CMS Manual System

Pub. 100-06 Medicare Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2911

I. SUMMARY OF CHANGES: This transmittal reconfigures and revises Chapters 3 & 4.

NEW/REVISED MATERIAL - EFFECTIVE DATE: February 6, 2004
***IMPLEMENTATION DATE: February 6, 2004**

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

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*** III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

CROSSWALK FOR CHAPTER 3

Previous Manual	Revision in this Transmittal
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10 - Interest Charges/Payments on Overpayments and Underpayments - General	10 – Overpayments Determined by the FI or Carrier
20 - Overpayment for Provider Services – General	20 – Recovery of Cost Report Overpayments- Cost Report Filed
30 - Determination of Amount of Provider overpayment	30 – Recovery of Cost Report Overpayments- Overdue Cost Report
40 - FI Referral to RO of Potentially Uncollectible Provider Overpayments	40 – Recovery of Claims Accounts Receivables from the Provider- FI Only
50 - Referral to the Department of Justice (DJ)	50 – Recovery of Overpayments When a Provider Changes its FI- FI Only
60 - Recovery of Overpayments, Due to Other Causes, Where a Cost Report Is Filed	60 – Interim Rate Adjustments and Periodic Interim Payment Adjustments – FI Only- **NEW**
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80 - Recovery of Overpayments When a Provider Changes Its FI	80 – Individual Overpayments Discovered Subsequent to the Third Year
90 - Individual Overpayments - General	90 – Provider Liability
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Medicare Financial Management Manual

Chapter 3 - Overpayments

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(Rev. 29, 01-02-04)

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Attachment A - Referral Checklist in Word format ***(41.9 KB)***
Attachment A - Referral Checklist in PDF format ***(PDF, 115 KB)***
Attachment B - Contractor Bankruptcy Checklist in Word format ***(30.5 KB)***
Attachment B - Contractor Bankruptcy Checklist in PDF format
(PDF, 57.6 KB)

10 - Overpayments Determined by the FI or Carrier

(Rev. 29, 01-02-04)

Overpayments are Medicare payments a provider or *beneficiary* has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor 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 attempt collection of claims of the Federal Government for money arising out of the activities of the agency. The FI or carrier will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part, *however once an intermediary or carrier determines an overpayment has been made* it must attempt recovery of overpayments in accordance with CMS regulations.

The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demands for repayment, and establishment of repayment schedules, suspension of interim payments by intermediaries to institutional providers, and recoupment or setoff, where appropriate.

In addition, The Debt Collection Improvement Act of 1996 requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center

(DCC) for cross servicing and offset. CMS is mandated to refer all eligible debt over 180 days delinquent for cross servicing and offset.

This chapter deals with two general types of overpayments.

Aggregate overpayments involve a group or all of a Part A provider's claims, e.g., overpayments discovered at cost-report settlement time or change of FI, overpayments resulting from a pattern of improper application of Medicare coverage provisions, overpayments resulting from a periodic interim payment adjustment, situations involving provider failure to file a cost report, or occasions of fraud or program abuse. Aggregate overpayments are described in §10.1, §20 and §30 of this chapter and Chapter 4, Debt Collection.

Individual overpayments refer to incorrect claims payment for services under Part A or Part B. Individual overpayments are described in §10.2, §80ff and Chapter 4, Debt Collection. Medicare Secondary Payer (MSP) instructions can be found in the Medicare Secondary Payer Manual, CMS Publication 100-5.

10.1 - Aggregate Overpayments

(Rev. 29, 01-02-04)

A - Institutional providers serviced by FIs

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

- A pattern of furnishing and billing for excessive or noncovered services (see Program Integrity Manual);
- Inclusion of non-allowable or excessive costs in the provider's cost report;
- Excessive interim payments made to the provider;
- Failure to repay accelerated payments;
- Failure to file cost reports (Chapter 3, §30);or
- Determination of amounts due upon filing the cost report, during desk review, final settlement and reopening of the cost report.

10.2 - Individual Overpayments

(Rev. 29, 01-02-04)

An individual overpayment is an incorrect payment for provider or physician services made under title XVIII.

Examples of individual overpayment cases are:

- Payment for provider, supplier or physician services after benefits have been exhausted, or where the individual was not entitled to benefits.
- Incorrect application of the deductible or coinsurance.
- Payment for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.
- Payment based on a charge that exceeds the reasonable charge.
- Duplicate processing of charges/claims.

- Payment to a physician on a non-assigned claim or to a beneficiary on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-entitlement.

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. 29, 01-02-04)

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 FI sends the first 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 FI sends the first 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 a first demand letter must also be sent. The NPR and the first demand letter may be sent simultaneously, the first demand letter may be sent as a separate document or the first demand letter may be incorporated into the NPR. If the issuance of the NPR changes the facts as stated in prior demand letters, the FI 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 30 days after the date of the first demand letter, the FI sends a second demand letter notifying the provider of the FI's 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.) If appropriate, the FI shall advise the provider that action to withhold its Federal share of Medicaid payments has been requested. The FI shall attempt to make personal (or telephone contact) with the provider, *15* days after sending the second demand letter to encourage either a lump-sum refund or a request for an extended repayment plan. It shall document each contact. *(See Chapter 4, §10-20)*

If there is no response or if the overpayment is still outstanding 30 days after the date of the second demand letter the FI shall send a third demand letter. *If eligible,*

the third demand 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. 29, 01-02-04)

If the FI 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 FI 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 first 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. 29, 01-02-04)

If the FI 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 first demand letter shall be sent and all subsequent collection activities performed as specified in *§20.1 and Chapter 4, §10-20.*

The first 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 second demand letter must provide notice that action to withhold its Federal share of Medicaid payments has been requested and will be initiated if repayment arrangements are not made. The FI shall send the third demand letter 30 days following the second where 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. 29, 01-02-04)

When a provider fails to submit a cost report by the due date the FI 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. 29, 01-02-04)

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 FI must send the first demand letter in Chapter 4, §20. (The seven-day timeframe allows for processing and mail time.) In addition the FI 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. (See Chapter,)

If the provider does not respond within 30 days of the first demand letter, the FI shall send the second demand letter. *(See Chapter 4, §20)*

The FI shall make a personal (or telephone) contact with the provider 15 days after mailing the second demand letter. It shall determine any problems the provider might be having in preparing the cost report, and if, and when, the provider expects to complete and submit it. It shall document the provider's response.

If the provider does not respond within 30 days of the second demand letter, the FI shall send the third demand letter. *(See Chapter 4, §20)*

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

(Rev. 29, 01-02-04)

Where the provider's Medicare agreement has terminated, *Medicare requires that a terminating cost report be filed with the intermediary within 150 days from the date of termination.* If the cost report is not received timely, it shall immediately send the first demand letter. *(See Chapter 4, §20)* The second and third demand letters follow at 30-day intervals if no response is received. *If the third demand letter does not generate a response, the FI shall refer the case to the Department of Treasury.*

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

(Rev. 29, 01-02-04)

Where a provider's agreement under title XVIII has terminated and one or more cost reports have not been submitted the FI shall send the first 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 first demand letter provides notice that initiation of the procedure for withholding the Federal share of Medicaid payments will begin in 15 days if the FI does not receive the cost report.

The FI shall continue sending demand letters to the provider. *(Chapter 4, §20 for the requirements for the second and third demand letters)* The demand letters must be sent at 30-day intervals where the provider has not responded even though the procedures for withholding the Federal share of Medicaid payments have been initiated.) 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. 29, 01-02-04)

Intermediary claims A/R arises from adjustments in the intermediary's claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). 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 intermediary that an adjustment was required, or an adjustment created from a credit balance report, CMS-838. 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. 29, 01-02-04)

The FI 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 must 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 HI number of the beneficiary involved;
- 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 is occurring;
- A reference to the Appeals rights in the remittance advice;

40.2- Sample Demand Letter for Claims Accounts Receivables

(Rev. 29, 01-02-04)

Below is a sample demand letter that FIs may use when demanding Claims Accounts Receivables. The Extended Repayment Plan enclosure can be found at Chapter 4, §20, Exhibit 2.

Date

Certified Mail

Name/Address

Re: Provider Number
Claims Accounts Receivable

Dear _____:

On _____, a claim adjustment was entered in our system under provider _____ for $_____. Since then, adjustments were made to the claim and a balance in the amount of $_____ has been outstanding for 60 days. As this amount has not been recouped through claims submission, the purpose of our letter is to request that this amount be repaid to our office. For your reference, a copy of the Claims Accounts Receivable Transaction Summary is enclosed. (Insert the name of the detailed summary report enclosed. This report should include sufficient information needed by the provider to identify the overpayment).

Please submit your check payable to _____, to the following address:

In order to ensure that your check is credited to this overpayment, please enclose a copy of this letter with your payment.

Until payment in full is received or an acceptable extended repayment request is received all payments due to you are being withheld. (This includes claims, settlement amounts, or interim payments.) If you have reason to believe that withhold should cease you must notify our office before _____ and provide documentation as to why this withholding action should not continue. We will review your documentation, but will not delay recoupment during the review process. This is not an appeal of the overpayment determination.

In addition, in accordance with 42 C.F.R. §405.378, simple interest at the rate of _____% will be charged on the unpaid balance of the overpayment, beginning on the 31st day. For periods of less than 30 days, the full monthly interest charge will be applied. Thus, if payment is received 31 days from the date of the final determination, two 30-day periods of interest will be charged. Each payment will be applied first to accrued interest and the remaining amount to principal.

Additional interest of $___ will be assessed against the principal balance on _____ and will continue to assess at the rate of ___% a year for each 30-day period the principal amount remains unpaid. In addition, please note that Medicare rules require that payment be either received in our office by ___ or United States Postal Service postmarked by that date in order for the payment to be considered timely. A metered mail postmark received in our office after ___ will cause an additional month's interest to be assessed on the debt.

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

If you feel you have reason to appeal this adjustment, please refer to the original remittance advice dated _____ for additional instruction.

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

If you have a question regarding why these adjustments were made, please contact our _____at _____. If we can assist you further in the resolution of this matter, we will be glad to do so. We look forward to hearing from you shortly.

Sincerely,

(name and title)

Enclosure

50 - Recovery of Overpayments When a Provider Changes Its FI- FI Only

(Rev. 29, 01-02-04)

Where CMS approves a change of FI, 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 FI

(Rev. 29, 01-02-04)

The outgoing FI 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 FI is also responsible for assuring that the incoming FI 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 FI is responsible for initiating the withholding of Title XIX payments (Medicaid) and for referring the overpayment to the Department of Treasury. The outgoing FI must copy the incoming FI on all correspondence with the provider to ensure a timely collection process.

A - Notification to Incoming FI

When the outgoing FI is notified by the RO that the provider's request for a change of FI has been approved, it shall notify the incoming FI 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; and
- *The original balance of the overpayment and the current principal and interest balance of the overpayment.*

The outgoing FI should also notify the incoming FI 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 FI the outgoing FI is recouping an overpayment by the withholding of interim payments the incoming FI will continue the withhold. The outgoing FI must notify the provider that the withhold will be continued by the incoming FI until the overpayment is liquidated or an acceptable ERS is approved. In addition, the outgoing FI must notify the incoming FI of the details of the withhold.

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

50.2 – Action by Incoming FI

(Rev. 29, 01-02-04)

The incoming FI is responsible for effectuating final settlements for the cost report periods after the change of FI becomes effective. If the FI receives a cost report from a prior period it should forward it to the outgoing FI to make the final settlement. If the outgoing FI is no longer participating in the Medicare program, the incoming FI shall contact the RO for further instructions.

After the outgoing FI has completed its review of the cost report, it notifies the incoming FI whether the cost report is acceptable, and the final settlement. The incoming FI, 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 FI, the incoming FI must keep the outgoing FI up to date regarding the provider's location and participation in the Medicare program. If the incoming FI learns of a provider's termination from the Medicare program it must notify the outgoing FI so that it may act accordingly.

A. Reduction of Outstanding Overpayment

Any actions taken by the incoming FI which reduce or eliminate the overpayment made by the outgoing FI shall be communicated, in writing, to the outgoing FI within 5 working days after the month in which the actions occurred. In addition, unless the provider indicates to the contrary, any collections or payment are applied first to the earliest overpayment. See Chapter 5, Financial Reporting for instructions on transferring any payment(s) between FIs.

50.3 - Extended Repayment Plan - Change of FI

(Rev. 29, 01-02-04)

Either the incoming or outgoing FI may negotiate an extended repayment plan. The need for an extended repayment plan must be documented in accordance with *Chapter 4, §50.* The FI that negotiates the repayment plan notifies the other about the terms. Referral to the RO with recommendations is required where the plan exceeds 12 months. Payments under the repayment plan should be made to the FI that negotiated the repayment plan.

Where an extended repayment plan is in effect at a change of intermediaries, and the provider later requests a revision in the terms of the existing repayment, either the incoming or outgoing FI may renegotiate the repayment plan depending upon which receives the provider's request. The need for a revision of the existing repayment plan must be documented in accordance with *Chapter 4, §50.* The FI that renegotiates the repayment plan notifies the other about the revised repayment plan within 5 working days and collects the required payments. Collections received by the incoming FI pursuant to a repayment plan negotiated by it are reported to the outgoing FI and RO within 5 working days after the month in which the collections were received.

60- Interim Rate Adjustments and Periodic Interim Payment Adjustments – FI only

(Rev. 29, 01-02-04)

The interest provisions of Chapter 4, §30 do not apply to FI 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 adjustment of the payments would provide a hardship to the provider and an extended repayment plan is requested instead, interest shall accrue on the overpayment. The interest rate charged shall be the rate in effect on the date the notice of payment adjustment was sent to the provider unless a specific instruction is issued as in the case of Interim Payment System (IPS) recoveries for FY 1998 & 1999 (Transmittal A-99-47). This is true for any entity that is reimbursed in such a way that interim rate adjustments and/or periodic interim payment adjustments are required.

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 FI will issue a tentative settlement payment, tentative settlement demand letter, or Notice of Program Reimbursement. When a demand letter or Notice of Program Reimbursement is issued, interest will be assessed if necessary, and the provider will be notified of it's appeal rights. Any determined overpayment shall then be recouped.

70 – Determining Liability and Waiver of Recovery for Overpayments

(Rev. 29, 01-02-04)

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, Chapter 31, Limitation On Liability.

The FI or carrier shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most FI 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 FI or carrier determines that it was without fault with respect to the overpayment.

If the FI or carrier 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. 29, 01-02-04)

Section 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 (prepay or postpay) 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 PIM Exhibits, §14.1)

A. <u>Limitation on Liability – Indemnification Procedures for Claims Filed under Part B</u> – Section 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/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 the limitation on liability provision. (See PIM 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. 29, 01-02-04)

For denials of nonassigned claims based on §1862(a)(1) involving physician services, the carrier 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 postpayment denials. (See PIM Exhibits, §14.3)

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment

(Rev. 29, 01-02-04)

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).*

Carriers make 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 the overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims denied under §1862(a)(1) of the Act for not being reasonable and necessary. Section 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. Section 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 third 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 FI or carrier makes these determinations.

B - 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 unnecessary services, then limitation on liability does not apply.

C – 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 third 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 Third Year

(Rev. 29, 01-02-04)

There are special rules that apply when an overpayment is discovered subsequent to the third 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 FI or carrier will not recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See PIM, Chapter 3.)

Example 1: On May 9, 2003 Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On January 6, 2007 the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The FI or carrier will not recover this overpayment as long as there is no evidence to the contrary because it was determined subsequent to the third year after notification of payment. (Any determination date later than Jan. 1, 2007 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, 2003 Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On September 20, 2006 the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The FI or carrier will attempt recovery of the overpayment. (Any determination dates up to Dec. 31, 2006 will be recovered.)

80.1 How to Determine the Third Calendar Year after the Year the Payment Was Approved

(Rev. 29, 01-02-04)

Only the year of the payment and the year it was found to be an overpayment enter into the determination of the 3-calendar year period. The day and the month are irrelevant. With respect to payments made in 2000, the third calendar year thereafter is 2003. For payments made in 2001, the third calendar year thereafter is 2004, etc. Thus, the rules apply to payments made in 2000 and discovered to be overpayments after 2003, to payments made in 2001 and discovered to be overpayments after 2004, 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 third 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 third 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, Chapter 30, Limitation on Liability.*

Reopenings *(See Medicare Claims Processing Publication 100-4, 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 FI or carrier will not recover the overpayment.

90 - Provider Liability

(Rev. 29, 01-02-04)

A provider is liable for overpayments it received unless it is found to be **without fault**. The FI or carrier, as applicable, makes this determination.

The FI or carrier considers a provider **without fault**, if it exercised reasonable care in billing for, and accepting, the payment; i.e.,

- It made full disclosure of all material facts; **and**
- On the basis of the information available to it, 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 FI or carrier's attention.

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

90.1 - Examples of Situations in Which Provider Is Liable

(Rev. 29, 01-02-04)

In accordance with *§90* the following are examples of situations in which the provider is liable for an overpayment it received.

A - The Provider 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 failed to report any additional payments he may have received from the beneficiary and situations in which a provider failed to request applicable information from the beneficiary including, but not limited to, information needed by the FI or carrier 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 are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help the FI or carrier 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 29, Coordination With Medigap Insurers.)

EXAMPLE 1: A provider submitted an assigned claim showing total fees of $600. The provider did not indicate on the CMS-1500 that any portion of the bill had been paid. After the deductible and coinsurance you determined the amount owed to the provider was $480 on the assumption that the provider had received no other payment. You later learned that the beneficiary had paid the provider $200 before the provider submitted his claim. Thus, the payment should have been split; i.e., $400 should have been paid to the provider and $80 to the beneficiary. The physician was at fault in causing the $80 overpayment since he failed to inform you of the amount he had received from the beneficiary.

B - Provider Receives Duplicate Payments.

This includes the following situations:

- Provider is overpaid because the FI or carrier processed the provider's claim more than once. If an overpayment to a provider is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the provider does not have a reasonable basis for assuming that the total payment the provider received was correct and thus should have questioned it. The provider is, therefore, at fault and liable for the overpayment.
- Provider received payment from Medicare on the basis of an assignment and a beneficiary received payment on an itemized bill and turned the beneficiary payment over to the provider. The provider is liable for only the portion of the total amount paid in excess of the provider'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, the provider is liable for that amount also. If the provider protests recovery of the overpayment on the grounds that the provider applied all or part of the check received from the beneficiary to amounts the beneficiary owed the provider for other services, the beneficiary, rather than the provider, 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 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, Chapter 29, Coordination With Medigap Insurers.) The provider 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, Chapter 29, Coordination With Medigap Insurers and/or Medicare Secondary Payer Manual.) However, if the provider 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 Could Have Known From Its Own Records the Beneficiary's Utilization Status.

Part A Provider 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 could have known the beneficiary's utilization status from its own records.

The provider 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, 2000. 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 FI for 30 days of inpatient hospital care. The FI 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 FI 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 FI 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 FI would seek recovery from the beneficiary.

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

Examples:

- Error in calculation by the FI or carrier in calculating reimbursement;
- Error by the provider in calculating charges, or
- Overlapping or duplicate bills.

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

E - The Provider Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

F - The Provider 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: www.cms.hhs.gov/manuals/cmsindex.asp, if fraud is suspected.)

G - The Beneficiary Was Not Entitled to Part A Benefits and the Provider Had Reason to Believe That the Beneficiary Was Not Entitled to Such Benefits.

For example, the Social Security Office notified the hospital that the individual was not entitled to hospital insurance benefits.

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

1. Services Other Than 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 Medicare Benefit Policy, Chapter 17, Exclusions.)

   In general, the provider should have known about a policy or rule, if:

   - The policy or rule is in the provider manual or in Federal regulations,

- The FI or carrier provided general notice to the medical community concerning the policy or rule, or
- The FI or carrier gave written notice of the policy or rule to the particular provider.

Generally, a provider's 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 was not at fault. The FI or carrier shall consider all of 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 FI or carrier misinformed the provider about the rule; in deciding whether a provider acted reasonably in billing for and accepting payment for noncovered services.

2. Medically Unnecessary or Custodial Services.

   The FI or carrier shall apply the criteria in Medicare Claims Processing, Chapter 31, Limitation on Liability in determining whether the provider should have known that the services were not covered.

I - For FIs, The Overpayment Resulted From Services Rendered in a Nonparticipating Portion of the Facility or in a Bed Certified for a Type of Care Other Than That Furnished.

J - For Carriers, The Physician Was Paid but Did Not Accept Assignment.

The physician is liable whether or not the beneficiary had also been paid.

K - For Carriers, Overpayment Was for Rental of Durable Medical Equipment and 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 on the basis of 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 carrier a statement that it assumes unconditional responsibility for rental overpayments for periods after the beneficiary's death or while he was institutionalized or while he no longer needed or used the equipment.

L - For Carriers, 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 Protests Its Liability

(Rev. 29, 01-02-04)

A provider's reply to a notification that the provider is liable for an overpayment may indicate dissatisfaction with some aspect of the overpayment decision. Such a protest should be considered a request for a reconsideration (Part A) or review (Part B). In conducting the appeal, the FI or carrier shall consider whether

a. There was an overpayment;

b. The amount of the overpayment was correctly calculated; and whether,

c. The provider is liable for repayment.

NOTE: Receipt of an appeal request does not delay or stop collection efforts on the overpayment.

100 - Beneficiary Liability

(Rev. 29, 01-02-04)

A beneficiary is liable for:

- Overpayments made to a provider that was without fault with the exception of 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 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. 29, 01-02-04)

When the FI or carrier 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 make a decision 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 make a decision 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 make a recommendation to approve or deny 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. 29, 01-02-04)

When the FI or carrier 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 and FI or carrier knowledge of the other plan or program, the FI or carrier believes there is a possibility that the other plan 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 FI or carrier 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 FI or carrier 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 FI or carrier shall use any one or a combination, as it finds appropriate. The most desirable method in a

given situation depends upon the particular circumstances, and the provisions of the other plan or program.

- The FI or carrier shall arrange with the other plan or program for direct refund of overpayments to it. If the FI or carrier 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 FI or carrier 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 FI or carrier 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 FI or carrier 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 FI's or carrier's request, (even though the provider has not billed the other plan or program) and to notify the FI or carrier of the payment. Upon receiving such a notice, the FI or carrier shall recover the Medicare overpayment from the provider.
- Where neither of the above methods is possible, the FI or carrier 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 FI or carrier 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 FI or carrier shall ask it to bill the other plan or program and to use the payment to refund the overpayment. If the FI or carrier 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 FI or carrier 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 FI or carrier 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.* 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 FI or carrier shall not attempt recovery from the beneficiary.

110.2 - Recovery From the Beneficiary

(Rev. 29, 01-02-04)

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.

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 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.

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

1. *Send a follow-up letter to the beneficiary, and*
2. *Arrange to begin recoupment 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) ***Prepare the case for referral to SSA for possible recovery from the individual's social security benefits****.*

However, if the HI number has a T or M suffix, do not refer the case to SSA since those beneficiaries are not entitled to monthly social security benefits. Offset should be continued in the case of beneficiaries whose HI number ends in T or M. If appropriate, the instructions for termination of collection action (See 110.3D for additional instructions.) should be followed.

The FI or Carrier 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 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.

Please submit this information, including the status of probate, if applicable, with an

Example:

Region #	Carrier #	Bene. Hic #	Claim #
xx	xxxxx	xxxxxxxxxx	xxxxxxxxxxxxxxxx

Claim paid date	Demand letter date	Det. date.	$ amt.
xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxx

explanation for the beneficiary Non-MSP overpayment Write-off.

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

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. 29, 01-02-04)

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 FI or carrier shall make no further recovery efforts until it disposes of the appeal request. *(See §110.9.)*

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

C - The Beneficiary Is Receiving Welfare Benefits

If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, the FI or carrier shall ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. *(See §110.1.)* If the welfare agency does not refund the overpayment in full, the FI or carrier 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. 29, 01-02-04)

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 carrier'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.)*

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.)*

110.5 - Sample Demand Letter to Beneficiary

(Rev. 29, 01-02-04)

The FI or carrier 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 FI or carrier 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 (FI or carrier 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 FI or carrier 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 FI or carrier 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 FI or carrier 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. 29, 01-02-04)

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

A - Inpatient Hospital Deductible or Coinsurance Not Properly Assessed - FI

1 - General - FI

"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 -Carrier

"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 (FI or carrier 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. 29, 01-02-04)

Where a beneficiary who is liable for an overpayment dies, the FI or carrier shall attempt to recover from such sources as State welfare agencies, or private insurance plans (see §110.1), 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, but shall not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The FI or carrier 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 (FI or carrier 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 FI or carrier 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 (FI or carrier name) in the enclosed, self-addressed envelope within 30 days.

NOTE: The FI or carrier 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. 29, 01-02-04)

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 effect recovery within 3 years; however, the FI or carrier 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 FI or carrier shall specify the amount (not less than $10) and the number of monthly installments necessary to recovery the overpayment.

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

The FI or carrier 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 FI or carrier shall treat such statement as a request for waiver. (See §110.9)

B - Notification of Installment Schedule

When agreement is reached with a beneficiary for refund by installments, the FI or carrier 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 Health Insurance Claim Number

Beneficiary's Address

I hereby agree to repay my Medicare overpayment totaling $ _____ to (FI or carrier 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 FI or carrier 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 FI or carrier learns that the beneficiary is deceased, see §110.7.

E - Beneficiary Can No Longer Afford Installment Amount But Can Afford a Lesser Amount

If the beneficiary notifies the FI or carrier that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the FI or carrier 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. 29, 01-02-04)

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, carrier fair hearing, or ALJ hearing as applicable, or a request for both waiver and appeal.

A - Protests To Treat As Requests Administrative Appeal

The FI or carrier shall consider a beneficiary's reply 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 FI or carrier 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 FI or carrier 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 FI or carrier

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 FI or carrier shall send the beneficiary another request for refund of the overpayment (including all information in §110.5), 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 FI or carrier 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 FI or carrier 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 FI or carrier shall conduct the appeal prior to the waiver determination.

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

(Rev. 29, 01-02-04)

The FI or carrier 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 FI or carrier makes a waiver determination.

The FI or carrier shall first determine if the beneficiary was without fault see §70.3. If it appears that the beneficiary was without fault the FI or carrier 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 of his or her current income to meet ordinary and necessary living expenses. (See 20 CFR §405.508)*

The FI or carrier 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 FI or carrier believes that the waiver of recovery is appropriate the FI or carrier 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 FI or carrier 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- FI

(Rev. 29, 01-02-04)

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 FI 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 FI 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 - Referral to the Department of Justice (DOJ)

(Rev. 29, 01-02-04)

If the FI/Carrier's attempts to recover an overpayment are unsuccessful and the FI/Carrier believes that the overpayment may be recovered through litigation the FI/Carrier should informally refer the overpayment to the RO to explore the possibility of litigation. If the RO, in conjunction with the Office of General Counsel, believes litigation is necessary it will request the FI/Carrier to prepare the case file for referral to the DOJ. The RO will inform the FI/Carrier of all elements to include in the case file.

A - General

The DOJ requires the submittal of a Claims Collection Litigation Report (CCLR) for overpayment litigation of claims. The CCLR is a checklist of all administrative collection actions*. If need be the RO can assist the FI/Carrier in obtaining a copy of the CCLR. The FI/Carrier will follow the advice received by their RO's OGC in completing the CCLR.*

In addition to completing the sections of the CCLR as much as possible the FI/Carrier must provide any relevant information to help DOJ. If applicable, the FI/Carrier must notify DOJ if there has been a change of ownership, if there have been any bankruptcy proceedings, and all necessary information concerning the identification of any outstanding overpayments regardless of the determination date. The following guidelines exist for providing information relevant to the identification of overpayments. However, the RO may request additional documents if they are relevant to the overpayment and/or provider.

<u>Identification of Overpayment(s)</u>

The FI/Carrier shall clearly identify the overpayment(s). Cost report overpayments should be identified for each cost reporting period, by total overpayment amount and each individual overpayment amount if multiple overpayments have occurred (tentative and final settlements, interim rate adjustments…). It shall show any

partial payments made by the debtor and clearly distinguish between principal and interest. It shall include documentation to support the overpayment determination. This includes copies of the cost reports, audits, and reviews, copies of all correspondence, and any other information relevant to the overpayment.

Refund Requests

The FI/Carrier shall include a copy of the demand letter(s) to the provider. Where demand letters were returned by the postal service, the FI/Carrier shall document other attempts to secure the address of the debtor(s).

Recovery Efforts

The following are required:

- The FI/Carrier's internal communications relative to recovery efforts;
- Detailed reports of all conferences the FI/Carrier held with the provider relative to the overpayment; and
- A detailed narrative of the current situation with the FI/Carrier's evaluation of the cause of the incorrect payment, including setoff against any payments that may have been due the provider.

Provider's Ability to Refund

The FI/Carrier shall include its evaluation of the provider's ability to pay. It shall include, if possible, an examination of a statement showing assets and liabilities and other relevant financial documents. It shall include:

- Corporate financial statement;
- Statement by the debtor showing assets and liabilities;
- Income and expenses (signed by the debtor under penalty of perjury);
- Any other financial data necessary including the age and health of the debtor, potential future income, and the possibility that the debtor concealed or improperly transferred assets.

120.1 - Communication on Cases Sent to RO for DOJ Referral (Rev. 29, 01-02-04)

If the FI/Carrier receives any funds, bills for current services, cost report (where one had not been filed), compromise offers, etc., after sending the case for referral to DOJ, it shall notify the RO. It will be advised by the RO as to how to respond to the provider's actions.

When a case is referred to the DOJ, the RO notifies the FI/Carrier, who will take no further collection actions except for withheld amounts that may become available. The FI/Carrier shall forward any communications received from the provider to the RO.

120.2 - Cases Referred to DOJ for Possible Litigation (Rev. 29, 01-02-04)

After a provider overpayment case has been referred to DOJ, the FI/Carrier shall not contact or negotiate with the provider, unless authorized to do so by the DOJ or the U.S. Attorney handling the case. Submit all requests for negotiation to the RO.

To avoid extensive legal proceedings and costs by both parties, compromise offers may be made by the provider or the DOJ. If the DOJ contacts the RO with such a request, the RO forwards the information to the FI/Carrier for provider notification. If the provider offers a compromise, the FI/Carrier shall notify the RO and submit the following information:

- Relevant documentation relating to the offer to compromise including, but not limited to, the name, title, and position of the party making the offer, the amount of the compromise offer to settle or otherwise dispose of the overpayment, and the financial standing of the debtors; and
- Recommendations of the U. S. Attorney, if any.

The FI/Carrier shall forward the offer of compromise to the *CMS Claims Collection Officer (CCO) through the RO.*

In most cases, the U.S. Attorney assigned the Medicare overpayment case will not be fully familiar with Medicare procedures, laws, regulations, or reimbursement. The FI/Carrier may be requested to provide technical information to supplement the U. S. Attorney's knowledge. As cases are readied for litigation, the RO may contact the FI/Carrier for assistance in documenting the administrative record, e.g., a list of FI potential witnesses and technical advisors.

130 – Change of Ownership (CHOW)

(Rev. 29, 01-02-04)

When a provider undergoes a CHOW, the provider agreement is automatically assigned to the new owner unless the new owner rejects assignment of the provider agreement. The paragraphs below describe the impact of assignment on overpayment recovery.

Assignment of Medicare Provider Agreement:

Automatic assignment of the existing provider agreement to the new owner means the new owner is subject to all the terms and conditions under which the existing agreement was issued. (See State Operations Manual, §3210) With assignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless fraud was involved. In addition, the new owner receives benefits of assuming the Medicare provider agreement, such as receiving underpayments discovered after the CHOW.

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 intermediary should attempt collection from the new owner. If this is not successful and the FI/Carrier has reasonable evidence that the previous owner can repay the overpayment it should refer the case to the regional office. The regional office will then confer with the regional OGC and decide if this case warrants collection from the previous owner. This should be completed before the debt is transferred to the Department of Treasury.

Nonassignment of a Medicare provider agreement:

If the new owner refuses to accept assignment of the Medicare agreement, the new owner must enter into its own Medicare agreement. In this case there would be no CHOW of the Medicare agreement and the previous owner would still be responsible for any outstanding overpayments.

140- Bankruptcy

12, 10-18-02)

This section contains actions that the contractors must take to safeguard the Medicare Trust Funds when a provider files for bankruptcy. This section does not address bankruptcy issues involving debts arising under the MSP provisions. (Although this Manual will usually use the term "provider," its provisions also apply to suppliers, including physicians). However, use of the term "provider" does not mean that the Medicare program considers suppliers and physicians to be providers. It also explains how to report accurately the Centers for Medicare & Medicaid Services' (CMS) accounts receivable balances and support CMS's efforts to effectively evaluate and manage bankruptcy cases.

This Manual will guide contractor staff through the initial stages of a provider bankruptcy. It is not intended to be, and cannot be, 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 must consult closely with the Regional Office (RO) before taking, omitting, continuing or discontinuing actions regarding a bankrupt provider. In some cases, attorneys from the Department of Justice (DOJ) in Washington, D.C. or United States Attorney's Offices will work directly with RO staff. However, in most cases, the RO will be in contact with Regional Counsel.

This section consists of eight subsections which are listed in the Table of Contents.

140.1 - Glossary of Acronyms

(Rev. 12, 10-18-02)

ARMG - Accounting and Risk Management Group

CMS - Centers for Medicare & Medicaid Services

DME - Durable Medical Equipment

DMERC - Durable Medical Equipment Regional Carrier

DMSO - Division of Medicaid and State Operations

DFRDR - Division of Financial Reporting and Debt Referral

DCC - Debt Collection Center

DOJ - Department of Justice

FI - Fiscal Intermediary

NPR - Notice of Program Reimbursement

POR - Provider Overpayment Report

PORS - Provider Overpayment Reporting System

PSOR - Physician/Supplier Overpayment Report

RC - Regional Chief Counsel's Office - the regional office component of the Office of the General Counsel

RO - Regional Office of the Centers for Medicare and Medicaid Services

140.2 - Basic Bankruptcy Terms and Definitions

(Rev. 12, 10-18-02)

140.2.1 - Bankruptcy is Litigation

(Rev. 12, 10-18-02)

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. You should not take any action for or against a debtor until you consult the Regional Office who will consult with the Regional attorney handling the bankruptcy. Do not share any information about bankruptcy strategy or activities with the bankrupt provider.

140.2.2 - Types of Bankruptcies

(Rev. 12, 10-18-02)

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 you 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 such as a hospital district. Chapter 9 provides for reorganization, much like Chapter 11.

3. Chapter 11 - Debtors file Chapter 11 to reorganize the debtor individual or business. To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan"). The Plan indicates the amount and schedule for payments to creditors. Creditors vote on the Plan, and the Court must confirm it. Recovery amounts vary. The Bankruptcy Code provides for discharge of the remainder of the debt.

4. Chapter 13 - Chapter 13 bankruptcies adjust the debts of individuals (including sole proprietorships) with a regular income. Generally, debtors must file a debt adjustment plan within 15 days after filing.

140.2.3 - Filing Bankruptcy Draws a Line in the Sand (Rev. 12, 10-18-02)

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 prepetition and postpetition actions. Events that occur on or before the petition date are prepetition. Events that occur after the petition date are postpetition. The automatic stay governs many actions that contractors may take concerning a debtor postpetition. You must therefore consult the RO before you take action concerning the debtor postpetition.

Medicare's right to recover overpayments can depend on whether they are prepetition or postpetition. The RO will direct you how to treat payments for prepetition services (prepetition payments) and payments for postpetition services (postpetition payments) to maximize Medicare's recovery.

140.2.4 Bankruptcy Affects Nearly All Medicare Operations (Rev. 12, 10-18-02)

Bankruptcy can affect every aspect of the interaction between the Medicare program and a debtor. Each contractor staff member who may come in contact with a debtor, is effectively a part of the Medicare "bankruptcy team" for that case. You, as contractor point of contact, must ensure that all potential bankruptcy team members alert you if they anticipate actions concerning the debtor, and that they then coordinate those actions with you and with the RO and Regional 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 prepetition and postpetition overpayments also varies by federal jurisdiction. (See discussion on set-off and recoupment in section F below). If you have overpaid a debtor, you must consult the RO, then take appropriate action to maximize recovery of Medicare overpayments from debtors. Contractor overpayment staff should not send any letters to the debtor until the RO approves them for release.

2. Fraud and Abuse

Ensure that you consult with CMS Program Integrity staff and the RO before you suspend an entity for fraud and/or abuse, recover fraud overpayments, or continue suspensions. If you have evidence that the provider filed for bankruptcy because of fraud it committed, advise the RO handling the bankruptcy.

3. Reimbursement

Contractor reimbursement staff must notify the RO before suspending payments to a debtor for failure to file a cost report or a credit balance report. DO NOT issue tentative settlement payments in bankruptcy cases unless explicitly requested by the RO.

Unless otherwise directed, contractor reimbursement staff should continue to review and audit cost reports as usual. However, the contractor must submit notices of program reimbursement to the RO for review and obtain approval before issuing them.

CMS will advise the contractor reimbursement staff about stipulations and settlements that affect audit and/or reimbursement. In making global settlements decisions CMS will consider the cost and benefits of auditing cost reports in cases where recovery is unlikely and direct contractor staff accordingly.

4. Payment

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

5. Appeals

Contractor staff will be asked about recent and current Administrative Law Judge, Provider Reimbursement Review Board and Department Appeal Board appeals involving a provider in bankruptcy.

6.Changes of Ownership

A debtor may attempt to transfer provider agreements so that both parties may avoid overpayment recovery. DMSO staff will notify other regional office staff when a debtor provider files for a CHOW, and immediately notify the Regional Counsel who is handling the bankruptcy. The CHOW will not be processed until the regional office obtains the concurrence of the Regional Counsel who is handling the bankruptcy.

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

(Rev. 12, 10-18-02)

Recoupment and set-off are two of Medicare's strongest tools for recovering overpayments to debtor providers. 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. Your RO/Regional Counsel can advise you whether current law in a given 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. Do not begin, continue or discontinue recoupment without approval of the RO.

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 RO.

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 prepetition claims against prepetition payments or postpetition claims against postpetition payments. They cannot set-off prepetition claims against postpetition 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. 12, 10-18-02)

Do not wait for formal notice of a bankruptcy and do not assume that someone else has notified the appropriate party. Medicare does not always receive timely and proper notice. By waiting, we may lose the opportunity to recover Medicare overpayments. Notify the RO/Regional Counsel immediately when you get credible information that a bankruptcy is about to occur. Good sources to obtain early information about bankruptcies include the Internet; newspapers, trade journals, and business magazines are good sources. Each individual item listed below should be relayed to the RO as soon as you receive it:

1. Name and address(s) of the individual or entity,
2. Type and timing of Medicare reimbursement the provider receives,
3. Amounts and types of outstanding overpayments,
4. Date of pending or planned reopening,
5. Status of any unsettled cost report years (expected settlement date and expected results); remember, DO NOT make tentative settlement payments to an individual or entity in bankruptcy, and make final settlement payments only after obtaining the RO's concurrence.
6. Dates and amounts of next Medicare payments if possible,
7. The name of the court and jurisdiction, case number, phone number of the debtor's attorney in the matter, and
8. Any current changes of ownership or quality of care issues).

140.2.7 - Definitions

(Rev. 12, 10-18-02)

You may encounter the terms listed below. The definitions are provided to give a general understanding. Specific terms may apply differently based upon the circumstances of a particular bankruptcy case.

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 CMS to turn over recouped monies is an example of an adversary proceeding.

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

Automatic Stay is an injunction that automatically springs into effect concurrent 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 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 or not 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 prepetition or postpetition. 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 a 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 knowing and fraudulent transfer or concealment of property by the debtor with intent to defeat the provisions of the Bankruptcy Code.

Lien is a recorded claim upon specific property in order 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 dischargeability 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 postpetition Medicare overpayments) are considered priority claims.

Secured Debt is a debt backed by a mortgage, pledged collateral, or other 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 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's claims are generally unsecured.

140.3 - Contractor's Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy

(Rev. 12, 10-18-02)

140.3.1 - Contractor Staff Must Establish Relationships to Ensure That the RO and Regional Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action

(Rev. 12, 10-18-02)

The contractor may receive notice of a bankruptcy from many sources including the provider, other fiscal intermediaries or carriers, the State, the Regional Office Certification staff, or Regional Counsel. It is imperative that contractor staff act quickly when a provider files for bankruptcy in order to meet filing deadlines in the bankruptcy court. Therefore, contractor staff must establish relationships to ensure that they receive information promptly about provider bankruptcies.

140.3.2 - Contractors Must Recognize and Advise RO Staff About Potential Provider Bankruptcies

(Rev. 12, 10-18-02)

Contractor staff must be alert to news or notices of bankruptcy and notify RO staff immediately. Contractor staff should alert the RO to all potential bankruptcies via a telephone call, an e-mail, or a fax.

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.

140.3.3 - Contractor Staff Will Establish a Relationship With the RO That has Jurisdiction Over the Bankruptcy

(Rev. 12, 10-18-02)

Contractors will proactively establish and maintain ongoing communications with the RO that has jurisdiction over a particular bankruptcy case. This is important because bankruptcy law 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 in 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 controlling within the States covered by that Circuit.

As discussed in greater detail below, CMS may want to take different actions in a bankruptcy case for different providers, including suspending payments, or recouping overpayments. In addition, CMS may have taken such actions before the provider filed for bankruptcy. Whether 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 CMS may recoup prepetition overpayments from postpetition payments without first 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 CMS may continue to suspend payments due to suspected fraud when the provider files for bankruptcy.

For these reasons, the contractors should neither initiate nor discontinue significant action affecting payment without first contacting Regional Counsel.

140.3.4 - RO Jurisdiction Generally Parallels the Bankruptcy Court Where Case is Filed

(Rev. 12, 10-18-02)

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 Regional Office Bankruptcy Point of Contact Staff Member

(Rev. 12, 10-18-02)

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. 12, 10-18-02)

140.4.1 - Establish Effective Lines of Communications With Partners

(Rev. 12, 10-18-02)

As soon as the contractor learns that a provider has filed for bankruptcy, it must immediately notify the following partners:

1. RO, Division of Financial Management Staff
2. Program Integrity Staff.

Obtain the name of individual(s) whom you should contact to obtain information quickly and to communicate information about the bankrupt Medicare provider.

140.4.2 - Respond to RO Requests for Information (Rev. 12, 10-18-02)

1. For Part A bankruptcies, provide overpayment information using the Part A Referral Checklist (see Attachment A).

Contractor staff must divide the overpayment information into prepetition and postpetition amounts.

The contractor will report the following overpayment information to the RO using the Referral Checklist as a reference when the contractor is seeking technical advice:

a. Provider Information:
    1. Provider Number
    2. Provider Name
    3. Provider Address
    4. Tax Identification Number (TIN)
b. Information about each overpayment:
    1. Cost year end
    2. Determination date
    3. Original overpayment
    4. Whether overpayment is based on a tentative or final settlement
    5. Notice of Program Reimbursement containing overpayment determination
    6. Amounts Recouped
    7. CMS 750/751 Line 7 reports a total ending balance for region. The intermediary would need to provide specific information on specific bankrupt providers, which are reflected on Line 7.
    8. The date of the CMS 750/751 report on which the receivable was reported

9. Overpayment type

c. Information to Estimate Potential Future Overpayments:

1. Cost Reports in-house pending settlement with expected completion date
2. Cost Reports pending submission with expected dates
3. Cost Reports, which are overdue, and total amount of payments made for those cost years
4. Interim Rate Information by Cost Year for Previous three years
5. Overpayment History by Cost Year for Previous three years
6. Medical Review Overpayments or Fraud and Abuse Overpayments or Investigations. You should also include these in the totals above.

NOTE: If the bankruptcy involves a provider with an audit and claims intermediary, (e.g., hospital with a provider-based home health agency or hospice), the RO will establish guidelines for obtaining information through the audit intermediary or establish direct communication with both intermediaries.

2. For Part B Bankruptcies, Carriers and/or DMERCs will provide overpayment information using the Referral Checklist (see Attachment A) as a reference when the contractor is seeking technical advice from the RO:

a. Provider Information:

1. Provider Number
2. Provider Name
3. Provider Address
4. Tax Identification Number (TIN)

b. Overpayment Information:

1. Claim numbers related to the overpayment
2. Dates of service for related claims (check with Regional Counsel on the need for this)
3. Dates of payment for related claims (check with Regional Counsel on the need for this)
4. Determination date of original overpayment
5. Correspondence notifying provider of overpayment
6. Original overpayment
7. Amounts recouped

8. CMS 750/751 Line 7 reflects outstanding receivable balance totals for entire region (both principal and interest)-You must request specific outstanding balances from FI carried for specific providers

9. The date of the CMS 750/751 report on which the receivable was reported

10. Overpayment Type

11. Medical Review overpayments

12. Fraud and Abuse overpayments or investigations

3. Inform the RO of any underpayments owed to providers. Ascertain whether any prepetition or postpetition underpayments have been determined. Do not release such funds until you have received RO approval.

140.4.3 - Immediate Contractor Directives From the RO (Rev. 12, 10-18-02)

The RO will give the contractors the following guidance as soon as a provider files for bankruptcy.

1. The RO will notify the Contractor of Provider Bankruptcy/Litigation.

a. Bankruptcy Filed

RO will inform the contractor that the RO has opened a bankruptcy case. RO will inform the contractor that it should clear any future actions concerning the bankrupt provider(s) through the RO.

b. Bankruptcy Filing Date.

The RO will notify the contractor of the bankruptcy filing date, since it impacts on actions that the contractor can take and the evaluation of whether payments are prepetition or postpetition.

c. Immediate response to requests.

Since bankruptcy has court imposed deadlines, the contractor must take immediate action whenever the RO or Regional Counsel makes a request.

d. Obtain approval of all correspondence to provider.

The contractor must submit all correspondence addressed to the provider to the RO for approval prior to release. The RO will inform Part B Carriers/DMERCs that they should write a notification letter to replace the system generated demand letter.

e. Lead RO

If another RO has the lead on the bankruptcy, the RO will provide the contractor with a contact name and telephone number. The Regional Office that supervises the contractor may need to continue to assist the contractor in an advisory role.

2. The RO Will Notify Contractor of Immediate Actions It Must Take.

a. Interim Rate Adjustment.

After consultation with Regional Counsel, RO will direct the intermediary to immediately perform an interim rate adjustment to ensure that payments are accurate and that no future overpayments occur. (Medicare Intermediary Manual §2760.1(C.). 42 CFR §413.64(i).

b. Recoupment.

RO will inform the contractor (after discussion with Regional Counsel) whether it should continue or cease any current recovery action.

c. Administrative Freeze.

RO will inform the contractor (after discussion with Regional Counsel) whether or not it should place payments in administrative freeze.

3. Actions The Contractor Must Take on an Ongoing Basis.

a. Expedite Cost Report Settlement

RO will tell the FI to expedite the settlement of any open cost reports. RO will caution the FI not to perform any tentative settlements unless explicitly requested by the RO (in consultation with Regional Counsel) and not to issue any final settlements to the provider without first obtaining permission from the RO (in consultation with Regional Counsel).

b. Contractors should suspend payments if provider does not timely file cost report.

If the bankrupt provider fails to submit a timely, acceptable cost report, immediately notify the RO and Regional Counsel prior to placing the provider in 100% withhold and immediately notify the RO and Regional Counsel that you have done so. When the provider submits an acceptable cost report consult with the RO and the Regional Counsel prior to release of the withheld funds.

c. Part B - Tracking Overpayments and Refunds

The carrier or DMERC may need to track overpayments and voluntary refunds for a bankrupt provider. The RO will work with Regional Counsel to determine what information Regional 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 RO before making other payments to provider.

It is important that intermediaries, carriers, and DMERCs 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 RO (in consultation with Regional Counsel) so directs. This is especially critical for intermediaries who must continue to settle open cost reports.

4. Contractors Will Track and Report Information to RO.

a. Cost Report Settlements and Claims Processed

Contractor staff should notify the RO promptly of any and 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 on an overpayment, contractor staff must keep RO staff informed on the outcome of the appeal. Appeals may take place at the contractor location, 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 CMS to amend its proof of claim because the provider would have a smaller overpayment. Alternatively, in some cases, the RO may direct the contractor to freeze any outgoing funds. The contractor will keep the RO and Regional Counsel updated on the status of appeals.

5. Record-Keeping.

a. Interest

The RO will advise the contractor whether or not it should continue to calculate interest for overpayments. Medicare's ability to assess interest varies based on the circumstances of the case. RO will consult with the Regional 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 should post these adjustments to the contractors' internal systems, the Provider Overpayment Reporting System (PORS) and the Physician Supplier Overpayment Report (PSOR) within ten (10) days of notice of transaction. The PORS reflects interest assessed and the PSOR reflects interest collected. It should also post the adjustments to the CMS 750/751 reports.

b. PORS/PSOR Update

RO will instruct the contractor to update the PORS/PSOR with appropriate bankruptcy status codes.

c. Bankruptcy Case At Contractor's Location.

RO will inform the contractor that they may not refer bankruptcy cases to the Debt Collection Center for collection under the Debt Collection Improvement Act. If the contractor has already referred a case to DCC and no recovery action has begun, the RO will take steps to retrieve the case. The overpayment case will remain at the contractor location for financial reporting purposes until the case is ready for termination write-off, or until the RO advises the contractor otherwise.

140.4.4 - Tracking Debts/CO Communications

(Rev. 12, 10-18-02)

Financial Reporting. While the lead RO is responsible for managing the bankruptcy case, all bankruptcy debt will remain at the contractor location for financial reporting purposes on the CMS 750/751 report. RO staff must work with contractor staff to ensure proper reporting on CMS 751 reports throughout the bankruptcy.

140.5 - Chain Bankruptcies

(Rev. 12, 10-18-02)

140.5.1 - Chain Providers

(Rev. 12, 10-18-02)

A chain provider is one that is owned by the same entity that owns another provider or providers. 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).

As set forth in §140.3.4, the lead RO for a bankruptcy is generally the office with jurisdiction over the state in which the provider files for bankruptcy. Nevertheless, Central Office staff may assign a chain bankruptcy to a specific region, or the Regional Counsel may request that a specific RO take the lead in a specific chain bankruptcy.

When a chain files bankruptcy, there may be multiple contractors involved in processing payments for the chain. If the bankruptcy involves other ROs and their contractors, the lead RO will work directly with the contractors, after informing their home RO(s) that they will be communicating directly with their contractor on the bankruptcy case. The lead RO and Regional Counsel are responsible for making all decisions. However, the lead RO should keep the contractor's home RO informed about its contractor's workload in connection with the bankruptcy.

140.5.2 - Single Providers Serviced by a National Contractor (Rev. 12, 10-18-02)

When a single provider who is serviced by a national contractor files for bankruptcy, the same principle for processing a bankruptcy of a chain provider will apply. The location where the bankruptcy is filed will determine the lead RO. The lead RO will work directly with the national contractor staff on the bankruptcy case. The lead RO will keep the home RO of the national contractor informed in all issues related to the case (e.g., a provider within the jurisdiction of the San Francisco RO files for bankruptcy and their contractor is Mutual of Omaha). The San Francisco RO will assume lead responsibilities and will keep the Kansas City RO informed of all issues related to this case.

140.6 - Affirmative Recovery Actions

(Rev. 12, 10-18-02)

140.6.1 - Working With the RO and Regional Counsel's Office (Rev. 12, 10-18-02)

The contractor will notify the RO/Regional Counsel's office immediately after it receives information that a provider has filed for bankruptcy. It is essential that you obtain information on all Part A, Part B, or DME 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 RO/Regional Counsel. After gathering the information described in §140.4.2 , it will send it to the RO.

The contractor will discuss with RO/Regional Counsel whether it should put payments in administrative freeze (a holding account) until Medicare has time to assess its position in the bankruptcy. Also, during initial discussions with Regional Counsel, the RO will determine when the proof of claim is due and whether the Regional Counsel or the RO 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 RO/Regional Counsel. The contractor will not take any further steps without obtaining the advice of RO/Regional Counsel. For example, the contractor should not send any overpayment letters to the debtor without RO/Regional Counsel approval. In addition, the contractor should not initiate new withholding or discontinue withholding without RO/Regional Counsel approval.

As the bankruptcy progresses, the Regional Counsel may ask the contractor to expedite settlement of cost reports, update the Regional 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 RO/Regional Counsel must have the highest priority in the workload, in order to protect Trust Fund assets.

140.6.2 - Assumption of the Medicare Provider Agreement (Rev. 12, 10-18-02)

The Medicare Part A 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 RO 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 RO 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. 12, 10-18-02)

During the course of a bankruptcy, the RO and the Regional Counsel, working with DOJ, may negotiate a settlement agreement or stipulation with the debtor's attorney. Once a settlement agreement or stipulation goes into effect, the RO will advise all affected contractors, ROs, and the Office of Financial Management, CO. The contractors will consult with the lead RO to ensure that they conform to the conditions established in the settlement agreement or stipulation.

140.6.4 - Recoupment (Rev. 12, 10-18-02)

Generally, bankruptcy law prohibits recovery of prepetition debt (debt arising prior to the filing of the bankruptcy petition) from postpetition 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 should always consult RO/Regional Counsel's office about the adjustment (or recoupment) of any payments to a bankrupt provider before you take, omit, continue or discontinue 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 Regional Counsel obtains permission from the court. RO/Regional Counsel will advise the contractor whether it can recoup overpayments in these jurisdictions. Again, the contractor must consult RO/Regional Counsel before adjusting or recouping payments to a bankrupt provider.

140.6.5 - Administrative Freeze/Set-off

(Rev. 12, 10-18-02)

Medicare can ask the court's permission to set-off prepetition debts against prepetition payments (payments for prepetition services, even if made postpetition) and postpetition debts against postpetition payments (payments for postpetition services). Regional Counsel, through 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 files for bankruptcy result from prepetition services. Therefore, the RO and Regional Counsel might decide to freeze all payments for prepetition services and then request bankruptcy court permission to set-off those payments against prepetition overpayments. Because there is such a short period during which there might be prepetition 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 prepetition payments, such as underpayments or payments delayed because of medical review may be available to set-off against prepetition overpayments. It is important to notify the RO and Regional 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 prepetition payments to recover the debts owed by the provider to other government agencies. However, we must use prepetition payments to recover Medicare overpayments before applying them to debts owed to other agencies.

140.7 - Preparing and Filing Proof of Claim

(Rev. 12, 10-18-02)

We provide a working definition of the term "claim" in §140.2.7. 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 in order to share in the bankruptcy estate Medicare must file a proof of claim. Regional Counsel will file the proof of claim. It is critical that contractors produce accurate and detailed overpayment data to the RO and Regional Counsel when requested so that Regional Counsel can 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. In order 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 Regional 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, contractors should update overpayment information on an ongoing basis.

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

(Rev. 12, 10-18-02)

140.8.1 - Closing the Bankruptcy Case

(Rev. 12, 10-18-02)

After a bankruptcy case is fully administered and the bankruptcy court has discharged the trustee (if there was one), the bankruptcy court closes the case. RO/Regional Counsel will provide guidance to the contractor regarding any required further actions.

Once the debtor has emerged from bankruptcy it resumes business as usual. A Chapter 11 bankruptcy ordinarily ends with the debtor emerging from Chapter 11 with a confirmed plan of reorganization. The ordinary course of business typically begins on the "effective date" of the plan of reorganization. In the case of a Chapter 7, the bankruptcy typically ends when the Trustee has dissolved the corporation, shut down operations, and distributed assets to pay creditors. RO/Regional Counsel will provide specific guidance to the contractor.

When a bankruptcy case closes, whether a Chapter 7, a 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 bankruptcy law does not require the provider to repay are considered "discharged," and Medicare must release the provider from liability for the debt.

All of the contractor's debt information, including the POR, PSOR, CMS-750, CMS-751, and Schedule 9 of contractor's financial statement, must incorporate the bankruptcy outcome by writing off or adjusting the amounts owed in accordance with applicable bankruptcy orders. This frequently will require you to remove line items and include new line items on affected reports. You must maintain detailed support for all revisions, as well as for any extended repayment arrangements. Detailed documentation related to principal, interest charges and immediate payments and extended repayment plans without interest are especially important in global settlement adjustments which are common in chain 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 Regional Counsel, the RO, CO and affected contractor staff. Coordination and immediate action is especially important if you discover 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 Regional Counsel, the RO 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 the Debt Collection Center. Contractors and ROs must ensure that their internal processing systems and financial reports no longer reflect the case as one under bankruptcy, and interest should be reassessed.

Always contact the RO/Regional Counsel for guidance on the closure of a bankruptcy. There is no 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 RO/Regional Counsel before closing the bankruptcy.

140.8.2 - Debt Located at the Debt Collection Center or Department of the Treasury - (Rev. 12, 10-18-02)

If a debt is at the Debt Collection Center (DCC) and the provider files for bankruptcy, the certifier of the debt (contractor or RO) must immediately notify the Central Office Division of Financial Reporting and Debt Referral (DFRDR). The certifier must request that Central Office recall this debt from DCC as debts in bankruptcy status are ineligible for crossservicing and offset.

NOTE: Debts for unfiled cost reports are not reported on the H751 and/or R751, therefore, if these debts become "bankrupt," you will record no transaction on these forms.

If the debt is active (less than two years old), the DFRDR, Central Office will recall the debt, update the POR/PSOR to reflect a bankruptcy status, and change the location back to the contractor location. DCB will send an email or fax of the location change to the RO.

If the DCC or Department of Treasury receives the initial notification of a bankruptcy filing while servicing a debt, they will notify CMS Central Office, who, in turn, will notify the RO of the bankruptcy.

140.8.3 - Managing Bankruptcy Debt at the Contractor Location - (Rev. 12, 10-18-02)

All bankruptcy debts will remain at the contractor location throughout the life of the debt. The lead RO will assume full ownership and the responsibility for managing the debt at the respective contractor site. The contractor, will help the RO establish communication procedures and will ensure that contractor staff follow them.

When chain providers are involved, the lead RO will contact the appropriate contractor and RO staff and establish dialogue procedures that will provide timely and accurate transfer of required information.

The lead RO is responsible for management of the debt from the initial filing of the Proof of Claim until the closure of the Bankruptcy. The Associate Regional Administrator for the Division of Financial Management will have the authority to terminate collection activity for cases that meet the criteria for being written off at the Associate Regional Administrator level.

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 CMS Regional Office. The CMS 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- The Accelerated Payment and the Provider Overpayment Reporting (POR) System

(Rev. 29, 01-02-04)

The FI has ten calendar days from the date the accelerated payment is issued to enter a record in the POR System. The POR System shall contain the following information:

Overpayment type of "D"
Status code of "CA"
Date of determination should be the date of payment

At the time of the payment, a payment withhold should be entered into the FI's internal processing system for the amount of the accelerated payment.

If the accelerated payment is not paid in full within the 90-day period and demand letters are sent, the FI shall update the status code to reflect the action that is occurring on the debt.[intent to refer letter, referral to Treasury]

150.4- Recoupment of the Accelerated Payment

(Rev. 29, 01-02-04)

The FI must 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 FI 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 FI, recovery by recoupment will be reasonably scheduled to coincide with improvement in the FI'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 FI processing the provider's claims.

If recovery is not complete 90 days after the accelerated payment is issued or 90 days after the FI begins processing claims, the accelerated payment is considered delinquent. The FI shall immediately send out a demand letter stating 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. FIs shall include the "Intent to Refer" language required to refer the debt to the Treasury Department. (See CR 1683 or 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 FI does not hear from the provider within 15 days from the date of the demand letter, the FI shall attempt to contact the provider by telephone. If the demand letter is returned undeliverable the FI shall attempt to locate the provider using some of the guidelines set forth in Chapter 4, §10. If the FI does not hear from the provider within 60 days of the date of the demand letter, the FI shall input the debt into the Debt Collection System for referral to the Treasury Department for additional collection activity.

EXHIBIT 1

SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCLERATED PAYMENT

1. Provider:_____ Provider Number:_____

Address:_____
_____
_____

2. FI: _____

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 FI.

(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- Termination of Collection Action

(Rev. 29, 01-02-04)

The FI or Carrier cannot terminate collection action and write off closed any debt. In addition, an FI or Carrier internal system or claims processing system cannot automatically abandon or write off debt. The decision to terminate collection action and write off closed any debt must be approved by CMS RO or CO.

Note: The under tolerance instructions detailed in CR 2292 are an exception to the termination of collection action instructions above.

160.1- Termination of Collection Action – Provider Overpayments

(Rev. 29, 01-02-04)

Under normal circumstances if the FI or Carrier is unable to collect an overpayment, the overpayment will be referred to the Department of Treasury for additional collection efforts. However, if the principal balance of the overpayment is less than $25.00 the overpayment is not eligible for referral to the Department of Treasury.

Therefore, once an overpayment with a principal balance less than $25.00 becomes 180 days old (from the date of the first demand letter), the overpayment should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a quarterly basis. These requests should be sent by hard copy no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- *Provider/Physician number*
- *Current principal amount of overpayment*
- *Current interest amount of overpayment*
- *Original amount of overpayment*
- *Other outstanding overpayments*
- *Cost Report Year (Part A) or Claim Paid Date (Part B)*
- *Determination Date*

- Overpayment Type

The above list is the minimum amount of information that must be sent to the servicing regional office. The servicing regional office may request additional information. Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed by the first day of the last month of each quarter (i.e., December 1, March 1, June 1, and September 1). Once approval is received appropriate steps should be taken to close the overpayment on the POR/PSOR System, the internal accounting system, and report it correctly on all necessary financial reports.

160.2- Termination of Collection Action – Beneficiary Overpayments

(Rev. 29, 01-02-04)

A demand letter is not sent for beneficiary overpayments less than $50. Therefore, no recovery action should take place on these overpayments. Beneficiary overpayments less than $50 should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a monthly basis. The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- Beneficiary HIC number

- Current principal amount of overpayment

- Other outstanding overpayments

- Claim Paid Date (Part B)

- Determination Date

Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed. Once approval is received appropriate steps should be taken to close the overpayment on the internal accounting system and report it correctly on all necessary financial reports.

Note: Carriers utilizing the VMS System automatically abandon beneficiary overpayments less than $50. This instruction does not apply to these carriers until such time that standard system changes can be made to stop the abandonment.

170 – General Overpayment Provisions

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.

jhCROSSWALK FOR CHAPTER 4

Previous Manual	**Revision in this Transmittal**
10 – Overpayment Demand Letters	10 – Overpayment Requirements for Fiscal Intermediaries – General
20 – Establishing Extended Repayment	20 – Cost Report Demand Letters
30 – Repayment Extended Longer Than 12 Months	30 – Interest Assessment/Payment on Overpayments and Underpayments
40 – Procedure for Suspending Interim Payments	40 – Withholds and Suspensions
50 – Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments- General	50 – Establishing Extended Repayment
60 – Recovery From the Physician – Overpayment Demand Letters- Carrier	60 - Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments - General
70.7.3 - Intermediary Claims Accounts Receivable (A/R) 70.7.4 - Physician/Supplier Overpayment Reporting (PSOR) System Summary Entry Debts 70.15.2 - Financial Reporting for Intermediary Claims Accounts Receivable (A/R)	70.7.3 - Intermediary Claims Accounts Receivable (A/R) 70.7.4 - Physician/Supplier Overpayment Reporting (PSOR) System Summary Entry Debts 70.15.2 - Financial Reporting for Intermediary Claims Accounts Receivable (A/R)
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Medicare Financial Management
Chapter 4 - Debt Collection

Table of Contents

(Rev. 29, 01-02-04)

10 - Requirements for Collecting Overpayments - Fiscal Intermediaries

(Rev. 29, 01-02-04)

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

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

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

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

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

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

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

to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed.

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

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

- *If the FI cannot reach the provider by telephone or the FI receives any demand letter back as undeliverable the FI shall attempt to locate the provider through other means. Overpayment departments shall refer to provider enrollment applications, Medical Review staff, and Fraud and Abuse staff for further ideas concerning the debtor's whereabouts. Overpayment departments shall attempt to find out if the provider is bankrupt and the names of the owner, partners, or the corporation officers. If the FI has access to an Internet search site, such as Lexis-Nexis® or a similar program, in the Overpayment department or another department this shall also be utilized. If the FI does not have access to a search program the servicing regional office shall be contacted to see if they could be of assistance. All attempts to find the provider shall be documented in the case file.*

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

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

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

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

20 – Cost Report Overpayment Demand Letters

(Rev. 29, 01-02-04)

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

- Sent to the provider. (For institutional providers, the FI will not address the letter to the facility only, but to the person(s) it identified as responsible for any debts incurred by the provider.
- Sent by certified mail, return receipt requested (FIRST REQUEST ONLY);
- Labeled either - FIRST REQUEST, SECOND REQUEST, or THIRD REQUEST;
- For a first request, mail *within 7 calendar days* of discovery or determination of the overpayment. In the case of the second or third request, mailed 30 days after the most recent demand letter;
- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined. *(Does not apply in situations involving overdue cost reports)*
- *The demand letter shall offer the provider the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be analyzed using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter. (Does not apply in situations involving overdue cost reports.)*
- The demand letter constitutes a request to the provider to refund the overpaid amount. The FI provides a brief description of the methods of repayment (or, where applicable, it requests the provider to submit the overdue cost report).
  The demand letter informs providers that continue to participate and have filed the cost report, that the FI will adjust (reduce or withhold) interim payments if it does not receive repayment, or a *request for a repayment plan along with the first month's payment* within 15 days of the demand letter. In

the situation of an unfiled cost report or an as filed cost report overpayment, the cost report reminder letter serves as sufficient notice that interim payments will be suspended if the overpayment is not received on or before its due date.

- The FI shall not recoup interim payments before the 16th day after the date of notification. *Exception: If the provider has provided the FI with a written request or written authorization to begin recoupment before the 16th day, the FI shall comply with the provider's request.*
- The demand letter also points out that, where a cost report has not been filed timely and the provider continues to participate, interim payments were adjusted (reduced or suspended) on the *seventh (7th) calendar* day following the due date of the cost report.

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

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

20.1 - Number of Demand Letters

(Rev. 29, 01-02-04)

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

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

20.2 - Content of Demand Letters - FI Serviced Providers

(Rev. 29, 01-02-04)

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

Exhibit 1: Contents of a Demand Letter
Exhibit 2: Sample Overpayment Demand Letter – Cost Report Filed -First Request

Exhibit 3: Sample Overpayment Demand Letter – Cost Report Filed - Second Request (30 days after the date of the first demand letter)
Exhibit 4: Sample Overpayment Demand Letter – Cost Report Filed - Third Request (30 days after the date of the second demand letter)
Exhibit 5: Sample Overpayment Demand Letter- Unfiled Cost Report- First Request
Exhibit 6: Sample Overpayment Demand Letter- Unfiled Cost Report- Second Request
Exhibit 7: Sample Overpayment Demand Letter- Unfiled Cost Report- Third Request

EXHIBIT 1: CONTENTS OF A DEMAND LETTER

Key: Overpayment Situations

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

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

Mail letter to provider 30 days after the date of the second demand letter									*X*	*X*	*X*

EXHIBIT 2- OVERPAYMENT DEMAND LETTER- COST REPORT FILED- FIRST REQUEST

FIRST REQUEST

Certified Mail #

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

Date

Dear Mr. Smith:

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

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

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

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

(Home Office Cost Report is Unfiled)
We have not received the home office cost report from _____. According to our records _____ serves as the home office for your facility. Since the home office cost report remains unfiled the amount stated on your filed cost report for the fiscal year ending _____ for home office costs has been disallowed. This disallowance will continue until the home office submits the home office cost report.

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

PLEASE MAIL TO:

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

In accordance with 42 CFR 405.378 simple interest at the rate of __ will be charged on the unpaid balance of the overpayment beginning on the 31st day. For periods of less than 30 days the full monthly interest charge will be applied. Thus, if payment is received 31 days from the date of final determination, two 30-day periods of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ .

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

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

Should you have any questions please contact _____ at _____.

We expect to hear from you shortly.

Sincerely,

(name and title)

Enclosure

APPLYING FOR AN EXTENDED REPAYMENT PLAN

* *Anytime a provider needs longer than thirty (30) days to repay the full amount of an overpayment, the provider should request an extended repayment plan (ERP). While a provider may request an ERP at any time during the debt collection process, submittal within the first 15 days may decrease the necessity to withhold all interim payments.*

* *If the ERP request is received within 15 days of the date of the demand letter and it is complete and first payment is included, interim payments will not be withheld unless interim payments are currently being suspended or withheld for another outstanding overpayment or investigation.*

* *If a provider notifies us within 15 days that they intend to submit an ERP request, but cannot submit the required documentation within 15 days, thirty (30) percent of interim payments will most likely be withheld. However, if a complete ERP application and first payment is not received by day 30 all interim payments will most likely be withheld.*

* *If we do not hear from the provider regarding an ERP application within 15 days from the date of the demand letter we will begin to recoup the overpayment by withholding a percentage of interim payments.*

* *Any payments withheld will be applied to the outstanding overpayment and will not be refunded.*

* *Any request for an ERP greater than 12 months must be forwarded to CMS for approval.*

* *Any approved ERP will run from the date of the initial demand letter.*

* *The provider must continue to submit monthly payments until written approval/denial is received. If a provider fails to continue to submit monthly payments, we may initiate withhold of interim payments.*

* *Any questions should be directed to an ERP Analyst at _____.*

DOCUMENTATION SUPPORTING A REQUEST FOR EXTENDED REPAYMENT

Items Included? Yes/No

□ □ *A written request must be submitted that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the approximate monthly payment amount (principal and interest, if possible), and include the first payment. If more than one overpayment exists, a separate request must be made for each overpayment. However, the intermediary may establish the same payment date for each overpayment and may include knowledge of both overpayments in its review of the provider's request.*

□ □ *Balance Sheets- The most current balance sheet and the one for the last complete Medicare reporting period (preferably prepared by the provider's accountant). If consolidated statements (including more than one entity) are submitted, separate statements showing the individual provider's contribution must also be submitted.*

Note: If the time period between the two balance sheets is less than six months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last TWO complete Medicare reporting periods in addition to the most current balance sheet.

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

□ □ *Cash Flow Statements for the periods covered by the balance sheets. If the date of the request for an extended repayment plan is more than three (3) months after the date of the most recent balance sheet, a cash flow statement should be prepared for all months between that date and the date of the request.*

□ □ *Projected Cash Flow Statement covering the remainder of the current fiscal year. If fewer than six (6) months remain, a projected cash flow statement for the following year should be included.*

□ □ *Amount of outstanding accelerated payments. (If any were issued to the provider.)*

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

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

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

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

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

□ □ *The percentage of occupancy by type of patient (Medicare, Medicaid, private pay) covered by the income statements. For home health and outpatient type facilities, this percentage should be based on visits to total by type. For hospitals and other inpatient type facilities, this percentage should be based on bed days utilized to total available in addition to bed days for that type to total bed days for the period.*

□ □ *Requests for extended repayment of more than twelve (12) months must be accompanied by at least one letter from a financial institution denying the provider's loan request for the amount of the overpayment.*

□ □ *First payment according to proposed repayment plan.*

□ □ *Copy of the overpayment notification letter or a copy of the settlement page of the as filed cost report indicating the amount of the overpayment.*

If the provider is unable to furnish some of the documentation, it should fully explain why it is unable to.

Your first payment, referenced "ERS Request", should be made payable to _____ and mailed directly to:

Mail a copy of your check and above requested information to:

Please submit all items checked "NO" within 10 days from the date of this letter to avoid the withholding of your interim payments.

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

SECOND REQUEST

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

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

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

Dear Mr. Smith:

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

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

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

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

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

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

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

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

If the overpayment is eligible for referral to the Department of Treasury the intent to refer language shall be placed in the third demand letter. See CR 1683 and Chapter 4, §70 for more information. If the overpayment is not eligible for referral to the Department of Treasury a third demand letter requesting repayment shall be sent. A sample third demand letter for overpayments not eligible for referral to the Department of Treasury is below.

THIRD REQUEST

<Date>

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

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

Dear Mr. Smith:

On August 25, 20xx, we sent you a second request for an overpayment that resulted from FY 20xx. We have not yet received payment or an application for an extended repayment plan. The outstanding amount due for this overpayment is $_____ which includes a principal amount of $_____ and interest assessed in the amount of $_____. This amount must immediately be refunded in full.

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

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

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

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

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

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

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

(Mailed 7 calendar days after cost report was due)

Date:

FIRST DEMAND LETTER

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

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

Dear {Title} {Last Name}

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

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

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

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

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

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

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

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

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

Cost Report Submission:
Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with any amounts due (principal and

interest), (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty days of the date of this letter, or (3) A request for a repayment plan of all interim payments, the deemed overpayment, within fifteen (15) days of the date of this letter. Checks are to be made payable to {Contractor}. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

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

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

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

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

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

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

Sincerely,

{Title} {Name}
{Position Title}

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

Date:

SECOND DEMAND LETTER

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

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

Dear {Title} {Last Name}

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

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

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

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

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

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

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

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report. A partial period is considered a full period. Under Title 42 CFR Section 405.378, interest charges are assessed on thirty days periods. Interest charges for a thirty (30) day period are calculated by multiplying the principal amount due by the interest rate and then dividing by twelve (12). Therefore, a debt that is paid thirty-one (31) days late is assessed two (2) full thirty-day periods.

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

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

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

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

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

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

Sincerely,

Name and title

Exhibit 7- Overpayment Demand Letter- Unfiled Cost Report- Third Request

If the overpayment is eligible for referral to the Department of Treasury the intent to refer language shall be placed in the third demand letter. See CR 1683 and Chapter 4, §70 for more information. If the overpayment is not eligible for referral to the Department of Treasury a third demand letter requesting the cost report shall be sent. A sample third demand letter for overpayments not eligible for referral to the Department of Treasury is below.

Date:

THIRD DEMAND

{Prime Contractor}
{Mail to Name}
{Mail to Address 1}
{Mail to Address 2}
{City} {State} {Zip}

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

Dear {Title} {Last Name}

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

Under Title 42 Code of Federal Regulations (CFR), Section 413.24, cost reports are due by the last day of the fifth month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS & R) reports from the contractor, whichever is later. Your report continues to be late as it was due {month/day/year}.

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

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

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

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

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

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

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report. A partial period is considered a full period. Under Title 42 CFR Section 405.378, interest charges are assessed on thirty days periods. Interest charges for a thirty (30) day period are calculated by multiplying the principal amount due by the interest rate and then dividing by twelve (12). Therefore, a debt that is paid thirty-one (31) days late is assessed two (2) full thirty-day periods.

Cost Report Submission:
Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with any amounts due (principal and

interest), (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty days of the date of this letter. Checks are to be made payable to {Contractor}. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

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

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

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

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

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

Sincerely,

Name and title

30 - Interest Assessment/Payment on Overpayments and Underpayments

(Rev. 29, 01-02-04)

CMS regulations, in accordance with the Federal Claims Collection Act, as amended, the Social Security Act, and common law establish specific rules for the payment of interest on Medicare overpayments and underpayments (42 CFR 405.378). As a general rule, interest shall be assessed at the prevailing rate specified by the

Secretary of the Treasury unless the overpayment is recouped or the underpayment is paid within 30 days of a "final determination."

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

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

30.1 - Final Determination

(Rev. 29, 01-02-04)

For purposes of this chapter:

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

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

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

- A written determination that an overpayment exists and a written determination for payment;
- A written determination of an underpayment;
- An Administrative Law Judge (ALJ) or hearing officer's decision that reduces the amount of an overpayment below the amount that CMS has already collected. *A final determination is deemed to have occurred only when the amount of the overpayment/underpayment has been calculated. This may be at the decision time and it may be at a later time if recalculations are necessary.*
- A written determination that an As Filed Cost Report has been received without payment;
- A written determination that an accelerated payment or advanced payment has occurred and has now been deemed an overpayment.

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

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

30.2 - Rates of Interest - FIs and Carriers

(Rev. 29, 01-02-04)

CMS will publish the applicable interest rate quarterly.

The interest rates on overpayments and underpayments shall be the higher of:

1) The rate as fixed by the Secretary of the Treasury after taking into consideration private consumer rates of interest published quarterly in the Federal Register by the Secretary of Treasury

2) The current value of funds rate published annually in the Federal Register by the Secretary of the Treasury, subject to quarterly revision.

Interest assessed for both late payments and installment payments is computed as simple interest using a 360-day year. Simple interest is interest that is paid on the original principal balance and after each payment interest accrues on the remaining unpaid principal balance. Interest charges will not be prorated on a daily basis for overdue payments received during the month (e.g., 10, l5, or 20 days late). Interest is assessed for the full 30-day period. The interest rate on any final determinations is the rate in effect on the date the determination is made.

30.3 - Interest Accruals

(Rev. 29, 01-02-04)

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

Interest will accrue from the date of the final determination and will either be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that complete liquidation is delayed. For periods of less than 30 days, a 30-day interest charge will accrue on any principal balance outstanding at the beginning of the 30-day period.

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

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

Cost Report Overpayment-Example of Interest Accrual- The provider with a FYE 08/31/00 submits a cost report on 01/28/01, showing $10,000 due the program, payment in full accompanies the cost report. On 02/15/01, the intermediary completes the desk review and determines an additional $25,000 overpayment. On 02/15/01 the first demand letter is sent. The provider does not pay the $25,000 additional overpayment until 04/03/01 (45 days after the date of the initial demand letter). Interest, therefore, accrues on the $25,000 for two full 30-day periods.

Physician/Supplier Overpayment-Example of Interest Accrual- The carrier discovers that an overpayment for $795.45 exists and sends a demand letter on 12/01/02. The provider does not remit payment on the overpayment until 01/15/02 (45 days after the date of the initial demand letter). Therefore interest accrues on the $795.45 for two full 30-day periods.

Example of Waiver of Interest- Overpayment Paid in Full within 30 days from the date of determination- The FI/Carrier determines and demands an overpayment on 3/02/03 for $1500.00. The provider remits payment of $1500.00. The postmark date on the payment is 3/30/03. Any interest accrual is waived since the overpayment was paid in full within 30 days of the date of determination.

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

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

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

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

Examples of Application when cost report not filed on time—

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

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

2. A provider with FYE 6/30/00 has a cost report that is due on 11/30/00. The cost report became overdue on 12/01/00. On 01/15/01 the cost report was submitted indicating an amount due the program; payment did not accompany the report. Due to the late submission of the cost report, interest is assessed for two 30-day periods. The interest rate assessed is the rate in effect on the day the cost report became overdue, 12/01/00. In addition interest, at the rate in effect on the day the cost report became overdue, will accrue on the declared overpayment from the date the cost report is filed to the date the amount due is paid.

On 03/12/01, the intermediary completes a desk review and determines an additional overpayment, issuing a NPR and demand letter. Interest will be assessed on this additional amount at the rate in effect on 3/12/01. In addition interest will be assessed for the period of delinquency at the rate in effect on the day the cost report became overdue, 12/01/00.

C. Accrual of Interest; Rejected Cost Report

In terms of interest accrual, a rejected cost report is treated like an unfiled cost report. If a cost report is officially rejected by the contractor, (see Audit and

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

Example of Interest Accrual When the Cost Report is Rejected

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

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

D - Underpayments

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

- An NPR (FI only) and a notice of final determination of an underpayment under §30.1.
- A notice of final determination of an underpayment under §30.1 when an NPR is not issued.
- *An Administrative Law Judge (ALJ) or hearing officer's decision that reduces the amount of an overpayment below the amount that CMS has already collected. Interest begins to accrue once the underpayment amount has been determined. This may be at the decision time if the ALJ reverses the entire overpayment amount or the ALJ states a principal amount to be paid upon which interest may be calculated. However, if the ALJ does not specify the overpayment amount and recalculations are necessary (not including a full reversal of the overpayment amount) interest will begin to accrue at the time of the recalculations. If the FI/Carrier is unsure when interest should accrue for a particular case, the servicing regional office should be contacted.*
- *An Intermediary Hearing or a Provider Reimbursement Review Board (PRRB) decision that reduces the amount of an overpayment below the amount that CMS has already collected.*

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

30.4 - Procedures for Applying Interest During Overpayment Recoupment

(Rev. 29, 01-02-04)

A - General

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

B - Recoupment Through Installment Payments

A provider is expected to repay any overpayment as quickly as possible. If a provider cannot refund the total amount of the overpayment within 30 days after receiving the first demand letter, it should immediately request an extended repayment plan. (See Chapter 4, §50 for extended repayment procedures.)

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

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

C - Proof of Receipt

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

30.5 - Notification to Providers Regarding Interest Assessment

(Rev. 29, 01-02-04)

A – Cost Report Reminder Letters

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

1. Late Filing Interest- If a cost report is not filed on time and indicates an amount is due CMS, or if it is subsequently determined that an additional overpayment exists, such as when an NPR is issued, interest will be assessed on the overpayment from the due date of the cost report to the date the cost report was filed. This interest assessment is made regardless of whether the overpayment is liquidated within 30 days.
2. Assessed Interest- If a cost report is filed on time and indicates an amount is due CMS, interest will accrue on that overpayment from the date the cost report is due, unless full payment accompanies the report or the provider and the contractor agree in writing, in advance, to recoup the amount of the overpayment from interim payments over the next 30-day period.

B - Notice of Program Reimbursement (NPR)

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

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

C - Overpayment Demand Letters

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

30.6 - Waiver and Adjustment of Interest Charges

(Rev. 29, 01-02-04)

A - Waiver of Interest Charges

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

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

liquidate the overpayment through a reduction in interim payments over the next 30-day period.

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

B - Adjustment of Interest Charges

1 – Reopenings-FI

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

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

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

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

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

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

Example of Application.--

A. On 07/18/01, the intermediary completes a final settlement and issues a NPR and a written demand showing an amount due the program of $16,000. On 09/15/01, the provider pays the $16,000 overpayment plus two 30-day periods of accrued interest.

As a result of a hearing on 12/l0/01, the PRRB reverses the intermediary's findings and determines that the correct amount due the program was $4,000. The excess $12,000 in principal and the accrued interest on $12000 that was assessed and collected must be returned to the provider.

3 - Judicial Review

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

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

40 – Withholds and Suspensions

(Rev. 29, 01-02-04)

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

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

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

40.1 – Recoupment by Withholding Payments

(Rev. 29, 01-02-04)

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

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

B. Requirements for Withhold--Comply with the following conditions to withhold interim payments:

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

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

Day 16	*No word from provider*	*100 % withhold*
Day 16	*Provider has submitted ERP application*	*No withhold as long as provider submitted a first payment along with ERP application. Payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If payment is not received with the application request, withhold shall be initiated at 30%.*
Day 16	*Provider has submitted ERP application but it is incomplete*	*No withhold as long as provider submitted a first payment along with ERP application. If payment is not received with the application request, withhold shall be initiated at 30%. Once a completed application is submitted payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If completed information is not received within an allotted amount of time (rarely more than 30 days) withhold shall be initiated at 100%.*
Day 16	*Provider has said that it is planning to submit an ERP application*	*30% withhold- when ERP application is received, cease withhold if the first payment accompanies the application request; maintain 30% withhold if payment does not accompany application*
Day 30	*Still no word from provider*	*Remain at 100%*
Day 30+	*ERP application is being reviewed by RO or CO*	*No withhold as long as provider continues to submit appropriate payments on a monthly basis under the terms of the application request. If provider did not submit a first payment or does not submit subsequent payments withhold shall be 30% unless RO or CO gives alternative instructions*
Day 30	*Provider said an ERP application was forthcoming but has not been received to date*	*Increase withhold to 100% If provider calls with an acceptable reason for the delay, make a judgement call to leave at 30% until day 45*
Day 45+	*No ERP application and no payment by*	*100%*

	provider	

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

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

NOTE: Additional Information for Both FIs and Carriers

If extenuating circumstances exist and the FI/Carrier believe that a higher or lower percentage of withhold is necessary to protect the Medicare Trust Fund, the FI/Carrier shall contact the servicing regional office for guidance and/or approval. Some examples include knowledge that the provider may file bankruptcy, a history of non-payment of overpayments, or evidence that the withhold percentage would cause irreparable harm.

The payment submitted with the ERP application shall be one month's payment based on the amortization schedule submitted with the ERP application. The amortization schedule shall not exceed 60 months, shall include principal and interest and the minimum monthly payment shall not be less than 1/60th of the overpayment. If the provider requests an ERP in excess of 60 months the payment submitted shall be 1/60th of the overpayment. If the payment submitted is not 1/60th of the overpayment, the FI/Carrier shall contact the provider (in writing or a documented telephone call with the appropriate personnel at the provider's place of business) requesting additional funds. If the provider does not submit additional funds within 15 days of the date of the request, the FI/Carrier shall initiate a 30% withhold.
Until a final decision is made regarding the ERP the provider should submit monthly payments based on the amortization schedule. If the provider does not continue to submit monthly payments, the FI/Carrier shall contact the provider requesting the payment. If the provider does not submit the monthly payment within 15 days of the date of the request, the FI/Carrier shall initiated a 30% withhold.

E. Disposition of Withheld Funds- All funds withheld shall be applied towards the outstanding overpayment. The funds shall be applied to the outstanding interest first and then to the outstanding principal balance.

F. Duration of Withhold- The withhold shall remain in effect until:

- *The overpayment is liquidated;*
- *You enter into an agreement with the provider for liquidation of the overpayment; or*

- *On the basis of subsequently acquired evidence, or otherwise, you determine that there is no overpayment.*

40.2 – Suspension of Payment *(See Program Integrity Manual)*

(Rev. 29, 01-02-04)

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

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

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

50 - Establishing Extended Repayment

(Rev. 29, 01-02-04)

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

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

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

Note: Once an ERP is established, the offset of an underpayment against the ERP is not automatic. If a Medicare underpayment is determined subsequent to an established ERP, the FI shall notify the provider in writing of the underpayment. The FI will permit the provider 15 calendar days following the date of notification to submit a statement (including any pertinent evidence) as to why the underpayment should not be offset.

If the provider does not respond in the required time, the FI shall offset the underpayment against the ERP. If the provider responds timely, the FI shall not take action to offset until it has completed its review of the documentation. Based on its review, the FI will make a determination as to whether the facts justify offsetting the underpayment. If the FI determines that offset is appropriate, in whole or in part, written notice will be sent to the provider. Such notice shall contain specific findings on the conditions upon which the offset was based, and an explanation for the final decision.

50.1 – Documentation Required in an ERP Application--Physician is a Sole Proprietor – Carrier Only

(Rev. 29, 01-02-04)

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

50.2 - Documentation Supporting a Request for Extended Repayment – Provider is an Entity Other Than a Sole Proprietor

(Rev. 29, 01-02-04)

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

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

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

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

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

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

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

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

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

Signed
Officer or Administrator of
Provider(s)
Title

Date

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50.3- Approval Process

(Rev. 29, 01-02-04)

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

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

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

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

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

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

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

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

Protocol for Reviewing Extended Repayment Plan (ERP)

Provider_____
Provider Number _____

(FIs Only) Cost Report FYE _____

(Carriers Only) Date(s) Overpaid _____

Overpayment Amount $_____

Date of Demand Letter_____No. of Months Requested for ERP_____

Date ERP Approved/Not Approved (12 mos. or less) _____No. of Mos. Approved_____
Date Referred to RO for Consideration _____

Name of FI/Carrier

Reviewed By_____.....Date _____
FI/Carrier Analyst

Supervisor Review_____ Date _____
FI/Carrier Official

1. Summarize the major reasons why the overpayment occurred.

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

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

   a. Current Ratio

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

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

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

      Normally, the FI/Carrier considers a current ratio of 2 to 1 adequate to meet current liabilities. However, a debtor with a current ratio (2 to 1 or greater) may have short-term payment problems if its current assets are

not expected to be in liquid form (cash or short-term investments) in time to meet the expected payment dates of the current liabilities.

b. Quick Ratio

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

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

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

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

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

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

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

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Provided by:

Operations - Net income for the period	$XXXX
Add: Charges not affecting working capital (depreciation, amortization, etc.)	XXXX
	$XXXX
Less: Operating revenues not affecting	XXXX

working capital		
Total fund provided by Operation		$XXXX
Long term loans	XXXX	
Unrestricted cash donations		XXXX
Other (identify)		XXXX
Total Funds Provided		$XXXX

Exhibit 2 (Cont.)

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Applied to:

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

*Current Assets less Current Liabilities

Exhibit 3, Cash Flow Statement Period Covered

CASH FLOW STATEMENT
FOR THE PERIOD

Cash provided by:

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

Exhibit 3 (Cont.)

CASH FLOW STATEMENT
FOR THE PERIOD

Cash applied to:

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

Increase (Decrease) in Cash	$XXXX

- -

Cash at end of period (date)	$XXXX
Less: Cash at beginning of period (date)	XXXX
Increase (Decrease) in Cash	XXXX

Exhibit 4, Projected Cash Flow Statement Cash From Operations (Schedule A) Period Covered

PROJECTED CASH FLOW
CASH FROM OPERATIONS (SCHEDULE A)

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

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

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

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

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

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

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

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

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

- The provider's proposed repayment plan and rationale;

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

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

50.5 - Monitoring An Approved Extended Repayment Plan

(Rev. 29, 01-02-04)

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

50.6 Requests from Terminated Providers or Debts that are Pending Referral to Department of Treasury

(Rev. 29, 01-02-04)

When approving/denying an ERP request the FI/Carrier is making a subjective decision concerning the provider/supplier's ability to repay. All complete ERP requests shall be reviewed. This includes ERP requests from terminated providers

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

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

(Rev. 29, 01-02-04)

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

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

(Rev. 29, 01-02-04)

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

- They have received an overpayment of title XVIII funds, and efforts to collect it have been unsuccessful; or
- Efforts to secure from the provider, the necessary data and information to determine the amount, if any, of the overpayment have been unsuccessful (i.e., a deemed overpayment because the provider failed to file a cost report); and
- For physicians or suppliers, they have previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act, and during the 12 month period preceding the quarter in which CMS proposes to withhold the Federal share of Medicaid payments for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of the overpayment.

CMS may order the State to withhold the Federal share of Medicaid payments of a provider to recover Medicare overpayments plus accrued interest.
The FI/Carrier shall establish whether or not a provider is subject to these procedures. The FI/Carrier must be sure the provider is participating in title XIX program prior to referring the case to the RO for withholding. It shall refer only those cases that it is unable to collect through established procedures. The RO resolves questions with respect to the provider's status in the Medicaid program.

Section 1914(a) of the Act permits, rather than requires, the Secretary to withhold the Federal share of Medicaid payments to recover Medicare overpayments. To allow flexibility in the administration of this provision, the ROs routinely determine whether

it would be cost effective to withhold the Federal share. If they determine that it is not feasible, they notify the FI/Carrier, citing the reason for not processing the collection request.

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

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

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

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

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

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

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

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

60.2 - Withholding Medicare Payments to Recover Medicaid Overpayments

(Rev. 29, 01-02-04)

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

The RO determines if withholding the Medicare payments due the overpaid Medicaid institution is appropriate. Where it determines that withholding the Medicare

payments is proper, it advises the FI/Carrier to withhold the Medicare payments to the institution by the lesser of:

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

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

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

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

70.7.3 - Intermediary Claims Accounts Receivable (A/R) (Rev. 19, 07-25-03)

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

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

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

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

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

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

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

For Recommendation of Write-Off (Termination of Collection Action):

When recommending write-off (termination of collection action), intermediaries will follow instructions as outlined in the overpayment section of this manual, which begins at Section 100, or contact their regional office (RO) for guidance.

- Claims A/R for an individual provider, totaling less than $25 for the aggregated principal balance, where no recoupment has occurred in the past 60 days, should be recommended for termination of collection action and write-off closed. A listing should be forwarded to the RO which contains the following information:
    - Provider number;
    - Provider name;
    - Amount of claims A/R being requested for termination of collection action and write-off closed;
    - Date of claims A/R;
    - Date of last activity; and
    - Reason for requesting/recommending termination of collection action and write-off closed.
- Claims A/R, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and write-off closed. This could include claims A/R received as a result of a Medicare contractor transition where no remittance advices are available, and other claims A/R where no remittance advice is available to support the balances. The intermediary must make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R must be forwarded to the RO for approval. The list should contain the same information as above, with the reason for termination of collection action and write-off recommendation that provides reasonable evidence to substantiate that the claim is no longer available.
- Claims A/R for an individual provider greater than 10 years old, regardless of amount, will be recommended and submitted to the RO for termination of collection action and write-off closed.

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

For issuing an initial demand letter:

This instruction supercedes any other instructions for issuing demand letters for claims A/R, including those found in FMM Section 130. These instructions, however, do not apply to medical review and fraud overpayments.

- Claims A/R for an individual provider with an aggregate principal balance greater than or equal to $25 and less than 10 years old, and where no recoupment has occurred in the past 60 days, must be validated and intermediaries will send an initial demand letter for the outstanding amount claim A/R balance. The demand letter will have a determination date equal to the date of the demand letter. In accordance with the intermediary's normal demand process, the provider will have 15 days to respond to the demand letter. In addition, the demand letter will contain the following:
    - The letter must explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest will begin to accrue if the debt is not paid in full within 30 days. The letter will provide the debtor with appeal rights and contain all provisions of a standard initial demand letter. The letter must also contain language that explains how the overpayment was determined and that the claims A/R has been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries will include the date(s) of the remittance advice and original amount(s) of the claims A/R.
    - If the initial demand letter is returned as undeliverable, the intermediary will attempt to locate a valid address. If a valid address is found, or it is determined that there was a change of ownership, the intermediary must send the demand letter to the valid address/owner.
    - If a current address cannot be located, send the Debt Collection Improvement Act (DCIA) intent letter, and follow regular debt referral procedures.
    - If the initial demand letter is not returned undeliverable, the intermediary will follow normal debt collection procedures, including sending the DCIA intent to refer letter if the overpayment is not recouped. The DCIA intent to refer letter must be sent no later than 120 days from the date of the initial demand letter.
- Each demanded claim A/R will be considered a separate identifiable debt and will not be aggregated with other demanded claim A/R.

Exception to above procedures for issuing the initial demand letter:

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

Claims A/R that are outstanding, but have not yet been demanded due to the fact that they have not met the timeframe for issuing an initial demand letter will be considered in cost report settlements. Intermediaries will review and include all outstanding undemanded claims A/R in the settlement process. Claims A/R that have been demanded, in accordance with these instructions, will not be included in

the cost report settlement process, as these are now considered as separate receivables.

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

70.7.4 - Physician/Supplier Overpayment Reporting (PSOR) System Summary Entry Debts

(Rev. 13, 02-03-03)

This instruction addresses the delinquent overpayments, with a principal balance greater than or equal to $25, which is listed in the PSOR in summary entries 0888888888 and 099999999.

If a debt does not meet the criteria set forth by the Code of Federal Regulations, 42 CFR 405.376 for termination of collection action and write-off closed, the debt should be processed for referral to the Debt Collection Center (DCC) for cross servicing/TOP. The "intent to refer" letter must be sent when the debt is no more than 90 days delinquent (120 days from determination date).

Carriers will not update the PSOR status code for summary entry debts to reflect that the "intent to refer" letter was sent, since all debts included in the summary entry will not have the "intent to refer" letter sent. Carriers will be responsible for identifying and tracking these debts for timely referral. Carriers will follow normal debt collection and referral procedures, including financial reporting on these debts.

Once an overpayment included on a summary entry is collected, the summary entry should be downwardly adjusted to reflect the correct outstanding balance.

70.15.2 - Financial Reporting for Intermediary Claims Accounts Receivable (A/R)

(Rev.13, 02-03-03)

Intermediaries must be able to identify and separate the claims A/R that have been demanded from those claims A/R that have not been demanded. The date of the initial demand letter will become the new determination date for aging purposes and the financial reporting of the receivable in Line 2a. New Receivables on the H751, Status of Accounts Receivable, report. The date of the initial demand letter must be the determination date for interest accrual, delinquency determination and referral to DCC. The demanded claims A/R adjustment must be reported as delinquent in Section B, Delinquent Receivables, if payment is not received within 30 days after the date of the initial demand letter. The accrual of interest will begin on the 31st day, and will be charged from the date of the initial demand letter. Claims A/R that have been demanded, in accordance with this instruction, will be recorded on CMS Form H750 on the line "Claims Accounts Receivable."

Claims A/R that have not been demanded will be included on the H750 under "Other." The outstanding balance of the undemanded claims A/R will be included in the "Adjustment" line on CMS Form H751. The claims A/R that have not been demanded will be reported as "current" for aging purposes.

80 – Requirements for Collecting Overpayments-Carriers

(Rev. 29, 01-02-04)

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

80.1 – Overpayment Recovery from the Beneficiary

(Rev. 29, 01-02-04)

See Chapter 3, §100 & 110ff

80.2 – Overpayment Recovery from the Physician/Supplier

(Rev. 29, 01-02-04)

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

- *Once an overpayment is discovered and a final determination is made a first demand letter shall be sent. This first demand letter shall meet the requirements set forth in Chapter 4, §90.*
- *If the overpayment is not paid in full by day 30 interest shall begin to accrue on day 31(See Chapter 4, §30)*
- *If a full payment is not received 40 days after the date of the first demand letter the Carrier shall start recoupment on day 41. (See Chapter 4, §90)*
- *If no response is received from the physician/supplier 30 days after the date of the first demand letter, a second demand letter shall be sent between day 31 and day 45 (See Chapter 4, §90)*
- *If by day 60 there has been no response or no contact with the physician/supplier the Carrier shall attempt to contact the physician/supplier by telephone. The carrier may cease attempting to contact the physician/supplier if the debt is referred to the Department of Treasury, if the physician/supplier files for bankruptcy, or under the guidance of CMS. At a minimum Carriers shall attempt to call the delinquent physician/supplier weekly until contact is made (A voicemail message is not considered contact.). If contact is made, the Carrier shall attempt to determine how the physician/supplier plans to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed. Document each attempted contact, as well as any discussions with the physician/supplier. If the Carrier is unable*

to contact the provider by telephone because of a disconnected number or a number not in service the Carrier shall attempt to locate the provider through other means. (See Chapter 4, §90)

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

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

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

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

- *If the debt is still delinquent 60 days after sending the third demand letter, the debt shall be input into the Debt Collection System for referral to the Department of Treasury for cross servicing and offset. Until the Department of Treasury accepts the debt, the collection of the debt is still the responsibility of the Carrier. Therefore, collection activities shall not cease until the acceptance from the Department of the Treasury is received. This acceptance shall be noted on the Carrier's internal system as well as in the case file. Recoupment by means of withhold will continue by the Carrier until the debt is collected in full or an acceptable extended repayment plan is approved. (See CR 1683 or Chapter 4, §70)*

- *Throughout all stages of the overpayment Carriers shall keep a record of all collection activity and attempted collection activity. This record can be in the overpayment case file or can be stored electronically or a combination of both. If electronic, the entire case file shall be retrievable. This record is in addition to the internal accounting system and the Physician/Supplier Overpayment Reporting (PSOR) System. This record shall be detailed and include all conversations and correspondence with the physician/supplier. An*

outside individual shall be able to make a complete audit trail with the case file. Hard copy files shall be available immediately upon request. Electronic files shall be available within 48 hours of request. Files that have been converted to microfilm shall be available within 48 hours of request. Files that have been store offsite shall be available within 72 hours of request. (See Ch. 5 §200 for additional information.)

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

90 – Physician/Supplier Overpayment Demand Letters - Carrier

(Rev. 29, 01-02-04)

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

90.1 – Part B Overpayment Demand Letters to Beneficiaries

(Rev. 29, 01-02-04)

See Chapter 3 §100 &110ff

90.2- Part B Overpayment Demand Letters to Physicians/Suppliers

(Rev. 29, 01-02-04)

When a physician/supplier is liable for an overpayment of $10 or more, the carrier shall attempt recovery through the following procedures.
It shall recover an overpayment made to a physician/supplier as an individual or to a professional corporation (following the procedures described below) only from the party to whom the overpayment was made. It shall make no attempt to recover an overpayment made to an individual physician/supplier from a professional corporation with which they may be associated as an employee or stockholder. Conversely, it shall not attempt recovery from an individual physician/supplier where the overpayment was made to a professional corporation with which they are, or were, associated.

Overpayment Amount Is At Least $10

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

If the overpayment is less than $50.00, the carrier shall issue only one demand letter. When overpayments less than $10.00 are aggregated to $10.00 or more, but less than $50.00, it shall issue one demand letter.

Overpayment Demand Letter

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

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

Content of Demand Letters

- Sent to the physician/supplier.
- *For a first request, mail within seven (7) calendar days of determination of the overpayment.*
- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined.
- The demand letter shall offer the physician/supplier the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be approved using the criteria set forth in *Chapter 4, §50*. *Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter.*
- The demand letter constitutes a request to the physician/supplier to refund the overpaid amount.
- The demand letter informs physicians/suppliers that the carrier will recover the overpayment through the recoupment of current payments due or from future claims submitted unless the carrier receives repayment or the physician/supplier provides a statement within 15 days of the date of the letter of why this action should not take place. The demand letter shall also inform physicians/suppliers that this recoupment will begin on the 41st day from the date of the letter.
- The demand letter informs physicians/suppliers that interest will accrue on the overpayment if payment in full is not received by the 31st day from the date of the letter. The demand letter shall also inform physicians/suppliers of the applicable interest rate that will accrue if payment in full is not received by the 31st day from the date of the letter.
- The demand letter informs physicians/suppliers that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) A review is available for disputed overpayments of any

amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least $100.

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

The carrier shall refer to Exhibits I through VI for the standard formats for each demand and voluntary refund letters to be used in various overpayment situations.

Recovery by Recoupment

If, within 15 days of the date of the initial demand letter, the physician/supplier submits a statement and/or evidence as to why offset should not be effectuated, the carrier shall promptly evaluate the material. *This is different from a request for appeal (see subparagraph F) in that you are deciding only whether there is a basis to not effectuate an offset. Any correspondence dealing with the basis of the overpayment does not affect your decision concerning offset.* If the carrier determines that offset shall begin, it shall notify the physician/supplier in writing of its determination. It shall give specific reasons for its decision.

If no such statement is received or an extended repayment plan has not been requested, the carrier shall initiate recovery by *recoupment* 40 days after the date of the initial demand letter (day 41), unless the physician/supplier refunds the overpaid amount in full. The carrier shall apply any amounts payable to the physician/supplier by reason of assignment on behalf of **any** beneficiary to *recoup* the overpayment. It shall apply any amount *recouped* first to the accrued interest and then to the principal.

If it is not possible to make an immediate *recoupment*, the carrier shall annotate the physician's account so that the overpayment can be recouped from future Medicare benefits payable. When *recoupment* is used, the carrier sends the regular Medicare Summary Notice (MSN) to the beneficiary. However, it includes with the physician's/supplier's MSN an explanation that the benefits (or a specified amount of the benefit) are being applied to the overpayment and that the physician may not request the beneficiary to pay the amount applied to the overpayment.

The carrier shall discontinue *recoupment* only when the overpayment, plus all accrued interest, is recovered, it is determined on appeal that the physician/supplier was not overpaid or an acceptable extended repayment plan request is received (See Chapter 4, §50). After a favorable appeal decision, the carrier shall refund any excess amount withheld through *recoupment*. Also, it shall refund any interest that was collected.

Follow-up Request

If the initial demand letter for an overpayment of $50 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

Physician Appeals Within 30 Days of Notification of the Intent to *Recoup*

If, within 30 days after the date of the initial demand letter informing the physician/supplier of the intention to *recoup*, the physician/supplier submits a request for a review or hearing or otherwise protests the recovery, the carrier shall make every effort to conclude the appeal procedure expediently. However, it shall begin *recoupment* 40 days after the initial demand, if payment has not been made, regardless of the status of any appeal request. (See subparagraph D.)

Demand Letter to Physician Returned as Undeliverable

Where a refund letter is returned as undeliverable, the carrier shall attempt to locate the physician/supplier using such sources as telephone directories, city directories, postmasters, driver's license records, automobile title records, State and local medical societies, the American Medical Association or its own Medicare beneficiary records. *(See Chapter 4, §80.)*

Direct Contact with Physician

If attempted *recoupment* of the overpayment is unsuccessful for 30 days, the carrier shall contact the physician/supplier by telephone. *(See Chapter 4, §80.)*

Third Demand Letter

If the overpayment has not been recouped and the debt is eligible for referral to the Department of Treasury an intent to refer letter shall be sent once the overpayment becomes 90 days delinquent. *(See CR 1683 or Chapter 4, §70)*

EXHIBIT 1- SAMPLE DEMAND LETTERS

Exhibits I through VI include: the initial demand letter with optional opening paragraphs and the follow-up letter. It also includes a limited set of optional paragraphs to be used in specific situations, e.g., medical necessity denials, and installment payments. The carrier shall follow these formats, with the optional paragraphs, when preparing demand letters.
This section also includes standard letters to be used when the physician/supplier voluntarily submits a check to the carrier. These letters are optional if the carrier uses the remittance advice to inform physicians/suppliers of receipt of their refund checks.

EXHIBIT 1 - INITIAL DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Date

Dear Dr. Smith:

Contractors should use the appropriate paragraph:

"This is to let you know that you have received Medicare payment in error which has resulted in an overpayment to you of $_____ for services dated _____ . The following explains how this happened."

or

"We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention."

or

"We have received your check in the amount of $_____. We thank you for bringing this overpayment to our attention. While we appreciate you submitting payment to us, our review found that the overpaid amount was $_____. Please remit the additional $_____."

How this overpayment was determined:

NOTE: This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.

Why you are responsible:

NOTE: For medical necessity determinations, the carrier shall insert appropriate paragraphs. It shall be sure to give an 1879 determination for each claim as well as the regulatory and statutory references for the 1879 determination.

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount.
If you dispute this determination please follow the appropriate appeals process listed below.
(Applicable Authorities: Section 1870(b) of the Social Security Act; §§ 405.350 - 405.359 of Title 42, §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.)

What you should do:

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

Carrier Address

If you do not refund in 30 days:

In accordance with 42 CFR 405.378 simple interest at the rate of __ will be charged on the unpaid balance of the overpayment beginning on the 31st day. For periods of less than 30 days the full monthly interest charge will be applied. Thus, if payment is received 31 days from the date of final determination, two 30-day periods of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ .

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may

determine if you are eligible for a repayment plan. *(See enclosure for details.) Any repayment plan (where one is approved) would run from the date of this letter.*

If payment in full is not received by, (specify a date 40 days from the date of the notification), payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. *If you have reason to believe that the withhold should not occur on _____ you must notify <contractor> before ___. We will review your documentation, but will not delay recoupment. This is not an appeal of the overpayment determination.*

If you wish to appeal this decision:

If this overpayment is less than $100, you may request a review. This request must be made within 120 days from the date of this letter. Please send your request for review to:

Address of Review Department

If this overpayment is $100 or more, you may request a fair hearing. This request must be made within 180 days from the date of this letter. Also, you may combine claims to meet the $100 minimum for a hearing. However, the dates of the determination letters must all be within six months of the hearing request in order for the amount in controversy to be included in the $100 minimum. If you would like to request such a hearing, please notify us in writing at:

Address of Hearings Department

If you have filed a bankruptcy petition:

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

Should you have any questions please do not hesitate to contact _____ at _____.

If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.

Sincerely,

(name and title)

Enclosure

DOCUMENTATION SUPPORTING A REQUEST

FOR EXTENDED REPAYMENT PLAN

Items Included? Yes/No

□ □ *A written request must be submitted that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the approximate monthly payment amount (principal and interest, if possible), and include the first payment.*

If a sole proprietor:

□ □ *A completed Form CMS-379*

□ □ *Income Tax Statements from the most recent calendar year*

If not a sole proprietor:

□ □ *Balance Sheets- The most current balance sheet and the one for the last complete fiscal year (preferably prepared by the provider's accountant). If consolidated statements (including more than one entity) are submitted, separate statements showing the individual provider's contribution must also be submitted.*

Note: If the time period between the two balance sheets is less than six months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last TWO complete fiscal years in addition to the most current balance sheet.

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

□ □ *Cash Flow Statements for the periods covered by the balance sheets. If the date of the request for an extended repayment plan is more than three (3) months after the date of the most recent balance sheet, a cash flow statement should be prepared for all months between that date and the date of the request.*

□ □ *Projected Cash Flow Statement covering the remainder of the current fiscal year. If fewer than six (6) months remain, a projected cash flow statement for the following year should be included.*

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

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

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

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

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

□ □ *The percentage of occupancy by type of patient (Medicare, Medicaid, private pay) covered by the income statements.*

All Requests:

□ □ *Requests for extended repayment of more than twelve (12) months must be accompanied by at least one letter from a financial institution denying the provider's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.*

□ □ *First payment according to proposed repayment plan.*

□ □ *Copy of the overpayment notification letter.*

Note: *If you are unable to furnish some of the documentation, you should fully explain why. Where the explanation is reasonable and the documentation is otherwise acceptable, forward the request to the RO with your recommendation.*

Your first payment, referenced "ERP Request", should be made payable to _____ and mailed directly to:

Mail a copy of your check and above requested information to:

Please submit all items checked "NO" within 10 days from the date of this letter to avoid the withholding of your remittance advices.

EXHIBIT 2 - FOLLOW UP DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Dear (Name of Physician/Supplier):

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the initial letter sent to you which explains how the overpayment was determined and why you are responsible. As of today, we have not heard from you, either to request an overpayment appeal or to make payment. *The overpaid amount is _____ (principal plus interest) for your claim that paid on _____. $_____ has been recovered.*

As stated in our initial letter, offset of the overpayment amount, plus interest, will be made against any pending and future assigned Medicare claims.

If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact us at _____.

Sincerely,

(Name of individual)

Enclosure

EXHIBIT 3- INTENT TO REFER LETTER

When an eligible physician/supplier overpayment remains delinquent for 90 or more days, the carrier shall send an intent to refer letter. (See CR 1683 and Chapter 4, §70 for more information.)

EXHIBIT 4 - OPTIONAL OVERPAYMENT CUSTOMIZING PARAGRAPHS

A1 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."
Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because...(i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community). (Applicable Authorities: Section 1879 of the Social Security Act; §§411.404 and 411.406 of Title 42 of the United States Code of Federal Regulations.)

NOTE: The carrier shall be sure to include the applicable authorities at the end of the §1879 language as it appears here.

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary. This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge.
The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

B2 - The carrier shall include one of the appropriate paragraphs below in all overpayment letters that involve duplicate payments.

- The overpayment resulted from excess payments caused by multiple processing of the same charge.
- The overpayment resulted from Medicare payment on an assigned claim for which the beneficiary also received payment on an itemized bill and turned his payment over to you. Therefore, you are liable for $_____ which represents that portion of the total amount paid in excess of the fee schedule amount.
- You have mistakenly received duplicate primary payment from both Medicare and another entity (Specific payer). (Specific payer) is the appropriate payer. As such, you are liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer.
- This overpayment resulted from duplicate Medicare payments to you for services you provided to (**named beneficiary**).

NOTE: The above paragraphs are not all-inclusive.

EXHIBIT 5 - SAMPLE LETTER - CHECK INCLUDED FOR CORRECT AMOUNT

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention, thereby protecting the integrity and resources of the Medicare program.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check in the amount of $_____ and applied it to the overpayment.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

EXHIBIT 6 - SAMPLE LETTER - CHECK INCLUDED BUT WRONG AMOUNT (TOO MUCH)

Dear (Name of Physician/Supplier):
We appreciate your recent inquiry regarding Medicare payment that you believe was paid in error. We thank you for bringing this overpayment to our attention.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check for $_____. You will notice that the amount of your check exceeds the overpayment amount. We will send you a check shortly for the excess amount.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

Enclosure

90.3 - Notification to the Beneficiary When Recovery Is Sought from the Provider or Physician

(Rev. 29, 01-02-04)

A notice to the beneficiary is required whenever recovery is sought from the provider. (See Chapter 3, §100 & 110*ff* when recovering from the beneficiary.)

The FI/Carrier shall include in the notification to the beneficiary a copy of the letter sent to the provider unless the letter to the provider mentions more than one beneficiary or deals with overpayments which do not concern the particular being notified. In such cases, a copy of the initial demand letter sent to the provider should **not** be attached to the beneficiary notice.

Where overpayments to a provider have been determined by means of a sample study, the FI/Carrier shall send a notice only to the beneficiaries identified in the overpayment notice sent to the provider as individuals on whose behalf the provider was overpaid a specified amount. It shall not send the notice to the beneficiaries until it has been established that recovery action will be taken.

In all cases the notice to the beneficiary should contain the following:

- The name and address of the provider and dates of service for which the overpayment was made.
- A clear explanation of why the payment was incorrect.
- A statement that the provider has been requested to refund the overpayment and, if the provider is liable for medically unnecessary services or (FIs only) custodial care, the following additional information, as applicable:

- If the error is discovered subsequent to the third calendar year after the year the payment was approved, and the other conditions described in *Chapter 3, §80* apply, the FI or carrier shall advise the beneficiary that the provider is prohibited, by law, from requesting payment for the services; or
- If the beneficiary is determined to be without fault, the FI or carrier shall state that if the beneficiary pays for the services, the beneficiary may request that the FI or carrier indemnify the beneficiary for such payment. Any indemnification paid to the beneficiary will be recovered from the provider. (See Medicare Claims Processing, Chapter 30, Financial Liability Protections.)
- In all other cases, Medicare law does not prohibit the provider from requesting the beneficiary to pay.
- An explanation of the beneficiary's appeal rights. (See Medicare Claims Processing, Chapter 29 Appeals of Claims Decisions.) In the notice to the beneficiary, however, the FI or carrier shall not mention waiver since there is no provision for waiver when the physician is liable for the overpayment.

90.4 - Sample Letter to Beneficiary Where Recovery Is Sought From Provider

(Rev. 29, 01-02-04)

Dear _____:

In (**month and year**), we made a payment to (**provider or physician name and location**) on your behalf for services provided to you (insert dates).

We have reviewed the payment and determined that the services were not covered under the Medicare program.

(The FI or carrier shall explain as clearly as possible the reason why all, or part, of the payment was erroneous.)

It shall use either paragraphs A, B or C below as appropriate:

A - Provider Liable for Medically Unnecessary or Custodial Care Services (Physician Liable for Medically Unnecessary Services)

(See Medicare Claims Processing, Chapter 30, Financial Liability Protections.)

We have found that you (the beneficiary) did not know or have any way of knowing that the services you (he/she) received during (**dates of services for which beneficiary's liability has been waived**) would not be considered to be reasonable and necessary by Medicare. However, the records show that (physician's name) should have known that such services would be considered noncovered. When this situation occurs, the law requires that the liability for these noncovered services be transferred to the physician.

Therefore, you (the beneficiary) are (is) not responsible for the charges billed by (**provider's name**) except for any charges for services or items never covered by Medicare. If you (the beneficiary) have (has) paid (**provider's name**) for these services, you may be entitled to a refund. To obtain this refund, please advise this office and enclose the following documents:

- A copy of this notice;
- The bill you received for the services; and

- The payment receipt from (provider's name), your cancelled check, or any other evidence showing that you (the beneficiary) have (has) already paid (provider's name) for the services at issue.

You should file your written request for payment within 6 months of the date of this notice.

B - Provider at Fault and Beneficiary Not at Fault for Medically Unnecessary or Custodial Services and the Overpayment was Discovered Subsequent to the Third Calendar Year After Year Payment Was Approved

(**Provider's name**) has been requested to refund this overpayment. Under the Medicare law, (**provider's name**) is prohibited from billing you, or any other source, for these noncovered services. If (**provider's name**) sends you a bill for these services, send it to us with a copy of this letter.

C - All Other Cases

(**Provider's name**) has been requested to refund the overpayment. Since the above services are not covered by Medicare, (**Provider's name**) may ask you to pay for them. However, if you are billed, this is a matter between you and (**Provider's name**) and will not affect your entitlement to future Medicare benefits in any way.

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