairs.* To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan")*, which specifies* the amount and schedule *of* payments to creditors. Creditors *whose claims are impaired under the Plan are entitled to vote on it, while creditors whose claims are unimpaired are deemed to accept the Plan. The Bankruptcy* Court must confirm *the Plan before it becomes effective.* Recovery amounts vary*, and once the Plan is confirmed, the* Bankruptcy Code provides for discharge of the *remaining debt, subject to certain exceptions.*

4. Chapter 13 - Chapter 13 bankruptcies *allow individuals* (including sole proprietorships) with regular income *to adjust their debts.* Generally, debtors must file a *repayment* plan within 15 days after filing *the petition. The Chapter 13 plan typically extends over a period of three to five years, during which the debtor makes regular payments to a trustee for distribution to creditors.*

140.2.3 - Filing Bankruptcy Draws a Line in the Sand

(Rev. 13825; Issued: 06-11-26; Effective:07-13-26; Implementation: 07-13-26)

The petition date (i.e., the date the debtor files its petition in bankruptcy with the Bankruptcy Court) draws a line in the sand between pre-petition and *post-petition* actions. Events that occur before the petition date are pre-petition. Events that occur on or after the petition date are *post- petition.* The automatic stay governs many actions that *Contractors* may take concerning a debtor *post-petition.*

Contractors shall therefore consult with the *servicing CMS Office* before taking action, concerning the debtor *post-petition.*

Medicare's right to recover overpayments *in a bankruptcy* case *can* depend on whether the *overpayment relates to* pre-petition or *post-petition periods.* The *CMS Office directs its Contractors* on *the procedures for recovering both* pre-petition *and post-petition overpayments to ensure that Medicare maximizes its recovery in accordance with the Bankruptcy Code. The distinction between pre-petition and post-petition overpayments is based on the date of service, not the date of the demand for repayment. Additionally, the ability of Medicare to recover overpayments may vary depending on the district in which the bankruptcy is filed, as courts in different jurisdictions can interpret and apply bankruptcy and Medicare recovery rules differently.*

140.2.4 Bankruptcy Affects Nearly All Medicare Operations

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Bankruptcy can affect every aspect of the interaction between the Medicare program and a debtor. Each *Contractor* staff member who may *encounter* a debtor, is effectively a part of the Medicare "bankruptcy team" for that case. *The Contractor* point of contact must ensure that all potential bankruptcy team members *notify the servicing CMS Office of any* anticipated actions *regarding* the debtor *and* coordinate those actions with the *CMS Bankruptcy Analyst or the assigned CMS* Counsel. In bankruptcy, **both** inaction and inappropriate action hurt Medicare's chances of recovery. Some commonly affected areas are:

1. *Overpayment* Recovery

Medicare's right to recover pre-petition and *post-petition* overpayments varies by federal jurisdiction. (see discussion on set-off and recoupment in section F below). If the Contractor has overpaid a debtor, they shall consult the *servicing CMS Office and* take appropriate action to maximize recovery of Medicare overpayments. *Contractor* overpayment staff shall not send any *manual* letters to the debtor until the *CMS Office* approves them for release, *with the exception of NPRs and revised NPRs.*

2. *Fraud* and Abuse

The Contractor shall ensure consultation with *the* CMS Program Integrity staff and the *CMS Bankruptcy Analyst* before *suspending* an entity for fraud and/or abuse, recovering fraud overpayments, or continue suspensions. If there is evidence that the provider filed for bankruptcy due to fraud it committed, advise the *CMS Bankruptcy Analyst* handling the bankruptcy.

3. *Reimbursement*

Contractor reimbursement staff *shall suspend payments if the provider does not timely file a cost report, unless the CMS Office or CMS Counsel contacts the Contractor that suspension is not appropriate due to circumstances requiring further review.* **DO NOT** issue tentative settlement payments in bankruptcy cases unless explicitly requested by the *CMS Office*.

Unless otherwise directed, *Contractor* reimbursement staff should continue to review and audit cost reports *following their* usual *procedures*. *The CMS Office will inform the Contractor of any stipulations or settlements that may affect the review or audit process. In such situations, the CMS Office will evaluate the costs and benefits of auditing cost reports when recovery is unlikely and will provide appropriate guidance.*

Contractors are no longer required to submit notices of program reimbursement *(NPRs) or revised NPRs* to the *CMS Office* for review *and approval when dealing with bankrupt providers. However, if the CMS Office determines that a bankruptcy case is unique or exceptional, it will provide written direction requesting the Contractor to submit NPRs or revised NPRs for the CMS Office's review and approval prior to issuance to the provider.*

Once a final cost report settlement has been determined, Contractors shall ensure the required language is included in the NPR or revised NPR before issuing it to the provider. If needed, Contractors may contact the CMS Office to confirm any necessary actions for proper handling of the determination in the Health Integrated General Ledger Accounting System (HIGLAS).

a. Cost Report Overpayment Letters shall include the following language:

Note: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please follow the instructions found at the end of this letter.

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. Nothing in this letter should be considered as a request or demand for payment. 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 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, the docket number, and the district where the bankruptcy is filed.

If you have already notified CMS of the bankruptcy, the purpose of this letter is to inform you of the overpayment owed to Medicare. Due to the automatic stay in bankruptcy, this letter does not demand that you submit payment at this time. Because of the bankruptcy, recovery of Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process, and pursuant to applicable jurisdictional and other provisions of the Medicare Act and regulations. Please note that in bankruptcy, CMS may still exercise recoupment rights, which constitute a defense to payment. Thus, we do not believe that the bankruptcy petition prohibits Medicare's recoupment rights, subject to the limitation on Medicare recoupment at section 1893(f)(2) of the Social Security Act and the implementing regulations at 42 C.F.R. § 405.379.

If you dispute this overpayment determination, please follow the appropriate rebuttal and/or appeals process described elsewhere in this letter.

To the extent any of the general instructions in this letter is not consistent with the bankruptcy law and procedures, they may be modified to comport with bankruptcy law.

b. Cost Report Underpayment Letters shall include the following language:

Note: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please follow the instructions found at the end of this letter.

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. Nothing in this letter should be considered as a request or demand for payment. 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 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, the docket number, and the district where the bankruptcy is filed.

If you have already notified CMS of the bankruptcy, the purpose of this letter is to inform you of the underpayment amount. Because of the bankruptcy, recovery of Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process, and pursuant to applicable jurisdictional and other provisions of the Medicare Act and regulations. Please note that in bankruptcy, CMS may still exercise recoupment rights, which constitute a defense to payment. Thus, we do not believe that the bankruptcy petition prohibits Medicare's recoupment rights, subject to the limitation on Medicare recoupment at section 1893(f)(2) of the Social Security Act and the implementing regulations at 42 C.F.R. § 405.379.

If you dispute this underpayment determination, please follow the appropriate rebuttal and/or appeals process described elsewhere in this letter.

To the extent any of the general instructions in this letter is not consistent with the bankruptcy law and procedures, they may be modified to comport with bankruptcy law.

4. ***Payment***

Contractor payment staff must receive approval from the *CMS Office* before taking any action that changes the amounts payable or owed by a debtor.

5. ***Appeals***

Contractor staff will be asked about *any* recent *or ongoing appeals involving a provider in bankruptcy, including Redeterminations, Qualified Independent Contractor (QIC) reviews, Administrative Law Judge (ALJ) hearings, Provider Reimbursement Review Board (PRRB) cases and Department Appeal Board (DAB) cases.*

The Contractor should keep the CMS Office or CMS Counsel informed of material developments related to appeals activity in bankruptcy cases that become known to it in the course of its operational responsibilities that may affect the overpayment amount or CMS' proof of claim.

If an appeal decision is favorable to the provider and reduces the overpayment amount, CMS or CMS Counsel may determine that amendment of the proof of claim is required. In some cases, the CMS Office may also direct the contractor to suspend or freeze outgoing funds.

6. *Change* of Ownership *(CHOW)*

A debtor may attempt to transfer provider agreements so that both parties may avoid overpayment recovery. The Center for Clinical Standards and Quality *(CCSQ)* staff will notify *the servicing CMS Office* when a debtor provider files for a *CHOW and* immediately notify the *CMS* Counsel who is *assigned* the bankruptcy. The CHOW will not be processed until the *CCSQ Office* obtains the concurrence of the *CMS* Counsel *assigned* the bankruptcy. *In addition to CCSQ, the Medicare Administrative Contractor's provider enrollment staff and the Provider Enrollment Operations Group (PEOG) within CPI also coordinate with the CMS Office assigned to the bankruptcy upon learning that a debtor provider has initiated or plans to initiate a CHOW.*

140.2.5 - Recoupment and Set-off *(see also §140.6.4)*

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Recoupment and set-off are two of Medicare's *primary* tools for recovering overpayments *from* debtor providers, *but these terms may be used differently in other federal contexts, including under the Federal Claims Collection Act. In bankruptcy,* jurisdictions vary in their decisions about how Medicare can use these tools. Some jurisdictions consider the Medicare *Part* A provider agreement one contract/transaction and allow it to be the basis for broad powers of recoupment. Other jurisdictions consider each cost report year as a distinct contract and restrict recoupment to periods within a particular cost report year. *The CMS Office/CMS* Counsel can advise *the Contractor* whether current law in a *specified* jurisdiction permits recoupment.

1. *Recoupment*

Recoupment permits a party to reduce current payments to account for prior overpayments made under the same contract or transaction. Recoupment permits adjustment across the petition date and does not require approval of the bankruptcy court. Therefore, Medicare should recoup in any jurisdiction where it is permitted.

2. Set-off

If recoupment is not permitted, set-off will be considered. Medicare must take quick action to recover overpayments using set-off. Set-off should not take place without specific instructions by the *CMS Office or CMS Counsel.*

Set-off permits making similar adjustments in situations involving one or more contracts or transactions. For example, suppose B owes A $40.00 under one contract and A owes B $50.00 under another contract. If set-off is *allowed*, then A can take her $40 from the $50 she is holding for B (A would only pay B $10.00). Generally, parties can request court permission to set-off. If allowed, parties can set-off pre-petition claims against pre-petition payments or *post-petition* claims against *post-petition* payments. They cannot set-off pre-petition claims against *post-petition* claims.

3. Administrative Freeze

Once it is discovered that a provider is in bankruptcy, Medicare can enact a **temporary** administrative freeze. An administrative freeze (sometimes called a Strumpf freeze, named after a Supreme Court case) will allow time for Medicare to determine if there are any overpayments and to ask the bankruptcy court to allow set-off. Speed is essential because courts do not permit set-off across the petition date. A pre-petition overpayment can only be set-off against a pre-petition claim.

140.2.6 - Time is of the Essence -
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Upon receiving credible information regarding an impending bankruptcy, the Contractor shall immediately notify the CMS *Office or* CMS Counsel. This notification is essential to avoid forfeiting the opportunity to recover Medicare overpayments. It is imperative not to wait for formal notice, and do not assume that someone else has notified CMS, as timely communication is crucial. Various sources may provide early bankruptcy information such as the Internet, newspapers, trade journals, and business magazines. *Contractors shall send information regarding an imminent provider/s bankruptcy to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov.*

140.3 - *Contractors* Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.3.1 - *Contractor* Staff Must Establish Relationships to Ensure That the *CMS Office and CMS* Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

The *Contractor* may receive notice of a bankruptcy from many sources including the provider, other *Medicare Administrative Contractors,* the State, the *CMS CCSQ,* or *CMS* Counsel. It is imperative that *Contractor* staff act quickly when a provider files for bankruptcy in order for CMS to meet filing deadlines in the bankruptcy court. Therefore, *Contractor* staff must establish relationships to ensure that they receive information promptly about provider bankruptcies. *Contractors shall send a notification of bankruptcy to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov*

140.3.2 - *Contractors* Must Recognize and Advise *CMS* Staff About Potential Provider Bankruptcies
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Contractor staff must be alert to news or notices of bankruptcy and notify *CMS* staff immediately. *Contractor* staff should alert the *CMS staff* to all potential bankruptcies *to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov*

Bankruptcy warning signs for *Contractors* (indications that a provider is experiencing financial difficulty, and may file for bankruptcy):

1. Frequent unfiled or late-filed cost reports.
2. Failure to make timely payments on an extended repayment plan schedule.
3. Frequent changes of ownership.
4. Litigation
5. Voluntary or involuntary termination from the Medicare Program.
6. Provider has difficulty meeting payroll.

7. History of significant overpayment determinations.

8. Significant decline in Medicare and/or total patient census.

If the Contractor sees multiple early warning signs, contact the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov

140.3.3 - *Contractor* Staff will Establish a Relationship *with* the *CMS Office* that *has Jurisdiction Over the* Bankruptcy

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Contractors shall proactively establish *a relationship with* the *CMS Office* that *handles bankruptcy cases.* This is important because bankruptcy *laws* may differ significantly from one jurisdiction to another, due to the structure of the federal court system.

In the federal system, a party may appeal *lower-level* court decisions to a higher court, which has the power to affirm or reverse the lower court. In order of increasing rank and authority, the federal system is comprised of Bankruptcy Courts, District Courts, Courts of Appeals, and the Supreme Court. Each court *on* this list generally hears appeals from the court immediately preceding it. Although the Supreme Court has the final word, it hears a highly limited number of cases each year. This permits conflicts between lower court decisions to continue for many years until they are resolved by the Supreme Court.

As a result, absent a Supreme Court decision, the most authoritative precedents that may exist (and which may conflict with one another) are issued by the Courts of Appeals. There are 11 Courts of Appeals (known as Circuits) covering various States, plus a District of Columbia Circuit. The decision of each Court of Appeals is *controlled* within the States covered by that Circuit.

As discussed in greater detail below, *the* CMS may want to take different actions in a bankruptcy case for different providers, including suspending payments, or recouping overpayments. In addition, *the* CMS may have taken such actions before the provider filed for bankruptcy. Whether *the* CMS can legally take or leave in place such actions may well depend on where the provider filed for bankruptcy, and the existing legal precedents within that Circuit.

For example, at the time of this writing there is conflict in the Circuits about whether *the* CMS may recoup pre-petition overpayments from *post-petition* payments without obtaining *relief* from the automatic stay. The Third Circuit (covering **Pennsylvania, New Jersey, *Delaware*, and the Virgin Islands**) forbids recoupment over different fiscal years without such relief. By contrast, the Ninth Circuit (**Alaska, Arizona, California, Guam, Hawaii, Idaho, Nevada, *Oregon*, and Washington**) and the District of Columbia Circuit permit such recoupment. No other Court of Appeals has decided the issue. There are various District Court decisions going both ways.

There are also conflicting decisions by District Courts on whether *the* CMS may continue to suspend payments due to suspected fraud when the provider files for bankruptcy.
For these reasons, the *Contractors shall* neither initiate nor discontinue significant action affecting payment without first contacting *the CMS Office.*

140.3.4 - *The CMS Office Jurisdiction* Generally Parallels the Bankruptcy Court Where Case is Filed

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

In most cases, the RO which has jurisdiction over a bankruptcy case is the one which has jurisdiction over the State in which the debtor files for bankruptcy (bankruptcy is filed in federal court). This RO will usually be the lead RO. The RO will contact the contractor.

The ROs will review each bankruptcy, even when no current overpayments exist, since the possibility of overpayment determinations remains until the FI settles all cost reports. Medicare is an unsecured creditor in bankruptcy, and is among the last creditors to receive a distribution of funds, unless it takes proactive steps to protect Medicare's interests.

140.3.5 - *Contractor* and *the CMS Office* Bankruptcy Point of Contact Staff Member

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

The contractors should contact their home RO to determine which RO will have responsibility for the bankruptcy case. The RO point of contact may be at the RO level or the Consortium level in keeping with Consortium agreements. The RO point of contact will consolidate information and manage, report, and coordinate ongoing communication and activities among the appropriate involved parties (e.g., contractors, other ROs, Chief Counsels, and Central Office) regarding bankruptcies. The RO will communicate the name, phone number, fax and e-mail address of the point of contact in writing or via e-mail to the Accounting Management Group, Regional Counsel, and the affected Associate Regional Administrators for Financial Management and respective contractors.

140.4 - Actions to Take When a Provider Files for Bankruptcy

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.4.1 - Establish *Effective* Lines of Communications

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Upon becoming aware that a provider has filed for bankruptcy, the Contractor shall immediately inform the OPOLE IFM Bankruptcy team via email at OPOLE_IFM_Bankruptcy@cms.hhs.gov *as soon as practicable, but no later than two (2) business days following such awareness.*

Timely communication is critical due to court-imposed deadlines and the potential impact on Medicare's recovery rights.

The CMS Office will inform the Contractor of the CMS Bankruptcy Analyst assigned to the case. The Contractor can coordinate with the assigned analyst regarding matters related to the bankrupt provider.

140.4.2 - Respond to *the CMS Office* Requests for Information

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Upon receiving notification of a new bankruptcy, the Contractor shall prepare a Bankruptcy Referral Checklist. The checklist is now divided into two (2) tiers, each designed to gather the bankruptcy information. The Contractor shall refer to Section 140.1 – Bankruptcy forms - for information required to be submitted to the CMS Office.

140.4.3 - Immediate *Contractor* Directives *from* the *CMS Office*

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

The *assigned CMS Office* will give the *Contractor* the following guidance as soon as *the provider* files for bankruptcy.

1. The *CMS Office* will notify the *Contractor* of Provider Bankruptcy/Litigation.

a. Bankruptcy Filed

The *servicing CMS Office* will inform the *Contractor* that *CMS* has opened a bankruptcy case. *The CMS Office* will inform the *Contractor* that it *shall* clear any future actions concerning the bankrupt provider(s) through the *CMS Office*.

b. Bankruptcy Filing Date.

The *servicing CMS Office shall* notify the *Contractor* of the bankruptcy filing date, since it impacts actions that the *Contractor* can take and the evaluation of whether payments are pre-petition or *post-petition*.

c. Immediate response to requests.

Since bankruptcy has *court-imposed* deadlines, the *Contractor shall* take immediate action whenever the *CMS Office* or *CMS* Counsel makes a request.

d. Obtain approval of all correspondence to provider.

The *Contractor shall* submit all correspondence *that is not system generated* to the *servicing CMS Office* for approval prior to release*, except for routine cost report settlement letters (e.g. NPRs or revised NPRs), unless the CMS Office has directed that such correspondence be submitted for review due to the unique or exceptional nature of the bankruptcy case*. The *servicing CMS Office* will *modify all manual letters, obtain CMS Counsel approval, and will inform the Contractor of the final copy of the letter that shall be released to the bankrupt provider.*

e. The Servicing CMS Office

The servicing CMS Office will provide the *Contractor* with a contact name and telephone number. The *CMS Bankruptcy Analyst* that *provides oversight to* the *Contractor* may need to continue to assist the *Contractor* in an advisory role.

2. *The CMS Office* Will Notify *the Contractor* of Immediate Actions It Must Take.

a. Interim Rate Adjustment.

After consultation with *the CMS Counsel*, *the CMS Office* will direct the *Contractor* to immediately perform an interim rate adjustment to ensure that payments are accurate and that no future overpayments occur. (Medicare *Financial Management* Manual §2760.1(C.). 42 CFR §413.64(i).

b. Recoupment.

The CMS Office will inform the *Contractor* (after discussion with *the CMS Counsel*) whether it should continue or cease any current recovery action.

c. Administrative Freeze.

The CMS Office will inform the *Contractor* (after discussion with *the CMS* Counsel) *whether* it should place payments in administrative freeze.

3. Actions *the Contractor* Must Take on an Ongoing Basis.

a. Expedite Cost Report Settlement

The CMS Office will *instruct* the *Contractor* to expedite the settlement of any open cost reports. *The CMS Office* will caution the *Contractor* not to *issue any tentative settlement payments* unless explicitly requested by the *CMS Office* (in consultation with *the CMS* Counsel). *The Contractor can issue final settlements to the provider without first obtaining permission from the CMS Office* (in consultation with *the CMS* Counsel) *providing there was no formal communication from CMS that the case is unique or exceptional in nature.*

b. *Contractors shall* suspend payments if *the* provider does not timely file *a* cost report.

If the bankrupt provider fails to submit a timely *and* acceptable cost report, immediately notify the *assigned CMS Office or the assigned CMS Counsel* prior to placing the provider in 100% withhold and immediately notify the *CMS Office or the CMS* Counsel *of the actions taken*. When the provider submits an acceptable cost report consult with the *CMS Office or CMS Counsel* prior to release of the withheld funds.

c. Part B - Tracking Refunds

The *Contractor* may need to track voluntary refunds for a bankrupt provider. The *assigned CMS Office* will work with *the CMS* Counsel to determine what information Counsel needs. The *Contractor* should be aware of the impact on beneficiary deductibles and coinsurance in a Part B bankruptcy.

d. *Contractors* should check with *the assigned CMS Office* before making other payments to *the provider.*

It is important that *all Contractors* establish a process to ensure they do not make payments (e.g., underpayments, lump sum payments, or payments resulting from appeals) to bankrupt providers who have outstanding overpayments unless the *CMS Office* (in consultation with *the CMS Counsel*) so *directs*. This is especially critical for *Contractors'* who must continue to settle open cost reports.

4. ***Contractors Shall Track and Report Information to the CMS Office.***

a. Cost Report Settlements and Claims Processed

Contractor staff *should* notify the *CMS Office* promptly of *all* proposed cost report settlements, changes in the amount of determined overpayments or underpayments, and claims processed.

b. Appeals

If a bankrupt provider files an appeal *for* an overpayment, *Contractor* staff must keep *the CMS Office* staff informed on the outcome of the appeal. Appeals may take place at the *Contractor*, with an Administrative Law Judge, or at any *Office* of Hearings and Appeals, at the Provider Reimbursement Review Board, or at Federal District Court. If the appeal is favorable to the provider, it may require *the* CMS *Office or CMS Counsel* to amend its proof of claim because the provider would have a smaller overpayment. Alternatively, in some cases, the *CMS Office* may direct the *Contractor* to freeze any outgoing funds. The *Contractor shall* keep the *CMS Office or CMS* Counsel updated on the status of appeals.

5. Record-Keeping.

a. Interest

The *CMS* will advise the *Contractor* whether it should continue to *accrue* interest for overpayments. Medicare's ability to assess interest varies based on the circumstances of the case. *The CMS Office* will consult with the *CMS* Counsel before determining whether the *Contractor* should make an adjustment. If the bankruptcy is in a district where interest should stop accruing on the petition filing date, the *Contractor* must make an adjustment to remove the interest.

The *Contractor shall* post these adjustments to the *Contractors'* internal systems *and to the Healthcare Integrated General Ledger Accounting System (HIGLAS). The Contractor shall* also post the adjustments to the *Treasury Report on Receivables (TROR).*

b. *HIGLAS* Update

The servicing CMS Office will instruct the *Contractor to update* the *provider in bankruptcy status in HIGLAS and whether recoupment of overpayments is permitted or not permitted.*

- *The Contractor shall allow for recoupment or netting of overpayments if recoupment of overpayments is permitted,*
- *The Contractor shall not allow recoupment or netting of overpayments, if recoupment of overpayments is not permitted.*

c. Bankruptcy Case *at the Contractor*

Once the assigned CMS Office notifies the Contractor of a provider's bankruptcy, the Contractor shall ensure the bankruptcy debt is not referred to Treasury for collection under the Debt Collection Improvement Act.

If any case has already been referred to Treasury – including debts automatically referred through HIGLAS due to delinquency thresholds — the Contractor shall immediately take appropriate action to recall the debt from Treasury upon notification of the bankruptcy.

All bankruptcy debts shall remain at the Contractor for financial reporting purposes. The Contractor is responsible for ensuring that each debt is maintained in a bankruptcy status in HIGLAS and that the correct netting indicator is applied or not applied, consistent with the CMS Office instructions.

Debts will remain with the Contractor until the CMS Office provides direction regarding the resolution of the debt, including whether to resume normal collection activities or proceed with debt closure (e.g. write-off).

d. System for Tracking Audit and Reimbursement (STAR)

If the bankrupt provider participates in the Medicare program under Part A, the Contractor shall ensure that STAR is updated with the effective date of the bankruptcy.

140.4.4 - Tracking Debts/*CMS* Communications

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Financial Reporting. While the *CMS Office* is responsible for managing the bankruptcy case, all bankruptcy debt will remain at the *Contractor* for financial reporting purposes on the *TROR*. *The CMS* staff must work with *Contractor* staff to ensure proper reporting on *the TROR* throughout the bankruptcy.

140.5 - Chain Bankruptcies

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.5.1 - *Chain* Providers

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

A chain provider is one that is owned by the same entity that owns another provider or *provider*. Chain affiliates may include facilities that are public, private, charitable, or proprietary. They may also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based clinics, are not chain affiliates (MFMM § 2760.1).

When a chain files bankruptcy, there may be multiple *Contractors* involved in processing payments for the chain. *The CMS Bankruptcy Analyst, in coordination with CMS Counsel, will oversee the initial bankruptcy case and* work directly with the *Contractors*, informing *them of the proper actions to take with respect to recovering Medicare overpayments.* The *servicing CMS Office* and *CMS* Counsel are responsible for making all decisions *and will communicate with Contractors regarding all aspects of the bankruptcy.*

140.5.2 - Single Provider Serviced *by* a *Contractor*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

When a single provider, who is serviced by a *Contractor, files* for bankruptcy, the same principle for processing a bankruptcy of a chain provider will apply. *The CMS Bankruptcy Analyst, in coordination with CMS Counsel, will oversee the initial bankruptcy case and work directly with the Contractor/s, informing them of the proper actions to take with respect to recovering Medicare overpayments. The servicing CMS Office and CMS Counsel are responsible for making all decisions and will communicate with Contractors regarding all aspects of the bankruptcy.*

140.6 - Affirmative Recovery Actions
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.6.1 - Working With the *CMS Office* and *CMS Counsel*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

The *Contractor notifies* the *servicing CMS Office or the CMS* Counsel's *Office* immediately after it receives information that a provider has filed for bankruptcy. It is essential *for the Contractor to* obtain information on all Part A, Part B, or *Durable Medical Equipment Administrative Contractor* entities involved in the bankruptcy, including Medicare identifying information, such as provider and supplier numbers. If the *Contractor* has difficulty obtaining this information, it will consult with the *CMS Office.* After gathering the information described in §140.4.2, *the Contractor* send*s* to the *servicing CMS Office.*

The *Contractor shall* discuss with *the CMS Office or CMS* Counsel whether it should put payments in an administrative freeze (a holding account) until Medicare has time to assess its position in the bankruptcy. Also, the *CMS Office or CMS Counsel* will determine when the proof of claim is due and whether the *CMS Office* or *CMS Counsel* will need additional information to prepare the proof of claim. The *Contractor* shall share all new information regarding the provider's overpayments and underpayments, cost report settlements, etc. with *the CMS Office or CMS* Counsel *if asked*. The *Contractor can*not take any further steps without obtaining the advice of *the CMS Office and CMS* Counsel.

As the bankruptcy progresses, the *CMS Office and* Counsel may ask the *Contractor* to expedite settlement of cost reports, update the *CMS* Counsel on provider overpayments or underpayments, and provide Counsel with assistance on all aspects of the bankruptcy. As bankruptcy cases often have short deadlines for filing pleadings and other documents, requests from *the CMS Office or CMS* Counsel must have the highest priority in the workload, *to* protect Trust Fund assets.

140.6.2 - Assumption of the *Medicare* Provider Agreement
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

The Medicare Provider Agreement is considered an executory contract for purposes of bankruptcy. Bankruptcy law permits a debtor to affirm ("assume") or reject each of its executory contracts. The debtor must first get the formal approval of the bankruptcy court. If the debtor formally assumes the Medicare provider agreement, and the Bankruptcy Court approves that assumption, the relationship between the provider and Medicare will generally return to the ordinary course of business. The *CMS Office* will inform the *Contractor* if the provider assumes the Provider Agreement.

If the debtor rejects the Provider Agreement, the rejection is a voluntary termination of the Provider Agreement. The *CMS Office* will inform the *Contractor* if the provider terminates its provider agreement in this way. The *Contractor* should not reimburse the provider for services it performs after the date it rejects/terminates the Provider Agreement. If the bankrupt provider sells a facility to another entity and that entity assumes the debtor's provider agreement, any outstanding Medicare underpayments or overpayments regarding that facility should be transferred to the new owner (the purchaser) when the new owner assumes the provider agreement. Although the debtor and the new owner may have a private agreement regarding who is responsible for refunding Medicare overpayments and who should receive any Medicare underpayments, CMS is not bound by such agreements.

The *Contractor* shall calculate net amounts that may be due to or owing from the *debtor*.

140.6.3 - Settlement Agreements *or Stipulations*

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

During a bankruptcy, the *servicing CMS Office* and the *CMS* Counsel, working with *the* DOJ, may negotiate a settlement agreement or stipulation with the debtor's attorney. Once a settlement agreement or stipulation goes into effect, the *CMS Office* will advise all affected *Contractors*, *other CMS Offices*, and the *Office* of Financial Management (CO). The *servicing CMS Office* will consult with the *Contractor* to ensure that they conform to the conditions established in the settlement agreement or stipulation.

140.6.4 - *Recoupment*

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Generally, bankruptcy law prohibits recovery of pre-petition debt (debt arising prior to the filing of the bankruptcy petition) from *post-petition* payments. However, Medicare Part A payments require adjustments of ongoing payments to a provider to account for overpayments previously made to that provider. 42 U.S.C. §1395g(a); §1395x(v)(1)(A). Most courts recognize this method of adjusting payments as recoupment, which is permitted in bankruptcy, and is not subject to the automatic stay. Alternatively, they recognize that bankruptcy law does not alter the adjustment of payments that the Medicare statute requires. Thus, in most *jurisdictions'* recoupment is appropriate. Nevertheless, the *Contractor* always consult *the CMS Office*/*CMS* Counsel's *Office* about the adjustment (or recoupment) of any payments to a bankrupt provider **before *taking, omitting, continuing or discontinuing* any action**. (See also, discussion of Recoupment in §140.2.5).

Some courts do not agree that Medicare can recoup overpayments (without first obtaining relief from the automatic stay*) unless* the provider incurred the overpayments in the current fiscal year. For instance, in bankruptcy cases filed in Pennsylvania, New Jersey, Delaware and the Virgin Islands, Medicare cannot recoup overpayments across fiscal years unless the debtor assumes the Medicare provider agreement or *CMS* Counsel obtains permission from the court. *The servicing CMS Office or CMS* Counsel will advise the *Contractor* whether it can recoup overpayments in these jurisdictions. Again, the *Contractor* consult*s the servicing CMS Office and the CMS Counsel before adjusting or recouping payments to a bankrupt provider.*

140.6.5 - Administrative *Freeze/Set-off*

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

Medicare can ask the court's permission to set-off pre-petition debts against pre-petition payments (payments for pre-petition services, even if made *post-petition*) and *post-petition* debts against *post-petition* payments (payments for *post-petition* services). *CMS* Counsel, through *the DOJ,* will file a motion requesting permission to set-off.

Bankruptcy law allows a creditor like Medicare to freeze payments if it thinks it has the right to set-off those payments. Generally, in the Part A context, the first 2-3 weeks of Medicare payments after a *debtor file* for bankruptcy result*ing* from pre-petition services. Therefore, the *CMS Office* and *CMS* Counsel might decide to freeze all payments for pre-petition services and then request bankruptcy court permission to set-off those payments against pre-petition overpayments. Because there is such a short period during which there might be pre-petition payments available to set-off available to freeze for set-off, it is critical to find out about the bankruptcy and the provider's overpayments quickly.

Other pre-petition payments, such as underpayments or payments delayed because of medical review may be available to set-off against pre-petition overpayments. It is important to notify the *CMS Office* and *CMS* Counsel of any such underpayments or delayed payments.

Finally, because the U.S. Government is considered one creditor in bankruptcy, a Contractor may be asked to freeze pre-petition payments to recover the debts owed by the provider to other government agencies. However, we must use pre-petition payments to recover Medicare overpayments before applying them to debts owed to other agencies.

140.7 - Preparing *and* Filing Proof of Claim

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

CMS provides a working definition of the term "claim" in §140.2. The proof of claim form alerts the court to the existence of Medicare's claim. While exceptions exist, the general rule of thumb is *that* to share in the bankruptcy estate, Medicare must file a proof of claim. *The CMS Office or CMS* Counsel will file the proof of claim. It is critical that *Contractors* produce accurate and detailed overpayment data*, if requested,* to the *CMS Office or CMS* Counsel *to* file a timely proof of claim.

In Chapter 7 and Chapter 13 bankruptcies, the deadline ("bar date") for the Government to file a proof of claim is 180 days after the bankruptcy court's order granting relief from creditors (usually the date the provider files for bankruptcy). The bankruptcy court establishes the bar date by court order in Chapter 9 and Chapter 11 bankruptcies. *To* meet the bar *date,* the Government must:

1. Get notice of the bankruptcy
2. Direct that notice to the appropriate agency and appropriate personnel
3. Determine exactly how many payment agreements the entity in bankruptcy has with Medicare (i.e., do they owe Medicare and if *so,* how much)
4. Determine the status of each payment agreement
5. Prepare the proof of claim form
6. Get *CMS* Counsel approval
7. Sign it; and
8. File it in the bankruptcy court

Because the time to finalize a proof of claim can be short, *the Contractors* update overpayment information *as requested*.

140.8 - *Reserved for Future Use*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.8.1 - *Reserved for Future Use*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

140.8.2 - Debt Located at the *Department of Treasury*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

If a debt is *located* at the *Department of Treasury (Treasury) for cross-servicing* and the provider files for bankruptcy, the *servicing Contractor* must immediately notify *Treasury*. The *Contractor shall* recall *the* debt from *Treasury* as debts in bankruptcy status are ineligible for *cross servicing* and offset.

If the Treasury receives the initial notification of a bankruptcy filing while servicing a debt, they will notify the Contractor, who, in turn, will notify the servicing CMS Office of the bankruptcy.

NOTE: Debts for unfiled cost reports are not reported on the *TROR*, therefore, if these debts become "bankrupt," *the Contractor shall* record no transaction on these forms.

140.8.3 - Managing Bankruptcy Debt at the *Contractor*
(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

All bankruptcy debts *shall* remain at the *Contractor* throughout the life of the debt. The *servicing CMS Office* will assume full ownership and responsibility for managing the debt at the *Contractor*. *The Contractor and* the *servicing CMS Office* establish communication procedures *to* ensure *the Contractor* staff *adhere to the procedures.*

When chain providers are involved, the servicing CMS Office will contact the necessary contractors and set up procedures for timely and accurate information transfer as requested.

During the bankruptcy, the Contractor is required to periodically review the Medicare Provider Bankruptcy Dashboard within the HIGLAS Business Intelligence (HBI). This review ensures that any transactions with discrepancies between the accounts receivable (AR) bankruptcy status and the Provider or Customer bankruptcy status are addressed and resolved. For instance, if a provider is in a bankruptcy status at the customer level and there are AR transactions not in a bankruptcy status, the Contractor investigates the discrepancy to determine if the AR transactions should be placed in a bankruptcy status.

The Contractor shall research and rectify the issue when a provider has a bankruptcy in a hold status, in the Accounts Payable (AP) module but no bankruptcy status in the AR module.

The HBI Data Dictionary is available for Contractors as a source of information to understand the definitions of the fields on the Medicare Provider Bankruptcy Dashboard. The Data Dictionary also

describes the situations that need to be researched and resolved by the Contractor in coordination with the CMS Office.

The *CMS Office or CMS Counsel* is responsible for management of the debt from the initial *petition date through filing* of the Proof of Claim*, and* the closure of the Bankruptcy. The *Group Director or Deputy Group Director* for the *Financial Operations & Oversight Group* will have the authority to terminate collection activity for cases that meet the criteria for being written off at the *Group Director or Deputy Group Director* level.

140.8.4 - Closure of Bankruptcy Cases and Treatment of Overpayment Reporting Systems at End of Bankruptcy

(Rev. 13825; Issued: 06-11-26; Effective: 07-13-26; Implementation: 07-13-26)

After a bankruptcy case is fully administered and the court discharges the trustee (if applicable), the bankruptcy court closes the case. Chapter 11 bankruptcy usually ends with a confirmed reorganization plan, beginning on the plan's "effective date", while Chapter 7 concludes when the Trustee dissolves the corporation, ends operations, and distributes assets to creditors. The CMS Office or CMS Counsel will provide specific guidance to the Contractor on required actions and resolving any remaining unpaid debts when a bankruptcy case closes.

When a bankruptcy case closes, whether Chapter 11, or a proceeding under some other chapter of the bankruptcy code, the Contractor must modify its financial records to reflect the outcome of the bankruptcy. In general, amounts that the bankruptcy court does not require the provider to repay are considered "discharged," and Medicare must release the provider from liability for the debt. All the Contractors debt information must incorporate the bankruptcy outcome by writing off or resuming normal collection of debts.

The Contractors are responsible to maintain detailed support for all revisions, as well as for any extended repayment arrangements. Detailed documentation related to principal, interest charges, immediate recoupment and extended repayment plans without interest are especially important in global settlement adjustments which are common in some bankruptcy situations. These amounts may need to be modified based on the global settlement. In global settlements which may cut across providers in a chain, existing amounts may be removed from the provider listing and the new amount(s) substituted in accordance with the bankruptcy documents. This will require close coordination among the CMS Counsel, the CMS Office, CO and affected Contractor staff. Coordination and immediate action are especially important if it is discovered that a bankruptcy discharge for a provider has occurred in a previously unknown bankruptcy proceeding.

Occasionally, the court dismisses a bankruptcy because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of CMS Counsel, the CMS Office and Contractor can usually treat the case as if the bankruptcy had never occurred and continue the normal recovery process, which might include an "intent to refer" letter and subsequent transfer to Treasury. ***Contractors shall ensure that their internal processing systems and financial reports no longer reflect the case as one under bankruptcy, and interest should be reassessed upon termination of the case.***

Always contact the CMS Office or CMS Counsel for guidance on the closure of a bankruptcy. There is no standard formula for closing a bankruptcy, as it all depends upon the nature of the proceedings and the court orders in the case. The closure could be preceded by a successful reorganization under Chapter 11, a conversion to Chapter 7, or the result of a settlement agreement or stipulation. In all cases, obtain approval from the CMS Office or CMS Counsel before closing the bankruptcy.

The servicing CMS Office instructs the Contractor on how to resolve unpaid debts after a bankruptcy case closes. If the court terminates the bankruptcy case, without a discharge entered, the CMS Office may direct the Contractor to resume collection of overpayments, including referring unpaid debts to Treasury. ***For Treasury-eligible debts, the Contractor shall update the AR Status to 'RESUME-COL-BNK-TERMINATED' on transactions emerging from bankruptcy.***

Note: This status code informs the Treasury to override the bankruptcy status and continue the normal collection process.

If the court concludes the bankruptcy case, with a discharge entered, the CMS Office will review the debts to determine if the discharge is applicable. If the discharge applies, either the Group Director or Deputy Group Director for the Financial Operations & Oversight Group will have the authority to terminate collection activity for cases that qualify to be written off at their respective level.

Contractors shall update STAR, for providers classified under Part A, to reflect the bankruptcy termination date. *This ensures the continuation of the standard cost report settlement process without requiring manual referral of settlement letters to the CMS Office, unless otherwise directed by specific instructions from the CMS Office to halt the auditing of cost reports.*

150 - ACCELERATED PAYMENTS- FI ONLY
(Rev. 29, 01-02-04)

An accelerated payment may be issued where there is:

- A delay in payment by the FI for covered services rendered to beneficiaries and this delay has caused financial difficulties for the provider,

- In highly exceptional situations where a provider has incurred a temporary delay in its bill processing beyond the provider's normal billing cycle, or

- In highly exceptional situations where CMS deems an accelerated payment is appropriate.

A request for an accelerated payment shall not be approved unless the provider meets all eligibility requirements, including an assurance that recoupment of the payment will be made on a timely basis. The amount of the accelerated payment is computed as a percentage (sufficient to alleviate the impaired cash position but in no case to exceed 70 percent) of the amount of net reimbursement represented by unbilled discharges or unpaid bills applicable to covered services rendered to beneficiaries.

Accelerated payments shall be approved by the FI and the appropriate regional office. The regional office will review each request for an accelerated payment to assure that the accelerated payment provisions are being correctly and consistently applied and to provide the Administration with timely information concerning provider and FI bill processing.

150.1 - Eligibility for Accelerated Payment
(Rev. 29, 01-02-04)

Provider eligibility for accelerated payments is contingent on the provider meeting all of the following conditions;

- A shortage of cash exists whereby the provider cannot meet current financial obligations; and
- The impaired cash position described in "A" is due to abnormal delays in claims processing and/or payment by the FI. However, request for accelerated payments based on isolated temporary provider billing delays may also be approved where the delay is for a period of time beyond the provider's normal billing cycle. In this instance, the provider must assure and demonstrate that the causes of its billing delays are being corrected and are not chronic; and
- The provider's impaired cash position would not be alleviated by receipts anticipated within 30 days which would enable the provider to meet current financial obligations; and
- The basis for financial difficulty is due to a lag in Medicare billing and/or payments and not to other third-party payers or private patients; and
- The FI is assured that recovery of the payment can be accomplished according to the instructions in §150.4.

NOTE: Each FI is cautioned that neither the revision of the current financing regulations nor the recovery of current financing payments is a basis for justifying a provider's request for an accelerated payment.

150.2- Computation of the Accelerated Payment

(Rev. 29, 01-02-04)
To compute the accelerated payment on account:

1. Determine the amount of the interim reimbursement for unbilled and unpaid claims;

2. Subtract the deductibles and coinsurance amounts, and

3. Multiply by 70% to determine the net reimbursable amount which can be paid to the provider.

150.3 - Recoupment of the Accelerated Payment
(Rev. 227, Issued: 09 17-13, Effective: 10-04-13, Implementation: 10-04-13)

The Medicare Contractor shall attempt to recover any accelerated payment within 90 days after it is issued. To the extent that a delay in the provider's billing process is the basis for the accelerated payment, recoupment is made by a 100 percent withhold against the provider's bills processed by the (Part A) contractor or other monies due the provider after the date of issuance of the accelerated payment. Any remainder is recovered by direct payment by the provider not later than 90 days after issuance of the accelerated payment.

If the payment is necessitated by abnormal delays in claims processing and/or payment by the contractor, recovery by recoupment will be reasonably scheduled to coincide with improvement in the contractor's bill processing situation and such recoupment will not impair the provider's cash position. In this situation, recoupment shall be completed within 90 days of the contractor processing the provider's claims.

If recovery is not complete 90 days after the accelerated payment is issued or 90 days after the contractor begins processing claims, the accelerated payment is considered delinquent. The contractor shall immediately send out an initial demand letter. This letter shall state that 100 percent recoupment by withhold of all payments is in effect and that the recoupment will remain so until the debt is paid in full or acceptable payment arrangements are made.

Contractors shall include the "Intent to Refer" language required to refer the debt to the Treasury Department. (See Chapter 4, §70) Interest shall begin to accrue on the 31st day after the date of the demand letter at the prevailing rate set by the Treasury Department. If the contractor does not hear from the provider within 15 days from the date of the demand letter, the contractor shall attempt to contact the provider by telephone. If the demand letter is returned undeliverable the contractor shall attempt to locate the provider using some of the guidelines set forth in Chapter 4, §10. If the contractor does not hear from the provider within 60 days of the date of the demand letter, the contractor shall input the debt into the Debt Collection System for referral to the Treasury Department for additional collection activity.

SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCLERATED PAYMENT:

1. Provider:_____ Provider Number:_____

Address:_____
_____

2. Contractor: _____

3. Check (a) or (b) if applicable:

Cash balance is seriously impaired due to:

(a) Abnormal delay in Title XVIII claims processing and/or payment by the health insurance Contractor.

(b) Delay in provider billing process of an isolated temporary nature beyond the provider's normal billing cycle and not attributable to other third party payers or private patients.

Note: If 3b is checked the provider should also include a narrative explaining the nature of the problem, how it will be fixed, and the expected duration of the delay.

4. a. General fund cash position for provider as of _____ $_____

b. Anticipated receipts from all sources (exclusive of accelerated payments) in the next 30 days $_____

c. Anticipated expenditures in next 30 days $_____

d. Indicated cash position in next 30 days (a + b – c) $ ____

160 - Debt Close-Out

(Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

The contractor can request close-out for any eligible debt. However, the final decision to close- out any debt must be approved by CMS. (See Chapter 4, §§ 70.16 and 70.17.2)

160.1- Reserved for Future Use

160.2 - Reserved for Future Use

170 – General Overpayment Provisions

(Rev. 29, 01-02-04)

The general overpayment provisions mentioned in this section are important to the overpayment collection process but could not be categorized into another section. Some of these provisions require input from other manual instructions and are only briefly mentioned in this manual. When necessary, another manual reference has been cited for additional information.

170.1 - Offset of Overpayments Against Other Benefits Due – FI

(Rev. 29, 01-02-04)

A. Benefits Payable Under Part B - FI

Where the FI determines that a Part A overpayment has been made to a provider on behalf of a beneficiary, it shall ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (See Medicare Benefit Policy, Chapter 6.) If it appears that Part B benefits are payable, it shall arrange for billings under Part B. It shall use any Part B benefit as an offset against the Part A overpayment.

B. Use of Lifetime Reserve Days - FI

If a Part A overpayment for which a beneficiary is liable was caused by payment for services rendered after exhaustion of benefit period days, the FI shall reduce the amount of the overpayment by the application of the beneficiary's lifetime reserve days, unless the individual elected not to use them. An individual who has been overpaid for services rendered after exhaustion of benefits can elect not to use reserve days only if the individual refunds the overpaid amount. (See Medicare Benefit Policy, Chapter 5.)

170.2 - When the Carrier Does Not Attempt Recovery Action

(Rev. 29, 01-02-04)

The carrier shall not attempt recovery action on individual overpayments if:

A. Total Overpayment Less Than $10

The cost of recovering such a small amount ordinarily exceeds the amount recovered. However, the Carrier shall accept unsolicited overpayment refunds regardless of the amount. See §160.1 for termination of collection action procedures.

B - The Carrier Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless fraud or similar fault is present, a payment determination may not be reopened where the Carrier has not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See Medicare Claims Processing, Chapter 30, Correspondence and Appeals for policies governing the reopening and revision of decisions to allow or disallow a claim.)

C - Payments to Providers for Medically Unnecessary Services or Custodial Care Where Waiver of Liability Applies

Where both the beneficiary and provider were without fault (see Medicare Claims Processing, Chapter 31, Limitation on Liability), the Carrier shall waive liability for the overpayments.

170.3 - Information and Help Obtainable from the Social Security Office (SSO)

(Rev. 29, 01-02-04)

Occasionally, it may be possible for the FI or carrier to get information or help from the local SSO. For instance, if the beneficiary has moved, the SSO may know the new address, or if the beneficiary has died, it may know the administrator of the estate. If the beneficiary takes a check representing an incorrect payment to the SSO, the SSO forwards the check to the FI or carrier. However, the FI or carrier shall not ask the SSO to collect, or indirectly aid in, the collection of an overpayment.

170.4 - Recovery Where Physician or Other Individual Practitioner Is Deceased - Carrier Only

(Rev. 29, 01-02-04)

Where a physician or other individual practitioner who is liable for an overpayment dies, the overpayment should be withheld from other Medicare payments due their estate. If recovery is not possible by recoupment, the carrier shall ascertain whether an administrator or executor has been appointed and then send a letter to the estate of the decedent at the address of the legal representative, if known, or the last known address of the deceased.

If the reply to the letter indicates that the estate will not refund the overpayment, or if a reply is not received within 30 days, the case should be forwarded to CMS for possible litigation. When referring such overpayments, the carrier shall include any information about the appointment of a legal representative, the size of the estate, etc., and copies of any correspondence with survivors or others concerning the overpayment.

170.5 -Provider Offers to Settle on Compromise Basis

(Rev. 29, 01-02-04)

An overpaid provider may offer to compromise an overpayment. The FI/Carrier shall forward compromise offers to the RO only when further collection efforts would be unproductive and would not benefit the Medicare Program.

170.6 - Unsolicited Overpayment Refunds
(Rev. 29, 01-02-04)

When a provider believes that an overpayment has been received and makes an unsolicited refund, the FI/Carrier accepts it regardless of the amount. All documentation submitted with the unsolicited refund should be forwarded to the correct department. (See Program Integrity Manual, Ch. 3, § 8.4 for unsolicited refunds related to an outstanding fraud investigation.)

170.7 - Timely Deposit of Overpayment Refund Checks
(Rev. 29, 01-02-04)

Promptly deposit all refund checks into the Medicare "Federal Health Insurance Benefits Account". The FI/Carrier shall credit all such deposits on the day following the date of receipt in its mailroom or initial point of entry. (It shall credit within 2 days if the bank is not located in the same city as the contractor.). (See Ch.5, §100.3)

170.8 – Informal Referral to RO
(Rev. 29, 01-02-04)

For Medicare overpayment purposes a referral is a request to the Regional Office for assistance in an overpayment. This may be for a waiver determination, a termination request, a request for technical assistance, a referral to the Department of Justice, or any other aspect of the debt collection process. The referral may be in the form of an email, phone, fax, or written correspondence. Any referral to the RO should occur before the debt is eligible to be referred to the Department of Treasury. If changes occur to the debt during the referral process, the FI/Carrier should immediately notify the RO.

Attachment A, located after the bankruptcy section, includes a referral checklist that FI/Carrier's should utilize if necessary.

180 - Reserved
(Rev. 227, Issued: 09 17-13, Effective: 10-04-13, Implementation: 10-04-13)

190 – Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment
(Rev. 315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Effective October 1, 2003, Common Working File (CWF) implemented the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based MA Enrollment coding files described in the CWF System Documentation at http://cms.csc.com/cwf/.

Upon receipt of notification that a beneficiary has previously enrolled in a MA Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive MA enrollment. The CWF compares the period between the MA enrollment start date and the date of service of the claims in history. Services that fall within the responsibility of the MA Organizations are identified.

The CWF generates an Informational Unsolicited Response (IUR) with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based MA payment rules. The IUR has all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the Medicare beneficiary identifier. The CWF electronically transmits the IUR to the contractor that originally processed the claim. The IUR is included in the existing CWF response file. The IURs in that file for claims to be adjusted are identified with a unique transaction identifier. The previously submitted claim is not canceled and will remain on the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the IUR the Shared System software reads the trailer for each claim and either a manual or automated adjustment is performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.

Carriers

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the carrier in trailer 11. Carriers are to recover any monies due back to Medicare resulting from these denials, by following the standard or (customary) recovery process. Carriers are also responsible for providing the M/A plan number to the providers in their correspondence.

In the event that a denial is reversed upon appeal, for carrier claims, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Fiscal Intermediaries (FIs)

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the intermediary in trailer 11. To recover any monies due back to Medicare resulting from these denials, claims are to be adjusted and overpayments are to be recovered through the customary recovery process.

In the event that a denial is reversed upon appeal, a 1 byte override code field is created at the header level for FI claims. The FIs should use override code "1" in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the HMO override field. The purpose of using "1" or "2" is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a MA, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an alternate method).

Language for Carriers to Use in Letter to Provider

Carriers

This beneficiary was enrolled in [Plan Alpha Numeric ID]; a risked based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is

available on the CMS Internet at
http://www.cms.hhs.gov/HealthPlansGenInfo/claimsprocessing20060120.asp#TopOfPage.

Fiscal Intermediaries

The plan number is not required on intermediary communications. Those providers are to determine which plan to contact through an eligibility inquiry or by contacting the beneficiary directly.

New Medicare Summary Notice (MSN)

The MSN code 16.57 - Medicare Part B does not pay for this item or service since our records show that you were in an Medicare + Choice Plan on this date. Your provider must bill this service to the Medicare + Choice Plan.

16.57 - La Parte B de Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Suproveedor debe facturar este servicio a el plan de Medicare + Opción.

200 - Section 935 of the Medicare Modernization Act (MMA) - Limitation on Recoupment Overpayments

(Rev. 293, Issued: 09-14-17, Effective: 04- 02-18, Implementation: 04-02-18)

For purposes of this instruction, the Provider, Physician and other Supplier will be referred to as "Provider".

Section 1893 (f)(2)(a) of the Social Security Act provides limitations on the recoupment of Medicare overpayments and the limitations extend to the redetermination (first level) and the reconsideration (second level). This section provides protection to providers during the initial stages of the appeal process. It also requires the payment of interest on monies recouped when the provider prevails at the Administration Law Judge (ALJ) or subsequent levels of appeal. These limitations do not affect a provider's right to appeal nor the requirements and timeframes associated with appealing; however,to stop recoupment, a provider must act decidedly to appeal. If the contractor discovers a Bankruptcy or the provider is in bankruptcy and appeals an overpayment, the contractor shall refer to publication 100.06, **C**hapter 4, Bankruptcy, § 140.4.3

The contractor shall cease recoupment or not begin recoupment when a valid redetermination or reconsideration request is received timely on an overpayment subject to these limitations (see § 200.1 below). The provider has until the appeal deadline to file an appeal (refer to publication 100.04, Chapter 29). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the contractor shall stop the recoupment. The contractor shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The contractor shall be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the contractor shall resume recoupment and Normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the ALJ, or subsequent levels (Department Appeals Board (DAB), or Federal court), the contractor shall initiate recoupment at 100% until the debt is satisfied in full, unless an Extended Repayment Schedule (ERS) is established. If the debt was referred to Treasury and the provider files for an appeal, the contractor shall recall the debt from Treasury while in an appeal status. If the appeal decision is

unfavorable to the provider, any outstanding debt will be referred back to Treasury, unless an approved ERS is established or the provider pays the debt in full.

The contractor shall take the necessary steps to adjust affected account receivables (AR) after each favorable appeal decision. The contractor shall apply the funds collected (ERS payments, voluntary payments or recoupments) to any outstanding eligible overpayments first (monies shall be applied to interest first and then to principal) and any funds in excess will then be refunded to the provider.

If the provider prevails at the third level of appeal or higher:

Payment of Section 935 (f)(2) interest is only applicable to overpayments recovered through involuntary recoupment under the limitation on recoupment provisions. Interest is not payable on the principal amount recouped on voluntary payments, (e.g., payments from existing ERS, immediate recoupment prior to the Qualified Independent Contractor (QIC) decision, payment suspensions and check payments, including checks paid to Treasury).

Requirements that remain in effect:

1. The appeal timeframes and filing requirements. (Refer to Publication 100.04, Chapter 29)

2. Overpayment interest accrual and assessment requirements. (Refer to 42 CFR 405.378 and Publication 100.06, Chapter 4)

3. Underpayment interest requirements. (Refer to 42 CFR 405.378 and Publication 100.06, Chapter 4)

4. Rebuttal requirements. (Refer to 42 CFR 405.373-405.375)

Note: Rebuttal statements are not appeal requests. Only valid appeal requests at the first and second level trigger Section 935(f)(2) Limitation on Recoupment rights in accordance with 42 CFR 405.379.

5. Suspended payment requirements. (Refer Publication 100-08, Chapter 4)

200.1 - Limitation on Recoupment Section 935 (f)(2) Eligibility

(Rev. 293, Issued: 09-14-17, Effective: 04- 02-18, Implementation: 04-02-18)

The contractor shall determine if the limitations apply once an overpayment is determined (refer to §200.1.1 and §200.1.2 for guidance). This will trigger the creation of the appropriate initial demand letter and recoupment timeframes.

200.1.1 - Overpayments Subject to Limitation on Recoupment

(Rev. 293, Issued: 09-14-17, Effective: 04- 02-18, Implementation: 04-02-18)

This applies to most Fee-For-Service claims for which a demand letter is issued (refer to 42 CFR, 405.379), such as:

A. Post-pay denial of claims (refer to 200.1.2 for exclusions).

B. Medicare Secondary Payer (MSP) Duplicate Primary Payment (DPP).
(That was referred to the MAC contractor by the BCRC, CRC, other MAC contractor, or due to Self-Reporting (42 CFR 411.25)).

C. MSP recovery due to provider's failure to file a proper claim with the third party payer plan,

program, or insurer for payment.

D. Final Claims associated with a Home Health Agency (HHA) Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), (refer to 200.1.2(D) for exclusions).

200.1.2 - Overpayments Not Subject to Limitation on Recoupment

(Rev. 293, Issued: 09-14-17, Effective: 04- 02-18, Implementation: 04-02-18)

A. All other MSP overpayments that aren't identified in § 200.1.1 above.

B. Beneficiary overpayments

C. Cost report overpayments

D. HHA Request for Anticipated Payment (RAP) (refer to 200.1.1 (D) for exceptions).

Note: This is not considered a claim for purposes of Medicare appeals regulations; however, it is submitted using the same format as Medicare claims. RAPs under the Home Health Prospective Payment System (HH PPS) **do not have appeal rights during (1) the 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP to submit the final claim; rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode** (refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 10, §§10.1.10 through 10.1.12, 40.1 & 50**).**

E. Hospice Caps calculations

F. Provider initiated claim adjustments (including MSP DPP provider initiated adjustments)

G. Accelerated/Advanced Payments

H. Reopening of claims (Clerical errors and mass adjustments)

I. Periodic Interim Payment (PIP) rate adjustments (with the exception of a RAC claim review, which determines an overpayment)

J. Payment Suspensions

200.1.3 - Adjustment of the Fee-For-Service Claims

(Rev. 293, Issued: 09-14-17, Effective: 04- 02-18, Implementation: 04-02-18)

The contractor shall adjust the claims after the 935 overpayment is determined. This will trigger the creation of the initial demand letter to begin recoupment on the 41st day after the date of the demand letter.

200.1.4 – The Rebuttal Process and the Limitation on Recoupment

(Rev. 293, Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

In 42 CFR 405.373 through 405.375, regulations require that providers be given an opportunity to rebut before recoupment takes effect. The provider can submit a statement that includes any pertinent information as to why recoupment should not be put into effect on the date specified in the notice/demand letter within 15 days. The rebuttal process **is not an appeal.** A rebuttal permits the provider a vehicle to indicate why the proposed recoupment should not take place. The contractor may, based on the rebuttal statement, determine to stop recoupment or proceed with recoupment. In contrast, the limitation on recoupment provision mandates that no recoupment begins when a valid and timely request for a first level or second level appeal is received.

Refer to Publication 100.08, Medicare Program Integrity Manual, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, § 3.6.5 - Provider Financial Rebuttal of Findings

200.1.5 – Extrapolated 935 Overpayments

(Rev. 293; Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

The contractor shall create **one account receivable (AR**) for the total amount of the extrapolated overpayment, which includes the statistical sampling of claims. Refer to Publication 100-08, Medicare Program Integrity Manual (PIM) for instructions on extrapolations.

200.1.6 – Medicare Secondary Payer (MSP) Provider Duplicate Primary Payment (DPP)

(Rev. 293; Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

The contractor shall not process new MSP DPP debts where the debtor is an individual or entity other than the provider; however, contractors shall continue to process provider MSP DPP Debts. The contractors shall separately identify MSP DPP (including provider initiated) debts from all Non-MSP Debts for **budget purposes only.** Contractors shall process MSP DPP debt as a 935 debt with the exception when the provider requests or initiates the adjustment, it will not be subject to the limitation on recoupment.

Note: All MSP DPP debt workload and cost associated need to be accounted for under the MIP funding.

1. **All Contractors shall :**

a) Adjust claims to reprocess as secondary when the Explanation of Benefits (EOB)/primary payment sheet is included with claims.

b) Adjust claims to a full claims denial when the EOB/primary payment sheet is not included with the submitted claim(s).

i. Contractors shall process these overpayments as any other 935 overpayment in accordance to the procedures outlined in Publication 100.06, Chapters 3, 4 & 5.

A. **Contractors on HIGLAS shall:**

Use the existing PART A and PART B MSP Transaction Type Codes for the 935 MSP DPP that was referred to the MAC contractor by the BCRC, CRC, other MAC contractor, or due to Self-Reporting (42 CFR 411.25).

They are as follows:

1. MAGHP-PROV935
2. MANONGHP-PROV935
3. MBGHP-PROV935
4. MBNONGHP-PROV935

B. **Contractors on HIGLAS shall:**

Use the transaction types for "**Provider Initiated Adjustments"** Not Subject to the Limitation on Recoupment.

These transaction types will be mapped to APROV1 and BPROV1 letters.

1. (APROV1.pdf): Part A Non-935 Aggregate Demand Letter (To be used for MSP DPP Part A Provider Initiated)

- MAGHP-PROV:
- MANONGHP-PROV

2. (BPROV1.pdf): Part B Non-935 Initial Letter (To be used for MSP DPP Part B Provider Initiated)

- MBGHP-PROV
- MBNONGHP-PROV

C. **Contractors not on HIGLAS shall:**

1. **Provider Initiated Overpayments:**

Refer to Publication 100.6, Chapter 4, §20.1 for Non-MSP / Non-935 demand letter language (Not Subject to Limitation on Recoupment)

2. **All other MSP DPP's :**

Refer to Publication 100.6, Chapter 4, §20.1 for the Non-MSP 935 Demand Letter

Language Use the HIGLAS-CMS Receivable Balance Detail Report (Extract) or CMS Receivable

Activity
Report to account for all MSP DPP debts under MIP.

200.1.7 - Immediate Recoupment Requirements for 935 Overpayments

(Rev. 293; Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

Contractors shall offer providers the opportunity to request immediate recoupment. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate

recoupment, they must understand that it is considered a voluntary repayment. The request for immediate recoupment should be received in writing at least 16 days from the date of initial demand letter to avoid the assessment of interest, **however when the request is received after 16 days from the date of the demand letter, the debt shall be placed in an immediate recoupment status and interest will continue to accrue if the debt is not fully collected by day 31.**

A. Contractors shall offer two immediate recoupment options.

1. A one-time request on the total overpayment amount (All accounts receivables) in a single demand letter and any future demanded overpayments; Or

2. A request on the demanded overpayment (All accounts receivables) addressed in a single demand letter only.

B. Contractors shall incorporate the following minimum information related to "immediate recoupment" on its website:

1. This option is **ONLY** for overpayments that receive a demand letter.

- The request must be in writing, and may be submitted using regular mail, Facsimile, or email with an encrypted file.
- The request must include the following:

1. Provider Name and contact phone number
2. Provider's Medicare Number and/or the National Provider Identification (NPI)
3. Provider, Administrator or CFO's signature (someone with authority is required to sign)
4. Letter number or a copy of demand letters first page
5. Which option the provider is requesting

- The contractor shall scan, copy or keep the original request for proof of receipt.

2. Contractors shall use their discretion when a provider does not submit all 5 requirements to either:

- Reach out to provider for the missing information or
- Not accept the request based on missing information

3. Contractors shall continue to maintain or update the website on the immediate recoupment

process as needed.

C. Contractors shall inform providers that going through the immediate recoupment process is considered voluntary payments and will not be subject to 935 (f)(2) interest pursuant to § 1893(f)(2).

D. Contractors shall consider all written requests for an immediate recoupment as a payment arrangement that constitutes a voluntary payment except for immediate recoupment 30 calendar days after reconsideration decision.

- When the provider appeals to the ALJ and prevails.

1. Any money recouped (applied to the principal balance) 30 days after the reconsideration decision will be subject to 935 Interest.

2. Contractors shall follow the 935 (f)(2)interest calculation rules when the provider prevails and recoupment continued after an unfavorable reconsideration decision.

E. Contractors shall ensure the demand letter and website explain that, when there is a remaining principal balance after the initial immediate recoupment, they shall continue recoupment and other collection activities.

F. Contractors shall update all ARs associated to the request within 14 calendar days from the Mailroom-stamped receipt date.

G. As applicable, contractors on HIGLAS shall use the functionality in HIGLAS, which allows user to set the flag to immediate recoupment for multiple ARs instead of only one AR.

H. Contractors shall update ALL AR's within the demand letter(s) in the shared systems when a provider requests the immediate recoupment option.

I. Contractors shall accept a written request to **discontinue** participation in the immediate recoupment process at any time. Once received, **Contractor's shall stop the immediate offset process as soon as possible from the mailroom receipt date, but no later than 14 calendar days from mailroom receipt date.**

J. Contractors shall consider all written requests for an immediate recoupment as a payment arrangement that constitutes a voluntary payment.

200.2 - Requirements for All Initial Demand Letters (Manual or Electronic)

(Rev. 293; Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

Contractors shall issue demand letters for all overpayments subject to the limitation on recoupment protections. Refer to Publication 100.6, Chapter 4, § 20 and §20.1 for the

935 demand letter template. In addition to the requirements listed in Chapter 3 & 4, on Initial Demand Letters (excluding Cost Report Demand Letters) the following are specific requirements for overpayments subject to the Limitation on recoupment protections:

Contractors shall:

1. Include a claim level detail report of the claim adjustments (AR's) that comprise the overpayment along
with each demand letter to each provider.

2. Use the language in the letter templates in chapter 4, § 20.1 for Overpayments subject to the limitation on recoupment protections.

- HIGLAS users shall select the appropriate system generated letters listed in Chapter 4, §20 and §20.1
  - Non-HIGLAS users shall use the template for the 935 Initial Demand Letter
  - Use the 935 Initial Demand Letter Template for manual letters.
  - Contractors shall use the paragraph under **(RAC Demand Letter Language only) in the**

  935 Initial Demand letter for RAC overpayments subject to 935 in chapter 4, §20 and 20.1.

3. Scan or copy all letters in the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to ensure the availability to obtain a copy of manual letters as needed.

4. Send the demand letter by first-class mail.

200.2.1 – 935 Initial Demand Letter

(Rev. 293; Issued: 09-14-17, Effective: 04-02-18, Implementation: 04-02-18)

Refer to Publication 100.6, Chapter 4, Debt Collections, § 20.1

200.2.2 - Recoupment After the Initial Demand: When Does it Begin?

(Rev. 311, Issued: 02-22-19, Effective: 10-07-19, Implementation: 10-07-19)

Timeframe	Medicare Contractor	Provider
Day 1	Send demand letter.	Receives notification by first class mail of overpayment determination. (The letter date is the determination date).

Day 1-15	Process rebuttal requests received before or by day 15 deadline. No recoupment occurs.	Can submit a rebuttal request within 15 days from the date on the demand letter. (The letter date is the determination date). Can request an Immediate recoupment
Day 16-30	Process rebuttal requests received before or by day 15. Performs administrative activity (i.e., validating Redeterminations and updating account receivables to the Redetermination status). No recoupment occurs unless the provider requested the Immediate Recoupment	Can request a redetermination and potentially prevent any recoupment from occurring on day 41.
Day 31-40	Performs administrative activity (i.e. validating Redeterminations and updating account receivables to the Redetermination status). No recoupment occurs unless the provider requested the Immediate Recoupment.	Can request a redetermination and potentially prevent any recoupment from occurring.
Day 41	Recoupment begins on overpayments without a validate redetermination request.	Can request a redetermination and potentially stop recoupment from continuing.

1. Recoupment shall proceed on day 41 (with the exception of immediate recoupment) from the initial demand letter without a timely and valid request for a redetermination.

2. To prevent recoupment from occurring on day 41, the provider must file the request for a redetermination no later than the 30th calendar day following the date of the initial demand letter.

3. Contractors shall refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 29, and Appeals of Claims Decision, to determine what constitutes a valid request for a redetermination.

4. Contractors shall have internal controls in place to ensure when a provider is in an immediate recoupment status the recoupment process continues unless a request from the provider is received to stop the immediate recoupment.

5. Contractors shall continue to stop recoupment on or after day 41 from the demand letter date when the appeal request is received and validated with an outstanding balance.

- Providers have 120 days after the date of receipt of the initial determination (the notice of initial determination is presumed to be received 5 days after the date of the notice unless there is evidence to the contrary) to request a redetermination in accordance with Publication 100.04, Chapter 29

200.2.3 - Payments Made Upon Notice of Demand or Through An Immediate Recoupment Request

(Rev. 311, Issued: 02-22-19, Effective: 10-07-19, Implementation: 10-07-19)

Payments made by a provider in response to a demand are not recoupments as defined in 405.372(e). Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments and recoupments from the immediate recoupment process made in response to a demand is voluntary and are not subject to 935 interest. Refer to section 200.1.5 Immediate Recoupment requirements in section 200.1.5

200.2.4 - Payment Suspension Relating to Limitation on Recoupment
(Rev. 311, Issued: 02-22-19, Effective: 10-07-19, Implementation: 10-07-19)

Suspended funds involving providers, physicians and suppliers who have been put on payment suspension under 405.372 (e) not a "recoupment" for purposes of the limitation on recoupment. Suspended funds is not a "recoupment" as this term is defined in §405.370. CMS is only limited by section 1893(f)(2) of the Act from recouping Medicare payments. We are not restricted in our ability to apply suspended funds to reduce or dispose of an overpayment. The Provider cannot appeal a payment suspension; only the resulting overpayment determination, may be appealed and subjected to limitation on recoupment.
Exception: If the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR § 405.379 "Limitation on Recoupment" provision under §1893(f)(2) of the act will be owed to Medicare.

200.2.5 Timeframe for Stopping Recoupment After a Redetermination Request is Received
(Rev. 311, Issued: 02-22-19, Effective: 10-07-19, Implementation: 10-07-19)

Contractors' corporate mailroom receives and stamps the date of receipt on each appeal request. The timeframe begins in the corporate mailroom starting with the stamped receipt/date. The date for filing a request is defined as the date it was received by the **a**ppropriate contractor in the corporate mailroom, the date received via facsimile, or the date received in the secure internet portal/application in accordance with Publication 100-04, Chapter 29, § 310.2.

Note: If the appeal request is not readily identifiable as such in the corporate mailroom the date for filing a request is defined as the date the Medicare Contractor identifies the correspondence as an appeal request. In such instances Contractors must ensure documentation is maintained on file justifying the alternate appeal request date.

Contractors shall implement the following upon receipt of a Redetermination Request:

A. Contractors shall take **eight (8) business days** when the redetermination request **is received on or after calendar day 31** to do the following:

1. Stamp the receipt date in mailroom
2. Review and validate the appeal request; and
3. Set the redetermination status to avoid/stop recoupment. (If the debt is under an immediate recoupment agreement, the recoupment continues and in the appeal status at the same time)

Note: Providers run the risk at having recoupments occurring when the request is received on or after day 31. When a recoupment occurs on day 41 or later, the contractor shall apply the amounts to the overpayment and not refund those amounts.

B. Contractors shall have an **exception to the eight (8) business day** requirement when the Redetermination request received prior to calendar day 31:

- Contractors shall have the additional time to process a redetermination request when received prior to calendar day 31 (from the date of the demand letter).

- The additional time shall not exceed (2-3 calendar days) before day 41 from the demand letter date to update systems (HIGLAS, MCS, VMS) timely to avoid systematic offset/ recoupments of the provider's overpayment.

C. Contractors shall have seven **(7) additional business days (from the redetermination appeal status update)** to generate and send the **r**edetermination receipt notice to provider.

D. Contractors shall **communicate and coordinate** between the appropriate operational areas, immediately following all validation(s), on 935 overpayment appeal requests.

E. Contractors shall have internal controls in place after the appeal validations for updating the redetermination status to stop recoupment from occurring on day 41.

- When the provider has an immediate recoupment agreement in place this shall continue with the appeal status update, unless the provider request the immediate recoupment to stop).

- Contractors shall update the appropriate systems (e.g., HIGLAS or VMS) to reflect the redetermination appeal status, to prevents further recoupments from occurring after day 41.

- Contractors on HIGLAS shall update closed debts to reflect the redetermination appeal status for tracking purposes.

200.2.6 - Extended Repayment Schedules (ERS) and Appealing an Overpayment Subject to Limitation on Recoupment

(Rev. 12261; Issued: 09-22-23; Effective: 12-11-23; Implementation: 12-11-23)

If a provider, physician or other suppliers has been granted an extended repayment schedule (ERS) and submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, the provider or other supplier will not be considered in default if payments were not made by the provider. The appeal would supersede the ERS agreement; (under normal circumstances this would have been put on withhold due to default of payment). The contractor shall send a notice to the provider explaining if they do not resume its ERS payments they may be placed on recoupment when there is no appeal status in place according to IOM 100.6 chapter 4 §50. Payments made
by a provider under an ERS are not recoupments for the limitation provision and are not subject to 935 interest if reversed at the ALJ appeal or above. However, if a provider defaults on the ERS schedule and recoupment begins before a valid and timely request has
been received, those recoupments are subject to payment of interest under the 935 interest requirements. For additional information on the Filing timeframes or instructions on
Extended Repayment Schedules refer to Chapter 4 §50.

200.3 - What to Do After the Validated Redetermination is Received

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

Action to take:

1. Contractors shall cease recoupment on validated redetermination requests. (Refer to Section 200.2.2 above).

2. If the contractor recouped funds prior to receiving and validating a redetermination request on or after day 41 from the demand letter date, the amount recouped shall be retained. (Contractors shall use their discretion to refund if the request was timely received but recoupment did not stop timely).

3. Contractors shall continue to collect other debts not in an appeal status subject to 935.

4. Contractors shall apply any excess monies from a check payment to 935 overpayments as a voluntary collection and update the system to reflect the collection as a check amount and not as a recoupment.

5. Contractors shall not recoup (exception: immediate recoupment) or place in suspense any monies related to 935 overpayment debt subject to “Limitation on Recoupment” while

it is in an appeal status.

6. Debts continue to age and accrue interest on the outstanding amounts.

7. Contractors shall send a redetermination receipt notice to the provider within the timeframes allotted in Section 200.2.2 above.

8. Construct a short paragraph, such as Exhibit 1 below. Contractors shall use the sample letter as an example and can use their discretion to change the language to address the overpayment accordingly, as needed:

Exhibit 1: Redetermination Receipt Notice:

Current Date
Provider Name
Address
City, State ZIP Code
Provider Number:
Demand Letter Number:
Account Receivable Number:

Dear Provider Name,

This letter serves as a notification that we have received your request for a redetermination
for the above accounts receivable or the services at issue. All collection processes have ceased on the unpaid balance of the accounts receivable, unless you have entered into an extended repayment schedule, immediate recoupment or paid in full. Interest will continue
to accrue on any outstanding unpaid balance of the overpayment as explained in your demand letter. If you have any questions, please contact our office at the number listed below. You
may also visit us at www._____.com.

Sincerely,
(Name and title)

200.3.1 – Outcome From the Redetermination Decision

(Rev. 12261; Issued: 09-22-23; Effective: 12-11-23; Implementation: 12-11-23)

Refer to Publication 100.04, Chapter 29, Appeals of Claims Decisions, Section 310.11 - Effectuation of the Redetermination Decision, as needed for additional guidance. When the redetermination decision is a favorable reversal, in whole or in part, adjustments shall be made with respect to the overpayment and the amount of interest charged, in

accordance with 42 CFR § 405.378 and Publication 100.06, Chapter 4, §30. A Partially Favorable Decision reduces the original principal overpayment amount and any interest that is attributable to the amount of principal that was reduced by the decision.

Contractors shall follow the appropriate actions below following the notification of a Redetermination decision:

A. Redetermination Fully and Partially Favorable Decision Outcome:

1. Contractors shall perform the following steps after the Fully and Partially Favorable Decisions:

- Effectuate the decision, which consists of a claim history adjustment correction in the internal system (FISS, MCS, and VMS).

Note: When there is an underpayment after the effectuation, those amounts shall be eligible for offset/recoupment, and be applied to other outstanding debts first before dispersing the refund amount. This does not include any open debts that are in an appeal status or other type of pending status of exclusion (i.e., bankruptcy, suspensions, and fraud) in accordance with Publication 100.6, Chapter 4, Section 70.14.8.1, and Chapter 5, Section 410.4 (10).

- Create a manual invoice in the Healthcare Integrated General Ledger System (HIGLAS) when there is an excess amount remaining.

- Send a Revised Overpayment Demand Letter.

a. There may be situations when a Fully Favorable decision outcome creates a remaining balance.

.

1. If this occurs Contractors shall need to send a revised overpayment demand letter to address this action.

b. For Fully Favorable decisions without an open balance remaining, the Remittance Advice (RA) shall be acceptable in place of additional written Notices.

- When a reversal in favor of the provider occurs, interest may be payable by Medicare only if the underpayment is not paid 30 calendar days from the finalized claims adjustment date. Refer to 42 CFR 405.378.

Contractors Shall:

1. Recalculate the overpayment and refund the remaining excess amounts to providers within 30 calendar days from the finalized claim adjustment date.

Note: With the exception of extrapolations, the timeframe is 30 calendar days from the receipt of the recalculation amounts. The process is once the appeal decision is received, the decision and claim information is sent to the appropriate contractor for the recalculation of the extrapolation. Once this recalculation is received back, the MAC effectuates the decision i.e., adjusting the balance of the AR in HIGLAS, issuing a recalculation letter or issuing a refund as needed.

Note: For extrapolations, the timeframe is 30 calendar days from the receipt of the Unified Program Integrity Contractor (UPIC) and the Office of the Inspector General (OIG) recalculations.

2. Shall not apply any excess funds to other overpayments that are in an appeal status or any other pending status in exclusion, such as bankruptcy, suspensions, fraud etc.

3. Update the AR Status from the finalized claim adjustment date.

4. Create a manual invoice to refund the provider within 30 calendar days from the finalized claim adjustment date.

5. Send the Revised Overpayment Demand Letter when the results are fully or partially favorable, and an outstanding balance remains.

Note: This entire process (1-5) shall be completed within 30 calendar days from the final determination (final claims adjustment) date.

B. Contractors shall perform the following steps after a Fully Unfavorable Reconsideration Decision:

1. Send the Redetermination Revised Overpayment Demand Letter on **open balances only** within 30 calendar days from the date of the appeal decision.

2. Follow normal collection processes, as outlined in the IOM publication 100.06, Chapter 3 and 4.

3. Recoupment begins on day 76 following the AR Status update in HIGLAS.

4. Issue the Intent to Refer letter after the Redetermination decisions when appropriate, in accordance with Chapter 4, Debt Collection.

- This does not apply to any open debts that are in a subsequent level appeal status or other type of pending status of exclusion (i.e., bankruptcy, suspensions,and fraud).

5. Contractors shall have the overpayment remain "eligible for internal offset" status until paid in full, received a timely and valid request for reconsideration, or referred to Treasury.

C. Recoupment after a Redetermination Decision

While the Redetermination Revised Overpayment Demand Letter states that recoupment can begin no earlier than the 61st calendar day, Contractors shall utilize the additional 15 calendar days before recoupment begins on any unpaid balance to reconcile the payment or perform administrative actions. In addition, the 15 calendar day period between when the provider is informed recoupment can begin (day 61) and when recoupment actually begins (day 76) is designed to facilitate communication between the QIC and the contractor to determine if a Reconsideration request has been received.

Recoupment shall not resume upon notification by the QIC of the receipt of a timely and valid request for a reconsideration. If the debt has been in an appeal status and no reconsideration has been received, the status of the debt shall be changed to reflect “eligible for internal offset" to “resume recoupment”.

D. When Recoupment Can Begin or Resume After the Redetermination Decision

Timeframe	Contractor actions for recoupment	Provider
Day 60	Overpayment remains in an Appeal Status - No recoupment occurs	Refunds the overpayment in full or submits a request for reconsideration, or requests an ERS.
Day 61-75	No recoupment if the contactor is in receipt of the reconsideration case-file and/or has official proof of request received and stamped. Overpayment remains in the appeal status.	Files reconsideration or refunds the overpayment, or requests an ERS.

Day 76 to 180	Recoupment stops with a valid receipt of the reconsideration.	Provider has 180 days from date of receipt of the redetermination to appeal to the reconsideration level.

E. Redetermination Revised Overpayment Demand Letter for Favorable and Unfavorable Appeal Decisions

Contractors shall use the letter template below in Exhibit 2 for favorable and unfavorable decisions. If the language in Exhibit 2 does not address the appropriate scenario, Contractors shall modify the language to address the overpayment as appropriate.

1. Contractors shall send a Redetermination Revised Overpayment Demand letter on partially and Fully Favorable Decisions when the recalculation resulted in:

   a. Paying the new, revised amount in full from previous recoupments/collections.
   b. Reducing the revised amount from previous recoupments/collections
   c. Reducing the revised amount from previous recoupments/payments on an established ERS.
   d. Reducing the original amount with no recoupments/collections.

2. Refer to chapter 4, Section 50 for ERS instructions on a revised extended repayment schedule.

3. Contractors shall use Exhibit 2 options or at their discretion, adjust the language to address the scenario when sending the Redetermination Revised Overpayment Demand Letter.

Exhibit 2: Medicare Redetermination Revised Overpayment Demand Letter

Current Date

Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear [Provider Name],

This letter is in reference to the redetermination decision dated_____, for the overpayment in the amount of_____ issued to you on _____ [Date of demand].

(Option 1 – Fully or Partially Favorable Revised Demand Letter)

Based on the Fully or Partially Favorable decision and the recalculation, the revised balance
of the Principal is _____ and Interest is _____. A payment totaling _____ is due by _____.

Or
(Option 2 – Partially Favorable on Debts Paid in Full Due to Decision)

According to our records, CMS has applied a total of [AMOUNT PAID ON DEBT BEFORE EFFECTUATION] to your debt. This amount represents the total amount of payments on the debt before the effectuation of your redetermination decision. Based on the effectuation of the redetermination decision, you had [AMOUNT] that was applied to the remaining outstanding balance, after the redetermination decision was effectuated, of [AMOUNT DUE AFTER REDETERMINATION] as a result, the debt has been paid in full. This does not affect your right to appeal to the next level Reconsideration at the Qualified Independent Contractor.

Or
(Option 3- Partially Favorable applied excess funds to other overpayments with or without a refund)

According to our records, after the effectuation, your debt had an underpayment for [AMOUNT] that was applied to other outstanding debts. The provider may request a listing of debts by contacting [xxx-xxx-xxxx].

Or
(Option 4 – Fully Unfavorable notification letter)
Based on the Unfavorable Determination, the balance of the principal is _____ and the balance of outstanding interest is _____. A payment totaling _____ is due by _____.

When the redetermination decision is [**Unfavorable or Favorable]**, we may begin to recoup no earlier than **61 days** after the date of **this [Notification or Revised demand letter].** Please note if recoupment stops, interest continues to accrue.

[Contractors shall select the correct option above based on the outcome of decision].

Rebuttal Process:

Under our existing regulations 42 CFR Sections 405.374, providers and other suppliers will have **15 days from the date of this demand letter** to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. A rebuttal is not intended to request a review of supporting medical documentation nor to express disagreement with the overpayment decision. A rebuttal shall not duplicate the redetermination process. This is not an appeal of the overpayment determination. Our office will advise you of our decision 15 days from the mailroom stamped receipt date of your request.

The rebuttal statement does not cease recoupment activities consistent with Section 935 (f)(2) of the Medicare Modernization Act (MMA).

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 second level of appeal is the reconsideration. You must file your request for the reconsideration within 180 days from date of receipt of the appeal decision letter in accordance to 42 CFR §405 962(a)**. However, if you wish to avoid recoupment from occurring, you need to file your request for reconsideration within 60 days from the date of this letter, as described above**. Unless you show us otherwise, we assume you received this letter, five days after the date of this letter.

[Include this paragraph when there is a remaining balance owed.]

If you have already sent a payment and will not be appealing to the next level appeal, thank you, and we ask that you disregard this letter.

If you are unable to repay the amount due in full, please visit our website for instructions on an extended repayment schedule (www.contractor.com).

Please refer to your initial demand letter for any other information not disclosed in this letter.

If you have any questions or concerns on this matter, please write to our office or contact us at the address at the bottom of this notice.

Thank you,
Analyst Name
Title
xxx
-
xxx

E. Initiating or resuming recoupment after a Withdrawal or Dismissal

Contractors shall initiate or resume recoupment following a request for a withdrawal from the provider or other suppliers or from a Redetermination dismissal notification. Remove the appeal status as soon as possible but no later than 30 calendar days from the requested withdraw or from the dismissal notification to resume recoupment. For additional guidance, refer to 42 CFR §§405.379, 405.952 and 405.972 and publication 100.04, Medicare Claims Processing Manual Chapter 29 – Appeals of Claims Decisions.

200.4 - Extended Repayment Schedules (ERS) With an Appeal That is Subject to Limitation on Recoupment

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation: 12-11-23)

The Qualified Independent Contractor (QIC) determines the validity and timeliness of a request for the reconsideration. To limit recoupment, the request should have a mailroom receipt date no later than the 60th calendar day from the date of the redetermination for Unfavorable Determinations or from the Revised Redetermination Overpayment Demand Letter date.

1. Contractors shall place overpayments in the Reconsideration appeal status toavoid further recoupments when validated on or after day 60 from the Redetermination decision date or the Redetermination Revised Overpayment Demand Letter date.

2. Contractors shall recall debts back to its location when the overpayment was referred to Treasury.

Note: Providers have 180 days from the date of receipt of the redetermination appeal decision tofile for a reconsideration request in accordance with Chapter 29, Claim appeals, section 240. Once the appeal is received and validated, Contractors shall update the appeal status to stop recoupment. When the QIC receives a request for reconsideration, it will request the case file from the MAC using the Redetermination Case File Request Form in accordance with Publication 100-04, Medicare Claims Processing Manual Chapter 29 - Appeals of Claims Decisions.

A. Contractors **shall** utilize the 15 additional calendar days (between the 61st day to the 76th day) starting from the redetermination appeal decision date or the

Revised Redetermination Overpayment Demand Letter date to address the listing below after the case file requests are received.

1. The appropriate unit shall continue to update the list for the overpayment recovery Unit with Part B case file requests received.
2. Review the MAS for updates on the Part A Reconsideration updates.
3. Update the HIGLAS to the reconsideration appeal status, when appropriate.
4. After the appeal status updates (in HIGLAS), send the Reconsideration Receipt Notice to the appellant within eight (8) business days.

B. Contractors shall have internal controls in place to avoid recoupment from starting on day 76.

C. Contractors shall contact the QIC **only when it becomes necessary** to confirm receipt of an appeal when notified by the provider and the 76th calendar day is approaching.

Contractors shall confirm:

1. There is no communication from the QIC for a request of the redetermination case file for Part B.
2. There is no information in the MAS for Part A.
3. The Provider submitted a copy of the tracking number from (FedEx, United States Postal Services (USPS), and United Parcel Services (UPS)) and/or a copy of the QIC notification of receipt date for the reconsideration request.

200.4.1 - Actions to Take Upon Receiving Notification from the QIC for Case Files:

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation: 12-11-23)

In accordance with Publication 100-04, Chapter 29, the QIC is required to use the Reconsideration Case File Request form when requesting the case file from the Contractors.

1. Contractors shall update the appeal status to stop or not start recoupment on Reconsideration requests received on or after day 76. This shall be completed within eight (8) business days from the email receipt date of the Redetermination case file request to the appeals unit or from the receipt date of the submitted reconsideration appeal request in MAS.

2. Contractors shall retain and apply any recouped funds collected on or after the 76th calendar day. However, if the request was timely stamped prior to day 76 and recoupment occurred, it is at the Contractors' discretion to refund those funds.

3. Contractors shall accept other legitimate information/sources to support placing the AR in the Appeal status to stop recoupment including:

a. Proof of receipt (written notification from the QIC) from the provider that shows the date the QIC received the reconsideration request.
b. Any legitimate information from an available and reliable source that can identify the date when the QIC received and/or validated the reconsideration request.
c. The tracking validation documentation (e.g., FedEx, United States Postal Service (USPS), and United Parcel Services (UPS)) that reflects the receipt date of the request.

4. Contractors shall continue to collect other debts owed by the provider but may not withhold or place in suspense any monies related to the debt(s) in an appeal status.

a. Contractors shall report overpayments that are in appeal status on the Treasury Report on Receivables (TROR).
b. Debts continue to age and accrue interest on the outstanding amounts.

5. Contractors shall send a Reconsideration Receipt Notice to the appellant within eight (8) business days from the Reconsideration Appeal status update. Contractors can send this notice via USPS mail or electronically (via email or a secure site).

The Reconsideration Receipt Notice example is provided in Section 200.4.2, Exhibit 3 below. Use the provided language or use your discretion to modify the proposed language as needed to address the overpayment scenario, which include the following:

a. The notice shall have validation language.
b. If there was collection activity, explain that when the overpayment is in an appeal status, recoupment stops during the appeal review process on those overpayments that are not included in an immediate recoupment agreement; or
c. If the provider has an Immediate Recoupment agreement, the notice shall state that the recoupment will continue due to this agreement.

200.4.2 - The Reconsideration Receipt Notice Example

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation: 12-11-23)

Exhibit 3: Reconsideration Receipt Notice

Current Date
Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter serves as a notification that [Contractor name] received confirmation that the Qualified Independent Contractor (QIC) [Name] **has validated your request for a reconsideration review**.

All collection processes have ceased on the unpaid balance of the accounts receivable unless you have entered into an extended repayment schedule or an immediate recoupment agreement.

Interest will continue to accrue on any outstanding unpaid balance of the overpayment as Explained in your demand letter.

You will receive a reconsideration decision letter after the QIC has rendered its decision.

If you have any questions, please contact our office at the appropriate number listed below. you may also visit us at [website].

Sincerely,
(Name and title)

200.4.3 - Actions to Take after the Reconsideration Decision

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

The QIC decision may require a recalculation of the debt's balance and effectuation by the Contractor. Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 §320.9 for additional information on effectuations. When a decision is in favor of the provider occurs, interest may be payable by Medicare if the underpayment is not paid 30 calendar days of the final determination (e.g., claim adjustments finalized due to decision). Refer to 42 CFR 405.378.

A. Contractors shall perform the following steps for Fully and Partially Favorable Reconsideration decisions:

1. Effectuate the decision, which consists of a claims history adjustment correction in the internal system (FISS, MCS and VMS).

Note: With the exception of extrapolations, the timeframe is 30 calendar days from the receipt of the recalculation amounts. The process is once the appeal decision is received, the decision and claim information is sent to the appropriate contractor

for the recalculation of the extrapolation. Once this recalculation is received back, the MAC effectuates the decision i.e., adjusting the balance of the AR in HIGLAS, issuing a recalculation letter or issuing a refund as needed.

Note: For extrapolations, the timeframe is 30 calendar days from the receipt of the Unified Program Integrity Contractor (UPIC) and the Office of the Inspector General (OIG) recalculations.

2. Create a manual invoice in HIGLAS when there is an excess amount.

3. Send a Revised Overpayment Demand Letter on Partially Favorable decisions.

a. There may be situations when a Fully Favorable decision outcome creates a remaining balance.

- If this occurs Contractors shall need to send a Revised Overpayment Demand Letter to address this action.

- For Fully Favorable decisions without an open balance remaining, the Remittance Advice (RA) shall be acceptable in place of additional written notices.

Contractors Shall:

1. Recalculate the overpayment and refund the remaining excess amounts to the provider within 30 calendar days from the finalized claim adjustment date.

- For extrapolations, timeframe for completion is 30 calendar days from the receipt of the UPIC and OIG recalculations.

2. Shall not apply any excess funds to other overpayments that are in an appeal status or any other pending status of exclusion (i.e., bankruptcy, suspensions, and fraud).

3. Update the AR Status from the finalized claim adjustment date.

4. Create a manual invoice to refund the provider.

5. Send the Revised Overpayment Demand Letter when the results are Fully or Partially Favorable, and an outstanding balance remains.

- For Fully Favorable decisions without an open balance remaining, the Remittance Advice (RA) shall be acceptable in place of additional written notices

Note: This entire process (1-5) shall be completed within 30 calendar days from the final determination (final claims adjustment) date.

B. Contractors shall perform the following steps below after a Reconsideration

Fully Unfavorable Decision:

1. Send the Reconsideration Revised Overpayment Demand Letter on **open balances only** within 30 calendar days from the date of the appeal decision.

2. Follow normal collection processes, as outlined in the IOM publication 100.06, Chapter 3 and 4.

3. Recoupment shall begin on day 30 following the AR status update in HIGLAS after receiving notification of the QIC decision or 30 days from the revised overpayment demand letter date.

4. Issue the Intent to Refer letter within 60 calendar days from the AR status update, such as (but not limited to) the 935-Reconsideration denied

- This does not apply to any open debts that are in a subsequent level appeal status or other type of pending status of exclusion (i.e., bankruptcy, suspensions, and fraud).

5. Contractors shall have the overpayment remain "eligible for internal offset" status until paid in full or referred to Treasury.

200.4.4 - Recoupment Timeframes and Reconsideration Notices after Decision

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

A. When does Recoupment Begin or Resume after the Reconsideration?

Timeframe	Medicare Contractor	Provider
Day 30 (following reconsideration decision)	Resume or begin recoupment without regard to the ALJ appeal request 30 calendar days from the Fully Unfavorable Reconsideration Decision, and from the revised demand letter for Partially Favorable decisions.	Must either pay Overpayment in full or submit request for an Extended Repayment Schedule (ERS) to avoid recoupment.

Day 60 (following reconsideration decision)	Recoupment continues until the debt is fully collected. This is also the timeframe to send the Intent to Refer letter (ITR) or refer to Treasury when the ITR was previously sent.	Provider can request an ERS prior to the referral to Treasury. Provider can also appeal to the ALJ.

1. Contractors shall use the Exhibit 4: Reconsideration Revised Overpayment Demand Letter specified in Chapter 3, Section 200.4.5 or use your discretion to modify the language, accordingly, to reflect the outcome of the adjustments to the overpayment.

- This letter states that the providers, physicians, and other suppliers have been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 §405.373(2) through §405.375.

200.4.5 - Reconsideration Revised Overpayment Demand Letter

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

Exhibit 4: Reconsideration Revised Overpayment Demand Letter:

Month, Date, Year
Provide Number or NPI Number
Original Demand Letter Reference Number:

Dear [Provider Name],

This letter is in reference to the Medicare reconsideration [Decision], dated [DATE], for the overpayment of [AMOUNT] issued to you on [**DATE OF DEMAND].**

According to our records, the balance on the Principal amount is [AMOUNT] and the Interest amount is [AMOUNT]. A payment is due totaling [AMOUNT] by [DATE]. We can begin to recoup no earlier than **30 days from the date of this letter**. Interest will

continue to accrue and will be assessed for the total amount due until the debt is collected in full as explained in your demand letter in accordance with 42 CFR § 405.378.

[After adjusting the ARs on the unfavorable amounts due to a Partially Favorable decision, Contractors shall modify this letter to show the claims that can be appealed, for example:

According to our records, due to the Partially Favorable decision the overpayment was collected in full. **[Refer to your reconsideration appeal decision letter for the listing of the unfavorable claims]**

Rebuttal Process:

Under our existing regulations at 42 CFR § 405.374, providers and other suppliers will have **15 days from the date of this demand letter** to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity, before the suspension, offset, or recoupment takes effect, to submit a statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. A rebuttal is not intended to request a review of supporting medical documentation nor to express disagreement with the overpayment decision.

A rebuttal shall not duplicate the reconsideration process. This is not an appeal of the overpayment determination. Our office will advise you of our decision 15 days from the mailroom stamped receipt date of your request.

The rebuttal statement does not cease recoupment activities consistent with Section 935(f)(2) of the Medicare Modernization Act (MMA).

If you wish to appeal this decision:

You can appeal the unfavorable amount if you disagree with this overpayment decision, to the Administration Law Judge (ALJ) 60 days from the date of receipt of the reconsideration. An Appeal is a review performed by people independent of those who have reviewed your claim so far. Refer to your reconsideration appeal decision letter for the listing of the unfavorable claims.

Recoupment proceeds regardless of the filing for an ALJ hearing. Following the final decision by
the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level after 30 days from the date of this letter due to the QIC decision or dismissal. **[Disregard this paragraph if debt was paid in full prior to or after recalculation]**

If you have already sent payment, we thank you and ask that you disregard this letter. **If you are unable to repay the amount in full, please visit our website for instructions on an Extended Repayment schedule [MAC WEBSITE].**

Please refer to your initial demand letter for any other information not disclosed in this letter.

Thank you,
[CONTRACTOR NAME]
[CONTRACTOR PHONE]

**NOTE: For revised letters on overpayments with a zero balance or paid in full, the Rebuttal Statement
is not necessary.**

200.4.6 - Initiating or Resuming Recoupment After a Reconsideration Withdrawal or Dismissal

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

A. A request for an appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant.
2. A request is made by the appellant to withdraw the appeal.
3. A determination that an appellant is not a proper party.
4. The amount in controversy requirements have not been met.
5. The appellant has died and no one else is prejudiced by the claims determination.

B.. Contractors shall perform the following actions following notification of a withdrawal or dismissal:

1. Update the AR status to remove the appeal status as soon as possible but no later than 30 calendar days from the notification of the withdrawal or dismissal of the appeal.
2. Initiate or resume recoupment on the overpayment immediately upon notice of withdrawal of an appeal.
3. Initiate or resume recoupment following the dismissal issued date from the QIC.
4. Update the AR status to resume recoupment as soon as possible but no later than 30 calendar days from the dismissal notification date.

C**.** For additional guidance, refer to 42 CFR §§405.379, 405.952, 405.972, and publication 100-04, Medicare Claims Processing Manual Chapter 29 - Appeals of Claims Decisions.

200.4.7 - QIC Remands on Dismissals

(Rev. 12261; Issued:09-22-23, Effective: 12-11-23; Implementation:12-11-23)

When the QIC performs its review of the dismissal, it will decide if the dismissal was correct. If it determines that the ~~c~~ontractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case back to the Contractor for a redetermination. When the QIC remands an appeal, it is mandatory for the Contractor to issue a new redetermination decision in accordance with Publication 100-04, Medicare Claims Processing Manual, and Chapter 29.

A. Contractors shall change the Reconsideration appeal status back to a Redetermination appeal status until a new decision is rendered.

1. Update the AR status within eight (8) business days from the email receipt date (from appeals) on all QIC remand notifications.

2. Contractors shall follow the Redetermination instructions specified in Chapter 3, § 200.3 (A) after the review is completed.

3. For additional guidance, refer to 42 CFR §§405.379, 405.952 and 405.972 and publication 100-04, Medicare Claims Processing Manual Chapter 29 - Appeals of Claims Decisions

200.5 - Administrative Law Judge (ALJ) Third Level and Subsequent Level of Appeals

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Whether or not the provider subsequently appeals the overpayment to the ALJ, Departmental of Appeals Board (DAB), or Federal court, contractors shall continue to recoup until the debt is satisfied in full. Recoupment remains in effect as provided in CFR 42 §405.373 (e). Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 §330-330.2. If an overpayment determination subject to the limitation on recoupment under 42 CFR §§ 405.379 and 405.378 is reversed in whole or in part on funds recouped (excluding voluntary payments, ERS collections, and immediate recoupments requested by the provider or supplier prior to the Qualified Independent Contractor decision), the 935 interest shall be paid to the provider or supplier.

A. Glossary:

Reversal - Although appeals in the administrative appeals process are de novo proceedings (i.e., a new determination/decision is made at each level), Medicare uses this term when the new determination/ decision is more favorable to the appellant than the prior determination/ decision, even if some aspects of the prior determination/decision remain the same.

Decisions and Determinations - If a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a “determination” or “decision.” There is no apparent practical distinction between these two terms although applicable

regulations use the terms in distinct contexts. A decision that is reopened and thereafter revised is called a "Revised determination."

Effectuate - This means for the MAC to issue a payment or change liability.

Affirmation - A term used to denote that a prior claims determination has been upheld by the current claims adjudicator. Although appeals through the OMHA level are de novo, CMS and its contractors often use this term when an adjudicator reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

Office of Medicare Hearings and Appeals (OMHA) - The Office of Medicare Hearings and Appeals is responsible for level 3 of the Medicare claims appeal process and certain Medicare entitlement appeals and Part B premium appeals. At level 3 of the appeals process, an appellant may have a hearing before an OMHA ALJ, or review by an attorney adjudicator.

Administrative Law Judge (ALJ) - Adjudicator employed by the Department of Health & Human Services (HHS), Office of Medicare Hearings and Appeals (OMHA) that holds hearings and issues decisions related to level 3 of the appeals process.

Department of Appeals Board (DAB) Review - The DAB provides an impartial, independent review of disputed decisions in a wide range of Department of Health and Human Services programs under more than 60 statutory provisions.

Appeals Council - The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment.

Remand - An action taken by an adjudicator to vacate a lower-level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Note: For additional information go to Publication 100.04, Medicare Claims Processing Manual Chapter 29 - Appeals of Claims Decisions

200.5.1- Actions on a Valid Notification for the ALJ or Subsequent Level Appeal Request

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

A. When the Provider Appeals to the ALJ and Higher:

1. Contractors shall update the systems upon receipt of an authorized request and/or a notification when the Provider appealed to the ALJ and higher.

a. Contractors shall accept written notification such as but not limited to:

- Copy of receipt from the courts,
- Copy of the tracking number from the post office or a fax cover sheet,
- Email with scanned documents
- Tracking numbers from UPS or FedEx as legitimate proof to update the debts to the appeal status.
- Receipt letter from the ALJ

2. Contractors shall recall the overpayment if referred to Treasury after receiving valid proof of the appeal request and update all systems to the appeal status.

200.5.2- Remanded Back to the QIC from the ALJ

(Rev.12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Remanding an appeal case is an action taken by an adjudicator to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new review and decision. See 42 Code of Federal Regulations (CFR) Section 405.1056 for additional discussion on this process.

A. Contractors shall update the Accounts Receivable (AR) back to the Reconsideration appeal status when notified of the ALJ remand. Upon receipt of the QIC decision for the ALJ remand, the contractors shall update the AR status to resume recoupment as soon as possible but no later than 30 calendar days from the notification of the remand of an unfavorable
decision.

- Contractors shall continue with the monthly payments as scheduled during the review period when the provider is under an ERS agreement. Refer to §200.8 below and Chapter 4 § 50, ERS instructions.

200.5.3- Actions to Take After the ALJ or Subsequent Level Appeal Decision

(Rev.12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Contractors work the debt immediately upon receipt of the effectuation notice from the Administrative Qualified Independent Contractor (QIC) or other notification of the Decision outcome to complete the computation and the effectuation, as applicable. Contractors adjust the claim(s) in the claims history system for the finalized claim payment, effectuate, and refund the amounts recouped on the favorable claims. This process is completed within 30 calendar days starting from the final determination (Final claims adjustment date) to the manual invoice
entry date in HIGLAS.

Contractors shall perform the following steps after receipt of the effectuation notice from the Administrative QIC related to fully and partially favorable decisions:

1. Contractors shall use the following suppression code when adjusting the claim (claim history) to prevent adjustments from going to HIGLAS.

- Part B uses the 'Y' suppression on the adjusted claim to prevent the adjustment from going to HIGLAS.

- Part A uses the 'A' tape to tape flag on the adjusted claim to prevent the Adjustment from going to HIGLAS.

- DMAC's use "P" and "B" adjustment force codes to the adjusted claim in VMS To prevent the adjustment from going to HIGLAS.

2. Effectuate any overpayments or refunds after the contractor computes the amount for Any adjustments or payment to the provider. For additional guidelines refer to Chapter 29, Section 330.4 - Effectuation Time Limits & Responsibilities.

3. Recalculate the overpayment and update the AR/s in HIGLAS and create a manual invoice to refund the provider within 30 calendar days. This timeframe begins at the final claims adjustment date to the entry date of the manual invoice.

Note: With the exception of extrapolations, the timeframe is 30 calendar days from the receipt of the recalculation amounts. The process begins once the appeal decision is received, the decision and claim information are sent to the appropriate contractor for the recalculation of the extrapolation. Once the recalculation is completed and returned, the MAC effectuates the decision i.e., adjusting the balance of the AR in HIGLAS, issuing a recalculation letter or issuing a refund as needed.

Note: For extrapolations, the timeframe is 30 calendar days from the receipt of the Unified Program Integrity Contractor (UPIC) and the Office of the Inspector General (OIG) recalculations.

4. Issue a Revised Overpayment Demand Letter when there is a new revised amount, and an open balance remains.

a. There may be circumstances when a Fully Favorable decision outcome creates a remaining balance.

- If this occurs contractors shall need to send a Revised Overpayment Demand Letter to address this action.

b. When the intent to refer letter (ITR) was previously sent:

- Include language that refers the provider back to the initial ITR.

c. For Fully Favorable decisions without an open balance remaining, the Remittance Advice (RA) shall be acceptable in place of additional written notices.

d. Follow the same instructions as in Publication 100.06, Chapter 4 to proceed with referring the remaining balance to Treasury.

3. Contractors shall use Exhibit 5 as an example and at their discretion, change the language to address the overpayment accordingly, as needed.

Use the appropriate appeal level within the content of the letter:

a. Medicare Administrative Law Judge (ALJ)
b. Departmental Appeals Board (DAB)
c. Federal court levels.

C. Fully Unfavorable Appeal Decision:

1. When the ALJ issues an unfavorable decision:

a. Contractors shall update the status of the AR and send the Revised Overpayment letter on **open balances only** after a Fully Unfavorable decision within 30-calendar days starting from the receipt date available in the MAS.

b. Contractors shall be able to access reports in MAS, which identifies the unfavorable ALJ appeal decisions.

- All ALJ level information in MAS is available once the ALJ level record is closed and ECAPE close web service has transferred data to MAS.

2. Contractor shall refer any outstanding debt to Treasury within 30 calendar days following the unfavorable decisions notifications for the ALJ or subsequent levels based on the ITR previously sent.

200.5.4- The Revised Overpayment Letter for ALJ and Subsequent Decisions:

(Rev.12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Exhibit 5:

Date:
Original Demand Letter Number:
Reference Number:
Provider Name:

This letter is in reference to the [Administrative Law Judge or subsequent levels] decisions on [DATE], for the overpayment, [AMOUNT] issued to you on [**DATE OF DEMAND]. According to our records, the** new revised overpayment amount is [AMOUNT]. Following the final decision by the ALJ, when the debt has not been paid in full, we will begin Recoupment immediately whether or not you appeal to the next level. Interest continues to accrue and will be assessed for the total amount due in accordance with 42 CFR § 405.378.

Rebuttal Process:

Under our existing regulations 42 CFR Sections 405.374, **within 15 days from the date of this letter**, providers and suppliers will have the opportunity to submit a rebuttal statement.

The rebuttal process provides the debtor the opportunity before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. A rebuttal is not intended to request a review of supporting medical documentation nor to express disagreement with the overpayment decision. A rebuttal shall not duplicate the appeal process. This is not an appeal of the overpayment determination. Our office will advise you of our decision 15 days from the mailroom stamped receipt date of your request.

The rebuttal statement does not cease recoupment activities consistent with Section 935(f)(2) of The Medicare Modernization Act (MMA).

If you wish to appeal this decision:

You may file an appeal request with the Medicare Appeals Council, the fourth level of administrative appeal, following the instructions included in the ALJ decision (see also, 42 CFR §§405.1100-1130). Recoupment proceeds regardless of the filing for a Council review. If there is no confirmation on the next appeal request, this debt may be referred to Treasury.

If you have already sent payment, we thank you and ask that you disregard this letter. If you are unable to repay the amount in full, please visit our website for instructions on an Extended Repayment Schedule (www.contractor.com).

Please refer to your Initial Demand and Intent to Refer letters for any other information not disclosed in this letter.

Thank you
Contractor Name

xxx-xxx-xxxx

200.6 - Obligation to Pay Interest on Underpayments Owed to Providers
(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Medicare has the obligation to pay providers interest if the reversed overpayment at any level of the administrative appeal process is not effectuated timely. Medicare will pay interest on the underpayment for each full 30-day period a payment remains delayed.

Note: This late (Penalty) interest is not to be mistaken for the 935 interest.
Contractors shall follow the instruction outlined in Publication 100-06, Chapter 4 § 30.1 and 42 CFR 405.378 when determining payment of late interest for underpayments that are delayed.

200.6.1 - Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest shall be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date). The contractor will have 30 days to calculate and refund the provider from the ALJ Decision date or the final determination Date.

NOTE: Contractors will need to issue a revised written determination to the provider, physician or other supplier in accordance to Publication 100-04, Medicare Claims Processing Manual, Chapter 29.

200.6.2 - Computing 935 Interest at the ALJ and Higher Levels
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest paid under 935 is only applicable at the ALJ or further appeal level when that decision results in a full or partial reversal of the prior decision and contractors retained recouped fund

What is needed to calculate 935 interest

The simple formula for calculating interest is: 1) Time; 2) Rate; and 3) Amount
For each recoupment action:

1. **TIME**: Determine the total Julian Days starting from the recoupment date to the ALJ Decision date or date the revised notice with the new overpayment, if applicable. Divide the number of Julian days by 30 to compute the number of 30-day periods. The interest will not be payable for any periods of less than 30 days in which we had possession of the recouped funds.

2. **RATE**: Use the Annual Rate of interest at the time of the ALJ decision date or from the revised New Written Determination date from an effectuation and convert interest rate to a monthly interest rate. (For example: The Rate of Interest as of April 18, 2008 is 11.375%). Convert annual Rate to a monthly rate by dividing by 12.

3. **AMOUNT**: The amounts that are to be used as the basis on which to compute interest earned by the provider are those amounts that are credited to principal resulting from any involuntary payments from the provider after the elimination/satisfaction of all Medicare debt. Recouped monies applied to interest are not included in determining the 935 interest. Only those principal funds recouped via withholding (e.g. payments recouped under a defaulted ERS or offset) are included. Do not include payments a provider makes under an ERS or other voluntary payments made by the provider.

200.6.3 - How to Calculate 935 Interest

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Where there are multiple recoupments 935 interest must be calculated separately for each recoupment action and then total for the amount due the provider.

Example:

How to calculate 935 Interest:

(935 interest at the ALJ and higher levels)

Fully Favorable

ALJ Decision Date: Jan 02,2008				
Recoupment Amounts	**Recoup Date**	**Rate of Interest from ALJ Decision Date**	**Length of Time Money Held**	**Interest Owed to Provider**
1) $ 9062	March 07, 2007	12.5%	301 Julian Days (10 mos. 1 day)	$ 943.95
2) $ 9806	May 18, 2007	12.5%	230 Julian Days (7 mos. 20 days)	$ 715.02
3) $ 9136	August 08, 2007	12.5%	148 Julian Days (4 mos. 28 days)	$ 380.66
			Total 935 Interest owed	**$ 2,039.63**

Calculation example: **Time x Rate x Amount = Interest**

1. 10 x (.125 ÷12) x $ 9062.00 = $943.95
2. 7 x (.125 ÷12) x $ 9806.00 = $715.02
3. 4 x (.125 ÷12) x $ 9136.00 = $380.66
4. 935 Interest amt owed Provider $2,039.63

200.6.4 - Obligation to Pay the Providers, Physicians, or Suppliers Late Payment Interest

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare has the obligation to pay providers, physicians and suppliers interest if the overpayment determination is reversed at the first (redetermination) and second (reconsideration) level of the administrative appeal process and the decisions are not effectuated timely. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment **is not paid** within 30 days of the final determination decision. See § 30.1 of Chapter 4.

200.7 - 935 Interest Calculation

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Section 200.7.1 - 2007.5 instructs contractors how to calculate the 935 interest.

200.7.1 - Assessment of 935 Interest

(Rev.12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

The limitation on recoupment provisions amended the way interest may be paid to a provider whose overpayment determination is overturned in the administrative appeals process subsequent to the second level of appeal (Reconsideration decision), or following judicial review in a federal court.

Contractors shall calculate the 935 interest on involuntary recoupments using the date the amount was recouped to the date of the decision.

A. The payment of 935 interest is only applicable to overpayments subject to the limitation on recoupment provisions.

- Interest is only payable on the recouped amounts applied to the principal balance prior to the decision.

B. Contractors shall not include any voluntary payments applied to the principal balance for the purpose of calculating the 935 interest such as but not limited to:

a. Amounts from a check,
b. Amounts applied (recouped or check) due to an ERS agreement,

c. Amounts applied due to providers on an Immediate Recoupment Agreement

200.7.2- Interest Rate and Calculation Periods on Recouped Funds for Purposes of Paying 935 Interest

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

We will pay simple interest rather than compound interest, and **we will not pay interest on interest. This mirrors the manner in which we assess interest against providers.** Monies we recouped and applied to interest are applied to outstanding debts as needed, or refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider. The periods of recoupment will be calculated in full 30-day periods; and interest **will not** be payable for any periods of less than 30-days in which we had possession of the recouped funds.

200.7.3 - Calculations for Each 30-Day Period at the ALJ or Subsequent Level Decision

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Interest shall be calculated for each full 30-day period using the interest Rate in Effect on the ALJ decision date or any subsequent level decision date in accordance with 42 CFR 405.378 (j)(2)(iii).

200.7.4- Timeframes When Calculating the 935 Interest on Favorable Decisions.

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

A. **Fully and Partially Favorable Decisions:**

1. Upon receipt of the Administrative QIC effectuation notice, contractors shall have 30 calendar days to calculate and refund the 935 interest to the provider.

    - Calculate and create a manual invoice in HIGLAS to refund the 935 interest

    - This calculation begins from the finalized claim adjustment date or the receipt date of the extrapolated recalculation to the entry date of the manual invoice.

    - Shall calculate and refund the 935 interest from the final claim adjustment date in accordance with 42 CFR § 405.378.

Note: On Partially Favorable calculations, if the decision by the ALJ, Medicare Appeals Council, Federal district court or a subsequent Federal reviewing court, reverses the overpayment determination, as modified by prior levels of administrative or judicial review, in part, the Medicare contractor in effectuating the decision may allocate recouped monies to that part of the overpayment determination affirmed by the

decision. Interest will be paid to the provider or supplier on recouped amounts that remain after this allocation in accordance with paragraph (j) in 42 CFR §405.378.

2. Contractors should review the ALJ, and subsequent levels Notice of decision to ensure all dates agree with the Administrative QIC Effectuation Notice and/or in the MAS.

D. Extrapolated overpayments with a Favorable Decisions:

- Contractors shall have an additional 15 calendar days (a total of 45 calendar days) for all extrapolation overpayments to calculate and refund 935 interest to the provider.

E. Line by Line (Claims with multiple lines of services) Partially Favorable Decision:

- Contractors shall have an additional 15 calendar days (a total of 45 calendar days) when the decision is on individual line/s to calculate and refund 935 interest to the provider.

Note: Office of Medicare Hearings and Appeals (OMHA) has developed a system similar to MAS called **Electronic Case Adjudication and Processing Environment (ECAPE)**. Due to system limitations, OMHA made changes to the decision letters and processes related to the decision date.

a. On/after May 2018, OMHA's decision letters no longer include a date of decision, only the wet signature of the ALJ.
b. The 'decision date' is captured in the Notice of Decision.
c. The date captured in the Notice of Decision will match the date captured in MAS.

For purposes of calculating interest for 935 Overpayments, contractors utilizing MAS shall use the date captured in the Notice of Decision for OMHA decisions after May 2018.

Website Information

The OMHA ALJ Appeal Status Information System serves to allow appellants to check the status of appeals submitted to OMHA.

https://www.hhs.gov/about/agencies/omha/filing-an-appeal/appeals-status-lookup/index.html

https://www.hhs.gov/about/agencies/omha/index.

200.7.5 - Computing 935 Interest on Favorable Decisions from the ALJ And Subsequent Levels

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Interest shall be calculated for each full 30-day period on the amounts applied (by recoupment "involuntary" on or after day 41) to the principal balance. Contractors shall use the interest rate in effect from the ALJ decision date or a subsequent level. **Interest paid under the 935 provisions (is only applicable) after the ALJ or subsequent appeal levels resulted in a full or partial reversal of the prior decision on retained recouped funds applied to the principal balance only.**

A. Elements of 935 Interest Calculation: Contractors shall use the following three elements when calculating 935 interest: 1) Time; 2) Rate; and 3) Amount.

1. **TIME**:

To determine the total calendar days by calculating the days duration, starting from the decision date and counting back to the recoupment date.

a. Divide the number of calendar days by 30 to compute the number of 30-day periods.

b. Calculate each full 30-calendar day period starting from the recoupment date Prior to the decision date for the purpose of calculating the 935 interest.

- Calculate each full 30-calendar day period starting from the recoupment date prior to the decision date. (Excluding any recoupments (involuntary) and voluntary payments (check) applied to an ERS, Immediate Recoupment prior to the QIC decision and any checks received and applied to an overpayment for the purpose of calculating the 935 interest.)

c. The interest will not be payable for any periods of less than 30-calendar days in which we had possession of the recouped funds.

2. **RATE**:

Use the Annual Rate of interest in effect from the ALJ decision date or subsequent level decision date to calculate the 935 interest.

a. Convert annual interest rate to a monthly interest rate.
b. For example: The Rate of Interest as of January 6, 2014, is 10.125%.

c. Convert Rate of Interest to a monthly rate by dividing the interest rate by 12.

3. **AMOUNT**:

The contractor shall calculate the favorable recouped amount/s applied to the principal balance only. The recouped amounts applied to the principal balance from involuntary collections shall be used to compute the 935-interest earned prior to the ALJ or subsequent levels decision date.

a. Recouped monies applied to interest shall not be included in determining the 935 interest.

b. Only those principal funds recouped via withholding (e.g. payments recouped due to a defaulted ERS) are included.

c. Payments made under an ERS or other voluntary payments (e.g., Immediate Recoupment requested by the provider or a check) shall be excluded for purposes of the calculation.

Please Note: Any monies recouped (due to an immediate recoupment request) after the QIC decision is considered to be involuntary.

B. Multiple Recoupments: For scenarios involving multiple recoupments.

a. When there are multiple recoupments, 935 interest shall be calculated separately for each recoupment action; and

b. Once interest is calculated separately, the amount shall be aggregated to compute the total amount due to the provider.

Note: Tolling of days is when providers request additional time to submit the appeal request after the normal timeframe, or include additional evidence to submit for the review to be suspended or delay review.

If the tolled days are **clearly identified in the decision letter by the ALJ or higher**, contractors should follow 42 CFR 405.378 (j)(3)(iv), 42 CFR 405.1014, and 42 CFR 405.1106 and exclude those days for purposes of calculating the 935 interest.

C. Calculation Examples:

1. Fully Favorable Example A:

% Annual Interest Rate for an ALJ or subsequent level: 10.125%

Recoupment Amounts Applied to Principal balance	**Recoup Date to ALJ Date or higher levels**	**Rate of Interest from ALJ or higher levels Decision Date**	**Length of Time Money Held**	**Interest Owed to Provider**
$ 9062	03/07/12- 01/06/14	10.125%	671 Julian Days (22 months)	$1,682.13
$ 5000	05/18/12-01/06/14	10.125%	599 Julian Days (19 months) 20 days- less than 30 days is dropped	$801.56
$ 25,000	08/08/12-01/06/14	10.125%	517 Julian Days (17 months)	$3,585.94
Total 935 Interest owed				**$6,069.63**

Note: When there is less than 30 full days do not use the remaining days for calculation purposes. In the second example above, the remaining "20 days" would not be included for the calculation, only the 19 months is used because there were 19 – full 30-day periods.

Time x Rate x Amount = 935 Interest

1. 22 mos. x (.10125 ÷12) x $ 9062.00 = $ 1,682.13
2. 19 mos. x (.10125 ÷12) x $ 5000.00 = $ 801.56
3. 17 mos. x (.10125 ÷12) x $ 25,000.00 = $ 3,585.94

Total 935 Interest Amount owed to Provider $ 6,069.63

2. **Partially Favorable Example B:**

935 ALJ Interest Calculation Sheet

Date	09/27/21	Clerk ID	C19
Provider #	45213		
AR Transaction #	599619157660006		
AXIOMOATS Case #	887167		
Original OP Amount	$ 1,737.81		
ALJ Revised OP Amount	$ 12.13		
Interest Rate on Date of ALJ Decision or Revised Demand	9.625%		
Date of ALJ Decision (No OP) or Revised Demand Date (Revised OP Amt):	09/13/21	ALJ Decision:	Partially Favorable
Date of FCSO Receipt:	09/15/21		
		Date claim adjustment finalized:	09/23/21
Was provider on immediate recoupment at the time of any of the recoupments? Y or N	No		
Note: If Yes, then interest is payable only after 31-days of from the QIC decision date or revised Demand Date			

Offset Date	Remaining Principal Balance	Involuntary Offset Amt	935 Principal Amount	# of Julian Dates	30 Day Period	Rounded 30 Day Period	935 Interest Amount
01/30/2020	(1,725.68)	$1,725.68	$1,725.68	592	19.733	19	$262.99
		$1,725.68	$1,725.68				$262.99

3. Partially Favorable Example C:

Original Overpayment Principal amount $ 4,608.01
ALJ Partially favorable amount - $ 3,232.80
Revised Overpayment Principal balance $ 1,375.21

Recoupment Date	Principal Amount Recouped	Amt applied to unfavorable revised O/P	935 eligible Principal Balance	ALJ Decision date	# of 30-day Period	% rate	935 interest refund amt.
06/05/12	$1,500.00	$1,500.00	(0)	07/20/15	0		$0
06/06/12	$700.00	$75.21 Line by Line Partial	624.79	07/20/15	38	9.75	$192.90
06/07/12	$832.80	0	$832.80	07/20/15	37	9.75	$250.36
07/05/12	$100.00	0	$100.00	07/20/15	37	9.75	$30.06
07/28/12	$100.00	0	$100.00	07/20/15	36	9.75	$29.25

Time x Rate x Amount = 935 Interest

1. 38 mos. x (.0975÷12) x $ 624.79 = $ 192.90
2. 37 mos. x (.0975÷12) x $ 832.80 = 250.36
3. 37 mos. x (.0975÷12) x $ 100.00 = 30.06
4. 36 mos. x (.0975÷12) x $ 100.00 = 29.25

Total 935 Interest Payment $ 502.57

4. Extrapolation Partially Favorable Example D:

ALJ 935 INTEREST CALCULATION			
Provider Name:		**Total Principal Collections:**	**1135303.47**
AR Number:		**New Overpayment Amount**	**142249.17**
Decision Type:	Partially Favorable	**Less: Suspension Release**	**0**
Original Overpayment Amount:	6,801,349.00	**Less: Payments made by Check**	**0**
Revised Overpayment Amount:	142,249.17	**Less: Loan Payments**	**731549.77**
Revised Accrued Interest:	2,400.46	**Less: Previous Refunds**	**2954.14**
ALJ Decision Date:	03/26/2019	**Less: Favorable Overpayments**	**258550.39**
Revised Overpayment Date:	07/25/2019	**Total Principal 935 Interest Eligible:**	**258550.39**
Interest Rate:	10.75%	**Total Principal 935 used to Calculate 935:**	**yes**
935 Interest Due:	**138,970.84**		
Comments:			

	NAME	DATE
Completed By:		
Reviewed By:		
Management Approval - Partial:		

Recoupment date	Principal Recoupment Amount	Interest Recoupment Amount	935 Interest Eligible Collection	Full 30 Day Cycles	935 Interest
03/26/2014	$ -	$92,137.13	No	60	-
03/26/2014	$	$18,260.32	No	60	-
03/26/2014	$142,249.17	$ -	No -ck	60	-
03/26/2014	$2,954.14	$ -	No -ck	60	-
03/26/2014	$258,550.39	$ -	Yes	60	**$138,970.84**
04/01/2014	$6,728.34	$ -	Loan-voluntary	60	-
05/01/2014	$6,786.12	$ -	Loan-voluntary	63	-
05/01/2014	$	$53,213.88	Loan-voluntary	63	-
06/01/2014	$6,843.38	$ -	Loan-voluntary	62	-
06/01/2014	$	$53,156.62	Loan-voluntary	62	-
07/01/2014	$6,901.12	$ -	Loan-voluntary	61	-
07/01/2014	$	$53,098.88	Loan-voluntary	61	-
08/01/2014	$6,959.35	$ -	Loan-voluntary	60	-
08/01/2014	$	$53,040.65	Loan-voluntary	60	-
09/01/2014	$7,018.07	$ -	Loan-voluntary	59	-
09/01/2014	$	$52,981.93	Loan-voluntary	59	-
10/01/2014	$7,077.28	$ -	Loan-voluntary	58	-
10/01/2014	$	$52,922.72	Loan-voluntary	58	-
11/01/2014	$7,137.00	$ -	Loan-voluntary	57	-
11/01/2014	$	$52,863.00	Loan-voluntary	57	-
12/01/2014	$7,197.21	$ -	Loan-voluntary	56	-
12/01/2014	$	$52,802.79	Loan-voluntary	56	-
01/01/2015	$7,257.94	$ -	Loan-voluntary	55	-
01/01/2015	$	$52,742.06	Loan-voluntary	55	-

02/01/2015	$7,319.18	$ -	Loan-voluntary	54	-
02/01/2015	$	$52,680.82	Loan-voluntary	54	-
03/01/2015	$7,380.93	$ -	Loan-voluntary	53	-
03/01/2015	$	$52,619.07	Loan-voluntary	53	-
04/01/2015	$47,443.21	$ -	Loan-voluntary	52	-
04/01/2015	$	$52,556.79	Loan-voluntary	52	-
05/01/2015	$47,843.51	$ -	Loan-voluntary	51	-
05/01/2015	$	$52,156.49	Loan-voluntary	51	-
06/01/2015	$48,247.19	$ -	Loan-voluntary	50	-
06/01/2015	$	$51,752.81	Loan-voluntary	50	-
07/01/2015	$48,654.28	$ -	Loan-voluntary	49	-
07/01/2015	$	$51,345.72	Loan-voluntary	49	-
08/01/2015	$49,064.80	$ -	Loan-voluntary	48	-
08/01/2015	$	$50,935.20	Loan-voluntary	48	-
09/01/2015	$	$50,521.22	Loan-voluntary	47	-
09/01/2015	$49,478.78	$ -	Loan-voluntary	47	-
10/01/2015	$	$50,103.74	Loan-voluntary	46	-
10/01/2015	$49,896.26	$ -	Loan-voluntary	46	-
11/01/2015	$	$49,682.74	Loan-voluntary	45	-
11/01/2015	$50,317.26	$ -	Loan-voluntary	45	-
12/01/2015	$	$49,258.19	Loan-voluntary	44	-
12/01/2015	$50,741.81	$ -	Loan-voluntary	44	-
01/01/2016	$	$48,830.05	Loan-voluntary	43	-
01/01/2016	$51,169.95	$ -	Loan-voluntary	43	-
02/01/2016	$	$48,398.31	Loan-voluntary	42	-
02/01/2016	$51,601.69	$ -	Loan-voluntary	42	-
03/01/2016	$	$47,962.92	Loan-voluntary	41	-
03/01/2016	$52,037.08	$ -	Loan-voluntary	41	-
04/01/2016	$	$47,523.86	Loan-voluntary	40	-
04/01/2016	$50,448.03	$ -	Loan-voluntary	40	-
05/09/2016	$	$4,504.19	No	39	-
05/10/2016	$	$768.93	No	39	-
05/17/2016	$	$147.33	No	38	-
05/18/2016	$	$895.34	No	38	-
05/25/2016	$	$1,119.57	No	38	-
06/16/2016	$	$1,270.85	No	37	-
06/23/2016	$	$1,805.01	No	37	-
06/28/2016	$	$1,580.27	No	37	-
06/29/2016	$	$3,551.93	No	37	-
07/01/2016	$	$3,542.16	No	37	-
07/08/2016	$	$2,886.24	No	37	-
07/11/2016	$	$6,785.34	No	36	-
07/13/2016	$	$890.36	No	36	-
07/26/2016	$	$1,438.45	No	36	-
08/05/2016	$	$497.48	No	36	-
08/10/2016	$	$2,486.16	No	35	-
08/11/2016	$	$602.27	No	35	-
08/16/2016	$	$765.90	No	35	-
08/18/2016	$	$854.74	No	35	-
08/23/2016	$	$686.88	No	35	-
09/14/2016	$	$413.57	No	34	-
09/26/2016	$	$2,638.57	No	34	-
10/05/2016	$	$3,605.91	No	34	-
10/11/2016	$	$1,916.53	No	33	-
10/18/2016	$	$872.56	No	33	-
10/19/2016	$	$1,541.62	No	33	-
12/12/2016	$	$558.72	No	31	-
12/15/2016	$	$3,285.16	No	31	-
12/21/2016	$	$602.27	No	31	-
01/09/2017	$	$775.35	No	30	-
01/11/2017	$	$4,505.74	No	30	-
01/12/2017	$	$2,330.08	No	30	-
01/17/2017	$	$686.88	No	30	-
02/08/2017	$	$628.47	No	29	-
02/14/2017	$	$2,249.28	No	29	-
02/23/2017	$	$1,276.13	No	29	-
04/21/2017	$	$22.01	No	27	-
10/01/2018	$	$506.20	No	9	-
02/04/2019	$	$129.63	No	5	-
05/13/2019	$	$1,273.09	No	2	-

200.8- Tracking and Report on the 935 Interest Payments

(Rev. 12509; Isuued:02-15-24; Effective: 07-01-24; Implementation: 07-01-24)

Contractors shall report 935 interest paid each calendar quarter based on an ALJ or subsequent level decision for fully and partially favorable decisions that were reversed from the previous decision.

- Report 935 Interest payment amounts on all provider types.
- When a provider has more than one decision, those amounts shall be aggregated.

Report shall be sent electronically to:

Medicareoverpayments@cms.hhs.gov.

The contractor shall have 30 calendar days from the end of the calendar quarter to submit the report to CMS.

Exhibit 1: 935 Interest Payment Tracking Report

1st Quarter: October, November and December
2nd Quarter: January, February and March
3rd Quarter: April, May and June
4th Quarter: July, August and September

Include the following on the report:

1. Provider Name
2. Appeal Case #
3. Decision Date
4. Decision
5. 935 Interest Amount

Example:

Provider Name	Appeal case #	Decision Date	Decision	935 Interest-Amount
ABC DME Home	XXXXXXXXX	01/03/2019 Favorable	Fully	135000
Georgia Homecare	XXXXXXXXX	01/05/2019	Fully Favora	25000
Total Care	XXXXXXXXX	01/18/2019 Favorable	Partially	29
Maximum Health group	XXXXXXXXX	01/29/2019 Favorable	Partially	156000
Total				**$316029**

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R13825FM	06/11/2026	Updates to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayments, Section 140-140.8.4 - Bankruptcy	07/13/2026	14418
R13235FM	05/22/2025	Updates to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayments, Sections 120 and 130	06/23/2025	14071
R13183FM	04/24/2025	100-06 Internet Only Manual (IOM) Updates - Chapter 3 - Beneficiary Liability	05/27/2025	14044
R12946FM	11/08/2024	Medicare Financial Management Manual Chapter 3 - Overpayments 10-90 Updates 2024	12/10/2024	13753
R12509FM	02/15/2024	Updating Chapter 3, Sections 200.5 - 200.8, Limitation on Recoupment; Medicare Overpayments Manual	07/01/2024	11808
R12261FM	09/22/2023	Updating Overpayment Manual, Chapter 3, Sections 200.2.6-200.4.7, Limitation on Recoupment	12/11/23	11262
R12236FM	09/07/2023	Updating Overpayment Manual, Chapter 3, Sections 200.2.6-200.4.7, Limitation on Recoupment– Rescinded and replaced by Transmittal 12261	12/11/2023	11262
R11787FM	01/19/2023	Publication (Pub.) 100-06, Chapter 4, Section 70 Revision (Removal of Debt Collection System References and Corresponding Updates) and Inclusion of Existing Debt Close-Out (Termination of Collection Action) Instructions	04/21/2023	12858
R11124FM	11/18/2021	Updates to Medicare Financial Management Manual Chapter 3, Section 140.1 Bankruptcy Forms	12/21/2021	12518
R335FM	01/31/2020	Updates to Medicare Financial Management Manual Chapter 3, Section 140.1 Bankruptcy Forms	03/02/2020	11386
R315FM	05/17/2019	Update to Publication (Pub.) 100-06 to Provide Language-Only Changes for the New Medicare Card Project	06/18/2019	11211
R311FM	02/22/2019	Updating Chapter 3, Section 200, Limitation on Recoupment; Medicare Overpayments Manual, 2 of 4 CRs	10/07/2019	10336

R293FM	09/14/2017	Revision to Publication 100-06, Chapter 3, Medicare Overpayment Manual, Section 200, Limitation on Recoupment	04/02/2018	9815
R292FM	09/01/2017	Revision to Publication 100-06, Chapter 3, Medicare Overpayment Manual, Section 200, Limitation on Recoupment	04/02/2018	9815
R294FM	10/06/2017	Pub. 100-6, Chapter 3 and 4 Revisions	07/03/2017	10079
R285FM	06/02/2017	Pub. 100-6, Chapter 3 and 4 Revisions	07/01/2017	10079
R275FM	11/18/2016	Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision	02/21/2017	9708
R260FM	01/29/2016	Revision to Chapter 3 Section 200: Limitation on Recoupment - Medicare Overpayments Manual	03/01/2016	9458
R227FM	09/17/2013	Removal of POR and PSOR instructions and the Glossary of Acronyms from the Internet Only Manual, Publication 100-06, Chapter 3	10/04/2013	8322
R225FM	09/04/2013	Removal of POR and PSOR instructions and the Glossary of Acronyms from the Internet Only Manual, Publication 100-06, Chapter 3	10/04/2013	8322
R224FM	08/02/2013	Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS)	09/03/2013	8347
R222FM	06/14/2013	Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayments; Section 140.2.3 - Filing Bankruptcy Draws a Line in the Sand	07/17/2013	8324
R220FM	06/07/2013	Removal of POR and PSOR instructions and the Glossary of Acronyms from the Internet Only Manual, Publication 100.06, Chapter 3 – Rescinded and replaced by Transmittal 225	07/09/2013	8322
R205FM	02/09/2012	Immediate Recoupment for Fee For Service Claims Overpayments	07/02/2012	7688
R204FM	01/27/2012	Immediate Recoupment for Fee For Service Claims Overpayments – Rescinded and replaced by Transmittal 205	07/02/2012	7688
R141FM	09/12/2008	Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments	09/29/2008	6183

R106FM	08/25/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment	06/26/2006	5105
R100FM	07/03/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment - Replaced by R106FM	06/26/2006	5105
R97FM	05/26/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment – Replaced by R100FM	06/26/2006	2801
R87FM	1/03/2006	Update to Carrier Demand Letter Appeals Language	01/03/2006	4211
R64FM	02/11/2005	For Fiscal Intermediaries (FIs), a new Provider Type 80, Status Code CH, and Method of Recoupment codes. For Carriers and Durable Medical Equipment Regional Carriers (DMERCs) Status Code 2	03/14/2005	3641
R61FM	12/10/2004	New Location Code ICC, Status Code AR and Modified Intent Letter for Unfiled Cost Reports Only	01/10/2005	3563
R47FM	06/25/2004	Expanded Identification and Workload Reporting for CMS Medicare Systems	10/04/2004	3256
R43FM	04/30/2004	Replaced by Revision 47FM	10/04/2004	3256
R41FM	04/30/2004	Change in Interest Calculation for Medicare Overpayments and Underpayments and Medicare Secondary Payer (MSP) Recoveries	10/04/2004	3163
R29FM	01/02/2004	Revisions to Chapter 3 & 4	02/06/2004	2911
R25FM	11/03/2003	Rates of Interest – FIs and Carriers	11/03/2003	2828
R22FM	10/03/2003	Provider Overpayment Reporting System	10/20/2003	2782
R12FM	10/18/2002	Rewrite of Chapter 3	10/25/2002	2350
R03FM	08/30/2002	Initial Publication of Chapter	N/A	N/A

Back to top of chapter