CMS Medicare Manual System
Pub. 100-6 Financial Management

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

Transmittal 5 **Date: AUGUST 30, 2002**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
5		Entire Chapter	

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Medicare contractors only: these instructions should be implemented within your current operating budget.

This transmittal includes chapter 5 of the restructured Medicare Financial Management Manual.

The completed manual includes ten chapters containing all CMS instructions to carriers and intermediaries about CMS requirements described in the table below. This material was derived from the source material as shown in the last column.

While this revision updates and reorganizes text from current manuals, it includes no new procedures. It is a reorganization and compilation of these instructions into a single financial management manual for intermediaries and carriers. Where there are differences in carrier and intermediary requirements, we distinguish to which contractor the instructions apply. Contractors should send any questions or suggestions for improvement to their ROs.

This manual is designed primarily for display on the Internet. The following changes from past paper manual protocols are used as a result of the Internet environment.

- Redline - It is not possible to place a vertical bar in the left margin on Internet documents. Therefore changed text is identified by red, italic font. Note that redline is not used on this initial transmittal because all the text is new.

- Displaying change dates - The date and revision number for the last change in the section or subsection is shown after each section/subsection heading instead of at the bottom of the page.

- Page numbers - are not applicable for Internet documents.

- Distribution of printed copies is discontinued.

Also for the initial issuance a cross-reference is placed after each section heading to identify the source from where the material originated. This will be eliminated as subsequent transmittals replacing the same sections are released.

As the ten chapters are distributed the current financial instructions in PMs and the Carrier and Intermediary Manuals will be deleted.

Chapter	**Chapter Title**	**Source**
1	Budget Preparation	MIM-1, Chapters 1, 2, & 6 MCM-1, Chapters 1, 2, & 6
2	Budget Execution	MIM-1, Chapter 3 and 5 MCM-1, Chapter 3 and 5
3	Overpayments	MIM-2, Chapter 3, MIM-3, Chapter 8 MCM-3, Chapter 7
4	Debt Collection	MIM-2, Chapter 3 MCM-3, Chapter 7
5	Financial Reporting	MIM-1, Chapters 4 & 9 MCM-1, Chapters 4 & 9
6	Workload Reporting	MIM-3, Chapter 9 MCM-3, Chapter 13
7	Internal Control Requirements	New Material Issued With This Manual (CR 2231)
8	General Audit Guidelines	MIM-2, Chapter 1, MIM-4, Chapter 1
9	Intermediary Procedures for Provider Audits	MIM-4, Chapter 2
10	Provider Statistical & Reimbursement Report	MIM-2, Chapter 3

MIM = Medicare Intermediary Manual, CMS Pub 13, e.g., MIM-1 is Part 1 of CMS Pub 13

MCM = Medicare Carrier Manual, CMS Pub 14, e.g., MCM-2 is Part 2 of CMS Pub 14

Medicare Financial Management Manual

Chapter 5 - Financial Reporting

Table of Contents

Notes: (1) Throughout this chapter, reference to **provider** includes institutional providers, physicians, and suppliers, i.e., all delivers of health care services that are reimbursed by either the intermediary or the carrier.

(2) Revision 5 includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - Checks Paid Method - General

(Rev. 5, 08-30-02)

A1-1400, B1-4400

Certified Letter-of-Credit Defined:

A certified letter-of-credit is a legal reservation of funds on deposit in the Federal Reserve Bank that covers payments for which the contractor has contracted to pay by issuing checks and authorizing electronic funds transfer.

The objective of the letter-of-credit checks paid method of financing is to reduce the level of the Federal debt and the interest costs of short-term borrowing. This method provides cash availability to meet Medicare program requirements, while at the same time, controls the timing of cash withdrawals so that the impact of these withdrawals on the public debt level and related financing costs is minimized. Cash flow is controlled by:

- Postponing withdrawal of funds from the U.S. Treasury until Medicare checks are presented to the contractor's Medicare servicing bank for payment;

- Limiting the amount withdrawn at any time; and

- Reducing the amount of Federal funds required to offset bank service charges.

The Treasury Department requires all Government agencies that make advance payments to utilize the letter-of-credit checks paid method of financing. (See Circular No. 1075, revised February 27, 1973, and Chapter 1000 of the Treasury Fiscal Requirements Manual.)

20 - Summary of Procedures

(Rev. 5, 08-30-02)

A1-1401, B1-4401

A contractor shall use the following steps to implement the letter-of-credit checks paid method of financing:

- It shall notify the RO 165 days prior to the expiration of the current three-party bank agreement when a new bank will be secured under the checks paid method;

- It shall request the latest copy of the Invitation for Bid (IFB) from the RO;

- It shall use the IFB package as a guide to prepare its IFB. The language contained in the package cannot be materially altered except for "BID FORMS AND

CONTRACTOR'S REQUIRED MEDICARE BANKING SERVICES." (See Attachment A, Section G, of the package.) The contractor shall obtain from its RO the implementation package that contains examples of material required for the bid process as follows:

- Letter to Commerce Business Daily requesting IFB advertisement; and

Sample write-ups of contractor's specifications for bank services, computer requirements, check specifications, and electronic funds transfer capability;

- It shall send the completed IFB to its RO for approval prior to its release for bid. It shall send an additional copy to:

  Centers for Medicare & Medicaid Services
  Office of Financial Management
  7500 Security Boulevard
  Baltimore, MD 21244-1850

- Obtain bids from two or more banks;

- Follow the Federal Acquisition Regulations (FAR), Part 14, when securing competitive bids;

- Evaluate the bank bids and, with the concurrence of the servicing RO, select the commercial bank that meets all of the mandatory requirements and submits the lowest required time account balance;

- Select a commercial bank and establish special bank accounts;

- Secure Signature Cards. Use Form SF-1194 to obtain the signatures of those individuals authorized **by the bank** to draw payment vouchers against the letter-of-credit and the signature of the bank official who has the authority to designate the authorized individuals;

NOTE: CMS executes the three-party bank agreement between the contractor, the bank, and the Government (the servicing RO). CMS also issues a letter-of-credit that sets forth the monthly limitation.

- Post (Bank) collateral with the Federal Reserve Bank;

- Establish (Bank) both the Benefits Account and the Time Account;

- Submit monthly letter-of-credit transmittals (form CMS-1521) via Contractor Administrative Financial Management (CAFM) to the Funds Control Branch, Central

Office. Distribute Medicare funds withdrawn by bank via FNS-5401 payment voucher according to type of benefits; and

- Submit the monthly form CMS-1522, TAA-1b and TAA-1C, to CMS via the CAFM system.

30 - Establishment of Special Bank Accounts

(Rev. 5, 08-30-02)

A1-1403, B1-4403

Keep all Federal funds withdrawn under the letter-of-credit separate from all other funds. Designate the Medicare account for deposit in a special bank account established by you in a member bank of the Federal Reserve System. Designate the special demand deposit checking account as follows:

(Name of Contractor)
Federal Health Insurance Benefits Account

Designate the special non-interest bearing time account as follows:

(Name of Contractor)
Federal Health Insurance Time Account

Restrict withdrawals to transfer of funds to the Federal Health Insurance Benefits account.(FHIBA)

30.1 - Execution of Bank Agreement

(Rev. 5, 08-30-02)

A1-1403.1, B1-4403.1

The contractor shall execute the three-party bank agreement with the selected commercial bank. The bank agreement requires that the Federal Government retain a lien on all funds held in the special bank account. The bank abides by written instructions of the Government with regard to the deposit and withdrawal of funds. The Government also has the right to inspect or audit the bank's books and records that pertain to the special accounts. (Refer to Attachment C of the IFB package.)

The contractor shall use the following guidelines when it executes a bank agreement;

- It must strictly adhere to the wording and format of the bank agreement.

- It may alter only Covenant 7. The provisions of Covenant 7 may, by agreement of all parties, be written to require either a one or two-year period of performance following the initial two year period;

- The RO forwards an original and three copies of the completed three-party agreement to the bank via the contractor for execution. Each copy of the bank agreement must contain original signatures. Facsimile signatures are not acceptable; and

- After it is countersigned by CMS, individual copies of the agreement are distributed to:

    - The contractor;

    - The bank;

    - The servicing RO; and

      Centers for Medicare & Medicaid Services
      Office of Financial Management
      7500 Security Boulevard
      Baltimore, MD 21244-1850

30.2 - Collateral Requirement

(Rev. 5, 08-30-02)

A1-1403.2, B1-4403.2

Posted collateral is based on the balance to be maintained in the time account less FDIC coverage, if applicable. The RO advises the contractor, upon notification by the Federal Reserve Bank, when collateral is posted. (Collateral must be acceptable under the guidelines provided to the Federal Reserve by the Department of the Treasury).

The contractor shall place the collateral with the Federal Reserve Bank or Branch of the district where its servicing financial institution is located or with a custodian designated by the Federal Reserve Bank or Branch. It shall include a letter with the collateral that states that the collateral is pledged as security for public money by CMS, agency account number 5555-4454-5 under the terms of 31 CFR, Part 202 (Treasury Circular 176).

30.3 - Changes in Collateral Pledged as Security for Federal Health Insurance Accounts

(Rev. 5, 08-30-02)

A1-1403.3, B1-4403.3

The CMS, Division of Contractor Financial Management (DCFM), monitors collateral requirements. DCFM continuously reviews the most recent balances maintained in the Federal Health Insurance Bank Accounts.

If an increase in pledged collateral appears necessary, DCFM requests the bank to post additional collateral with its Federal Reserve Bank.

If a decrease in pledged collateral appears warranted, DCFM advises the Federal Reserve Bank of the amount of excess collateral pledged.

The contractor shall direct any request for release of excess bank collateral to the local Federal Reserve Bank.

30.4 - Check Format Specifications

(Rev. 5, 08-30-02)

A1-1403.4, B1-4403.4, B2-5215

The following phrase must appear on all checks or drafts written for purposes of paying benefits and related administrative costs authorized under the Medicare program:

MEDICARE PAYMENT
For Health Insurance - Social Security Act

The contractor shall use the following check format specifications:

Check Front — The contractor shall center the words "Medicare Payment" at the top of the check or draft and print these words in at lease l/4-inch type. Contractor name and address should appear on the face of the check. The check may also include the contractor's emblem or a picture of a building it occupies. The contractor may not include advertising on the face of the check. (Advertising should not appear on the envelope in which the check is mailed.) It is expected that the type sizes of the items placed on the check will not detract from the required "Medicare Payment" phrase.

Check Back — The contractor shall print on the back of all Medicare checks the following statement:

> "This payment is made with Federal funds. Fraud in procuring, forging a signature or endorsement, or materially altering this check is punishable under the U. S. Criminal Code."

For carriers, assigned claims must also include the following statement:

"As provided by the terms of the law under which this check is issued, the undersigned payee, in accepting assignment, agreed that the charge determination by the Medicare carrier shall be the full charge for any service which the check is payable. The patient is responsible only for the applicable deductible and coinsurance, and for non-covered services."

It is not necessary to show the account name on the check. If one is shown, it should read "Federal Health Insurance Benefits Account." If both Part A and Part B are shown, it should read, "Federal Health Insurance Benefits Account - Part A" and "Federal Health Insurance Benefits Account - Part B."

The time limitation for cashing the check (if specified on the check) cannot be less than 6 months.

The contractor shall clear formats of checks with the servicing RO prior to printing or contracting for printing.

40 - Signature of Bank Individuals Authorized to Draw on the Letter-Of-Credit

(Rev. 5, 08-30-02)

A1-1405, B1-4405

Signatures of bank representatives authorized to sign payment vouchers must be on file along with the letter-of-credit at the servicing Federal Reserve Bank or branch in order to honor payment vouchers (FMS-5401). The contractor shall submit a signature card, Form SF-1194, for the person(s) authorized by the bank to sign payment vouchers.

NOTE: Executed signature card(s) must be received in DCFM no later than 20 calendar days prior to the effective date of a new letter-of-credit.

40.l - Revision of Signature Cards

(Rev. 5, 08-30-02)

A1-1405.1, B1-4405.1

The contractor shall prepare new card(s) if more than two signatures are no longer valid.

It shall prepare two original cards for every four individuals. If more than one card is needed, i.e., more than 4 individuals are authorized, it shall number the cards 1 of 2, 2 of 2 to ensure that all cards are received.

New signature cards must contain the signatures of all individuals who will sign payment vouchers and be certified by an official of the bank. The contractor need not resubmit a

new signature card if change in position or title of an individual authorized to sign payment vouchers is involved.

The contractor shall mark new signature cards "Replaces and Supersedes all Previously Submitted Cards" on the top edge of the card.

40.2 - Request for Additional Cards

(Rev. 5, 08-30-02)

A1-1405.2, B1-4405.2

The contractor shall send requests for additional signature cards to:

Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Boulevard
Baltimore, MD 21244-1850

40.3 - Signatures of Contractor Personnel Authorized for Federal Health Insurance Time Account

A1-1405.3, B1-4405.3

Signatures of two or more individuals designated by the contractor to sign withdrawal requests to transfer funds from the Federal Health Insurance Time Account to the Federal Health Insurance Benefits Account must be on file with the designated commercial bank.

50 - Withdrawal of Federal Funds

(Rev. 5, 08-30-02)

A1-1406, B1-4406

The Federal Government assures that funds are always in the Federal Reserve Bank to honor properly drawn payment vouchers within the limits of the letter-of-credit. This arrangement is consistent with State banking laws since it eliminates any possibility of intent to defraud.

60 - Use of Payment Vouchers

(Rev. 5, 08-30-02)

A1-1408, B1-4408

To obtain Federal funds, the bank prepares a daily payment voucher, Treasury Form FMS-5401, and forwards it to the servicing Federal Reserve Bank or Branch holding the letter-of-credit.

When the bank receives the initial letter-of-credit, the bank sequentially numbers payment vouchers drawn beginning with the number one (l). Amendments to the letter-of-credit do not interrupt the sequential numbering of payment vouchers.

Payment vouchers are prepared only in an amount equal to the contractor's total checks, bank debit memos, and electronic funds transferred. These vouchers are presented for payment each day less any balance in the benefits account representing collected other deposits or transfers from the Federal Health Insurance Time Account.

If the bank is not located in a Federal Reserve Bank (FRB) city, CMS requests the Treasury Department to implement a telephonic method of receiving funds for the bank. The bank calls its FRB and requests a specific funding amount. The FRB prepares the payment voucher and a copy is sent to the bank.

The letter-of-credit provides a ceiling on the amount that may be drawn during the month and is purposely set high to meet peak cash needs. In no instance is a payment voucher to be drawn for less than $5,000 or more than $5,000,000 (unless the letter-of-credit has been annotated "Authorized to draw payment vouchers in excess of $5,000,000"). Only one payment voucher should be drawn per day. Regardless of the factors considered in determining when and in what amount to draw payment vouchers, banks are expected to abide by the intent of the letter-of-credit Checks Paid Method of financing system by assuring that the total of the daily voucher processed is the minimum required to finance current disbursements.

NOTE: The "Name and Address of Drawer" block on the Treasury Form FMS-5401 must include the name of the bank as it appears on the letter-of-credit sent by CMS and the annotation "agent for" (name of contractor). Due to space limitations, the contractor does not have to show the address in this block. A supply of payment vouchers is provided to each commercial bank. Additional supplies of payment vouchers may be ordered from:

Centers for Medicare & Medicaid Services
Office of Budget and Administration
Distribution Liaison Officer
7500 Security Boulevard
Baltimore, MD 21244-1850.

70 - Form CMS-1521, Payment Voucher on Letter-Of-Credit Transmittal

(Rev. 5, 08-30-02)

A1-1410, B1-4410

The purpose of form CMS-1521, Payment Voucher on Letter-of-Credit Transmittal, is to record daily voucher data that the contractor's bank submits to the Federal Reserve Bank for payment of Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) benefit payments. Administrative costs paid through the Smartlink System are also reported on the form. Administrative costs are allocated to current or prior fiscal years and to special projects.

Transmit form CMS-1521 to CMS by the 15th of each month via the CAFM System. (See operating instructions for completion that are contained in the CAFM Users Guide.)

70.1 - Instructions for Completion of Form CMS-1521

(Rev. 5, 08-30-02)

A1-1410.1, B1-4410.1

Data comes from Treasury Form FMS-5401 Payment Voucher.

- Date drawn - Contractor enters the date funds were drawn. It shall use 2 digits.

- Voucher Number - Contractor enters the payment voucher number in 3 digits beginning with voucher number 001 to 999. It shall inform the bank to start over when number 999 is reached.

- Serial Number - Contractor enters the serial number of the payment voucher.

- Hospital Insurance Benefits - Contractor enters the total amount drawn for HI and SMI. The total of HI and SMI benefits should equal the total funds drawn.

NOTE: Part B contractors enter amounts for SMI only.

PMS Smartlink Communication System for Administrative Costs -

- On pages 1 and 2, the contractor shall continue to report administrative costs drawn via the PMS Smartlink Telecommunications System in the same designated "Administrative Cost" column 4. However, it shall show these amounts after it reports all benefit payment amounts.

- Contractor shall indicate in the "date drawn" column the date the money was deposited into its commercial bank account and not the date it requested the money. This entry (entries) may occur on either page 1 or 2 depending on the number of entries.

- Contractor shall not make entries in the columns for Voucher Number, Serial Number, and Voucher Totals.

- Contractor shall reflect the current or prior year administrative costs drawn via Smartlink. It shall report on page 3 any special project(s) amount(s) drawn via Smartlink.

Public reporting burden for collecting this information is estimated to average 1 hour per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Contractor shall send comments regarding this estimated burden or any other suggestions for reducing the burden to:

Office of Management and Budget
Paperwork Reduction Project (0938-0361)
Washington, D.C. 20503;

and to:

Centers for Medicare & Medicaid Services
Office of Financial Operations
7500 Security Boulevard
Baltimore, Maryland 21244-1850.

80 - Form CMS-1522, Monthly Contractor Financial Report

(Rev. 5, 08-30-02)

A1-1412, B1-4412

Form CMS-1522 is designed to provide a reconciliation of Medicare benefit dollars between CMS, the contractor, and the bank. The contractor shall transmit this report to CMS by the 15th of each month via the CAFM System.

80.1 - Instructions for Completion of Form CMS-1522

(Rev. 5, 08-30-02)

A1-1412.1, B1-4412.1

- Screen 1 - Section A - Purpose for Which Funds are Drawn:

  - Contractor shall reflect the current or prior year administrative costs drawn via Smartlink. It shall report on page 3 any special project(s) amount(s) drawn via Smartlink.

- Funds Drawn this Month - Contractor enters the total amount of Federal funds drawn via payment vouchers during the calendar month for use as HI benefits, line 1-B, or SMI benefits, line 2-B. Each entry must equal the sum of the amounts shown in this category on the Form CMS-1521 dated during the calendar month.

- Total Funds Expended This Month - Contractor enters total funds expended for HI benefits, line 1-D, and SMI benefits, line 2-D during the calendar month. Totals should equal the sum of all checks drawn and electronic funds transfer payments against the special bank account during the calendar month. (It shall include all checks issued and electronic funds transferred, i.e. dated during the calendar month.) Any refunds received from beneficiaries or their assignees during the calendar month because of prior overpayments deposited in the special bank account should serve to reduce total funds expended.

- Funds Drawn for Fiscal Year - This is a calculated field.

- Funds on Hand End of Month - This is a calculated field.

- Line 3, Drugs and Line 4, Regular Administrative Costs - Contractor shall not use at this time.

- Bills Paid - Lines 7 and 8 - Completed by Part A intermediaries. Part B carriers complete only line 8.

- Retro-Adjustment - Part A contractors enter credit adjustments on appropriate lines. Part B contractors do not use lines 9 or 10.

- Benefits Bank Account

  - From Bank Statement - The contractor shall take information for lines 15 through 19 from the statement of the special bank account issued by the bank at the end of the calendar month.

  - Line 15 - Balance Beginning of Month Per Bank - Contractor enters the balance in the special bank account as of the beginning of the calendar month as shown on the bank statement.

  - Line 16a - Payment Vouchers Drawn During Month - Contractor enters the total amount of funds drawn on payment vouchers (FMS-5401) during the calendar month and credited to the benefits account as shown on the bank statement. Since all checks drawn for deposit in the Time Account are cleared through the benefits account, a payment voucher is drawn for this transaction and is included in line 16a. The amount shown on this line must agree with the totals from the Form CMS-1521 corresponding to the calendar month and

also with Section A, Line 5, column (b). The only exception is for vouchers in transit (line 20).

- Line 16b - Other Deposits - Contractor enters all other deposits credited during the month to the special bank account as shown on the bank statement. It shall reduce the next payment voucher by the amount of the deposited refunds in the account in order to minimize idle funds in the account. It shall Include any credits or adjustments made to the bank account during the calendar month in this line.

- Line 16c - Contractor shall include funds withdrawn from the Time Account and deposited in the Benefits Account.

- Line 16d - Miscellaneous Credit Memo - Contractor enters any miscellaneous adjustments to the benefits bank account during the calendar month.

- Line 17 - This is a calculated field.

- Line 18A - Contractor shall subtract: Checks and EFT Payments Honored by Bank During Month - It enters from the bank statement the total funds charged to the special bank account as a result of checks honored and electronic funds transferred by the bank during the month. This total must include all checks that were drawn for deposit in the time account and honored by the bank during the month.

- Lines 18B and C - Miscellaneous Bank Charges - Contractor enters any miscellaneous charges made to the special bank account that are part of the bank statement.

- Line 19 - This is a calculated field.

- Line 20 - Add: Deposits in Transit. - Enter payment vouchers drawn and other deposits made during the calendar month that the bank has not yet credited to the special bank account according to the statement.

Line 21. - This is a calculated field.

Line 22 - Subtract: Outstanding Checks. - Enter the total of all checks issued during the current month or any previous month that the bank has not yet paid as of the end of the calendar month. If during the calendar month payment is stopped on any check previously issued, or any previously issued check is otherwise voided, subtract the amount of funds represented by that check from this total before making an entry on this line.

Line 23 - This is a calculated field.

- Line 24 - Highest Balance During Month Per Bank.—Contractor enters the highest balance in the special bank account during the calendar month as reflected on the bank statement.

- Time Account
  - Line 15 - Balance Beginning of Month - Contractor enters the balance in the time account as of the beginning of the calendar month as shown on the bank statement.
  - Line 16a - Other Deposits - Contractor enters the amount of funds drawn from the benefits account for deposit in the time account.
  - Line 17 - Total. - This is a calculated field.
  - Line 18a - Contractor enters only amount of funds withdrawn from the time account and deposited in the benefits account during the month.
  - Line 18b - Contractor enters any miscellaneous items.
  - Line 19 - Balance EOM Per Bank - This is a calculated field.

- Screen 4 - Completed by Part A Contractors Only
  - Periodic Interim Payments - Contractor enters amounts paid during the month by category.
  - Accelerated Payments - Contractor enters the amount of accelerated payments paid out and received during the month.
  - Suspended Payments - Contractor enters the amount of payments suspended and released during the month.

- Screen 5 - Bills Paid - Contractor enters the amount of money actually paid during the calendar month as follows:
  - Amount paid for disabled or disability (identified by Codes 1 and 3 as contained in S trailer of query reply).
  - Amount paid for chronic renal disease (identified by Code 2 as contained in S trailer of query reply).
  - Amount paid for premium paying enrollees (identified by Codes 8 and 9 as contained in S trailer of query reply).

- Amount paid for aged. Contractor shall complete entries for disabled, chronic renal disease, and premium paying enrollees prior to completing the entry. It shall then subtract the sum of these entries from the calculated Total and enter that amount.

- Total - (Bills paid for the month). This is a calculated field.

NOTE: For those Part A intermediaries that transmit bills to CMS from more than one point, each processing point should submit to the home office at the end of the calendar month all of the data requested in screen 1. (It shall consolidate data related to amounts paid in screen 1.)

- Only Part A Intermediaries complete retroactive adjustments.

- Only Part A Intermediaries complete adjustments between trust funds.

- Interest:

  - Interest Received From Providers On Overpayments - Separate Check for Interest Collected - When a check is received for interest on an overpayment, the contractor shall deposit the check immediately in the Medicare bank account. It shall report this check as an "Other Deposit" (line 16b). Also, it shall report the check as "Interest Received" on screen 5 and use as a reduction to expenditures on screen 1, funds expended column.

  - Check Includes Both Interest Collected and Overpayment Recoupment - Contractor shall deposit the check immediately into the Medicare bank account. It shall report the entire amount of the check as an "Other Deposit" (line 16b) on screen 2. It shall report the interest portion as "Interest Recovered" on screen 5. Both the interest recovered and the overpayment recoupment are used as a reduction to expenditures on screen 1, funds expended column.

  - Interest Paid to Providers on Underpayments - Separate Check for Interest Paid - When a check is issued for interest due to a provider on an underpayment, the contractor shall report it as a "Check Honored" (line 18a) on screen 2. Also, it shall report this amount as "Interest Paid" on screen 5 and as an increase to expenditures on screen 1, funds expended column.

- Screen 6 - No entries are required at this time.

Public reporting burden for this collection of information is estimated to average 16 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Contractors may send comments regarding this estimated burden or any other suggestions for reducing the burden to:

Centers for Medicare & Medicaid Services
Bureau of Program Operations
Office of Financial Management, CMS,
Baltimore, Maryland, 21244-1850;

and to:

Office of Management and Budget,
Paperwork Reduction Project (0938-0361)
Washington, D.C. 20503.

90 - Intermediary Benefit Payment Report (Form CMS-456)

(Rev. 5, 08-30-02)

A1-1414

90.1 - Purpose and Scope

(Rev. 5, 08-30-02)

A1-1414.1

The Intermediary Benefit Payment Report (IBPR) is a report of current monthly information that covers the categories of benefits the contractor paid and selected statistical data that relates to those payments. CMS uses this data to:

- Track benefit payments by type of provider to detect significant shifts in program expenditures;

- Monitor implementation of new programs, e.g., hospice benefits, and comprehensive outpatient rehabilitation benefits; and

- Identify operation problem areas for resolution by the contractor or CMS.

90.2 - Due Dates and Transmittal

(Rev. 5, 08-30-02)

A1-1414.2

Contractor shall input the reports accompanying the reconciliation between IBPR and the Monthly Intermediary Financial Report (Form CMS-1522) into the CAFM system 20 work days following the report month.

90.3 - Verification of Data

(Rev. 5, 08-30-02)

A1-1414.3

The various subsidiary records that include the individual provider files must support the data entered on the report.

The contractor must have the capability to trace all data entered on the report to the individual provider files.

Where applicable, the Provider Statistical and Reimbursement Report and other provider reports containing benefits paid data must support the data on the report.

90.4 - Accuracy of Data Contained on Report and Reconciliation of Data Reflected on Monthly Intermediary Financial Report (Form CMS-1522)

(Rev. 5, 08-30-02)

A1-1414.4

The contractor must ensure that all data reflected on the report is accurate.

Line 36, column (g) of the report, should equal the amount shown on the CMS-1522, column (d), lines 1 and 2 in the aggregate. In the event that the amounts do not agree, the contractor shall complete a reconciliation report.

90.5 - General Reporting Instructions

(Rev. 5, 08-30-02)

A1-1414.5

Where money is withheld from payments due the provider (as an offset) for monies due the contractor, the contractor shall show the gross amount (less any deductibles, coinsurance, interest, or sequestration) as the payment on the appropriate line and column. It shall show the offset as a negative amount in its appropriate line and column.

For example, when the contractor reduces a PPS Periodic Interim Payment (PIP) for a settlement amount due from the provider, it shall record the gross PIP amount (less any deductibles, coinsurance, interest, or sequestration) on line lA in column l (a) or l(b), as appropriate. It shall record the offset on line 6B in column l(a) or l(b), as appropriate.

However, it shall record a claim adjustment (e.g., a PRO disallowance or subsequent reversal) as a reduction of claims payments on line 2A for a non-PIP/PPS hospital.

Where the contractor makes an accelerated payment and the provider repays a portion of the accelerated payment during the same reporting period, the contractor shall show the net amount on the appropriate line and column.

For example, when an accelerated payment of $100,000 is made to a provider during the period, and the provider repays $30,000 during the same period, the contractor shows $70,000 as the net accelerated payment.

In situations where an accelerated payment is made during the period, and the contractor recovers a portion of the accelerated payment through reduction of interim payments, it shall show the gross amount (less any deductibles, coinsurance, interest, or sequestration) of interim payments as payment on the appropriate line and column. It shall show the offset amount as a negative amount on the appropriate line and column.

For example, when an accelerated payment is made for $100,000 and later in the month $30,000 of the accelerated payment is recouped by offset against PPS/PIP amounts of $150,000 paid to the provider, the contractor shows the $150,000 gross PPS/ PIP amount on line 1A in column 1(a) or 1(b), as appropriate. It shows a net accelerated payment of $70,000 ($100,000-$30,000) on line 7 in column 1(a) or 1(b), as appropriate.

90.6 - Instructions for Completion of the IBPR

A1-1414.6

(Rev. 5, 08-30-02)

A - Heading

The contractor enters its name and assigned number. Multi-regional intermediaries use the number assigned to the home office for administrative budget and cost reporting purposes. The contractor shall furnish a consolidated report for all locations.

The contractor enters the calendar month and year as a four-digit entry, e.g., 1000, 1100, 1200, 0101.

B - Column Definitions - Page 1

- Column (a) - Single Facility - refers to payments to PPS hospitals that do not have distinct part facilities, such as SNFs, HHAs, psychiatric units, or rehabilitation units.

- Column (b) - Facility With Distinct Parts - refers to payments to PPS hospitals that include distinct parts, such as SNFs, HHAs, psychiatric units, or rehabilitation units.

NOTE: The contractor enters non-PPS payments to the distinct part on the appropriate line and column of page 2.

- Column (c) - Non-PPS Payment - refers to payments to the following:
    - Hospitals excluded from PPS (e.g., psychiatric, children's, rehabilitation and long term);
    - Hospitals receiving payments via an alternative payment program (waiver States);
    - Hospitals yet to be phased into PPS; and
    - PPS hospitals for bills or underpayments applicable to **pre-PPS** fiscal years.
- Column (d) - Total - refers to the total of columns (a), (b), and (c).

C - Line Item Definitions - Page 1:

1. Hospital Inpatient (PIP) - refers to hospitals paid by the PIP method. The contractor shall show these figures less any deductibles, coinsurance, and interest for all items on the PIP bills and any sequestration applicable to this line with any offsets shown on line 6A or 6B.

1A. Inpatient Operating Payments - refers to the amount of the PIP that covers items that would otherwise be paid on a per claim basis plus those items paid on a per claim basis in addition to PIP payment. (Such as payments for outliers and hemophilia blood clotting factor add-on.)

The contractor enters the PIP amounts paid as follows:

PPS Provider Payments - Payments related to services furnished after conversion to PPS in columns l(a) or 1(b), as applicable. This includes outlier payments, hemophilia blood clotting factor add-on payments, disproportionate share amounts, indirect medical education, ESRD payments, and phased-in capital-related costs during the transition period.

Non-PPS Provider Payments - column (c) - Payments related to services furnished prior to conversion to PPS. Payments to all providers listed in the definitions for column (c).

1B. Pass Through Costs - Contractor enters the PIP payments, including any withholdings, but less any sequestration amounts for items paid on a reasonable cost basis as follows:

- Capital;

- Direct medical education which includes nursing and paramedical health professional (allied health) programs and graduate medical education;
- Kidney and other organ acquisitions;
- Bad debts; and
- Nonphysician anesthetists.

NOTE: This includes that part of capital-related costs not included in line 1A.

1C. Indirect Medical Education - Contractor enters the PIP payments for the indirect medical education adjustment, whether on a PIP or a claim-by-claim basis for PIP providers, less any sequestration (already included in line 1A).

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the amount of indirect medical education for PIP hospitals.

2. Hospital Inpatient (Non-PIP), refers to hospitals paid based upon bills reviewed and approved. Contractor shall show total payments less any reductions on line 6A or line 6B.

2A. DRG Bills Paid/Non-DRG Bills Paid - Contractor enters the calculated payment less any deductibles, coinsurance, and interest for all items on the bill and any sequestration applicable to this line. It shall include payments for outliers, disproportionate share, indirect medical education, high percentage of end-stage renal disease beneficiary discharges, and hemophilia blood clotting factor add-on payments on a claim-by-claim basis. Also, it shall include phased-in capital-related costs during the transition period.

For DRG bills, it shall use columns (a) and (b). For non-DRG bills paid, it shall use column (c).

It shall report all retroactive adjustments pertaining to hospitals on line 6A or 6B.

2B. Pass Through Costs - The contractor enters the interim payments, less any sequestration, for items paid on a reasonable cost basis as follows:

- Capital;
- Direct medical education which includes nursing and paramedical health professional (allied health) programs and graduate medical education;
- Kidney and other organ acquisitions;
- Bad debts; and
- Nonphysician anesthetists.

NOTE: This includes that part of the capital-related costs that are not

included in line 2A.

2C. Indirect Medical Education - Contractor enters the interim payments for the indirect medical education adjustment (already included in line 2A).

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the amount of indirect medical education for non-PIP hospitals. It shall **not** adjust these amounts for MSP or sequestration.

3. Outlier Payments - Contractor enters **additional** amounts paid for outlier cases.

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the total outlier payments that are found in the UB82 billing form in Locator 46-49 in Value Code 17. These amounts are already included in the amounts recorded on lines lA and 2A.

3A. Days - The contractor enters additional payments made as a result of the length of stay exceeding the day outlier threshold criteria. It shall make entries on this line for memorandum purposes only. These are non-add items.

NOTE: After FY 1997, outlier days no longer exist.

3B. Cost - The contractor enters additional payments made for claims where extraordinary costs were approved. It shall make entries on this line for memorandum purposes only. These are non-add items.

4. Subtotal - Contractor enters the total of the amounts on lines 1A, 1B, 2A, and 2B.

NOTE: The amounts included in lines 1C, 2C, 3A and 3B are memo entries only and have been included in lines 1A, 1B, 2A and 2B.

5. Outpatient Payments - Contractor enters the payment, less deductibles, coinsurance and sequestration for outpatient and Part B inpatient services. It shall report any offset against these amounts on line 6A or 6B. See line 19 for reporting SNF outpatient payments.

6. Retroactive Adjustments:

- PPS Provider Payments - Contractor enters on lines 6A and 6B (as applicable), columns (a) or (b), the net amount of retroactive adjustments paid and received as a result of interim rate adjustments, pass through cost adjustments, and cost report settlements applicable to current or prior provider

fiscal years.

Contractor shall show interest on cost report overpayments and late-filed cost reports on these lines. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 of cash received from the provider as the first installment of the final settlement of $l,000,000 due the program from the prior year's cost report.

Another example would be an entry of $500,000 offset against current PIP payments due of $1,000,000. (The $1,000,000 would be shown on line 1A.)

- Non-PPS Provider Payments - Contractor enters on line 6A or 6B (as applicable) in column (c) the **net** amount of retroactive adjustments **paid** and **received** as a result of interim rate adjustments and cost report settlements applicable to current or prior provider fiscal years.

It shall show interest on cost report overpayments and late-filed cost reports on these lines.

7. Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from hospitals and distinct part units. (See §160.5 for an explanation of the appropriate recording of offsets.)

8. Total - The contractor enters the total of lines 4 through 7.

D - Statistical Data-Hospitals-Page 1:

9. PIP:

   A. Contractor enters the total number of bills processed for hospitals paid by the PIP method.

   B. Contractor enters the dollar amount that would have been paid if the bills processed were not subject to PIP in accordance with the definition of line 2A.

10. Non-PIP - Contractor enters the total number of bills for hospitals paid on a submitted-bill basis.

11. Number of Hospitals - Contractor enters the total number of hospitals participating in the Medicare program.

12. Number of Admissions - Contractor enters the total number of admissions the Common Working File (CWF) has approved for payment.

13. Number of Discharges - Contractor enters the number of discharge bills processed during the reporting month.

14. Number of Readmissions - Contractor enters the total number of readmissions to a hospital within 7 calendar days of discharge from an acute care facility.

15. Number of Transfers - Contractor enters in column (a) and column (b) the total number of transfers to a PPS hospital. It enters in column (c) the total number of transfers to a non-PPS hospital.

16. Outlier Bills:

    A. Days - Contractor enters the total number of day outlier bills paid that relate to the dollar amounts shown in line 3A.

    NOTE: Outlier days have been obsolete since the end of FY 1997.

    B. Costs - Contractor enters the total number of cost outlier bills paid that relate to the dollar amounts shown in line 3B.

17. Outpatient - Contractor enters the total number of outpatient bills and Part B inpatient bills paid that relate to the dollar amounts shown in line 5.

E. Column Definitions - Page 2

- Column (e) - Single Facility - Refers to all providers that are not part of a hospital complex.

- Column (f) - Part of Hospital Complex - Refers to providers that are an integral part of a hospital and are operated with other departments of the hospital under common licensure and governance.

- Column (g) - Total - Refers to total of columns (e) and (f).

F. Line Item Definitions - Page 2

Skilled Nursing Facilities - Including swing bed payments for SNF care.

18. PIP - Contractor enters all PIP payments made to SNFs. It enters total payments (less any deductibles, coinsurance, interest or sequestration) with any withholding reductions being shown on line 20.

19. Bills Paid - Contractor enters total payments less any deductibles, coinsurance, interest, or sequestration with any withholdings shown on line 20. It enters the calculated payment, less any deductibles, coinsurance and interest for all items, and any sequestration applicable to SNFs on a submitted-bill basis. It shall

include Part A and Part B services.

20. Retroactive Adjustments - Contractor enters the **net** amount of retroactive adjustments **paid** and **received** as a result of cost report settlements and lump sum interim rate adjustments made in prior or current provider fiscal years.

    It shall show interest on cost report overpayments and late-filed cost reports on this line. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 cash received from the provider as the first installment of the final settlement of $l,000,000 due the program from the prior year's cost report.

21. Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from SNFs. (See §160.5) for an explanation for reporting accelerated payments.)

22. Total SNF Payments - Contractor enters the total of lines 18 through 21.

Home Health Agencies:

23. PIP - Contractor enters all PIP payments made to HHAs including SNF-based.

    It shall show total payments less any deductibles, coinsurance, interest, or sequestration with any withholding reductions shown on line 25.

24. Bills Paid - Contractor shall show total payments (less any deductibles, coinsurance, interest, or sequestration) with any withholdings shown on line 25. It enters the calculated payment, less any deductibles, coinsurance, and interest, for all items, and any sequestration applicable to HHAs on a submitted-bill basis. It shall include Part A and Part B services and SNF-based HHAs payments.

25. Retroactive Adjustments - Contractor enters the net amount of retroactive adjustments paid and received as a result of cost report settlements and lump sum interim rate adjustments made in prior current provider fiscal years.

    It shall show interest on cost report overpayments and late-filed cost reports on this line. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 cash received from the provider as the first installment of the final settlement of $l,000,000 due the program from the prior year's cost report.

26 Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from HHAs. (See §160.5) for an explanation for reporting accelerated payments.)

27. Total HHA Payments - Contractor enters the total of lines 23 through 26.

Additional Providers:

28. ESRD - Contractor shall include in these columns payments to ESRD networks, as applicable:

    Column (e) - It enters net payments to independent facilities.

    Column (f) - It enters net payments to hospital-based facilities.

29. Hospice - Contractor enters net payments made to hospices.

30. RHC - Contractor enters net payments made to rural health clinics (RHCs).

31. OPA/HL - Contractor enters net payments made to organ procurement agencies and histocompatibility laboratories.

32. CORF - Contractor enters net payments made to comprehensive outpatient rehabilitation facilities (CORFs).

33. Distinct Part Units - Contractor enters net payments made to exempt distinct part rehabilitation and psychiatric units.

34. All Others - Contractor enters net payments made to other providers not listed in lines 28 -33.

NOTE: Contractor shall make adjustments, pertaining to providers, identified on lines 28 through 34 directly to the specific line. This includes checks received and offsets or withholdings.

35. Total - Contractor enters the total of lines 28 through 34.

36. Grand Total - Contractor enters the total of lines 8(d), 22(g), 27(g) and 35(g).

G. Statistical Data - Page 2:

37. SNF:

- Number of SNFs - Contractor enters the total number of participating SNF

SNFs.

- Number of Admissions - Contractor enters the total number of SNF admissions.

38 HHA:

- Number of HHAs - Contractor enters the total number of participating HHAs.

- Number of Bills - Contractor enters the total number of bills processed. (Audit intermediaries should not complete this line.)

40. Number of Transfers to Distinct Part Units - Contractor enters the total number of transfers to distinct part units for which payments are shown in line 33.

It shall use edit checks to ensure completeness, arithmetical accuracy, and to discover inconsistencies. It shall have an authorized official sign and date the report.

90.7 - Form CMS-456 - Schedule R

(Rev. 5, 08-30-02)

A1-1414.7

(Page 3 of 3 of the Monthly Intermediary Benefit Payment Report) Reconciliation Between IBPR and CMS-1522.

A - Purpose and Scope

The contractor shall use the Schedule R to account for any variances between line 36(g), Total on the IBPR, and the HI and SMI Benefits reported on lines 1(d) and 2(d) of the CMS-1522 Report.

Schedule R is an integral part of the IBPR and must be completed each month whether or not a variance exists between the IBPR and the CMS-1522 Report. If there is no variance, the contractor shall complete line 36(g) of the IBPR and HI and SMI Benefits for lines 1(d) and 2(d) of the Form CMS-1522. If there is a variance, it shall reconcile the two reports by completing the appropriate lines.

It must have the capability to substantiate all amounts reflected on Schedule R.

Schedule R includes line items that will facilitate the contractor’s reconciliation process.

It shall input the Schedule R, along with pages 1 and 2 of the IBPR, into the Contractor Administrative Budget and Financial Management System (CAFM) for each report month.

B - Instructions for Completion of Schedule R:

- Heading - The contractor enters the report month and year. (See §160.6A) for intermediary name and number.) Also, it enters its current letter-of-credit number.

- Line Item Definitions - Schedule R:

CMS-456 (IBPR) Column:

Line 36(g) Total - Contractor enters the amount obtained from page 2 of 3 on line 36(g) of the IBPR.

1. Medicare Secondary Payer (Non-Providers Cash Recoveries) - Contractor enters the cash receipts and offsets applied to claims payments or other refunds that are received from attorneys, beneficiaries, insurance companies or other non-providers. These amounts should be negative numbers since they represent cash receipts.

2. Other Recoveries Identify - Contractor enters recovered or offset amounts not included in any other line item (lines 1 through 36 or lines 1 and 3 of Schedule R). These amounts should be negative numbers since they represent cash receipts.

3. Other Items Identify (Lines 3A through 3E) - Contractor enters any other benefit payments or refunds not included elsewhere on the CMS-456 or on lines 1 and 2. The items shown here may be unique to its operation and should be identified accordingly. It shall itemize each major category on lines 3A. through 3E. These amounts could be positive or negative numbers.

4. Total - Contractor enters the sum of all line items in this column. It must take care to subtract negative amount(s) included on the above lines. The total amount must equal the amount in the total adjacent CMS-1522 column.

5. Remarks - Contractor enters an explanation to clarify any item or amount.

- Line Item Definitions - Schedule R:

CMS-1522

1. HI Benefits, Line 1 (d) - Contractor enters the HI benefits amount from form CMS-1522 in line 1(d).

2. SMI Benefits, Line 2(d) - Contractor enters the SMI benefits amount from form CMS-1522 in line 2(d).

3. Subtotal - Contractor enters the total HI and SMI benefit amounts.

4. Other Items Identify - Contractor enters any other benefit payments or refunds that may be unique to your operation that are not included on lines 1(d) or 2(d) of form CMS-1522. It shall itemize each major category and identify on line 1 through 6. These amounts could be positive or negative numbers.

5. Total - Contractor enters the sum of all line items in this column. It must take care to subtract negative amounts included in items 1 through 6. The total amount must equal the amount in the total adjacent CMS-456 column.

Public reporting burden for this collection of information is estimated to average 30 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this estimated burden or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Office of Financial Management, CMS,
P.O. Box 26684
Baltimore, Maryland, 21207;

and to:

Office of Management and Budget,
Paperwork Reduction Project (0938-0361)
Washington, D.C. 20503.

100 - Issuance of Letter-Of-Credit

(Rev. 5, 08-30-02)

A1-1416, B1-4414

The Letter-of-Credit, Standard Form-1193, authorizes a Federal Reserve Bank or Branch to advance funds to a designated commercial bank on behalf of CMS. Under the Checks Paid Method of financing, a letter-of-credit is issued to authorize the designated commercial bank to withdraw funds for deposit only to the contractor's Benefits Account when a bank presents a payment voucher (FMS-5401).

Upon receipt of the properly executed signature cards and notification from the Federal Reserve Bank that the required collateral has been posted, CMS prepares and certifies a letter-of-credit in favor of the designated commercial bank. The certified letter-of-credit, together with the executed signature cards, are sent to the Treasury Department for forwarding to the servicing Federal Reserve Bank or Branch. A copy of the certified letter-of-credit and signature cards are also sent to the contractor, the RO, and the designated commercial bank.

100.1 - Monthly Limitation

(Rev. 5, 08-30-02)

A1-1416.1, B1-4414.1

The letter-of-credit specifies a maximum amount of funds that the bank may draw during each month. The ceiling amount on the letter-of-credit is established at a sufficiently high level to provide for fluctuations in monthly disbursement patterns and is based upon benefit payments estimated by CMS and the contractor. The unused portion of the letter-of-credit is revoked at the end of each month, and the full monthly ceiling amount is automatically renewed at the beginning of each month. There is no carryover of any unused ceiling amount. Each month stands by itself.

100.2 - Amending Letter-of-Credit

(Rev. 5, 08-30-02)

A1-1416.2, B1-4414.2

Any one of the following conditions require a revised letter-of-credit from CMS:

- A significant increase or decrease in Medicare workload or expenditures that is expected to continue for an extended period and affects the contractor's financial requirements;

- The bank's letter-of-credit monthly limitation is insufficient to cover all Medicare checks presented to the bank for payment during the current month;

- A change in contractor name;

- A change in the name of the contractor's servicing bank; or

- A change in the Federal Reserve Bank or Branch servicing the contractor's commercial bank.

The contractor shall make all routine requests for changes in the monthly letter-of-credit limitation to the RO no later than 20 calendar days before the end of the month. If the revision is urgent, it shall make the request for an increase by telephone to the RO. It shall follow-up all telephone requests, in writing, and include the reason for the revision to the letter-of-credit. An amendment to the letter-of-credit does not interrupt the progression of the numbers assigned to the payment vouchers.

100.3 - Establishment of Accounting Records

(Rev. 5, 08-30-02)

A1-1416.3, B1-4414.3

The contractor shall establish adequate accounting records to ensure that:

- The total monetary amount on the payment vouchers issued during the month does not exceed the monthly limitation established by the letter-of-credit;

- Funds drawn are properly allocated between HI and SMI benefits. The contractor shall establish memorandum accounts to separate the respective benefit payments;

- Refunds received from providers or beneficiaries resulting from prior overpayments or retroactive adjustments are immediately deposited into the FHIBA. The contractor shall credit all such deposits on the day following the date of receipt in its mail room or initial point of entry. (It shall credit within 2 days if the bank is not located in the same city as the contractor.); and

- Bank charges for services furnished are in accordance with the contractual agreement and that the volume by types of service (e.g., checks paid and deposits) are in agreement with the contractor's records.

110 - Initial Federal Health Insurance Time Account Deposit

(Rev. 5, 08-30-02)

A1-1418, B1-4416

To preclude excessive use of Federal funds, the contractor shall delay the initial deposit in the Time Account until it has actually started processing checks that are cleared against the FHIBA. It shall effect the initial deposit of Federal funds into the Federal Health Insurance Time Account by drawing a check on the new FHIBA payable to the Time Account.

It shall establish the amount of the initial time deposit check by re-computing the Award Schedule (AS) (Page 2 of 2) that the selected bank submits to reflect the effective prime rate (i.e., prime minus one percent) in effect on the date the new accounts are implementation.

It shall make the check payable to the designated bank with the following directive clearly printed on the reverse:

> For Deposit Only In (Name of Contractor)
> Federal Health Insurance Time Account

The contractor shall delay use of the Federal Health Insurance Accounts until the Federal Reserve Bank has received authorization from the Treasury Department for the designated commercial bank to process payment vouchers under the letter-of-credit procedure.

110.1 - Subsequent Time Account Deposits and Adjustments

(Rev. 5, 08-30-02)

A1-1418.1, B1-4416.1

The quarterly review of bank activity in the Benefits Account may disclose the need for an adjustment in the Time Account balance. When an adjustment is indicated, the contractor shall make the adjustment within 15 calendar days after the close of the quarter.

It shall follow the procedures outlined for the initial Time Account deposit as described in §110 to increase the Time Account balance.

To decrease the Time Account balance, it shall prepare a Time Account withdrawal slip that instructs the bank to transfer the amount of the required reduction from the Time Account to the FHIBA.

NOTE: The contractor shall report all initial deposits and subsequent adjustments in the Time Account balance on form CMS-1522

110.2 - Bank Account Analysis

(Rev. 5, 08-30-02)

A1-1418.2, B1-4416.2

To ensure a continuing evaluation of all bank services and associated charges, the contractor shall adhere to the following procedures:

- Arrange to receive from the bank its account analysis on a regular monthly basis no later than the 10th of the following month. Bank analysis must include:
    - Bank Processing Charges (Schedule TAA-lb); and
    - A list of daily closing bank balances (Schedule TAA-1c).
- The contractor shall verify the accuracy of the data presented for the average daily bank balance, units of service, and all other computations on the bank's account analysis.

- The contractor shall complete and forward, within 30 calendar days after the end of each month to CMS via CAFM, the following schedules:

Monthly account activity of bank processing charges (Schedule TAA-lb); and

Recap of Daily Available Balances (Schedule TAA-1c).

- The contractor shall complete and forward, within 30 calendar days after the end of each quarter to CMS via CAFM, the following schedules:

Summary of Bank Processing Charges for Quarter, Schedule TAA-la; and

Quarterly Adjustment of Federal Health Insurance Time Account, Schedule TAA.

120 - Reviewing Bank Agreements

(Rev. 5, 08-30-02)

A1-1420, B1-4418

The contractor shall determine if it wants to continue, renegotiate, or terminate the bank agreement by reviewing the bank's performance and processing charges for the present term. It shall review 165 days prior to the expiration of the three-party bank agreement.

If the bank's performance is acceptable, and the bank does not request a rate increase, the contractor shall recommend to the RO, in writing, that it wants to continue with the bank agreement and that it be continued for another year or two year period. It shall advise the RO as soon as a bank's request for a rate increase is received along with its evaluation of the bank's performance and recommendation, to continue or renegotiate the contract. The RO develops comparative analysis of three banks' charges with similar volumes to support the recommendation to continue the bank agreement at a higher processing charge. If the higher processing charge is not justified, the contractor will be advised to begin the termination process.

120.1 - Terminating Bank Agreements

(Rev. 5, 08-30-02)

A1-1420.1, B1-4418.1

The contractor, the Government, or the bank may terminate the bank agreement when the party wishing to terminate submits written notification to the other parties 150 days prior to the expiration of the current term. In the event of termination, the bank agrees to retain

the contractor's Federal Health Insurance Account(s) for an additional 180-day period (phase-out) beyond the current term to allow for clearance of outstanding checks.

120.2 - Terminating Federal Health Insurance Accounts

(Rev. 5, 08-30-02)

A1-1420.2, B1-4418.2

- Initial Adjustment to the Federal Health Insurance Time Account - Pending receipt of the prior month's bank statement, the contractor shall reduce on the first day of the phase-out period the current balance in the Federal Health Insurance Time Account by seventy-five percent (75%). It shall prepare a Time Account withdrawal slip that instructs the bank to immediately transfer the computed amount to the FHIBA.

- Time Account Analysis - Within 7 days of the expiration of the current term, the contractor shall complete Schedule TAA in its entirety to determine whether the time account should remain open during the phase-out period. It shall include in line 4 the total projected service charges for the entire phase-out period. It shall modify the 25 percent figure on line 10 to reflect the actual length of the phase-out period, e.g., 6-month period would show 50 percent.

    - If line 13 of Schedule TAA (page 1 of 3) indicates a positive amount, the contractor shall maintain that amount of money in the time account during the phase-out period, and adjust the present time account balance accordingly in lines 14-16.

    - If line 9 of Schedule TAA (page 1 of 3) indicates a negative amount, the contractor shall immediately transfer the current time account balance to the benefits account, and the contractor should secure from the bank a check payable to the benefits account in an amount equal to the negative amount reflected on line 9.

- Closing Federal Health Insurance Time Accounts - At the expiration of the phase-out period, the contractor shall transfer all funds on deposit in the Time Account, if applicable, and FHIBA immediately to the new FHIBA.

120.3 - Phase-out Period for Federal Health Insurance Bank Accounts

(Rev. 5, 08-30-02)

A1-1420.3, B1-4418.3

In the event of termination of the bank agreement, the bank agrees to retain the contractor's Federal Health Insurance Account(s) for up to an **additional** 180-day period, beyond the current term, to allow for clearance of outstanding checks. (See subsection C

of the IFB.) The letter-of-credit issued to the bank remains in effect to allow the bank to draw payment vouchers to cover all outstanding checks as they are presented for payment.

During this phase out period, the current bank agreement continues in effect with the exception of the following:

- Letter-of-Credit - Covenant 5;
- The Term of the Bank Agreement - Covenant 7;
- Termination of Agreement - Covenants 8 and 9; and
- Renegotiation of Agreement - Covenant 10.

It is further understood that during the phase out period:

- The bank maintains collateral in an amount sufficient to cover the high balances in the account(s) less FDIC coverage on each account;
- All bank service charges and earnings credits are consistent with those amounts reflected in the current agreement;
- All terms and conditions of the original bid submitted by the bank, which are not inconsistent with this additional term, remain in effect; and
- The contractor continues to complete the CMS-1521, CMS-1522 and the TAA Schedules.

130 - Invitation for Bid (IFB) to Provide Banking Services Under the Checks Paid Method of Letter-Of-Credit Financing

(Rev. 5, 08-30-02)

A1-1422, B1-4420

The contractor shall request the most recent copy of the IFB package from the RO to prepare its procurement. The IFB is constantly being updated to meet CMS requirements in the changing banking environment.

140 - Bonding

(Rev. 5, 08-30-02)

A1-1424, B1-4422

The contractor is required to have a fidelity bond on, as a minimum, each certification and disbursement employee. Blanket bonds are an acceptable alternative.

Bonds must protect against at least the risks contained in the contractor's agreement (specified in the article entitled "Certification and Disbursement and Indemnification").

As a general rule, the amount of the bond should equal 1/10 of the monthly limitation of the letter of credit but not exceed $500,000.

CMS accepts a bond in excess of $500,000 and assumes an allocated share of its total cost if the contractor determines that a larger bond is desirable.

No deductibles are permitted with respect to coverage, risks, and amounts.

150 - Letter-Of-Credit Check List

(Rev. 5, 08-30-02)

A1-1426, B1-4424

FORM NAME	DUE DATE
Intermediary Benefit Payment Report, CMS-456	Monthly - within 20 working days after the end of the reporting month.
Payment voucher on Letter-of-Credit Transmittal - CMS-1521	Monthly - within 15 days after the end of the reporting month.
Monthly Intermediary Financial Report, CMS-1522	Same as above
Time Account Adjustment Schedules, TAA, pages 1 - 3	Quarterly - within 30 days after the end of the reporting quarter
TAA-1b and TAA-1c	Monthly - within 15 days after the end of the reporting month

160 - Electronic Funds Transfer (EFT)

(Rev. 5, 08-30-02)

A1-1430, B1-4430

The contractor shall pay claims from providers of services according to the following criteria.

A - Requirement

The contractor may transmit payments electronically to each provider who bills Medicare, elects to receive payments electronically, and who provides the necessary bank account and routing data to enable the contractor to pay electronically.

B - Notification Requirement

The contractor shall provide its Regional Office (RO) with quarterly data on the number of providers paid under EFT, the transmission protocol, such as the ANSI X12 835 used for its EFT transmissions, and the benefit payment amount of EFT transactions. It shall

use Form CMS-588, Authorization Agreement for Electronic Funds Transfer, to maintain a record of those physicians and suppliers that authorize Medicare payment under EFT.

C - Claims Processing Timeliness (CPT) Requirement

When transmitting electronic payments to providers, the contractor shall pay claims in a timely manner consistent with the payment floor in effect at the time of payment. It shall transmit the EFT authorization to its originating bank upon the expiration of claims processing timeliness payment floor, as discussed in the Medicare Claims Processing Manual, Chapter 1, General Billing Requirements. For example, an EFT payment in March 2001 for an electronic claim may not be transmitted to the originating bank earlier than 14 days after the date of receipt. An EFT payment in March 2001 for a paper claim may not be transmitted to the originating bank earlier than 27 days after the date of receipt. Payment settlement, i.e., the date on which funds are posted to the provider's account, should not be earlier than 2 business days following transmission of the electronic payment data to the originating bank. The contractor shall accomplish this by designating an effective payment date on the electronic payment file of no earlier than 2 business days after the transmission date.

D - Electronic Transmission Standard

When making direct deposits to the accounts of providers under EFT, the contractor shall use a transmission format that is both economical and compatible with its servicing bank and the Automated Clearing House.

For Standard Systems Maintainers, the Medicare standard ANSI 835 health care payment/advice can be abbreviated and used to generate an ACH-FORMATTED EFT file that contains no beneficiary-specific data. In these cases, the bank translates the abbreviated ANSI 835 into an ACH-COMPATIBLE payment file. The entire ANSI 835 Remittance advice record will be sent directly to the provider. In the event these abbreviated ANSI data are not acceptable to certain banks for purposes of initiating electronic payments through the appropriate ACH, the standard system users should consult with their individual banks to determine which electronic payment data format is acceptable. The contractor should refer to Part 3, Chapter 24, EDI Support Requirements for more information on the abbreviated ANSI-835.

E - Alternatives to Electronic Payment

When EFT is not used, the contractor shall make payments to providers via hardcopy checks drawn on the commercial bank servicing its Medicare account. It shall send the hardcopy check by first class U.S. Postal Service only.

NOTE: The pickup, next-day delivery, express mail or the use of a courier service for hardcopy checks is prohibited except in emergency situations, as authorized by the contractor's RO.

F - Modification of Tri-partite Bank Agreement to Include EFT Method of Payment

The contractor shall work with its servicing bank and its RO to ensure that the Tri-partite bank agreement is modified to include wording that allows funding of the Letter of Credit to include electronic payments as well as hardcopy checks. The Tri-partite bank agreement needs to clearly state that all references to checks in the original bank agreement shall mean checks and/or electronic funds transfer (EFTs).

The contractor shall have its legal department and that of the originating bank review the Tri-partite bank agreement to ensure that it meets contractor needs and the requirements of the Medicare program. It shall forward any modifications to the Tri-partite bank agreement at least 1 month prior to its effective date to the RO and the Chief, Financial Management Unit, OCA, BPO in CO for review and approval. See §160.1, Exhibit 2 for a sample addendum to the Tri-partite bank agreement that includes general provisions for payment under the EFT method.

G - The Receiving Bank's Role in EFT/Electronic Remittance Advice (ERA)

While providers may wish to consider criteria such as experience with EFT and receipt of ANSI-formatted financial data when choosing a bank, these procedures should in no way be interpreted as requiring providers to do business with a particular financial institution (e.g., receiving bank only).

H - Electronic Funds Transfer Transaction Costs

Prior to transmitting payments electronically, the originating bank fills in the relevant EFT transaction costs on the Schedule AS (Schedule of Bank Processing Charges), and submits it to the contractor. The contractor shall transmit this information to both the RO and CO. Once electronic payments are initiated, the originating bank shall include all payment information on the Monthly Schedule of Bank Processing Charges, (TAA 1-b), and transmit this form to the contractor, who enters the data into the Contractor Administrative Budget and Financial Management (CAFM) system where it is reviewed and approved first by the RO and then CO.

NOTE: The EFT costs reported on line 8 of the AS Schedule and the Monthly Schedule of Bank Processing Charges (TAA 1-b) shall include a breakdown of all costs associated with EFT, including the cost per EFT transaction, set-up costs, monthly charges, transmission costs, etc.

I - Contractor Responsibility for EFT/ERA Records Retention

The contractor shall retain records on EFT/ERA in accordance with established CMS and Department of Justice procedures for retention of documentation associated with electronic claims.

J - Provider Responsibility for the Accuracy of Claims Data

To minimize errors and disruptions to cash flow, providers are responsible for verifying the accuracy of claims payment information submitted to their Medicare contractor.

170 - Electronic Remittance Advice (ERA)

(Rev. 5, 08-30-02)

A1-1431, B1-4431

The contractor shall accommodate provider requests to receive hardcopy checks or electronic payments with ERAs. Providers have the option to receive remittance information on paper or electronically. Providers who elect EFT are not required to receive ERAs. The contractor shall furnish ERAs to providers using the following criteria:

A - Standard Format Requirement

In lieu of the traditional method of sending hardcopy remittance advices and checks to providers, effective October 1, 1992, the contractor shall transmit, over wire only, the ANSI X12.835, Health Care Claim Payment/Advice (ANSI-835) to a requesting provider or to a requesting provider's billing service. The ANSI-835 is the only electronic remittance option available as of this date. If the contractor has any technical questions on formats or electronic remittance transmission requirements, it should contact its RO.

B - Privacy Act Compliance

Unless otherwise directed by CO, the contractor shall ensure that remittance information is transmitted to providers or their authorized billing agents either directly, through a Value Added network, or as authorized by a provider, to a bank that is capable of receiving ERA data and agrees to safeguard the data.

C - Reconciliation Requirement

Prior to entering into an electronic payment arrangement with a provider, the contractor shall ensure that its providers are able to reconcile their accounting records using the ANSI-835 remittance advice. Once this determination is made, it shall provide telephone support during normal business hours and allow for an initial reconciliation period of up to 30 days during which it will produce both paper and electronic remittances. After this 30-day phase-in period, it shall eliminate paper remittances for these providers.

D - Standard Format Reference

See the Claims Processing Manual, Chapter 22 - Remittance Notice to Providers, for information and additional requirements concerning the standard remittance advice format.

180 - Exhibits

(Rev. 5, 08-30-02)

A1-1435

Exhibit 1 - Form CMS-1521

Exhibit 2 - Form CMS-1522

Exhibit 3 - Intermediary Benefit Payment Report

Exhibit 4 - Authorization Agreement For Electronic Funds Transfers

Exhibit 5 - Addendum to Medicare Bank Agreement

Exhibit 1

This space has been reserved for the Form CMS-1521 exhibit.

Exhibit 2

This space has been reserved for the Form CMS-1522 exhibit.

Exhibit 3

This space has been reserved for the Form CMS-456.

Exhibit 4

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFERS

PROVIDER/PHYSICIAN ID NUMBER_____

PROVIDER/PHYSICIAN NAME_____

I hereby authorize **(Insert Contractor Name**), hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my ( ) Checking ( ) Savings account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME_____ **BRANCH**_____

CITY_____ **STATE**_____ **ZIP**_____

TRANSIT NUMBER_____ **ACCOUNT NUMBER**_____

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

NAME_____ **TITLE**_____

(PLEASE PRINT)

SIGNED X_____ **DATE**_____

Exhibit 5 - Addendum to Medicare Bank Agreement

The parties have executed this Agreement for the Medicare A(B) Bank Accounts using the Checks Paid Method of Letter of Credit Financing and desire to add changes to the existing agreement currently in force. These changes are necessitated by the implementation by (**Insert Contractor Name**) of the Electronic Funds Transfer (EFT) method of paying providers effective (**Insert Date**). This change in payment method is under the direction of the Centers for Medicare and Medicaid Services (CMS) as an initiative to increase the uniformity and efficiency of the provider payment process.

Also, item number 10 below, although not related to EFT, is incorporated into the bank agreement to insure that no excessive earnings credits accumulate during the period of the bank agreement.

The parties hereby agree to the following terms and conditions that shall be considered an integral part of the bank Agreement:

1. The rates as reflected on the Schedule of Bank Processing Charges shall be in effect for the term of this Agreement.

2. This Agreement, with all its provisions and covenants, shall continue in force from year to year after the expiration of such term; provided, however, that notification to terminate or renegotiate has not been given by any party as specified in the Agreement executed on (**Insert Date**).

3. All references to checks in the original Agreement shall hereby mean checks and/or Electronic Funds Transfers (EFTs).

4. The Fiscal Intermediary (Carrier) is obligated to obtain, retain, and provide copies of provider authorizations, particularly with regard to the rights, liabilities, and responsibilities of Medicare contractors and financial institutions under Regulation E.

5. The nature, format and medium of entries, or entry information is to be furnished to the originating bank in writing by the Fiscal Intermediary (Carrier) prior to entering into an EFT arrangement.

6. The Fiscal Intermediary (Carrier) and the originating bank shall negotiate the level of security to be established for delivering the payment data from the Fiscal Intermediary (Carrier) to the originating bank, such as transmittals with authorized signatures, and the method used to verify authenticity of telecommunicated data, prior to entering into an EFT arrangement.

7. The Fiscal Intermediary (Carrier) shall specify the time when funds are to be provided to the originating bank prior to entering into an EFT arrangement.

8. The Fiscal Intermediary (Carrier) and the originating bank shall agree to the deadline for reversals, corrections, or changes by the Fiscal Intermediary (Carrier) of entries or entry information furnished to the originating bank prior to entering into an EFT arrangement.

9. In those cases where the Fiscal Intermediary's (Carrier's) Medicare bank is unable to originate EFT transactions, the Medicare bank may subcontract certain functions. The Medicare bank agrees that none of the functions to be performed under the Tri-partite agreement shall be subcontracted without prior written approval of the Fiscal Intermediary (Carrier) and the CMS. Any such approved subcontract shall contain the language of the Examination of Records Clause contained in the bank agreement (Covenant 3).

10. If Line 7 of Page 1 of the Quarterly Time Account Adjustment Schedule reflects **any** positive balance, the contractor shall immediately forward supporting documentation and a check made payable to CMS for that amount to:

    Centers for Medicare & Medicaid Services
    Director, Division of Accounting
    P.O. Box 17255
    Baltimore, MD 21203-7255

    Send a copy of the check and transmittal letter to:

    Centers for Medicare & Medicaid Services
    Director, Division of Financial Management
    P.O. Box 26677
    Baltimore, MD 21207

190 - General Information about Termination Costs

(Rev. 5, 08-30-02)

A1-1800

The contractor shall prepare a shut-down cost budget voucher based on its natural expense line items, and submit the budget to both CMS's Central Office (CO) and to the contractor's Regional Office (RO).

It shall include the following information on the voucher:

- All incurred shut-down expenses determined by the contractor's natural cost items;
- The amount, and a detailed explanation, for each item it claims; and
- An attestation signed by a company official that validates the costs the contractor is claiming are correct.

CMS pays shut-down costs based on the contractor's voucher's information. The contractor shall not draw administrative funds, via its letter-of-credit, after the official date of either contract close-out or termination.

It shall submit the voucher on official company letterhead. It shall make sure the voucher is signed by an authorized company official, and forward a copy to CMS's CO at the following address:

Centers for Medicare & Medicaid Services
Division of Contractor Financial Management, OFO
7500 Security Boulevard
Baltimore, MD 21244-1850

200 - General

(Rev. 5, 08-30-02)

A1-1900, B1-4900

The Contractor Financial Reports provide a method of reporting financial activities for benefit payments by Medicare contractors according to the Chief Financial Officers (CFOs) Act of 1990. The contractor is required to maintain accounting records according to government accounting principles and applicable government laws and regulations. This requirement complies with the Office of Management and Budget (OMB) Bulletins about Financial Statements. These policies and procedures are developed by the Federal Accounting Standards Advisory Board (FASAB).

The accounting principles and the auditing standards required are not substantially different from Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS) as formulated by the accounting profession. Government accounting principles which are developed by FASAB, however, require maintaining records not only for preparing financial statements, but also to enforce applicable laws and regulations. Accounts are maintained to provide control over operations as well as to provide financial information.

Medicare contractors are required to use double entry bookkeeping and accrual basis accounting. For example, if an accounts receivable is established, accounts receivable should be debited and, most likely, operating/program expense should be credited. If an accounts payable is established, accounts payable should be credited and, most likely, operating/program expense should be debited. In addition, the information reported must be supported by the contractor's books and records as of the end of the period requested and adequate audit trails must be maintained. To ensure accurate reporting, proper cutoff procedures must also be established in order to limit reporting to activities attributable to the reporting period. Where actual data is not available, reasonable estimates are acceptable. See Exhibits 12 through 15 for protocols for estimating relevant accounts. When end of period entries are made to accrue account balances, the contractor shall reverse the entries in the following quarter to allow normal processing of accounting transactions.

In order to maintain consistent and accurate financial reporting, Medicare contractors must have an internal control structure that integrates the accounting and claims processing systems. The internal control structure must provide for the following control procedures:

1. Independent review of proper valuation of recorded amounts and performance;
2. Segregation of duties (separate authorization, record-keeping, and custody);
3. Safeguards over access to assets and records;
4. Authorization of transactions and activities;
5. Documents and records that are adequate to ensure proper recording; and
6. Quarterly reconciliation of internal systems to the Provider Overpayment Report (POR) system for intermediaries and the Physician Supplier Overpayment Report (PSOR) system for carriers.

Supporting documentation must be maintained and available for review and audit. This must include lead schedules for all amounts used for report preparation and detailed documentation, such as demand letters for accounts receivable. A very good procedure that CMS recommends to ensure the accuracy of reported amounts, is trending and comparative analysis. This analysis involves comparing reported amounts to prior amounts to identify material errors.

Hardcopy books and records used to prepare the annual financial reports should be retained for 6 years unless microfilmed. Then, the hardcopy needs to be retained for 3 years and the microfilm retained for the balance of the 6-year period.

The Office of the Inspector General (OIG) will conduct audits of contractors according to government auditing standards. This requirement complies with OMB Bulletin No. 98-08, Audit Requirements for Federal Financial Statements. Applicable government laws and regulations also supplement the government auditing standards. These standards are similar to those contained in the "Comptroller General of the United States Standards for Audit of Governmental Organizations, Programs, Activities, and Functions" (The Yellow Book).

210 - Instructions for Completing the Form CMS-750A/B, Contractor Financial Reports

(Rev. 5, 08-30-02)

A1-1910, B1-4910

There are separate reports and data screens for Part A, Hospital Insurance (HI), and Part B, Supplementary Medical Insurance (SMI) in the Contractor Administrative-Budget and Financial Management (CAFM) system. The intermediary enters data in both HI and SMI data screens (see Exhibits 1 and 2). The carrier enters data in the SMI data screens (see Exhibit 2).

The data for the report is HI and SMI financial information as defined in the Medicare Account Definitions (see Exhibit 11). In order to facilitate reconciliation, balancing and error resolution, the contractor shall report all data in dollars and cents.

The data on the report may not equate on a one-to-one basis with data reported to CMS in other reports, such as Draws on Letter of Credit, reported on Form CMS-1521. The contractor must maintain records that will allow reconciliation of Form CMS-750A/B with those other reports.

220 - Due Date

(Rev. 5, 08-30-02)

A1-1911, B1-4911

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

230 - Certification

(Rev. 5, 08-30-02)

A1-1912, B1-4912

Medicare contractor certification by the Chief Financial Officer (CFO) is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of the Form CMS-750A/B:

> "I hereby CERTIFY that I have examined the Statement of Financial Position prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.
>
> NAME_____ DATE_____ TITLE_____"

240 - Instructions for Completing Form CMS-751 A/B, Status of Accounts Receivable

(Rev. 5, 08-30-02)

A1-1920, A1-1940, B1-4920, B1-4960

Forms CMS-H751A/B and CMS-M751A/B are similar data entry screens used to report the following receivables.

- Form CMS-H751A to report debt under Part A (HI) by intermediaries
- Form CMS-H751B to report debt under Part B (SMI) by intermediaries and carriers
- Form CMS-M751A to report MSP debt under HI by intermediaries;
- Form CMS-M751B to report MSP debt under SMI by intermediaries and carriers;

MSP accounts receivable data reported on CMS-M751A/B is a subset of total accounts receivable data reported on Form CMS-H751A/B (e.g., CMS-H751A/B includes the data reported on the CMS-M751A/B **and** non-MSP data.)

The screen heading indicates whether the report is for the MSP subset.

Samples of the screens are shown in Exhibits 3 - 9. There are separate reports and data screens for Part A, HI, and for Part B, SMI in the CAFM system. The intermediary enters data in both HI and SMI data screens (Exhibits 3 and 4). The carrier enters data in only the SMI data screens (Exhibit 4).

The intermediary or carrier reports the accounts receivable activity for fiscal year-to-date (FYTD) for the period of the report. In order to facilitate reconciliation, balancing and error resolution, it reports the accounts receivable in dollars and cents.

The reports require information both for the amount and the number of accounts receivable. To provide standardization, CMS suggests that contractors use their collection process as a guide when reporting the number of accounts receivable. For

example, a separate, stand alone accounts receivable collected would be reported as a quantity in the number column.

EXAMPLES:

1. (Intermediaries only). A cost report is one receivable. Even though several claims are associated with the cost report, the collection activity would be against the entire cost report rather than each claim.

2. A demand letter issued in a Medicare Secondary Payer (MSP) case to one debtor with several claims listed on the letter. If the collection is made and posted against an individual claim, each claim on the demand letter would be an individual receivable.

3. A demand letter issued to a physician based on adjustments projected from sampling claims equals one. Even though many claims are represented by projection of the sample.

Once the principal number is established, the contractor shall report the interest associated with the principal amount in the same manner. There can be a difference between the principal number and the interest number because some receivables are not subject to interest.

250 - Due Date

(Rev. 5, 08-30-02)

A1-1921, A1-1941, B1-4921, B1-4941

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

260 - Certification

(Rev. 5, 08-30-02)

A1-1922, A1-1942, B1-4922, B1-4942

Medicare contractor certification by the CFO is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of Form CMS-H751A/B:

I hereby CERTIFY that I have examined the Status of Accounts Receivable prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is

a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

For (Status of MSP Accounts Receivable) (Form CMS-M751) the statement includes a reference to MSP and reads as follows:

I hereby CERTIFY that I have examined the Status of MSP Accounts Receivable prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

The name, date and title of the person making the certification are on both certifications.

270 - Line Item Instructions Form CMS-H751A/B

(Rev. 5, 08-30-02)

A1-1923, A1-1943, B1-4923, B1-4943

Medicare contractors must develop and maintain transaction level detail (at a minimum, this would include the provider name, provider number, date of determination, outstanding balance, and any adjustments or recoupments) by debt to support the amounts reported for each line outlined below.

In addition, non-MSP amounts must be reconciled to the POR (intermediary) or PSOR (carrier) system as applicable.

Part I, Status of Receivables

For each line in Section A, below, the instruction applies to each the Form CMS-H751 and Form CMS-M751, and to the intermediary report and to the carrier report unless otherwise noted. The instructions are applicable only to MSP amounts for the Form CMS-M751 and are applicable to all amounts for the Form CMS-H751.

Section A - Outstanding Receivables

270.1 - Line 1, Beginning FY Balance (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.1, A1-1943.1, B1-4923.1, B1-4943.1

The contractor enters the number and amount for all accounts receivable outstanding as of the beginning of the FY. These amounts will be pre-filled with the ending balances reported on the preceding (9/30/XX) FY Contractor Financial Reports. The contractor

must make any corrections to the beginning principal and interest FY balance on Line 5a, Adjusted Amounts, Internal Adjustments. It shall apply the offsetting entry, on the related Form CMS-750A/B report (debit or credit) to Operating/Program Expense for transactions that affect principal, or interest revenue if the transaction affects interest.

270.2 - Line 2a, New Receivables (Principal)

(Rev. 5, 08-30-02)

A1-1923.2, A1-1943.2, B1-4923.2, B1-4943.2

The contractor enters the number and amount for all new receivables established at its location during the FY. New receivables for intermediaries include cost report settlements and credit balances. For both intermediaries and carriers, overpayments and claims accounts receivables for all claim types are included. For carriers only, beneficiary debt and under-tolerance accounts receivable are included.

For MSP new receivables includes group health plan data-match, non-data-match, liability (including worker's compensation, auto and no fault), etc.

The contractor does not include those receivables transferred from other Medicare contractors, other CMS locations, Currently Not Collectible (CNC), or other transferred locations in prior fiscal periods. It includes all of these items on Lines 5b, 5d, 5f, or 6b, Transferred In Amounts.

NOTE: MSP accounts receivable are not established until a settlement, judgment or award has been reached and a demand letter is sent.

270.3 - Line 2b, Accrued Receivables (Principal)

(Rev. 5, 08-30-02)

A1-1923.3, A1-1943.3, B1-4923.3, B1-4943.3

Line 2b is not applicable to carriers or to MSP.

The intermediary enters the number and amount of Periodic Interim Payment (PIP) accrued receivables, fiscal year-to-date on this line. The **only** receivables a FI will accrue are those that result from comparing PIP payments to claims submitted. For each quarterly reporting period, a new accrual is established and the prior quarter's accrual must be reversed or zeroed out. Both the establishment and reversal of the PIP accrual must be reflected in this line, **except** for the reversal of the September's quarterly accrual, which would be reflected in Line 5a, Adjusted Amounts, Internal Adjustments (see Exhibit 13, Periodic Interim Payments (PIP) Protocol for Estimating Payables/Receivables for the Form CMS-750A/B, Statement of Financial Position).

270.4 - Line 3, Interest Earned (Interest)

(Rev. 5, 08-30-02)

A1-1923.4, A1-1943.4, B1-4923.4, B1-4943.4

The contractor enters the number and amount of interest earned on: (a) existing or new receivables established at its location during the FY; and (b) the interest earned on receivables transferred to it, following the date the receivables are established on its records. The contractor shall not include the amount of accrued interest earned at other locations. It shall report the accrued interest earned at other locations as transferred in on Line 5b, 5d, 5f or 6b, Transferred In Amounts.

270.5 - Line 4a, Cash/Check Collections on Receivables (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.5, A1-1943.5, B1-4923.5, B1-4943.5

The contractor enters the amount collected by cash or check on receivables during the fiscal period.

270.6 - Line 4b, Offset Collections on Receivables (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.6, A1-1943.6, B1-4923.6, B1-4943.6

The contractor enters the amount collected by offset on receivables during the fiscal period.

270.7 - Line 4c, Collections Deposited at Another Location (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.7, A1-1943.7, B1-4923.7, B1-4943.7

The contractor enters the amount collected or offset by CMS Central Office (CO) for collections on accounts receivable referred under the Debt Collection Improvement Act (DCIA). Do not transfer the case to CO where the deposit or offset of the money is made. Upon receipt of the Collection Reconciliation/Acknowledgement form, enter the amount collected or offset by cross servicing/TOP and received by CO in this line to reduce the outstanding amount of the receivable being reported on Form CMS-751A/B.

CO will record the actual deposit of cash/check/offset on Line 10, Cash/Offsets Received for Receivables at Another Location of its' Form CMS-R751.

270.8 - Line 5, Adjusted/Transferred/Waived Amounts (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.8, A1-1943.8, B1-4923.8, B1-4943.8

The contractor enters the amount of receivables it has adjusted, transferred in from or out to other locations, or waived. It is required to maintain supporting documentation and records for all these receivables transferred in and out. Amounts transferred in from or out to other CMS locations or Medicare contractors must be reconciled to the other entity's records for the same reporting period **prior** to submission of the quarterly reports to ensure that only **approved** transfers are being reported. Documentation of the reconciliation must be maintained and must indicate that a supervisory review of the reconciliation was performed. Refer to Exhibit 17 for instructions for the transfer of debt between other reporting entities.

The contractor reports in Lines:

5a. **Adjusted Amounts (Principal & Interest)**. The contractor enters the amount for any adjustments to the beginning balance, or corrections/adjustments of receivables previously established during the fiscal period. These adjustments can be either positive or negative. It separately reports adjustments resulting from Auditor/Consultant recommendations, and those determined independently.

5b. **Transfers In from other Medicare Contractors (Principal & Interest).** The contractor enters the amount transferred in from other Medicare contractors during the fiscal period.

5c. **Transfers Out to other Medicare Contractors (Principal & Interest).** The contractor enters the amount transferred out to other Medicare contractors during the fiscal period.

5d. **Transfers In from other CMS Locations, POR/PSOR (Principal & Interest). (Carriers report PSOR, and intermediaries report POR).** The contractor enters the amount transferred in from other CMS locations and reported on the POR/PSOR during the fiscal period. **(Applies to non-MSP debt only)**

5e. **Transfers Out to other CMS Locations, POR/PSOR (Principal & Interest). Carriers report PSOR, and intermediaries report POR).** The contractor enters the amount transferred out to other CMS locations and reported on the POR/PSOR during the fiscal period. **(Applies to non-MSP debt only)**

5f. **Transfers In from other CMS Locations, Not POR/PSOR**

(Principal & Interest). The contractor enters the amount transferred in from other CMS locations and not reported on the POR/PSOR during the fiscal period.

5g. **Transfers Out to other CMS Locations, Not POR/PSOR (Principal & Interest).** The contractor enters the amount transferred out to other CMS locations and not reported on the POR/PSOR during the fiscal period.

5h. **Waivers (Principal & Interest).** The contractor enters the amount of accounts receivable waived based on the application of §§ 1862(b) and 1870(c) of the Social Security Act.

270.9 - Line 6, Amounts Written-off Closed (Bad Debts)/Transferred CNC (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.9, A1-1943.9, B1-4923.9, B1-4943.9

The contractor enters the amount which it has written-off as a bad debt, or transferred to or from CNC.

The contractor reports in lines:

6a **Amounts Written-off Closed (Bad Debts)(Principal & Interest).** The contractor enters the amount for which collection efforts have been abandoned. (This would include the remaining balance on accounts receivable after the bankruptcy court has ruled on bankruptcy, appeals, and other litigated cases).

6b **Transfers In from CNC (Principal & Interest).** The contractor enters the amount re-established as active debt that was previously classified as CNC during the fiscal period.

6c **Transfers Out to CNC (Principal & Interest).** The contractor enters the amount removed from the ending balance and reclassified as CNC during the fiscal period.

270.10 - Line 7, Ending Balance (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.10, A1-1943.10, B1-4923.10, B1-4943.10

The ending balance is a computed field reporting the number (manual entry) and amount for receivables outstanding as of the end of the reporting period. It equals:

	Principal		**Interest**
+	Beginning FY balance (Line 1)	+	Beginning FY balance (Line 1)
+	New Receivables (Line 2a)	+	Interest Earned (Line 3)

+/-	Accrued Receivables (Line 2b)		
-	Collections on Receivables (Line 4a-4c)	-	Collections on Interest (Line 4a-c)
+/-	Adjusted/Transferred Amounts (Line 5a-5g)	+/-	Adjusted/Transferred Amounts (Line 5a-5g)
-	Waivers (line 5h)	-	Waivers (line 5h)
+/-	Amounts Written-off/Transferred CNC(Lines 6 a - c)		Amounts Written-off/Transferred CNC (Lines 6 a - c)
=	Ending Balance (Line 7)	=	Ending Balance (Line 7)

NOTE: Although Line 7 is a calculated amount, the contractor must be able to provide a detailed listing of all outstanding receivable balances that support this line at any given period of time. The ending balance must be equal to the accounts receivable and interest receivable amounts reported on the form in Statement of Financial Position.

270.11 - Line 7a, Current Receivables (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.11, A1-1943.11, B1-4923.11, B1-4943.11

The contractor enters the amount of the receivables due within 12 months following the reporting period. The definition of current and non-current does not depend on the time a debt is outstanding but when the debt is due. A receivable for which the due date is 12 months or less from the report date is a current receivable. For example, a debt due September 30, 2003, within 12 months from the date of a report for September 30, 2002, is a current receivable. In addition, all delinquent receivables are to be reported as current. The contractor shall assign between current and non-current the appropriate amount of those receivables for which it has negotiated extended repayment schedules, based on the installment payment dates.

270.12 - Line 7b, Non-current Receivables (Principal)

(Rev. 5, 08-30-02)

A1-193.12, A1-1943.12, B1-4923.12, B1-4943.12

The contractor enters the amount of non-current receivables due more than 12 months after the reporting period. The definition of non-current receivables includes those receivables for which the due date is more than 12 months from the end of the reporting period. For example, those receivables for which the due date is October 1, 2003, 1 year from the date of a report for September 30, 2002, are non-current receivables.

270.13 - Line 8, Allowance for Uncollectible Accounts (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923. 13, A1-1943.13, B1-4923.13, B1-4943.13

The contractor enters the amount of the ending balance reported in Line 7 for accounts receivable it estimates will not be collectible. (See Exhibit 14, Allowance for Uncollectible Accounts).

270.14 - Line 9, Total Receivables Net of Allowance

(Rev. 5, 08-30-02)

A1-1923.14, A1-1943.14, B1-4923.14, B1-4943.14

Total Receivables Net of Allowance is a computed field (Line 7 less Line 8) reporting the contractor's estimate of the amount of accounts receivable it reasonably expects to collect.

270.15 - Line 10, Cash/Offsets Received for Receivables at Another Location (Principal & Interest).

(Rev. 5, 08-30-02)

A1-1923.15, A1-1943.15, B1-4923.15, B1-4943.15

This line shall be used only be used in the instances where CO receives collection from cross servicing/TOP for DCIA debt.

The Medicare contractor who reports the receivable on Form CMS-751A/B will reduce the outstanding balance of the receivable for the amount deposited by CO by recording the amount of the collection in Line 4c, Collection Deposited at Another Location. (See Exhibit 18, Collection Reconciliation/Acknowledgement Form).

Section B - Delinquent Receivables

270.16 - Line 1, Total Not Delinquent (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.16, A1-1943.16, B1-4923.16, B1-4943.16

The contractor enters the total number and amount of accounts receivable that are not delinquent.

270.17 - Line 2, Total Delinquencies (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.17, A1-1943.17, B1-4923.17, B1-4943.17

The contractor enters the total number and amount of delinquent receivables. It enters the amount of the past due payment unless the full amount is normally due and declared payable. The debt becomes delinquent the day following the date that the debt is due with all extensions recognized. Thus, for non-MSP, if the debt is due 30 days after demand, the first day of delinquency starts on day 31. For MSP, if the debt is due 60 days after demand, the first day of delinquency starts on day 61. If any portion of a debt has been delinquent more than 180 days, the entire amount is reported as delinquent. The contractor enters the amount of receivables that are delinquent for the respective periods (a through i) indicated.

270.18 - Line 3, Status of Delinquent Receivables, Less Than or Equal to 180 Days (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.18, A1-1943.18, B1-4923.18, B1-4943.18

The contractor enters the total number and amount of delinquent receivables 180 days delinquent and less, which are in (a) Bankruptcy, (b) Appeal, (c) Department of Justice, (d) Referred for Cross Servicing and/or (e) Other Status.

270.19 - Line 4, Status of Delinquent Receivables, Greater Than 180 Days (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.19, A1-1943.19, B1-4923.19, B1-4943.19

The contractor enters the total number and amount of delinquent receivables 181 days delinquent and greater, which are in (a) Bankruptcy, (b) Appeal, (c) Department of Justice, (d) Referred for Cross Servicing and/or (e) Other Status.

Section C - Other Collections

270.20 - Line 4c, Collections Deposited at Another Location (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.20, A1-1943.20, B1-4923.20, B1-4943.20

The contractor enters the distribution of collections on receivables, by location, for amounts offset or received and deposited at another location. The total amounts listed in this section must equal the amount reflected in Section A, Line 4c of this report.

270.21 - Line 10, Cash/Offsets Received for Receivables at Another Location (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.21, A1-1943.21, B1-4923.21, B1-4943.21

This will not apply to Medicare contractors.

270.22 - Collections on Delinquent Debt (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.22, A1-1943.22, B1-4923.22, B1-4943.22

The contractor enters the number and amount of collections on receivables that were delinquent upon collection. The total amount should be less than total collections for the FY.

Section D - Transferred Receivables

The contractor enters the distribution of debts transferred to Medicare contractors or other CMS locations.

For Form CMS-H751A/B, the data in this section is also reported in Section A, Status of Accounts Receivable Transfers Out to other Medicare contractors or other CMS locations, and will be used by the contractor and other CMS locations to reconcile its books and records.

For Form CMS-M751A/B, the data in this section is also reported in Section A Outstanding Receivables, Line 5c, Transfers Out to other Medicare Contractors; Line 5e, Transfers Out to other CMS locations on the POR/PSOR; and Line 5g, Transfers Out to other CMS Locations, Not POR/PSOR.

270.23 - Line 5c, Transfers Out to other Medicare Contractors (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.23, A1-1943.23, B1-4923.23, B1-4943.23

The contractor enters the distribution to Medicare contractor locations of the debts, entered in Line 5c, Transfers Out to other Medicare Contractors, reflected in Section A of this report.

270.24 - Line 5e, Transfers Out to other CMS Locations, POR/PSOR (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.24, A1-1943.24, B1-4923.24, B1-4943.24

The contractor enters the distribution to the various regional offices (ROs) or CO of the debts on the POR, entered in Line 5e, Transfers Out to other CMS Locations, POR/PSOR, reflected in Section A of this report.

270.25 - Line 5g, Transfers Out to other CMS Locations, Not POR (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1923.25, A1-1943.25, B1-4923.25, B1-4943.25

The contractor enters the distribution to the various ROs or CO of the debts not reported on the POR/PSOR, entered in Line 5g, Transfers Out to other CMS Locations, Not POR/PSOR, reflected in Section A of this report. POR is applicable to FIs. PSOR is applicable to carriers.

280 - Instructions for Completing the Form CMS-C751A/B, Status of Debt - Currently Not Collectible (CNC), and Form CMS-MC751A/B, Status of MSP Debt - Currently Not Collectible (CNC)

(Rev. 5, 08-30-02)

A1-1930, A1-1950, B1-4930, B1-4950

Form CMS-C751A/B and Form CMS-M751A/B are similar data entry screens used to report the following.

- Form CMS-C751A to report non-MSP debt under Part A (HI) by intermediaries;

- Form CMS-C751B to report non-MSP debt under Part B (SMI) by intermediaries and carriers;
- Form CMS-MC751A to report MSP debt under HI by intermediaries; and
- Form CMS-MC751B to report MSP debt under SMI by intermediaries and carriers;

Note that currently not collectible debt reported by Forms CMS-C751 and CMS-MC751 is reported separately for non-MSP and MSP accounts receivables.

The screen heading indicates whether the CNC report is for the non-MSP or MSP subset.

Samples of the screens are shown in Exhibits 5 and 6. Note that intermediaries must prepare separate reports for each category by trust find.

There are separate reports and data screens for Part A, HI, and for Part B, SMI in the CAFM system. The intermediary enters data in both HI and SMI data screens (Exhibits 5 and 6). The carrier enters data in only the SMI data screens (Exhibit 6).

The data for each of these reports is essentially the same.

The contractor reports the CNC accounts receivable activity for FYTD for the period of the report. In order to facilitate reconciliation, balancing and error resolution, it reports the CNC accounts receivable in dollars and cents.

The reports require information both for the amount and the number of accounts receivable. To provide standardization, CMS suggests the contractor use its collection process as a guide when reporting the number of accounts receivable. For example, a separate, stand alone accounts receivable collected would be reported as a quantity in the number column.

Once the principal number is established, the contractor reports the interest associated with the principal amount in the same manner. There can be a difference between the principal number and the interest number because some receivables are not subject to interest.

290 - Due Date

(Rev. 5, 08-30-02)

A1-1931, A1-1951, B1-4931, B1-4951

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

300 - Certification

(Rev. 5, 08-30-02)

A1-1932, A1-1952, B1-4932, B1-4952

Medicare contractor certification by the CFO is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of the Form CMS-C751A/B (as well as the Form CMS-MC751A/B):

I hereby CERTIFY that I have examined the Status of Non-MSP Debt - CNC prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

_____	_____	_____
NAME	DATE	TITLE

NOTE: In the above statement, "MSP" replaces "Non-MSP" for the MSP report.

310 - Line Item Instructions Form CMS-C751A/B - Non-MSP and Form CMS-MC751A/B - MSP

(Rev. 5, 08-30-02)

A1-1933, A1-1953, B1-4933, B1-4953

The following instructions are to be used by Medicare contractors to report the status of Non-MSP or MSP, as applicable, CNC debt. Medicare contractors must develop and maintain transaction level detail (at a minimum, this would include the provider name, provider number, date of determination, outstanding balance, and any adjustments or recoupments) by debt to support the amounts reported for each line outlined below (see Exhibits 5 and 6). Medicare contractors must reclassify MSP or Non-MSP debt as CNC in accordance with CMS policy (see Exhibit 19 and Exhibit 20).

Within this subset of instructions, the designation "MSP" or "Non-MSP" is implied, depending on which report is being submitted, MSP or Non-MSP.

Section A - CNC Debt

310.1 - Line 1, Beginning FY Balance (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.1, A1-1953.1, B1-4933.1, B1-4953.1

The contractor shall report the number and amount for all CNC debts outstanding as of the beginning of the FY. These amounts will be pre-filled with the ending balances from the prior FY on Form CMS-C751A/B, Status of Non-MSP Debt-CNC Financial Report or Form CMS-MC751A/B, Status of MSP Debt-CNC Financial Report. It shall make any corrections to the beginning principal and interest FY balance only on Line 4e, Reclassified CNC Debt - Other.

310.2 - Line 2, New CNC Debt (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.2, A1-1953.2, B1-4933.2, B1-4953.2

The contractor enters the number and amount of all debt approved by CMS RO and CO for CNC during the FY. This line should include the outstanding principal balance and all outstanding interest associated with the debt that was earned up to the date the debt was removed from Form CMS-751A/B or Form CMS-M751A/B reports, as appropriate, and included on the current Form CMS-C751A/B report or Form CMS-MC751A/B. This amount must equal the principal and interest amounts reported on Line 6c, Transfers Out to CNC.

310.3 - Line 3, Interest Earned Since CNC Approval (Interest)

(Rev. 5, 08-30-02)

A1-1933.3, A1-1953.3, B1-4933.3, B1-4953.3

The contractor enters the amount of interest earned in this fiscal year on CNC debt since the date the debt was reclassified and included in Line 1, Beginning FY Balance and interest earned on debts reclassified to CNC during the FY included in Line 2, New CNC Debt on the current report.

310.4 - Line 4(a) through (e), Reclassified CNC Debt (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.4, A1-1953.4, B1-4933.4, B1-4953.4

Reclassified CNC debt reported on Line 4a, Re-established as Active Accounts Receivable (A/R) Due to Collection of Cash; Line 4b, Re-established as Active A/R Due to Collection by Offset; and Line 4c, Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse, Litigation, or Appeal must agree with the total amount reported on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Medicare contractors must retain all documentation supporting any reclassified amounts.

The contractor reports in Lines:

4a. **Re-established as Active Accounts Receivable (A/R) Due to Collection of Cash (Principal & Interest).** The contractor enters the amount of CNC debt that is re-established as active debt because cash/checks have been collected on CNC debts during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval on Form CMS-C751A/B or Form CMS-MC751A/B, as appropriate,) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Simultaneously, the collection should be recorded on Line 4a, Cash/Check Collections on Form CMS-H751A/B. The effect of this transaction will reclassify the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. Additionally, if the outstanding balance of the CNC debt was greater than the amount collected, the remaining balance of the debt is now considered an active account receivable that will be reported on the Status of Accounts Receivable report (Form CMS-H751A/B & Form CMS-M751A/B as appropriate). Any new interest assessed on the remaining balance after it becomes active again will be reported on Line 3, Interest Earned on Form CMS-H751A/B.

For non-MSP only, if after 12 months there is no collection activity on this debt, the contractor shall consider reclassifying it as CNC.

Any remaining MSP balance after reactivation is automatically eligible for reclassification to CNC and must again be submitted to the RO to request reclassification to NC.

4b. **Re-established as Active A/R Due to Collection by Offset (Principal and Interest.)** The contractor enters the amount of CNC debt that is re-established as active debt because offsets have been made on CNC debt during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval of Form CMS-C751A/B or Form CMS-MC751A/B, as appropriate,) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Simultaneously, the collection should be recorded on Line 4b, Offset Collections on Form CMS-H751A/B. The effect of this transaction will reclassify the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. Additionally, if the outstanding balance of the CNC debt was greater than the amount collected, the remaining balance of the debt is now considered an active account receivable that will be reported on Form CMS-H751A/B. Any new interest assessed on the remaining balance after it becomes active again will be reported on Line 3, Interest Earned on Form CMS-H751A/B

For non-MSP only, if after 12 months there is no collection activity on this debt, the contractor shall consider reclassifying it as CNC.

Any remaining MSP balance after reactivation is automatically eligible for reclassification to CNC and must again be submitted to the RO to request reclassification to NC.

4c. **Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse, Litigation, or Appeal (Principal & Interest).** The contractor enters the amount of the CNC debt that has been re-established to be active debt because the CNC debt is now determined to be in bankruptcy, fraud & abuse, litigation, or appeal during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval of the Form CMS-C751A/B) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. The effect of this transaction will reclassify the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. No new interest should be accrued on debts re-established as active due to bankruptcy, fraud and abuse, litigation or appeal.

This item is not applicable for MSP. MSP receivables on which the status changes to bankrupt, fraud and abuse, litigation or appeal will not be re-established as active accounts receivable.

4d. **Written-off Closed (Principal & Interest).** The contractor enters the number and amount of CNC debt that has been approved for written-off closed during the FY. The receivables will be "closed" in its internal systems. No further action will be taken on these debts. CNC debts that are written-off as closed will not be reported on the financial statements, and all collection activity (i.e., future offsets or interest accruals) and servicing of the debt will be terminated. The debts will be closed within the contractor's records, reports, and accounts receivable systems. These debts will be written-off and closed through Form CMS-C751A/B, or Form CMS-MC751A/B as applicable, on this line. These debts **should not be reactivated** on Form CMS-H751A/B or Form CMS-M751A/B.

NOTE: **Medicare contractors cannot write-off debt until formal approval has been received from the appropriate authorized official in accordance with the existing CMS delegations of authority.**

4e. **Other (Principal & Interest).** The contractor uses this line only to make corrections to Form CMS-C751A/B or Form CMS-MC751A/B beginning principal and interest FY balance. Medicare contractors must retain all documentation justifying any adjustments made to the beginning balance.

310.5 - Lines 5(a) through (f), Amounts Transferred (Principal & Interest

(Rev. 5, 08-30-02)

A1-1933.5, A1-1953.5, B1-4933.5, B1-4953.5

The contractor enters the amount of CNC debts that have been transferred in from or out to Medicare contractors or CMS RO or CO during the FY. It shall not enter an amount on these lines until it has received confirmation that the Medicare contractor, CMS RO or CO, has accepted the debt. (See Exhibit 17, Transfer of Debt Between Reporting Entities).

The contractor shall report in lines:

5a. **Transfers In from other Medicare Contractors (Principal & Interest).** The amount of CNC debt transferred in from other Medicare contractors during the fiscal period.

5b. **Transfers Out to other Medicare Contractors (Principal & Interest).** The amount of CNC debt transferred out to other Medicare contractors during the fiscal period.

5c. **Transfers In from CMS RO (Principal & Interest).** The amount of CNC debt transferred in from RO during the fiscal period.

5d. **Transfers Out to CMS RO (Principal & Interest).** The amount of CNC debt transferred out to RO during the fiscal period.

5e. **Transfers In from CMS CO (Principal & Interest).** The amount of CNC transferred in from CO during the fiscal period.

5f. **Transfers Out to CMS CO (Principal & Interest).** The amount of CNC transferred out to CO during the fiscal period.

Collection efforts do not cease when debt is reclassified to CNC. Medicare contractors must recognize that all debts including CNC debt will continue to be referred (if eligible) to the Program Support Center (PSC), Department of Health and Human Services (DHHS) or the Treasury Offset Program (TOP).

Medicare contractors are expected to follow existing procedures for the routine referral of delinquent debt to the Debt Collection Center (DCC) in accordance with the Debt Collection Improvement Act (DCIA) of 1996.

Amounts transferred in from or out to other CMS locations or Medicare contractors for the reporting period must be reconciled to the other entity's records for the same reporting period **prior** to submission of the quarterly Forms CMS-750/751A/B. Medicare contractors and other CMS locations must reconcile the transfers out lines to ensure that only **approved** transfers are being reported. Documentation of the reconciliation must be maintained and must indicate that a supervisory review of the reconciliation was performed. See Exhibit 17 for instructions for the transfer of debt between other reporting entities.

310.6 - Line 6, Ending Balance (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.6, A1-1953.6, B1-4933.6, B1-4953.6

The ending balance is a computed field, reporting the number (manual entry) and amount of CNC debt outstanding as of the end of the reporting period. It equals:

	Principal		**Interest**
+	Beginning FY balance (Line 1)	+	Beginning FY balance (Line 1)
+	New CNC Debt (Line 2)	+	New CNC Debt (Line 2)
		+	Interest Earned (Line 3)
-	Re-established as Active A/R Due to Collection of Cash (Line 4a)	-	Re-established as Active A/R Due to Collection of Cash (Line 4a)
-	Re-established as Active A/R Due to Collection by Offset (Line 4b)	-	Re-established as Active A/R Due to Collection by Offset (Line 4b)
-	Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse Litigation or Appeal (Line 4c)	-	Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse Litigation or Appeal (Line 4c)
-	Written-off Closed (Line 4d)	-	Written-off Closed (Line 4d)
+/-	Other (Line 4e)	+/-	Other (Line 4e)
+	Transfers In From Medicare Contractors/ RO/CO (Lines 5a, 5c, 5e)	+	Transfers In From Medicare Contractors/ RO/CO (Lines 5a, 5c, 5e)
-	Transfers Out to Medicare Contractors/ RO/CO (Lines 5b, 5d, 5f)	-	Transfers Out to Medicare Contractors/ RO/CO (Lines 5b, 5d, 5f)
=	Ending Balance (Line 6)	=	Ending Balance (Line 6)

NOTE: Although Line 6 is a calculated amount, the contractor must be able to provide a detailed listing of all Non-MSP (or MSP, as applicable) CNC receivable balances that support this line at any given period of time.

Section B - Aging of MSP or Non-MSP CNC Debt

310.7 - Line 1, Total Aged CNC Debt (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.7, A1-1953.7, B1-4933.7, B1-4953.7

The contractor enters the number and amount of MSP or Non-MSP CNC debt, as applicable. The total dollar amount equals the sum of lines (a) through (e), and should also equal Line 6, Ending Balance on Form CMS-C751A/B or Form CMS-MC751AB, as applicable.

The contractor reports on lines (a) through (e) the dollar amounts of receivables aged from the date of determination of the debt for the respective time periods listed. For Non-MSP, it provides an explanation in the remarks section regarding why debts in category (d) and (e) were not recommended for written-off closed.

Section C - Collection Information

310.8 - Collections on CNC Debt (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.8, A1-1953.8, B1-4933.8, B1-4953.8

The contractor enters the number and amounts of cash/checks/offsets actually collected on Non-MSP or MSP CNC debt, as applicable, that is reported on Line 4a, Re-established as Active A/R Due to Collection of Cash, and Line 4b, Re-established as Active A/R Due to Collection by Offset.

Section D - Status CNC Debt over 181 Days

310.9 - Status of CNC Debt over 181 Days (Principal & Interest)

(Rev. 5, 08-30-02)

A1-1933.9, A1-1953.9, B1-4933.9, B1-4953.9

The contractor enters the total number and amount of delinquent receivables over 181 days old, which are in (a) Bankruptcy, (b) Appeal, (c) Department of Justice, (d) Referred for Cross Servicing, and/or (e) Other Status.

NOTE: Lines (a), (b), and (c) are not applicable to Non-MSP CNC debt.

400 - Exhibits

(Rev. 5, 08-30-02)

A1-1960, B1-4960

Exhibit 1	CMS-750A Contractor Financial Reports, Hospital Insurance (HI) Statement of Financial Position/Statement of Operations
Exhibit 2	CMS-750B Contractor Financial Reports, Supplementary Medical Insurance (SMI) Statement of Financial Position/Statement of Operations
Exhibit 3	CMS-751A Status of Accounts Receivable, Hospital Insurance (HI)
Exhibit 4	CMS-751B Status of Accounts Receivable, Supplementary Medical Insurance (SMI)
Exhibit 5	Form CMS-C751A Status of Non-MSP Currently Not Collectible (CNC) Accounts Receivable, Hospital Insurance (HI)
Exhibit 6	Form CMS-C751B Status of Non-MSP Currently Not Collectible (CNC) Accounts Receivable, Supplementary Medical Insurance (SMI)
Exhibit 7	Form CMS-M751A Status of Medicare Secondary Payer (MSP) Accounts Receivable, Hospital Insurance (HI)
Exhibit 8	Form CMS-M751B Status of Medicare Secondary Payer (MSP) Accounts Receivable, Supplementary Medical Insurance (SMI)
Exhibit 9	Form CMS-MC751A Status of MSP Currently Not Collectible (CNC) Accounts Receivable, Hospital Insurance (HI)
Exhibit 10	Form CMS-MC751B Status of MSP Currently Not Collectible (CNC) Accounts Receivable, Supplementary Medical Insurance (SMI)
Exhibit 11	Medicare Contractor Account Definitions, Data Element Definitions
Exhibit 12	Accounts Payable, Protocol for Estimating Claims
Exhibit 13	Periodic Interim (PIP) Payments Protocol for Estimating Payables/Receivables on the CMS-750A/B, Statement of Financial Position
Exhibit 14	Protocol for Estimating Allowance for Uncollectible Accounts

400.1 - Exhibit 1 - Statement of Financial Position and Statement of Operations - HI/SMI

(Rev. 5, 08-30-02)

A1-1960 Exhibit 1, B1-4960.1

The FI submits the HI report (Form CMS-H750A). Both FI and carrier submit the SMI report (Form CMS-H750B).

- The HI report, in applicable line item descriptions, refers to "provider" and the SMI report refers to “physicians, provider or supplier”.

- For the SMI report (Form CMS-H750B), the FI completes the items dealing with cost reports, PIP, and credit balances; but the carrier omits them. Also, the intermediary inserts data relating to the Provider Overpayment Report (POR), while the carrier inserts data relating to the Physician Supplier Overpayment Report (PSOR).

Exhibit 1 (Cont.)
Contractor Financial Reports
Statement of Financial Position
Hospital Insurance (HI)
As of _____

Contractor Name	ID Number
_____	_____

Assets	Balance
Cash	
Benefits Account	_____
Time Account	_____
Undeposited Collections	_____
Total Cash	_____
Accounts Receivable	
Non-Medicare Secondary Payments (Non-MSP) Overpayments	
Provider *(Carriers Omit)*	_____
Cost Report Settlements *(Carriers Omit)*	_____
Claims Accounts Receivable *(Carriers Omit)*	_____
PIP Accrual *(Carriers Omit)*	_____
Credit Balances *(Carriers Omit)*	_____
Other *(Carriers Omit)*	_____
Physician/Supplier Overpayments *(Intermediaries Omit)*	_____
Beneficiaries	_____
Total Non-MSP	_____
Medicare Secondary Payer (MSP)	
Group Health Plan	
Data Match	_____
Non-Data Match	_____
MSP Provider/Physician/Supplier/Beneficiary Liability (including WC, Auto, No Fault, MSP beneficiary and other MSP)	
MSP Beneficiary	_____
	_____
Other MSP	_____
Total MSP	_____

CMS-H750A/B

Exhibit 1 (Cont.)

Contractor Financial Reports
Statement of Operations
Hospital Insurance (HI)
As of _____

Contractor Name	ID Number
_____	_____
Other (footnote)	_____
Total Accounts Receivable	_____
Advances to Others	
Advance Payments	_____
Accelerated Payments *(Not applicable to carriers)*	_____
Total Advances	_____
Interest Receivable	_____
Other Assets (footnote)	_____

Liabilities	Balance
Accounts Payable	
Unprocessed Claims	
Benefits Payable	_____
Provider	
PIP Providers A Cost Report Settlements *(Carriers Omit)*	_____
PIP Providers A Estimated Payable Accrual *(Carriers Omit)*	_____
Non-PIP Providers A Underpayments (Interim Reviews) *(Carriers Omit)*	_____
Non-PIP Providers A Underpayments (Cost Settlements) *(Carriers Omit)*	_____
Claims Withheld for Non-receipt of Cost Reports *(Carriers Omit)*	_____
Physicians/Suppliers *(Intermediaries Omit)*	_____
Beneficiaries	_____
Claims on the Payment Floor	_____

Exhibit 1 (Cont.)

Contractor Financial Reports
Statement of Operations
Hospital Insurance (HI)
As of _____

Contractor Name	ID Number
_____	_____
Suspended Payments	
Claims	_____
Common Working File (CWF)	_____
MR/UR Prepayment Review	_____
Medicare Secondary Payer (MSP)	_____
Total Accounts Payable	_____
Accrued Interest Payable	_____
Other Liabilities	
Unapplied Receipts	_____
Excess Recoupments	_____
Due Medicaid	_____
Other (footnote)	_____
Total Other Liabilities	_____
TOTAL LIABILITIES	_____
Fund Account Balance	
Cumulative Results of Operations	_____
TOTAL LIABILITIES AND FUND ACCOUNT BALANCE	_____

Revenue	Amount
Interest Revenue	Line 3
Adjustments (Interest)	Line 5a
Waivers (Interest)	Line 5h
Write-offs (Bad Debts)(Interest)	Line 6a
Transfers in from other Medicare Contractors	Line 5b
Transfers out to other Medicare Contractors	Line 5c
Transfers in from CNC (Interest)	Line 6b
Transfers out to CNC (Interest)	Line 6c
Transfers in from other CMS Locations (POR/PSOR (as applicable)) (Interest)	Line 5d

Exhibit 1 (Cont.)

Contractor Financial Reports
Statement of Operations
Hospital Insurance (HI)
As of _____

Contractor Name _____	ID Number _____
Transfers out to other CMS Locations (POR/PSOR (as applicable)) (Interest)	Line 5e
Transfers in from other CMS Locations (Not POR/PSOR (as applicable)) (Interest)	Line 5f
Transfers out to other CMS Locations (Not POR/PSOR (as applicable)) (Interest)	Line 5g
Draws on Letter of Credit	_____
Other Revenue (footnote)	_____
TOTAL REVENUE	_____

Expense

Operating/Program Expense	Line 2 + Benefit Expense
Adjustments (Principal)	Line 5a (CR or DR)
Transfers In from other Medicare Contractors (Contra Account)	Line 5b
Transfers Out to other Medicare Contractors (Principal)	Line 5c
Transfers In from CNC (Contra Account)	Line 6b
Transfers Out to CNC (Principal)	Line 6c
Transfers In from other CMS Locations (POR and Not POR) (Contra Account)	Line 5d&5f
Transfers Out to other CMS Locations (POR and Not POR) (Principal)	Line 5e&5g
Less: Waivers (Principal)	Line 5h
Less: Write-offs (Bad debts) (Principal)	Line 6a

Exhibit 1 (Cont.)

Contractor Financial Reports
Statement of Operations
Hospital Insurance (HI)
As of _____

Contractor Name	ID Number
_____	_____

Total Program Expense	_____
Interest Expense	
CPT Interest	_____
Other Interest	_____
Other Expense (footnote)	_____
Prior Period Adjustments (footnote)	
TOTAL EXPENSE	_____
NET RESULTS OF OPERATIONS	_____
OTHER DATA *(Intermediaries)*	
Value of 1st PIP Payment Cycle in ensuing quarter	_____

CMS-H750A/B

400.2 - Exhibit 2 - Statement of Financial Position and Statement of Operations - SMI

This report is a duplicate of the above Exhibit 1, Statement of Financial Position and Statement of Operations - HI, except:

- The HI report, in the applicable line item descriptions, refers to "provider", and the SMI report refers to “provider, physician, and supplier”.

- For the SMI report (Form CMS-H750B), the FI completes the items dealing with cost reports, PIP, and credit balances; but the carrier omits them. Also, the intermediary inserts data relating to the Provider Overpayment Report (POR), while the carrier inserts data relating to the Physician Supplier Overpayment Report (PSOR).

400.3 - Exhibit 3 - Status of Accounts Receivable - HI

This exhibit is the same as Exhibit 4, Status of Accounts Receivable - SMI, with the following exceptions:

Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for the HI report and refer to the POR/PSOR for the SMI report. Only intermediaries enter POR data on both the HI report and the SMI report. Only carriers enter the PSOR data on the SMI report.

Form CMS-H751A is the CMS Form Number for the HI (Part A) report.
Form CMS-H751B is the CMS Form Number for the SMI (Part B) report.

Exhibit 3 (Cont.)

Status of Accounts Receivable
Hospital Insurance (HI)
As of _____
Contractor Name ID Number
_____ _____

Section A: Outstanding Receivables

		Principal Number	Principal Dollars	Interest Dollars	Interest Number
1.	Beginning FY Balance	_____	_____	_____	_____
2a.	New Receivables	_____	_____		
2b.	Accrued Receivables	_____	_____		
3.	Interest Earned			_____	_____
4a.	Cash/Check Collections		_____	_____	
4b.	Offset Collections		_____	_____	
4c.	Collections Deposited at Another Location		_____	_____	
5a.	Adjusted Amounts	_____			
	Internal Adjustments		_____	_____	
	Auditor/Consultant Adjustments		_____	_____	
5b.	Transfers In from other Medicare Contractors		_____	_____	
5c.	Transfers Out to other Medicare Contractors		_____	_____	
5d.	Transfers In from other CMS Locations, POR/PSOR		_____	_____	
5e.	Transfers Out to other CMS Locations, POR/PSOR		_____	_____	
5f.	Transfers In from other CMS Locations, not POR/PSOR		_____	_____	
5g.	Transfers Out to other CMS Locations, not POR/PSOR		_____	_____	
5h.	Waivers		_____	_____	
6a.	Amounts Written-off (Bad Debts)	_____	_____	_____	
6b.	Transfers In from CNC	_____	_____	_____	
6c.	Transfers Out to CNC	_____	_____	_____	
7.	Ending Balance	_____	_____	_____	_____
	a. Current		_____	_____	
	b. Non-current		_____		
8.	Allowance for Uncollectible Accounts		_____		
9.	Total Receivables Net of Allowance		_____	_____	
10.	Cash/Offsets received for Receivables at Another Location		_____	_____	

CMS-H751A

Exhibit 3 (Cont.)

Status of Accounts Receivable
Hospital Insurance (HI)
As of _____

Contractor Name _____ ID Number _____

Section B: Delinquent Receivables

	Principal Number	Principal Dollars	Interest Dollars	Interest Number
1. Total Not Delinquent	_____	_____	_____	_____
2. Total Delinquent	_____	_____	_____	_____
(a) 1 - 30 days		_____	_____	
(b) 31 - 60 days		_____	_____	
(c) 61 - 90 days		_____	_____	
(d) 91 - 180 days		_____	_____	
(e) 181 - 365 days		_____	_____	
(f) 1 - 2 years		_____	_____	
(g) 2 - 6 years		_____	_____	
(h) 6 - 10 years		_____	_____	
(i) Over 10 years		_____	_____	
3. Total Delinquent 1 - 180 days	_____	_____	_____	_____
(a) In Bankruptcy		_____	_____	
(b) In Appeal		_____	_____	
(c) At Department of Justice		_____	_____	
(d) Referred for Cross Servicing		_____	_____	
(e) Other Status		_____	_____	
4. Total Delinquent 181 days & over	_____	_____	_____	_____
(a) In Bankruptcy		_____	_____	
(b) In Appeal		_____	_____	
(c) At Department of Justice		_____	_____	
(d) Referred for Cross Servicing		_____	_____	
(e) Other Status		_____	_____	

Exhibit 3 (Cont.)

Status of Accounts Receivable
Hospital Insurance (HI)
As of _____

Contractor Name _____ ID Number _____

Section C: Other Collections

4c. Collections Deposited at another Location

Contractor/Region	Principal Dollars	Interest Dollars
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Cash Offsets Received for Receivables at another Location

Contractor/Region	Principal Dollars	Interest Dollars
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Collections on Delinquent Debt	_____	_____	_____	_____

Section D: Transferred Receivables

5c. Transfers Out to other Medicare Contractors

Contractor Number	Principal Dollars	Interest Dollars
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exhibit 3 (Cont.)

Status of Accounts Receivable
Hospital Insurance (HI)
As of _____

Contractor Name _____ ID Number _____

5d. Transfers Out to other CMS Locations, POR		
1. Boston	_____	_____
2. New York	_____	_____
3. Philadelphia	_____	_____
4. Atlanta	_____	_____
5. Chicago	_____	_____
6. Dallas	_____	_____
7. Kansas City	_____	_____
8. Denver	_____	_____
9. San Francisco	_____	_____
10. Seattle	_____	_____
11. Central Office	_____	_____

5e. Transfers Out to other CMS Locations, Not on POR		
1. Boston	_____	_____
2. New York	_____	_____
3. Philadelphia	_____	_____
4. Atlanta	_____	_____
5. Chicago	_____	_____
6. Dallas	_____	_____
7. Kansas City	_____	_____
8. Denver	_____	_____
9. San Francisco	_____	_____
10. Seattle	_____	_____
11. Central Office	_____	_____

400.4 - Exhibit 4 - Status of Accounts Receivable - SMI

This exhibit is the same as Exhibit 3, Status of Accounts Receivable - HI, with the following exceptions:

- Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for the HI report and refer to the POR/PSOR for the SMI report.
- Only intermediaries enter POR data on both the HI report and the SMI report.
- Only carriers enter the PSOR data on the SMI report.
- Form CMS-H751A is the CMS Form Number for the HI (Part A) report.
- Form CMS-H751B is the CMS Form Number for the SMI (Part B) report.

400.5 - Exhibit 5 - Status of Non-MSP Debt - CNC - HI

The screen formats in exhibits 5 and 6 are identical except 5 is for HI non-MSP and 6 is for SMI non-MSP.

MSP is reported in exhibits 9 and 10.

Exhibit 5 (Cont.)

One of: Status of Non-MSP Debt - CNC; or Status of MSP Debt - CNC will be shown.
One of: Hospital Insurance (HI); or Supplementary Medical Insurance (SMI) will be shown
As of _____

Contractor Name _____ ID Number _____

Section A: CNC Debt

		Principal Number	Principal Dollars	Interest Dollars	Interest Number
1.	Beginning FY Balance	_____	_____	_____	_____
2.	New CNC Debt	_____	_____	_____	_____
3.	Interest Earned Since CNC Approval			_____	
4.	Reclassified CNC Debt				
	a. Re-established as Active A/R due to collection of cash	_____	_____	_____	____
	b. Re-established as Active A/R due to collection by offset	_____	_____	_____	____
	c. Re-established as Active A/R due to bankruptcy, fraud & abuse, litigation and appeal	_____	_____	_____	____
	d. Written-off Closed	_____	_____	_____	____
	e. Other	_____	_____	_____	____
5.	Amounts Transferred				
	a. Transfers In from Medicare Contractors	_____	_____	_____	____
	b. Transfers Out to Medicare Contractors	_____	_____	_____	____
	c. Transfers In from CMS RO	_____	_____	_____	____
	d. Transfers Out to CMS RO	_____	_____	_____	____
	e. Transfers In from CMS CO	_____	_____	_____	____
	f. Transfers Out to CMS CO	_____	_____	_____	____
6.	Ending Balance	_____	_____	_____	_____

Exhibit 5 (Cont.)
Status of Non-MSP Debt - CNC
Hospital Insurance (HI)
As of _____

Contractor Name _____ ID Number _____

Section B: Aging of CNC Debt (from the determination date)

1.	Total CNC Debt	_____	_____	_____	_____
(a)	181 - 1 year		_____	_____	
(b)	1 - 2 years		_____	_____	
(c)	2 - 6 years		_____	_____	
(d)	6 - 10 years *		_____	_____	
(e)	Over 10 years *		_____	_____	

* Provide an explanation why debts in these categories were not recommended for write-off closed

Section C: Collection Information

Collections on CNC Debt	_____	_____	_____	_____

Section D: Status CNC Debt over 181 Days

Total Delinquent			
(a)	In Bankruptcy	_____	_____
(b)	In Appeal	_____	_____
(c)	In Department of Justice	_____	_____
(d)	Referred for Cross Servicing	_____	_____
(e)	Other Status	_____	_____

400.6 - Exhibit 6 - Status of Non-MSP Debt - CNC - SMI

See §400.5, Exhibit 5 - Status of Non-MSP Debt - CNC - SMI.

The formats in exhibits 5 and 6 are identical except 5 is for HI non-MSP and 6 is for SMI non-MSP.

MSP is reported in exhibits 9 and 10.

400.7 - Exhibit 7 - Status of MSP Accounts Receivable - HI

This is an exact duplicate of Exhibit 3 - Status of Accounts Receivable - HI, except that the data is limited to data involving Medicare as secondary payer.

This exhibit, and Exhibit 8, Status of MSP Accounts Receivable - SMI, are identical with the following exceptions:

- Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for HI reports and refer to the POR/PSOR for the SMI report.
- Only carriers enter the PSOR data on the SMI report.
- The CMS Form Number for this report (HI) is Form CMS-M751A.
- The CMS Form Number for the SMI report is Form CMS-M751B.

400.8 - Exhibit 8 - Status of MSP Accounts Receivable - SMI

See Exhibit 7 - Status of MSP Accounts Receivable - HI, above.

400.9 - Exhibit 9 - Status of MSP Debt - CNC - HI

See Exhibit 5 - Status of Non-MSP Debt - CNC - HI

400.10 - Exhibit 10 - Status of MSP Debt - CNC - SMI

See Exhibit 5 - Status of Non-MSP Debt - CNC - HI.

400.11 - Exhibit 11 - Medicare Contractor Account Definitions - Data Element Definitions

Medicare Contractor Account Definitions

Data Element Definitions

Account Number	Title
1000	Assets
1100	Cash
1100.01	Part A and Part B
1100.01.01	Benefit Account
1100.01.02	Time Account
1110	Undeposited Collections
1110.01	Part A and Part B
1110.01.01	Undeposited Collections
1310	Accounts Receivable
1310.01	Part A and Part B
1310.01.01	Non-MSP Overpayments
1310.01.01.01	Provider
1310.01.01.01.01	Cost Report Settlements (FI)
1310.01.01.01.02	Claims Accounts Receivable (FI)
1310.01.01.01.03	PIP Accrual (FI)
1310.01.01.01.04	Credit Balance (FI)
1310.01.01.01.05	Other (FI)
1310.01.01.02	Beneficiaries
1310.01.01.03	Physicians/Suppliers
1310.01.04	Medicare Secondary Payer (MSP)
1310.01.04.01	Group Health Plan
1310.01.04.01.01	Data Match
1310.01.04.01.02	Non-Data Match
1310.01.04.02	Liability MSP
1310.01.04.02.01	MSP Beneficiary
1310.01.04.02.02	MSP Provider/Physician Supplier
1310.01.04.03	Other MSP
1310.01.99	Other
1311	Advances to Others
1311.01	Part A and Part B
1311.01.01	Advance Payments
1311.01.02	Accelerated Payments

Account Number	Title
1330	Interest Receivable
1330.01	Part A and Part B
1990	Other Assets
1990.01	Part A and Part B
2000	Liabilities
2110	Accounts Payable
2110.01	Part A and Part B
2110.01.01	Unprocessed Claims
2110.01.02	Benefits Payable
2110.01.02.01	Provider
2110.01.02.01.01	PIP Provider Cost Report Settlements
2110.01.02.01.02	PIP Provider Estimated Payable Accrual
2110.01.02.01.03	Non-PIP Provider Underpayments - Interim Rate
2110.01.02.01.04	Non-PIP Provider Underpayments - (Cost Report Settlement)
2110.01.02.01.05	Claims Withheld for Non-receipt of Cost Reports
2110.01.02.02	Beneficiaries
2110.01.02.03	Physicians/Suppliers
2110.01.02.04	Claims on the Payment Floor
2110.01.03	Suspended Payments
2110.01.03.01	Claims
2110.01.03.02	Common Working File (CWF)
2110.01.03.03	MR/UR Prepayment Review
2110.01.03.0	Medicare Secondary Payer (MSP)
2140	Accrued Interest Payable
2140.01	Part A and Part B
2990	Other Liabilities
2990.01	Part A and Part B
2990.01.01	Unapplied Receipts
2990.01.02	Excess Recoupments
2990.01.03	Due Medicaid
2990.01.04	Other
3010	Fund Account Balance
3310	Cumulative Results of Operations
3310.01	Part A and Part B
5000	Revenue

Account Number	Title
5303	Interest Revenue
5303.01	Part A and Part B
5303.01.01	Adjustments/Waivers (Contra Account)
5303.01.02	Write-off Closed/Transfers
5303.01.02.01	Bad Debt (Contra Account)
5303.01.02.02	Transfers Out to Other CMS Locations (Contra Account)
5303.01.02.02.01	Transfers In from Other CMS Locations
5303.01.02.03	Transfers Out to CNC (Contra Account)
5303.01.02.03.01	Transfers In from CNC
5303.01.02.04	Transfers Out to Other Medicare Contractors (Contra Account)
5303.01.02.04.01	Transfers In from Other Medicare Contractors
5700	Appropriated Capital Used
5700.01	Part A and Part B, Draws on Letter of Credit
5900	Other Revenue
5900.01	Part A and Part B
5900.01.01	Other
6000	Expense
6100	Operating/Program Expense
6100.01	Part A and Part B
6101	Waivers
6101.01	Part A and Part B
6101.01.02	Transfers Out to Other CMS Locations (Contra Account)
6101.01.02.01	Transfers In from Other CMS Locations
6101.01.03	Transfers Out to CNC (Contra Account)
6101.01.03.01	Transfers In from CNC
6101.01.04	Transfers Out to Other Medicare Contractors (Contra Account)
6101.01.04.01	Transfers In from Other Medicare Contractors
6106	Write Offs/Transfers
6106.01	Part A and Part B
6106.01.01	Bad Debts
6330	Interest Expense
6330.01	Part A and Part B
6330.01.01	CPT Interest
6330.01.02	Other Interest

Account Number	Title
6909	Other Expense
6909.01	Part A and Part B
7400	Prior Period Adjustments
7400.01	Part A and Part B

Exhibit 11 (Cont.)

Medicare Contractor Account Definitions
Data Element Definitions

The account numbers used in this chart are for reference purposes only. They are not mandated for use by Medicare contractors.

1000	Assets
	The contractor reports amounts of physical items or rights to ownership
1100	Cash
	The contractor reports monetary resources on hand or on deposit with banks or other financial institutions. Balances are the end of quarter amounts per the contractor's books.
1100.01	Part A and Part B
	The contractor reports cash allocable for Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) activities. HI data must reconcile to Column E, Line 1, on Form CMS-1522, Monthly Contractor Financial Report. SMI data must reconcile to Column E, Line 2. Prorate the Time Account by the number of checks and electronic funds transfers (EFTs) issued for HI or SMI services. (See Exhibit 15 Protocol for Prorating Intermediary Time Account Balances between HI and SMI.)
1100.01.01	Benefits Account
	The contractor reports the Federal Health Insurance Benefits Account by HI and SMI
1100.01.02	Time Account
	The contractor reports the balance as of the end of the quarter in the Federal Health Insurance Time Account by HI and SMI.
1110	Undeposited Collections
1110.01	Part A and Part B
	The contractor reports undeposited collections for HI and SMI activities
1110.01.03	Undeposited Collections

The contractor reports collections on hand not deposited within the accounting period. Undeposited collections include those items received by the last day of the quarter that will be deposited during the subsequent quarter. The contractor prorates undeposited collections on the basis of Column D, Funds Expended, on Form CMS-1522, Monthly Contractor Financial Report for Part A (HI) and Part B (SMI). Report deposits in transit as part of the book balance for either 1100.01.01, Benefits Account, or 1100.01.02, Time Account. It reports amounts due from others. A receivable is the identification of an overpayment for services rendered. CMS will only recognize receivables related to Fraud and Abuse once they are litigated by the Department of Justice (DOJ)

1310 Accounts Receivable

The contractor reports amounts due from others. A receivable is the identification of an overpayment for services rendered. A demand letter is not the primary instrument for recognizing an accrual. CMS will only recognize receivables related to Fraud and Abuse once they are litigated by the Department of Justice (DOJ).

1310.01 Part A and Part B

The contractor reports accounts receivable attributable to HI and SMI activities

1310.01.01 Overpayments

The contractor accounts receivable for overpayments. It includes amounts that exceed adjudicated claims processed, cost reports settled, or other authorized payments. This includes, but is not limited to, overpayments resulting from adjustment bills. It reclassifies any overpayment when Medicare is deemed as secondary payer to 1310.01.04, MSP

1310.01.01.01 Provider

The intermediary reports overpayments for institutional providers. This includes, but is not limited to, those items listed on the Provider Overpayment Report (POR) and the Credit Balance Summary Report. Include periodic interim payments (PIP) in excess of PIP bills. Include overpayments resulting from the receipt of cost reports, tentative settlements or cost settlements when the Notices of Provider Reimbursement (NPR) are prepared. It includes overpayments from PRRB settlements when the Notices of Correction (NOC) are prepared.

This is not a carrier function.

1310.01.01.01.01 Cost Report Settlements

The intermediary reports the accounts receivable as a result of cost report settlements, interim rate reviews and overpayments as a result of accelerated payments

1310.01.01.01.02 Claims Accounts Receivable

The intermediary reports the accounts receivable as a result of claims accounts receivable.

This is not a carrier function.

1310.01.01.01.03 PIP Accrual

The intermediary reports the amount accrued for the (estimated) accounts receivable PIP. (See Exhibit 13 Protocol for Estimating Payables and Receivables for PIP).

This is not a carrier function.

1310.01.01.01.04 Credit Balances

The intermediary reports the accounts receivable as a result of credit balance reports

This is not a carrier function.

1310.01.01.02 Beneficiaries

The contractor reports overpayments for beneficiaries. This includes, but is not limited to, those items listed on the CMS-2174, Carrier Beneficiary Overpayment Activity Report.

1310.01.01.03 Physicians/Suppliers

The carrier reports overpayments for physicians and suppliers. This includes, but is not limited to, those items listed on the Physician/Supplier Overpayment Report (PSOR)

This is not an intermediary function.

1310.01.04 Medicare Secondary Payer

The contractor reports accounts receivable for amounts due as a result of MSP activity, and based on documented debts due Medicare for all debtors. Debtors are employers, insurers, providers, beneficiaries or other persons to whom a demand letter has been issued

1310.01.04.01 Group Health Plan (GHP)

1310.01.04.01.01 Data Match (FI)

The contractor includes the amounts identified (CMS supplied receivables via tapes with an identified report ID on MPaRTS) as a result of MSP activity for which a demand letter has been issued for IRS/SSA Data Match cases. Outstanding receivables are the amount of debt that has been demanded and payment has not yet been received

1310.01.04.01.02 Non-Data Match (FI)

The contractor includes the amounts identified (debt specific to GHP debt, working aged, disability, End-Stage Renal Disease (ESRD) as a result of MSP activity for which a demand letter has been issued. Outstanding receivables are the amount of debt that has been demanded and payment has not yet been received

1310.01.04.02 Liability MSP

The contractor includes the amounts (inclusive of all workman's compensation, automobile/no fault and liability debt, this includes CMS identified cases) due to MSP activity for which a settlement has been reached related to liability cases. Outstanding receivables are the amount of debts that have been demanded, subsequent to settlement and/or other action, and payment has not yet been received.

1310.01.04.02.01 MSP Beneficiaries

1310.01.04.02.02 MSP Providers/Physicians/Suppliers

Outstanding receivables are the amount of MSP initiated debts that have been demanded and payment has not yet been received.

1310.01.04.03 Other MSP

The contractor includes the amounts due as a result of other MSP activity for which a valid MSP debt has been recognized.

1310.01.99 Other

The contractor reports actual or estimated other accounts receivable. It includes those receivables not otherwise classified in the categories presented above. It provides an identifying footnote on CAFM of the nature of this receivable

1311 Advances to Others

The contractor reports payments made to providers, physicians, or suppliers in anticipation of claims being processed. Advances are not to be considered as accounts receivable. It does not include them on Form CMS-751A/B, Status of Account Receivable report

1311.01 Part A and Part B

The contractor reports advance payments and accelerated payments attributable to HI and SMI activities

1311.01.01 Advance Payments

The contractor the outstanding balance for payments authorized by CMS instructions for advanced payments based on actual provider claims data. If not recovered according to CMS instructions, it reclassifies and reports as overpayments

1311.01.02 Accelerated Payments (FI)

The intermediary reports the outstanding balance for payments authorized by CMS instructions for accelerated payments based on actual provider claims data. If not recovered according to CMS instructions, it reclassifies and reports as overpayments

This is not a carrier function.

1330 Interest Receivable

The contractor reports interest receivable on accounts receivable. It accrues interest through the last day of the reporting period.

1330.01 Part A and Part B

The contractor reports HI and SMI interest receivable on accounts receivable, including extended repayment plans

1990	Other Assets
	The contractor reports assets that are not otherwise classified. It provides an identifying footnote in the remarks section of Form CMS-750A/B report.
1990.01	Part A and Part B
	The contractor reports HI and SMI unclassified assets.
2000	Liabilities
	The contractor reports amounts owed after processing Medicare claims and related activities
2110	Accounts Payable
	Report amounts owed after processing Medicare claims or other authorized expenditures. This includes, but is not limited to, underpayments resulting from adjustment bills
2110.01	Part A and Part B
	The contractor reports accounts payable attributable to HI and SMI activities
2110.01.01	Unprocessed Claims
	The contractor reports the value of the accounts payable for unprocessed claims received in-house that have not yet started processing. The actual value may be developed after the reporting period but before the required date for reporting. It uses the 30 day rolling average for the number of claims received and not processed to determine the number of average unprocessed claims.
2110.01.02	Benefits Payable
	The contractor reports accounts payable for those claims that have completed processing checks, but have not yet been issued nor offsets applied. This includes, but is not limited to, underpayments resulting from adjustment bills. It includes claims approved by the Common Working File (CWF) and claims not approved by the CWF, but approved by the RO for payment outside the CWF

2110.01.02.01 Provider

The intermediary reports benefits payable to institutional providers of Medicare services. This includes, but is not limited to the following: accounts receivable accrual where the periodic interim payment (PIP) bills is in excess of periodic interim payments (PIP); underpayments from receipt of accepted cost reports, tentative settlements and final cost settlements, when Notices of Provider Reimbursement (NPR) are prepared; and underpayments for PRRB settlements, when Notices of Correction (NOC) are prepared, etc

This is not a carrier function.

2110.01.02.01.01 PIP Providers - Cost Report Settlements

The intermediary reports benefits payable to PIP providers as a result of Cost Report Settlements

This is not a carrier function.

2110.01.02.01.02 PIP Providers - Estimated Payable Accrued

The intermediary reports the amount accrued for the (estimated) accounts payable PIP. (See Exhibit 13 Protocol for Estimating Payables and Receivables for PIP).

This is not a carrier function.

2110.01.02.01.03 Non-PIP Providers - Underpayments (Interim Rate)

The intermediary reports benefits payable to Non-PIP providers as a result of Interim Rate Reviews

This is not a carrier function

2110.01.02.01.04 Non-PIP Providers - Underpayments (Cost Report Settlement)

The intermediary reports benefits payable to Non-PIP providers as a result of Cost Report Settlements

This is not a carrier function.

2110.01.02.01.05 Claims Payments Withheld for Non-receipt of Cost Reports

The intermediary reports benefits payable for claims withheld for payment for non-receipt of provider cost reports

This is not a carrier function.

2110.01.02.02 Beneficiaries

The contractor reports benefits payable to beneficiaries for reimbursement for Medicare services

2110.01.02.03 Physicians/Suppliers

The carrier reports benefits payable to physicians or suppliers of Medicare services. This includes, but is not limited to, underpayments of quarterly Health Professional Shortage Area (HPSA) bonus amounts for which a check has not been issued.

Not an intermediary function.

2110.01.02.04 Claims on the Payment Floor

Adjudicated claims not yet paid

2110.01.03 Suspended Payments

The contractor reports actual or estimated benefits payable for claims that were suspended from payment to allow for additional processing.

2110.01.03.01 Claims

The contractor reports estimated benefits payable for claims needing additional information or further development, including CWF rejects and adjustments

210.01.03.02 Common Working File (CWF)

The contractor reports benefits payable for claims that are pending submission or were submitted to the CWF for approval

2110.01.03.03 MR/UR Prepayment Review

The contractor reports estimated benefits payable, based on a developed rate, suspended for MR/UR before payment. The payables after MR/UR are in 2110.01.02, Benefits Payable

2110.01.03.04 Medicare as Secondary Payer (MSP)

The contractor reports benefits payable that are suspended for investigation of third party liability for MSP prior to payment

2140	Accrued Interest Payable
	The contractor reports actual or estimated interest payable on Medicare liabilities through the end of the reporting period including, but not limited to, pending claims, court settlements, claims payment timeliness (CPT), etc.
2140.01	Part A and Part B
	The contractor reports HI and SMI interest payable on Medicare liabilities
2990	Other Liabilities
	The contractor reports liabilities not otherwise classified. It provides an identifying footnote in the remarks section of Form CMS-750A/B report.
2990.01	Part A and Part B
	The contractor reports other liabilities attributable to HI and SMI activities.
2990.01.01	Unapplied Receipts
	The contractor reports amounts deposited and not yet applied to an accounts receivable.
2990.01.02	Excess Recoupments
	The contractor reports amounts recovered from overpayments or from other sources in excess of receivables established and which are eligible for refund. It includes those payables identified as due to third party liability payers, e.g., excess recoupment of MSP recoveries being returned to the third party
2990.01.03	Due Medicaid
	The contractor reports Medicare claims reimbursements withheld based on RO instructions for payment to Medicaid.
2990.01.99	Other
	The contractor reports actual or estimated amounts payable not otherwise classified. These include, but are not limited to, claims

payments withheld to satisfy Internal Revenue Service liens, court liens, unidentified receipts that have not been applied to an account receivable. It provides an identifying footnote in CAFM.

3010 Fund Balance

Fund balance reflects the cumulative results of program operations and extraordinary items. It equals the difference between assets and liabilities.

3310 Cumulative Results of Operations

These accounts track the net difference between income and expense activity as reported on the Statement of Operations. This account is updated with the current year-to-date net results of operations

3310.01 Part A and Part B

The contractor reports HI and SMI interest revenue from accounts receivable. It includes current fiscal period earned interest, and any adjustments. It also includes accrued interest in account 1330, Interest Receivable

5000 Revenue and Other Financing Sources

The contractor reports the amount of income from Medicare activities. Typical sources are draws on letter of credit, interest and recoveries of amounts expended in prior periods.

5303 Interest Revenue

The contractor reports interest earned from accounts receivable.

5303.01 Part A and Part B

The contractor reports HI and SMI interest revenue from accounts receivable. Include current fiscal period earned interest, and any adjustments. This will also include accrued interest in account 1330, Interest Receivable.

5303.01.01 Adjustments/Waivers (Interest)

The contractor reports the reduction of the amounts of interest receivable based on Collections on Delinquent Debt in accordance with §§1862(b) and 1870(c) of the Social Security Act. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5h, Waivers (Interest).

5303.01.02 Write-offs Closed/Transfers (Interest)

The contractor reports interest receivable for which collection efforts have been abandoned or that have been transferred to another Medicare contractor or other CMS location. These accounts must be reconciled with the receiving Medicare contractor or other CMS location.

5303.01.02.01 Amounts Written-Off Closed (Bad Debts) (Interest)

The contractor reports interest receivables for which collection is no longer being pursued according to CMS regulations. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6a, Amounts Written-off Closed (Bad Debts).

5303.01.02.02 Transfers Out to other CMS Locations (POR/PSOR & Not POR/PSOR) (Interest).

POR not applicable to carriers.

The contractor reports interest receivable transferred to other CMS locations. Reconcile with Form CMS-751A/B, Status of Accounts Receivable, Line 5e, Transfers Out to Other CMS Locations, POR/PSOR, (interest) and Line 5g, Transfers Out to Other CMS Locations, Not POR/PSOR, (interest).

POR not applicable to carriers.

5303.01.02.02.01 Transfers In from other CMS Locations (POR/PSOR & Not POR/PSOR) (Interest).

POR not applicable to carriers.

The contractor reports interest receivable that has been transferred to your location from other CMS locations in the current period. It reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5d, Transfers In from Other CMS Locations, POR, (interest), and Line 5f, Transfers In from Other CMS Locations, Not POR, (interest).

POR not applicable to carriers.

5303.01.02.03 Transfers Out to CNC (Interest)

The contractor reports interest receivable transferred to CNC in

accordance with CMS regulations. It transfers the full amount of interest due on the debt. It reconciles this with Form CMS-C751, Status of Non-MSP Debt - CNC, Line 2, New CNC A/R (interest) and Line 6c, Transfers Out to CNC

5303.01.02.03.01 Transfers In from CNC (Interest)

The contractor reports interest receivable that has been transferred in to its location from CNC.

5303.01.02.04 Transfers Out to other Medicare Contractors (Interest)

The contractor reports interest receivable transferred to other Medicare contractors. Reconcile with Form CMS-751A/B, Status of Accounts Receivable, Line 5c, Transfers Out to Other Medicare Contractors

5303.01.02.04.01 Transfers In from other Medicare Contractors (Interest)

The contractor reports interest receivable transferred to your location from other Medicare contractors. It reconciles this with Form CMS-751A/B Status of Accounts Receivable, Line 5b, Transfers In from Other Medicare Contractors (Interest)

5700 Appropriated Capital Used

The contractor reports the amount of Medicare funds drawn to be matched against current period expense. This amount must be consistent with amounts reported on Form CMS-1521, Contractor Draws on Letter of Credit, and on Form CMS-1522, Monthly Contractor Financial Report. The contractor does not include administrative draws through the Payment Management System (PMS), (Smartlink)

5700.01 Part A and Part B, Draws on Letter of Credit

The contractor reports HI and SMI draws on Letter of Credit on Form SF(TFS)-5805, Request for Funds.

5900 Other Revenue

The contractor reports revenue not otherwise classified. It provides identifying footnote(s) in the remarks section of Form CMS-750 A/R report

5900.01 Part A and Part B

	The contractor reports HI and SMI other revenue
5900.01.01	Other
	The contractor reports revenue not otherwise classified
6000	Expense
	The contractor reports the outflow of assets or incurrence of liabilities during a period resulting from rendering Medicare services.
6100	Operating/Program Expense
	The contractor reports net benefits costs incurred throughout the FY. The expense is the adjusted benefits outlay in cash or its equivalent and accrued liabilities incurred in carrying out the Medicare program. This includes, but is not limited to, adjustments for MSP recoveries, reconsiderations, and pending litigation.
6100.01	Part A and Part B
	The contractor reports HI and SMI benefit program expense.
6101	Waivers (Principal)
	The contractor reports HI and SMI waiver expense.
6101.01	Part A and Part B
	The contractor reports the reduction of the amounts receivable based on application of §§1862(b) and 1870(c) of the Social Security Act. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5h, Waivers.
6101.01.02	Transfers Out to other CMS Locations (Principal)
	The contractor reports accounts receivable transferred to other CMS locations. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5e, Transfers Out to Other CMS Locations, POR/PSOR and Line 5g, Transfers to Other CMS Locations, Not POR/PSOR. POR not applicable to carriers.
6101.01.02.01	Transfers In from other CMS Locations (Principal)

The contractor reports accounts receivable amounts that have been transferred to its location from other CMS locations in the current period. It reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5d, Transfers In from Other CMS Locations, POR/PSOR (principal), and Line 5f, Transfers In from Other CMS Locations, Not POR/PSOR (principal).

POR not applicable to carriers.

6101.01.03 Transfers Out to CNC (Principal)

The contractor reports accounts receivable amounts that have been transferred to CNC in accordance with CMS regulations. . It reconciles this with Form CMS-C751A/B, Status of Non- MSP Debt - CNC, Line 2, New CNC A/R, and Line 6c Transfers Out to CNC of Form CMS-751A/B, Status of Accounts Receivable report. It transfers the full amount of principal due.

6101.01.03.01 Transfers In from CNC (Principal)

The contractor reports accounts receivable amounts that have been re-established as an active accounts receivable. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6b, Transfers In from CNC

6101.01.04 Transfers Out to other Medicare Contractors (Principal)

The contractor reports HI and SMI accounts receivable transferred out to a Medicare contractor for collection. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5c, Transfers to Other Medicare Contractors.

6101.01.04.01 Transfers In from other Medicare Contractors (Principal)

The contractor reports HI and SMI accounts receivable transferred to your location from other Medicare contractors. It reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5b, Transfers In from Other Medicare Contractors.

6106 Write-offs Closed/Transfers (Principal)

The contractor reports accounts receivable for which collection efforts have been abandoned, or that have been transferred to another Medicare contractor or other CMS location. These accounts must be reconciled with the receiving Medicare contractor or other CMS location.

6106.01 Part A and Part B

The contractor reports HI and SMI accounts receivable written off or transferred.

6106.01.01 Amounts Written-Off Closed (Bad Debts) (Principal)

The contractor reports receivables for which collection is no longer being pursued according to CMS rules. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6a, Amounts Written-off Closed (Bad Debts).

6330 Interest Expense

The contractor reports interest expense incurred for claims for Medicare benefits or accounts payable.

6330.01 Part A and Part B

The contractor reports HI and SMI interest expense.

6330.01.01 Claims Payment Timeliness (CPT) Interest

The contractor reports interest paid for claims that failed the claims payment timeliness (CPT) requirement. It reconciles this with Form CMS-1522, interest paid, claims timeliness.

6330.01.02 Other Interest

The contractor reports interest for other late payments. It reconciles this with Form CMS-1522, interest paid, provider underpayments.

6909 Other Expense

The contractor reports benefit expenses not reported in named categories or otherwise classified. It provides an identifying footnote in the remarks section of Form CMS-750A/B report.

6909.01 Part A and Part B

The contractor reports HI and SMI unclassified benefit expenses.

7400 Prior Period Adjustments

The contractor reports adjustments for prior period activity to restate

assets, liabilities, etc. It provides an identifying footnote in the remarks section of Form CMS-750 report.

7400.01 Part A and Part B

The contractor reports HI and SMI prior period adjustments.

400.12 - Exhibit 12 - Accounts Payable - Protocol for Estimating Claims - Form CMS-H750A/B, Statement of Financial Position

(Rev. 5, 08-30-02)

A1-1960.12, A3-3893.3, B1-4960.12

Accounts Payable
Protocol for Estimating Claims
Form CMS-H750A/B, Statement of Financial Position

The amounts recorded in accounts payable (A/P) may be estimated based on actual volumes and historical rates; therefore, the FI or carrier calculates and accrues a new estimated liability each reporting period and reverses the accrual for the previous period in full. It charges the expense accounts, rather than the A/P, as actual payments are made.

INTERMEDIARY PROCEDURES

Methodology for Calculating Average Reimbursement Amount and Average Interest for Pricing Claim Liabilities

To assign an estimated value to claims for which the amount to be paid is unknown, the contractor counts claims and multiplies the total by the average reimbursement amount (net of interest) and an average interest amount (CPT), if applicable, determined as follows:

The intermediary calculates the average reimbursement amount by taking a representative sample of the most recent 12 months of paid claims history. It totals the reimbursement amount minus interest and divides by the total number of claims processed. It calculates the Claims Payment Timeliness (CPT) by adding the interest from the same claims and divides by the total number of claims (not just those bearing interest).

The intermediary performs these calculations for each UB-92 (HCFA 1450) bill type and prepares separate reports for Part A and Part B.

GENERAL PROCEDURES

These methods may be used to assign an estimated value to claims in the following categories:

1. In-house, unprocessed claims; and

2. Claims suspended for prepayment review

Claims
MR/UR
PRO

400.13 - Exhibit 13 - Periodic Interim Payments (PIP) Protocol for Estimating Payables/Receivables for the Forms CMS-H750/H751A/B, Statement of Financial Position and Status of Accounts Receivable Report (Intermediaries Only)

(Rev. 5, 08-30-02)

A1-1960.13, B1-4960.13

Periodic Interim Payments (PIP)
Protocol for Estimating Payables/Receivables for the Form CMS-H750/H751A/B, Statement of Financial Position and Status of Accounts Receivable Reports

It is necessary to report on Form CMS-H750, a cumulative estimated accounts receivable or payable for all fiscal periods since the provider's last accepted cost report period. To estimate this amount, the intermediary performs the following steps:

1. It determines the total amount for PIP bills processed for the fiscal period less outlier amounts;

2. It compares the PIP bills amount to the actual PIP cash payment and lump sum payments (checks issued) made during the fiscal period. This does not include any outlier payments that may have been issued on the same check with the PIP;

3. It reports the amount that PIP bills exceed the PIP cash payment as an account payable; and

4. It reports the amount that PIP cash payment exceeds the PIP bills as an account receivable.

For example: If the provider's FY ends on December 31, then the cost report should be received and accepted before the June 30 reporting period. The following demonstrates how the PIP accumulations would be reported for this provider.

Period Ending:	**Reporting:**
December 31	Assuming all prior year cost reports have been accepted, the only entry on the books for this provider would be the estimated accounts receivable or accounts payable after comparing PIP payments to claims submitted since January 1st to current.
March 31	Given the same assumption regarding prior cost reports, the PIP estimate for this provider will include the entire prior FY for the provider (January 1 - December 31) unless the cost report has been filed and accepted, and the current FY for the provider (January 1- March 31).

June 30	Given the same assumption regarding prior cost reports, assuming the latest cost report has now been received and accepted and the appropriate accounts receivable or accounts payable are booked, the PIP estimated for this provider will now include only the current FY for the provider (January 1- June 30).

Period Ending:	**Reporting:**
Sept 30	Given the same assumption regarding prior cost reports, assuming the latest cost report has now been received and accepted, the PIP estimate for this provider will now include only the current FY for the provider (January 1- September 30).

400.14 - Exhibit 14 - Protocol for Estimating Allowance for Uncollectible Accounts Form CMS-751A/B, Status of Accounts Receivable

(Rev. 5, 08-30-02)

A1-1960.14, B1-4960.8

Protocol for Estimating Allowance for Uncollectible Accounts
Form CMS-H751A/B, Status of Accounts Receivable

The Federal Accounting Standards Advisory Board (FASAB) recommends through Statement of Federal Financial Accounting Standard Number 1 (Paragraphs 44 & 45) that losses on receivables should be recognized when it is more likely than not that the receivables will not be totally collected. The phrase "more likely than not" means more than a 50 percent chance of loss occurrence. An allowance for estimated uncollectible amounts should be recognized to reduce the gross amount of receivables to its net realizable value. The allowance for uncollectible amounts should be re-estimated on each annual financial reporting date (at a minimum) and when information indicates that the latest estimate is no longer correct. These losses should be measured through a systematic methodology. The systematic methodology should be based on analysis of both individual accounts and a group of accounts as a whole.

Accounts that represent significant amounts, i.e., greater that $1 million, should be individually analyzed to determine the loss allowance. Loss estimation for individual accounts should be based on (a) the debtor's ability to pay, (b) the debtor's payment record and willingness to pay, and (c) the probable recovery of amounts from secondary sources, including liens, garnishments, cross collections and other applicable collection tools.

The entire allowance for losses generally cannot be based solely on the results of individual account analysis. In many cases, information may not be available to make a reliable assessment of losses on an individual account basis or the nature of the receivables may not lend itself to individual account analysis. In these cases, potential losses should be assessed on a group basis.

CMS has implemented FASAB's recommendations and has developed this protocol for Medicare contractors to follow for estimating the allowance for uncollectible accounts. The following section outlines this methodology.

Protocol for Estimating Allowance for Uncollectible Accounts

Medicare contractors must recognize on Line 8, Allowance for Uncollectible Accounts, on Form CMS-H751A/B, an estimated amount for uncollectible debt in order to reduce the gross amount of receivables to its net realizable value. Medicare contractors must re-

estimate the allowance for uncollectible amounts on March 31 and September 30 of each FY and when information indicates that the latest estimate is no longer correct.

Exhibit 14 (Cont.)
Protocol for Estimating
Allowance for Uncollectible Accounts
Form CMS-H751A/B, Status of Accounts Receivable

Medicare contractors must measure potential losses due to uncollectible amounts through a systematic method. This systematic method must be based on an analysis. Receivables will be further stratified into sub-groups (i.e., Cost Report Settlement Activity, Claims Accounts Receivable, Credit Balances, Group Health Plan (GHP) MSP, Liability MSP and Other Accounts Receivables). The subgroups are somewhat different for Group1 - Intermediaries, as compared to Group 2 - Carriers

Group 1 (Fiscal Intermediaries)

Sub-Group 1
1. Cost Report Settlements Activity (Non MSP)
2. Claim Account Receivables, Credit Balances & Other Accounts Receivables (Non-MSP)

Sub-Group 2
1. Group Health Plan (Data Match/Non Data Match) MSP
2. Liability MSP

or Group 1, Subgroup 1, intermediaries perform 3 steps to calculate and validate the allowance for uncollectible accounts.

1. It calculates the allowance based on the historical collection percentage (see detailed instructions below) for Non-MSP as a whole.

2. Individual Account Analyses: For cost report settlement activity only, fiscal intermediaries will identify and total those provider debts that meet certain risk characteristics (i.e., bankruptcy, terminations, poor collection history, no collection activity for 6 months or more). These will be considered risk accounts, and the fiscal intermediary should total all risk accounts identified through this analysis.

3. The contractor uses the most conservative (largest) amount of the two amounts mentioned above. In addition, the selective amount should be compared to the total delinquencies exceeding 180 days (Section B of Form CMS-H751A/B "Delinquent Receivables") for reasonableness.

For Group 1, Subgroup 2, the intermediary performs 2 steps to calculate and validate the allowance for uncollectible accounts.

1. The intermediary calculates the allowance based on the historical collection percentage (see detailed instructions below) for MSP as a whole.

2. The intermediary compares the calculated amount to the total delinquencies exceeding 180 days (Section B of Form CMS-H751A/B "Delinquent Receivables") for reasonableness.

Historical Collection Percentage Calculation

A - Determine Total Receivables Eligible for Collection. (Using Form CMS 751A/B)

Required Formula:

Beginning Balance	(Line 1)
Plus: New	(Line 2a)
Plus/Less: Adjustment (plus if positive number - less if negative number)	(Line 5a)
Plus: Transfers In from other Medicare Contractors	(Line 5b)
Plus: Transfers In from other CMS locations, POR & Not POR	(Lines 5d & 5f)
Plus: Transfers In from CNC	(Line 6b)
Less: Transfers Out to other CMS locations, POR & Not POR	(Lines 5e & 5g)

Equals: Total Receivables Available to be Collected

B - Determine Rate of Collections

Line 4a, Collections plus Line 4b Offsets divided by total Receivables Available to be Collected (number calculated from Step 1a) multiplied times 100 determines the rate of collections percentage.

C - Determine the Allowance Rate

1.00 minus the percentage determined from Step B, equals the allowance rate

D - Average the Percentage Calculated in Step C with a 5-year Historical Allowance Rate (if available, if not available, maintain statistical data to develop historical rate, and go proceed to step E).

E - Calculate the Allowance

Multiply the ending balance (Line 7) by the allowance rate from Step C or Step D.

Exhibit 14 (Cont.)

Group 2 (Carriers)

Sub-Group 1

1. Claim Account Receivables, Credit Balances & Other Accounts Receivables (Non-MSP)

Sub-Group 2

1. Group Health Plan (Data Match/Non Data Match) MSP
2. Liability MSP

For Group 2, Subgroup 1, the carrier performs 2 steps to calculate and validate the allowance for uncollectible accounts.

1. It calculates the allowance based on the historical collection percentage (see detailed instructions below) for Non-MSP as a whole.

2. It compares the calculated amount to the total delinquencies exceeding 180 days (Section B of Form CMS-H751B "Delinquent Receivables") for reasonableness.

For Group 2, Subgroup 2, the carrier performs 2 steps to calculate and validate the allowance for uncollectible accounts.

1. It calculates the allowance based on the historical collection percentage (see detailed instructions below) for MSP as a whole.

2. Then it compares the calculated amount to the total delinquencies exceeding 180 days (Section B of Form CMS-H751A/B "Delinquent Receivables") for reasonableness.

Exhibit 14 (Cont.)

Group 2 (Carriers)

Historical Collection Percentage Calculation

A. Determine Total Receivables Eligible for Collection. (Using Form CMS-751B)

Required Formula:

Beginning Balance	(Line 1)
Plus: New	(Line 2a)
Plus/Less: Adjustment (plus if positive number - less if negative number)	(Line 5a)
Plus: Transfers In from other Medicare Contractors	(Line 5b)
Plus: Transfers In from other CMS locations, POR & Not POR	(Lines 5d & 5f)
Plus: Transfers In from CNC	(Line 6b)
Less: Waivers	(Line 5h)
Less: Transfers Out to Medicare Contractor(s)	(Line 5c)
Less: Transfers Out to CNC	(Line 6c)
Less: Transfers Out to CMS Locations	(Line 5e & 5g)

Equals:Total Receivables Available to be Collected

. Determine Rate of Collections

Line 4a Collections plus Line 4b Offsets divided by Total Receivables Available to be Collected (number calculated from Step A) multiplied times 100 determines the rate of collections percentage.

C. Determine the Allowance Rate.

1.00 minus the percentage determined from Step B, equals the allowance rate

D. Average the percentage calculated in Step C with a 5-year historical allowance rate (if available, if not available, maintain statistical data to develop historical rate, and go proceed to step E).

E. Calculate the Allowance

Multiply the ending balance (Line 7 of the From CMS-751B) by the allowance rate from Step C or Step D.

Each Medicare contractor must complete the allowance for uncollectible account matrix on March 31 and September 30 of each year. In addition, this matrix is to be mailed to CMS CO. Supporting documentation must include assumptions used to calculate the

allowance for uncollectible accounts and should be available for review by CMS, OIG, GAO or other parties as required.

400.15 - Exhibit 15 - Protocol for Prorating Intermediary Time Account Balances Between Form CMS-H750A (HI) and Form CMS-H750B (SMI)

(Rev. 5, 08-30-02)

A1-1960.15, B1-4960.15

Protocol for Prorating Intermediary Time Account Balances Between Form CMS-H750A (HI) and Form CMS-H750B (SMI)

The contractor selects a representative sample of checks and EFT payments issued and determines the ratio of the number of HI checks/EFT payments to the number of SMI checks/EFT payments. Checks or EFT payments for both HI and SMI will be split 50-50. It uses this ratio to prorate the time account balance for the financial reports.

400.16 - Exhibit 16 - Electronic Certification

(Rev. 5, 08-30-02)

A1-1960.16, B1-4960.16

Electronic Certification

The Electronic Certification process requires that the Chief Financial Officer (CFO) enter their password in the certifying official's current password field on the remarks page of Form CMS-H750A/B and Form CMS-H751A/B. When the password is keyed in, the CFO's name and title will appear on the document, and allow the document to be submitted electronically through the CAFM. For security purposes, the new password field is present to allow the certifying official to change the password assigned by CMS to one only the CFO knows.

Two people are required to submit a certified report. The preparer may input the financial data, but cannot certify the reports. The CFO may not input data. The preparer must retrieve the report in order to allow certification.

1. From the CAFM Main Menu select option 2 - Data Entry
2. Select the type of report to certify
3. From the Data Entry Menu select option 5 - Update Remarks
4. Select the package (report) to certify
5. Enter the certifying official's current password

If there are no serious errors (use PF6 SHOW ERRS to show errors), the contractor may submit the report (use PF2 SUBMIT to submit the report) and it will be accepted.

If the contractor is working in a worksheet and decides to certify and submit the report, it may either use the function keys (PF7 PAGE- and PF8 PAGE+), enter FREM (find remarks) on the transporter line or use the jump key (PF9 JUMP) to go to the remarks page.

The contractor must re-enter its password if it reviews any portion of the report after certification and prior to submission even if no changes are made. CAFM will not store the contractor’s password.

400.17 - Exhibit 17 - Instructions for the Transfer of Debt Between Reporting Entities

(Rev. 5, 08-30-02)

A1-1960.17, B1-4960.10

Instructions for the Transfer of Debt Between Reporting Entities

CMS continues to receive criticism from the OIG and its financial statement auditors for being inconsistent in methods of transferring accounts receivable cases to and from Medicare contractors, and other CMS locations. This criticism is a direct result of the lack of a formalized process and specific instructions for transferring accounts receivable cases between reporting entities.

For financial reporting purposes, the term "referred" is used when a case is not physically sent to the receiving entity for collection purposes. In a "referral" situation, the receiving entity merely "advises and/or assists" the referring entity on what actions to take next with respect to the debt. The responsibility to collect and report the accounts receivable remains with the referring entity and must be reported as part of the ending accounts receivable balance on their Form CMS-H751A/B, Status of Accounts Receivable report.

A "transfer" results when a copy of the up-to-date overpayment case file is physically "transferred" to another reporting entity, i.e., the RO, CO or another Medicare contractor. Along with the case file, the transferring entity must attach a "**Transfer Request and Notification of Acceptance**" form (see Exhibit 17, Attachment I for intermediaries (parts A and B transfers and Attachment II for carriers). This form will serve as both: 1) the transferring entity's request to transfer the case(s), and 2) the receiving entity's notification of acceptance of the transfer.

The transferring entity must complete the form and sign Line 1. The form summarizes the case(s) requiring transfer approval. No entry will be made on Form CMS-751A/B at this time. Upon receipt of the form, the entity receiving the request will sign Line 2 of the form and forward a copy of the form back to the transferring entity. This will notify the transferring entity of the receipt of the request. The receiving entity will process the request within 30 days of receipt of the transfer, and will return a copy of the Transfer Request and Notification of Acceptance form indicating the case(s) approved for transfer by signing Line 3 of the form.

Only upon receipt of the form signed by the receiving entity, will the transferring entity update its internal systems to reflect the transfer of the accounts receivable to the receiving entity. The transferring entity will reflect the dollar amount of the case(s) approved for transfer on the appropriate transfers out line of Form CMS-H751A/B (Line 5c, Transfers Out to Other Medicare Contractors; Line 5e, Transfers Out to Other CMS Locations, POR/PSOR; Line 5g, Transfers Out to Other CMS Locations, Not on POR/PSOR). Also upon receipt of the form, the transferring entity must sign Line 4 and

forward a copy to the receiving entity to acknowledge receipt of the formal approval for transfer.

Exhibit 17 (Cont.)

The receiving entity will update all internal systems, as well as the POR/PSOR to reflect the transfer. The location or Medicare contractor number must also be updated in the POR/PSOR system to reflect the transfer. In addition, the receiving entity will reflect the dollar amount of the case(s) approved for transfer on the appropriate transfers in line of Form CMS-H751A/B (Line 5b, Transfers In from Other Medicare Contractors; Line 5d, Transfers In From Other CMS Locations, POR/PSOR; Line 5f, Transfers In from Other CMS Locations, Not POR/PSOR).

Prior to submission of the quarterly Form CMS-H750/751A/B, reporting entities must reconcile the transfers in and transfers out lines to ensure **approved transfers** are only being reported. In addition to the requirement to maintain detailed transaction level documentation to support these lines, reporting entities must also retain copies of the signed Transfer Request and Notification of Acceptance forms.

Exhibit 17, Attachment I

TRANSFER REQUEST AND NOTIFICATION OF ACCEPTANCE FORM
INTERMEDIARY PART A OR PART B - ACCOUNTS RECEIVABLE (Indicate whether HI or SMI)

Provider Name	Provider Number	Cost Report Period	Overpayment Determination Date	Original Amount	Outstanding Principal Balance	Outstanding Interest Balance	Acceptance Of Transfer Yes/No	Reason for Rejection

Line 1:Requesting/Transferring Entity Official:___(Signature required) Total Dollar Amount Requested for Transfer: $_____
Title:_____
Telephone:_____ Date Requested:_____

Line 2: Acknowledgement of Receipt of___(Signature required)__(Date received)___
Request Form

Line 3: Approving/Receiving Entity Official:___(Signature required) Total Dollar Amount Approved for Transfer: $_____
Title:_____
Telephone:_____ Date Approved:_____

Line 4: Acknowledgement of Receipt of ___(Signature required)___(Date received)___
Approved Form

Exhibit 17 - Attachment II

TRANSFER REQUEST & NOTIFICATION OF ACCEPTANCE FORM
CARRIER ACCOUNTS RECEIVABLE

Provider Name	Provider Number	Claim Number	Claim Paid Date	Overpayment Determination Date	Original Amount	Outstanding Principal Balance	Outstanding Interest Balance	Acceptance Of Transfer Yes/No	Reason for Rejection

Line 1:Requesting/Transferring Entity Official:___(Signature required) Total Dollar Amount Requested for Transfer: $_____
Title:_____
Telephone:_____ Date Requested:_____

Line 2: Acknowledgement of Receipt of___(Signature required)__(Date received)___
Request Form

Line 3: Approving/Receiving Entity Official:___(Signature required) Total Dollar Amount Approved for Transfer: $_____
Title:_____
Telephone:_____ Date Approved:_____

Line 4: Acknowledgement of Receipt of ___(Signature required)___(Date received)___
Approved Form

400.18 - Exhibit 18 - Collection Reconciliation/Acknowledgement Form

(Rev. 5, 08-30-02)

A1-1960.18, B1-4960.11

Collection Reconciliation/Acknowledgement Form

There are instances where one reporting entity has received and deposited cash/check/offset/electronic funds transfers (EFTs) for a receivable that is being reported by another entity. In this situation, **accounts receivable cases will not be transferred to the location where the deposit of the money is made**. To ensure proper matching and application of the collection of monies to the outstanding receivable, the "Collection Reconciliation/Acknowledgement" form must be completed. This form must be completed by the entity (Medicare contractor, CMS RO or CO) receiving a collection for an accounts receivable that is currently being reported on the financial reports (Forms CMS -H751A/B-CMS-R751A/B) of another entity.

Medicare contractors are required to ensure that internal controls are in place over the cash/check receipts process to ensure adequate accounting, recording and custody of Medicare assets.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at Another Medicare Contractor Location (applies to Non-Medicare Secondary Payer (MSP) accounts receivables and MSP accounts receivables)

If a Medicare contractor collects a debt on behalf of another Medicare contractor, whether the receipt was solicited or unsolicited, then the collection must be forwarded to the Medicare contractor that has the accounts receivable. In these instances, the Medicare contractor receiving the collection would deposit the collection and re-issue that amount to the Medicare contractor that is reporting the accounts receivable. The Medicare contractor reissuing the check should ensure that proper segregation of duties exist over the check re-issuance (e.g., that the preparer is different from the check authorizer).

The re-issued check must be made payable to "Medicare." In addition, the check must be accompanied by a completed Collection Reconciliation/Acknowledgement Form (see MIM §1960.18 and MCM §4960.11), any correspondence received, and a copy of the original check including the postmark date. The CFO for Medicare Operations for the Medicare contractor reporting the accounts receivable should be contacted and informed of the pending check. A listing of CFO contacts has been issued to each Medicare contractor CFO. The deposit and re-issuance of the collection will only affect the CMS-H750A/B of the Medicare contractor that received the collection. The Collection Reconciliation/Acknowledgement Form will allow for tracking of the payment.

Upon receipt of the check and Collection Reconciliation/Acknowledgement Form, the Medicare contractor reporting the receivable will apply its normal cash receipt procedures. However, a signed copy of the Collection Reconciliation/Acknowledgement Form must be returned to the Medicare contractor that sent the collection.

MSP additional information: Medicare contractors should follow the deposit and re-issue process whenever another Medicare contractor has the account receivable or another Medicare contractor is or should be the lead Medicare contractor. If there is no account receivable established but Medicare contractor X is the lead and Medicare contractor Y receives payment, Medicare contractor Y should follow the deposit/re-issue process. If there is no lead established and Medicare contractor Y receives payment, Medicare contractor Y should do an electronic referral via the Electronic Correspondence Referral System (ECRS) and follow the deposit/re-issue process if another Medicare contractor is assigned lead. This rule should be followed even if the non-lead Medicare contractor has an interest and/or has paid some of the claims at issue.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at a CMS Regional Office Location (applies to Non-MSP accounts receivables and MSP accounts receivables)

If a Medicare contractor collects a debt on behalf of a CMS RO location, whether the receipt was solicited or unsolicited, then the account receivable balance must be transferred to the Medicare contractor that received the collection. In these instances, the Medicare contractor receiving the collection would initiate the process by completing the Collection Reconciliation/Acknowledgement Form and sending it to the CMS RO who is reporting the receivable to notify them of the collection. The Medicare contractor that received the collection would deposit any cash or checks received into unapplied receipts, which would be reported as a liability until the transfer is complete.

In turn, the CMS RO reporting the receivable will complete the Transfer Request and Notification of Acceptance Form (TRNA) described in §1960.17 of the MIM and §4960.10 of the MCM. (The use of the TRNA is also discussed in question number 68.) Once both parties sign the TRNA, the transfer is considered complete and the collection would then be applied to the account receivable. The CMS RO transferring the receivable would record the account receivable on Line 5c, Transfer Out to other Medicare Contractors. The Medicare contractor receiving the account receivable would record it on Line 5d/5f, Transfers In from other CMS Locations POR/PSOR or Not on POR/PSOR and the applicable collection on either Line 4a, Cash/Check Collections or Line 4b, Offset Collections.

Only in the instance where a **collection is made by offset** for an account receivable at a CMS RO location can notification of the offset be e-mailed. The e-mail must be retained for audit trail purposes. The e-mail notification must be followed-up with the actual Collection Reconciliation/Acknowledgement Form and the Transfer Request and Notification of Acceptance form with all the appropriate signatures. Furthermore, since offsets may only be identified after being applied, the offset transaction must be moved

manually on the Forms CMS-751A/B (i.e., the full amount of the accounts receivable prior to the offset must be shown as a transfer in and the amount of the offset must be captured on Line 4b, Offset Collection.) To assist in accounting for these offset transactions ONLY, Medicare contractors can prepare the Collection Reconciliation/Acknowledgement Form(s) on a monthly basis.

Treatment of Collections Made by A Medicare Contractor for an Account Receivable at CO

Non-MSP: If Medicare contractors receive collections on debt that is at the Debt Collection Center (DCC), and that debt is being reported by CO, the Medicare contractor must notify the CO by submitting the Collection Reconciliation/Acknowledgement form (refer to §1960.18 of the MIM and §4960.11 of the MCM). In addition, the receipt should be deposited into unapplied receipts until the actual account receivable is transferred back to the Medicare contractor.

Once CO receives the Collection Reconciliation/Acknowledgement form, it will perform the necessary steps to update the collection information in the Debt Collection System (DCS) and the Provider Overpayment Reporting (POR) system or the Physician/Supplier Overpayment Reporting (PSOR) system. CO will change the accounts receivable location code in DCS from "H," which means CO is reporting the account receivable to "C," which means the Medicare contractor is reporting the account receivable. CO will also update the POR/PSOR with the appropriate location code of "IDC," which means the fiscal intermediary at debt collection or "CDC," which means the carrier at debt collection (i.e., the debt has been forwarded to debt collection but the debt is still on the books of the fiscal intermediary or carrier). If a balance is remaining after posting the collection, the debt will remain at DCC for cross servicing/TOP.

To allow the Medicare contractors to properly apply the collection in their internal systems, CO will then transfer the receivable back to the Medicare contractor using the TRNA (refer to §1960.17 of the MIM and §4960.10 of the MCM). Upon CO receiving the signed TRNA from the Medicare contractor, CO will cease to report the receivable on its Form CMS-R751A/B. Once the TRNA has been signed and the receivable has been transferred, the Medicare contractor will record the transfer in of the receivable on Line 5d, Transfers In from other CMS Locations, POR/PSOR, or Line 5f, Transfers In from other CMS Locations, Not POR/PSOR. The receipt would then be applied to the account receivable and the collection would be recorded on Line 4a, Cash/Check Collections or Line 4b, Offset Collection on the appropriate Form CMS-H751A/B.

MSP: If Medicare contractor X has an account receivable other than a debt which has been referred to the Department of Health and Human Services (DHHS) Program Support Center (PSC) under the DCIA and the CO/RO receives payment, the Medicare contractor should use Line 4c, Collections Deposited at Another Location and footnote in the comments section of the Form CMS-M751A/B that the CO/RO received the payment. An example of this type of receipt would be coordination of benefits contractor misrouted checks.

Usage of the Collection Reconciliation/Acknowledgement Form

In the instance where a Medicare contractor, RO or CO receives a collection (whether cash, checks, offset or EFT) the entity receiving the collection must complete lines 1 through 10 of the form and attach all documentation showing the collection and the re-issued check, if applicable. In the instance where a RO receives cash/checks and does not maintain a Medicare bank account to deposit the funds received, the RO must complete lines 1 through 10 of the form and attach the cash/check. This form should be forwarded to the reporting entity no later than (15) fifteen days before the end of the quarter. The entity receiving the form and the check must sign the form on line 11 and forward a copy of the form to the official who signed line 10, no later than (15) fifteen days after receipt of the form. This will acknowledge the receipt of the form and the check.

Exhibit 18 (Cont.)

Collection Reconciliation/Acknowledgement Form

(1) Location of A/R_____(i.e., Medicare contractor, RO, or CO)

(2) Location of the Collection _____(i.e., Medicare contractor, RO, or CO. If RO Collection, indicate such even though actual deposit is made at Central Office)

(3) Region_____ Medicare contractor Name and Number_____

(4) Non-MSP Accounts Receivable
Provider/Physician/Supplier Number_____
Provider/Physician/Supplier Name_____
Provider/Physician/Supplier Name_____
Overpayment Determination Date_____
Claim Number_____ Claim Paid Date_____ or
Cost Report Year _____

MSP Accounts Receivable
Debtor Name _____
HIC # / Report ID _____
Determination Date _____
Beneficiary Name _____

(5) Was debt in CNC status prior to this collection: _____(Yes/No)

(6) Date of Collection (Postmark or Government Collection date)_____

(7) Type of Collection _____ (i.e., cash/check or offset)
Check Number or Government Collection Number
_____
Amount of Collection $_____
Amount Applied to Principal $_____
Amount Applied to Interest $_____

(8) Collection Reported in quarter ending_____

(9) A/R Reported in quarter ending_____

_____ _____

(10) Signature of Official at Location Where Collection is Reported

Phone #_____
Fax #_____

(11) Signature of Official at Location Where Reduction of A/R is Recorded

Phone #_____
Fax #_____

400.19 - Exhibit 19 - Instructions for Reporting Non-MSP Currently Not Collectible (CNC) Debt

(Rev. 5, 08-30-02)

A1-1960.19, B1-4960.19

Instructions for Reporting Non-MSP Currently Not Collectible (CNC) Debt

This debt will be categorized as "Currently Not Collectible" (CNC) debt. Debts that are recommended by the Medicare contractor to be "written-off closed," in accordance with established write-off policies and procedures, must first obtain approval from its' CMS's Regional Office (ROs).

CNC debt is not recognized as an accounts receivable for financial reporting purposes, because to do so would overstate the true economic value of the assets on the financial statements. While CNC debts are not accounts receivable reported on the financial statements, CNC debt remains eligible for collection including using the tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

The Department of Treasury and the Office of Management and Budget require that Agencies submit reports to them on financial management and performance data so that debt collection programs and policies can be evaluated. Thus, CMS requires Medicare contractors to report and monitor CNC debt on a quarterly basis. CMS Central Office (CO) will continue to review and approve debts for CNC status. CMS RO will also review and recommend approval of debts submitted by their Medicare contractors for CNC.

Quarterly Review of Debt for CNC Reclassification

CNC is defined as debts over two years old with no payment, recoupment, or offset activity within the past twelve months. CNC debts must be valid, legally enforceable, not in bankruptcy, appeal, or under fraud and abuse investigation, and the debtor cannot be deceased. These debts should remain as active debts in Medicare contractors' claims processing systems.

Fiscal Intermediary claims accounts receivables are also excluded from CNC reclassification and should remain on the contractors' books as active debt. On the other hand, Carrier claims accounts receivable will be considered for CNC status, and must meet the CNC definition referred to above for recommendation to CNC reclassification.

Debts recommended for "write-off closed" should be referred to the ROs under normal debt collection "write-off closed" and referral procedures. Debts previously approved for CNC reclassification which now exceed the six year statute of limitations for collection,

should also be recommended for "write-off closed" by the Medicare contractor. Debts cannot be reclassified to CNC or "write-off closed" in the Medicare contractors' internal systems until formal CMS approval has been received.

Medicare contractors must continuously review all debt and **quarterly** request approval to reclassify debts as CNC. Therefore, Medicare contractors are required to submit a report to RO Debt Collection Staffs **each quarter** containing all debts that are being recommended for CNC reclassification. RO Debt Collection Staffs will review these reports for completeness and forward them to the CO Debt Collection Branch for final review and approval by the CMS Claims Collection Officer. A Medicare contractor must submit a **negative report** if it does not have any debts eligible for CNC for the quarter. ROs are required to submit a package, including the reports of all Medicare contractors in its' region, to CO no later than 45 days after the end of each quarter. CO will return approved listings to the ROs within 30 days of receipt. Approved reports will be returned to the contractors through the ROs.

The Financial Workgroups for each shared system are encouraged to include this criteria when requesting systems changes for CNC debts. The Medicare contractor systems should produce a report that identifies debts meeting the CNC definition. Quarterly reports submitted to the RO requesting CNC approval must be reviewed and certified by the **Chief Financial Officer of Medicare Operations** at each Medicare contractor site. This report should include a concurrence line for the RO and CO Debt Collection Branch, and an approval line for the signature of the Claims Collection Officer. The Medicare contractor should update their internal systems to identify the approved CNC.

Each report must include the following information:

Fiscal Intermediary Overpayments:

- Medicare Contractor Name and Number;
- Medicare Contractor Contact Person/Phone/Fax;
- Medicare Contractor Mailing Address;
- Provider Name and Number;
- Cost Reporting Period;
- Overpayment Determination Date;
- Status Code;
- Overpayment Type;
- Original Amount of Debt;
- Balance Outstanding (principal and accrued interest listed separately);
- Date interest accrued through;
- Date of last payment, offset or recoupment;
- Debtor Tax Identification Number;
- Last Known Address Of Debtor; and
- Medicare Contractor's Recommendation: CNC or Closed.

Carrier Overpayments:

- Medicare Contractor Name and Number
- Medicare Contractor Contact Person/Phone/Fax;
- Medicare Contractor Mailing Address;
- Physician/Supplier Name and Number;
- Claim Number;
- Claim Paid Date;
- Overpayment Determination Date;
- Status Code;
- Source Code;
- Original Amount of Debt;
- Balance Outstanding (principal and accrued interest listed separately);
- Date interest accrued through;
- Date of last payment, offset or recoupment;
- Debtor Tax Identification Number;
- Last Known Address Of Debtor; and
- Medicare Contractor's Recommendation: CNC or Closed.

Reports requesting approval to reclassify debt as CNC must be submitted to the RO quarterly and no later than 30 days after the end of the quarter. (See Exhibit 19, Attachments I and II for examples of required reporting format). After formal CMS approval is received, Medicare contractors are responsible for updating the new status of the debt in their internal systems, as well as the Provider Overpayment Reporting (POR) system and the Physician/Supplier Overpayment Reporting (PSOR) system. The update must be performed within ten calendar days from the receipt of the approval.

Financial Reporting

All transaction level detailed documentation concerning any adjustments, write-off closed, CNC, etc. must be retained for the Office of Inspector General (OIG) or any other internal or external review organization, in accordance with record retention procedures outlined in the Medicare Intermediary Manual. This detailed documentation must be readily available for review upon request by CMS, OIG and/or the General Accounting Office.

Medicare contractors are reminded that debts that are reclassified to CNC may still be collected. Thus, memorandum entries of CNC debt must be maintained within the Medicare contractor shared systems in the event a collection occurs. The Medicare contractor's recoupment/offset flags in the shared system must remain in effect even after the debt is reclassified as CNC. Again, transaction level detail documentation to support each line item balance of CNC debt reported on Form CMS-C751A/B is required to be maintained to ensure that CMS and its Medicare contractors have supportable balances.

Debts that have received approval for CNC reclassification must be reported in the following manner:

1. On Form CMS-H751A/B, the amount reclassified as CNC, including principal and interest, will be recorded on Line 6c, Transfers Out to CNC. This will reduce the ending balance reflected on Form CMS-H750A/B.

2. On Form CMS-H750A/B, the correct ending balance (now reduced by the CNC debt) will be reported on the appropriate line (i.e., Provider, Beneficiary or Physician/Supplier) in the asset section of the balance sheet. Accordingly, the Transfers Out to CNC amount reflected in the Expense portion of the income statement should be increased to reflect the value of principal debt reclassified as CNC; a reduction of revenue on the Transfers Out to CNC line should be recorded in the Revenue section of the income statement for the value of interest reclassified as CNC.

3. Debts which are reclassified as CNC, may still be collected. These debts should not be removed from internal accounting systems or the POR/PSOR. Memorandum entries should be maintained in the Medicare contractor systems, and if collection subsequently occurs, an upward adjustment for the full amount of the debt collected should be recorded on line 6b, Transfers In from CNC of Form CMS-H751A/B, and a simultaneous collection recorded on Line 4a, Cash/Check Collections or Line 4b, Offset Collections of Form CMS-H751A/B.

4. Amounts reclassified to CNC during each reporting period, and a cumulative amount for that fiscal year should be reported on Line 2a, New CNC Debt of Form CMS-C751A/B.

5. A CNC date field has been added in the POR/PSOR and additional status codes have been developed. Each debt approved for CNC must be updated with the status code "01". The current date must be entered in the CNC date field. The update must be performed within ten calendar days of identification as a CNC debt. Do not change the location code of the debt.

   Debts previously approved and updated to CNC status in the POR/PSOR may need to be reactivated as collections or events occur that will render the debt ineligible to remain in CNC status. These debts will be returned to active status. Status codes in the POR/PSOR have been developed that will show that the debt was previously CNC, but has now been returned to active status

   These codes will also be the same on the POR/PSOR, but will be preceded with a "0" (zero) and will be available at all location codes.

Exhibit 19 (Cont.)

Additional Status Codes for POR/PSOR:

01 CNC
02 Write-Off Closed
03 CNC - DCIA letter sent
04 Reactivate - Bankruptcy
05 Reactivate - Payment received
06 Reactivate - Appeal/Litigation/Fraud & Abuse Investigation
07 Reactivate - Compromise
08 Reactivate - Extended Repayment Agreement
09 CNC Debt - Written-Off Closed
00 Reactivate - Other (includes Debtor Deceased)

The "09" must be accompanied by a valid closed date. Cases with a status code of 09 (POR/PSOR), and a valid closed date will be rolled to a history file at the end of the quarter.

In addition to updating the POR with the appropriate status codes for the reactivation, the CNC date previously inputted should be removed. This can be performed in the POR by depressing the enter key at the update screen, tabbing to the CNC Date Field, entering all zeroes, and depressing the enter key a second time.

Medicare contractors must continue to accrue interest for debt that has been reclassified as CNC. Additionally, CMS recognizes that for those systems where interest is updated automatically, the interest submitted with a recommendation for CNC may differ from the interest shown in the Medicare contractor's system at the time the Medicare contractor receives approval for CNC. The CMS approval of the principal and interest recommended for CNC is sufficient support for the subsequent reclassification, including any increase in the interest, as long as the principal remains the same.

Exhibit 19, Attachment I - Intermediary Part A (Hospital Insurance)

Medicare Contractor Name and Number:
Medicare Contractor Contact Person/Phone/Fax:
Medicare Contractor Mailing Address:

Part A - HI

Provider Name	Provider Number	Cost Reporting Period	Overpayment Determination Date	Status Code	Overpay-ment Type	Original Amount of Debt	Outstanding Principal Balance	Outstanding Interest Balance	Interest Accrued Through Date	Date of Last Payment, Offset or Recoupment	Debtor Tax ID Number	Last Known Address of Debtor	Recommended: CNC or Closed

(Provide totals for each column if applicable)

Chief Financial Officer of Medicare Operations: (signature required)
Associate Regional Administrator/Division of Financial Management: (signature required)
CMS Debt Collection Branch Chief: (signature required) ___ Concur ___ Non Concur
CMS Claims Collection Officer Approval: (signature required)

Exhibit 19, Attachment II - Intermediary Part B (Supplementary Medical Insurance)

This is an exact duplicate of Attachment I, Part A - HI, except that the data entered is Part B data for intermediaries, and the form is identified as Part B.

Medicare Contractor Name and Number:
Medicare Contractor Contact Person/Phone/Fax:
Medicare Contractor Mailing Address:

Part B - SMI

Provider Name	Provider Number	Cost Reporting Period	Overpayment Determination Date	Status Code	Overpay-ment Type	Original Amount of Debt	Outstanding Principal Balance	Outstanding Interest Balance	Interest Accrued Through Date	Date of Last Payment, Offset or Recoupment	Debtor Tax ID Number	Last Known Address of Debtor	Recommended: CNC or Closed

(Provide totals for each column if applicable)

Chief Financial Officer of Medicare Operations: (signature required)
Associate Regional Administrator/Division of Financial Management: (signature required)
CMS Debt Collection Branch Chief: (signature required) ___ Concur ___ Non Concur
CMS Claims Collection Officer Approval: (signature required)

Exhibit 19, Attachment III - Carrier Part B (Supplementary Medical Insurance)

Medicare Contractor Name and Number:
Medicare Contractor Contact Person/Phone/Fax:
Medicare Contractor Mailing Address:

Part B - SMI

Physician/ supplier name	Physician/ supplier Number	Claim Number	Claim Paid Date	Overpayment Determination Date	Status Code	Overpay-ment Type	Original Amount of Debt	Outstanding Principal Balance	Outstanding Interest Balance	Interest Accrued Through Date	Date of Last Payment, Offset or Recoupment	Debtor Tax ID Number	Last Known Address of Debtor	Recommended: CNC or Closed

(Provide totals for each column if applicable)

Chief Financial Officer of Medicare Operations: (signature required)
Associate Regional Administrator/Division of Financial Management: (signature required)
CMS Debt Collection Branch Chief: (signature required) ___ Concur ___ Non Concur
CMS Claims Collection Officer Approval: (signature required)

400.20 - Exhibit 20 - Medicare Secondary Payer (MSP) - Procedures for Reporting MSP Currently Not Collectible (CNC) Debt

(Rev. 5, 08-30-02)

A1-1960.20, B1-4960.20

Medicare Secondary Payer (MSP) - Procedures for Reporting MSP Currently Not Collectible (CNC) Debt

As part of its effort to improve financial reporting, CMS has implemented the category of currently not collectible (CNC) for delinquent debt that is unlikely to be collected within a reasonable time frame. CMS's CNC policy provides that CNC debt will not be recognized as accounts receivable (A/R) for financial statement reporting purposes because to do so would overstate the true economic value of the assets on the financial statements. While CNC debts are not A/R reported on the financial statements, Medicare contractors must continue appropriate recovery efforts for these debts until they are recommended and approved by CMS for "write-off - closed." The CNC process permits and requires the use of tools of the Debt Collection Improvement Act (DCIA) of 1996.

Criteria for Selection

The criteria for selection for CNC and the specific instructions for implementation of this category are different for MSP A/R and non-MSP A/R due to the differing characteristics of MSP and non-MSP debt. All MSP A/R that are 180 days delinquent must be recommended for CNC reclassification. The MSP A/R must be 180 days delinquent as of the last day of the quarter prior to the quarter in which the CNC recommendation is submitted for RO approval. "All MSP A/R" means all, without regard to whether the debt is Group Health Plan (GHP) based or liability/no-fault/workers' compensation based and without regard to the type of debtor (employer, insurer, beneficiary, provider/supplier, etc.). Where the MSP recovery demand letter stated that the debt was due and payable 30 days from the date of the demand, the debt is delinquent on day 31 if it has not been paid in full or there is no valid documented defense for the unpaid amount. Where the MSP recovery demand letter stated that the debt was due and payable 60 days from the date of the demand, the debt is delinquent on day 61 if it has not been paid in full or there is no valid documented defense for the unpaid amount. Additionally, all MSP accounts receivable which are 180 days delinquent will be reclassified as CNC without regard to whether or not the debt is in bankruptcy, under fraud and abuse investigation, has an appeal pending at any level, or is in litigation/negotiation. A MSP debt's eligibility for DCIA referral to a Department of the Treasury designated Debt Collection Center for further collection efforts, including the Treasury Offset Program (TOP) has no bearing on or relationship to whether or not the debt should be reclassified as CNC.

Additional Considerations

If a Medicare contractor believes that a particular MSP A/R meets the criteria for both "write-off - closed" and CNC, the MSP A/R should be recommended for "write-off - closed."

These instructions supplement but do not supercede instructions for the category of "write-off - closed" for MSP debt. MSP debts on Form CMS-M751A/B report and MSP

debts which have been reclassified as CNC should be recommended for "write-off - closed" if they meet the criteria for MSP "write-off - closed." The difference is that the final "write-off - closed" action for CNC debt will be reported on Form CMS-MC751A/B rather than on Form CMS-M751A/B.

These instructions only apply to established MSP A/R. They may **not** be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

Some Medicare contractors may still have old MSP-based provider/supplier (including physician) debt or MSP-based beneficiary debt which has not been reported on their Form CMS-M751A/B and which has been referred to the RO under non-MSP rules or otherwise treated as a non-MSP receivable. Old MSP-based debt that has been treated as non-MSP debt (that is tracked and processed under non-MSP rules) should be treated as non-MSP debt for CNC purposes as well.

Medicare contractors may only recommend CNC for a MSP A/R which is being reported as part of their ending MSP A/R balance. MSP A/R that have been **transferred** to the ROs for referral to other agencies or entities such as the Department of Justice or Office of General Counsel will be addressed by the ROs. MSP A/R with CO locations will be addressed by CO. MSP A/R that have been **referred** to another location, without transfer, remain the responsibility of the Medicare contractor.

Medicare contractors may not recommend CNC for less than the full amount of an outstanding MSP debt. For GHP-based MSP A/R where the demand was issued to the employer, insurer, or third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand to a debtor for a particular beneficiary. For GHP Data Match (DM) recoveries, this would be all of the claims associated with a particular Mistaken Payment and Recovery Tracking System (MPaRTS) Report ID although a single cover letter might have been issued for multiple beneficiaries' Medicare reimbursed claims. For duplicate primary payment recovery demands to a provider/supplier (including physician), the debt includes all claims in the recovery demand regardless of the number of beneficiaries involved. For liability, no-fault, or workers' compensation, the debt includes all claims in the recovery demand.

Previously some Medicare contractors processed/tracked MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R as non-MSP A/R and did not include such A/R on their Form CMS-M751A/B report. Medicare contractors may no longer do this for new MSP A/R. Any pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R which are not reflected in the Medicare contractor's Form CMS-M751A/B report may not be recommended for MSP CNC. Pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R which have been tracked/processed, or otherwise treated as non-MSP debt should follow the rules for non-MSP CNC.

Medicare contractors must continue to accrue interest for debt that has been reclassified as CNC. Additionally, CMS recognizes that for those systems where interest is updated automatically, the interest submitted with a recommendation for CNC may differ from the interest shown in the Medicare contractor's system at the time the Medicare contractor receives approval for CNC. The CMS approval of the principal and interest recommended for CNC is sufficient support for the subsequent reclassification, including any increase in the interest, as long as the principal remains the same.

Medicare contractor systems must be able to maintain transaction level detail of debt that has been reclassified as CNC to enable future collection activities and to maintain a proper audit trail.

Data requirements and format for recommendations for CNC:

MSP A/R recommended for CNC require the submission of the following information to the Medicare contractor's RO MSP coordinator: (see Exhibit 20, Attachment I for the recommended format)

- Medicare contractor name and number.
- Medicare contractor mailing address.
- Medicare contractor contact person/phone number/fax number/e-mail address.
- Type of MSP Debt (GHP or non-GHP (this includes liability, no-fault, and workers' compensation)).
- Beneficiary Health Insurance Claim Number (HICN).
- Beneficiary name.
- Name of debtor.
- Name of insurer **for GHP based debts** where the current debtor is the insurer/employer/third party administrator/GHP/other plan sponsor.
- Type of debtor (A=insurer/employer/third party administrator/GHP/other plan sponsor; B=provider/supplier(including physicians); C=beneficiary, D=other (must specify)).
- Date of initial recovery demand letter to current debtor.
- Original A/R amount for the current debtor.
- Existing A/R amount (principal and interest listed separately, as well as a total amount for principal plus interest; HI/SMI must also be listed and reported separately).
- Date of last payment, collection, recoupment, offset, or adjustment activity (provide date or "none")
- Tax Identification Number (TIN) for debtor. The TIN is the Employer Identification Number (EIN) or Social Security Number (SSN).

NOTE: The debtor is the individual or entity to whom the last recovery demand was issued. Where the demand was issued to an individual in their capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in their own right, the debtor is the attorney or other representative.

The above listed data elements are mandatory for CNC for all MSP A/R established October 1, 2000 or later. It is also mandatory for all MSP A/R with a recovery demand date of October 1, 2000, or later, regardless of when the MSP A/R was established. For CNC recommendations for MSP A/R established prior to October 1, 2000, Medicare contractors may submit recommendations without the following data elements if the CNC recommendation certifies that these data elements are not readily available: Beneficiary name and HIC number where the beneficiary is not the debtor; Insurer name where the insurer is not the debtor; and Type of debtor.

If a Medicare contractor has bulk MSP A/Rs on the GTE system for older Data Match and non-Data Match GHP debt, the contractor - for these MSP A/R only - must: 1) Identify the A/R as a bulk receivable on the GTE system, 2) Identify the insurer, 3) Identify the date of the demand, and 4) Identify the associated dollar amounts for principal and interest. Any contractor who created bulk receivables for GHP-based MSP debt using any system other than GTE must contact their RO for assistance. The RO will, in turn, discuss the issue with CO.

Each listing must contain a written certification that all of the required criteria/considerations for CNC are met.

Recommendations must be signed by the CFO of Medicare Operations. The CFO's signature constitutes his/her certification to all information/statements contained in the recommendation.

CNC Approval Process

Recommendations for the approval of CNC should be sent to your RO MSP Coordinator electronically and by hard copy no later than the first day of the second month of each quarter (November 1, February 1, May 1, and August 1). Hard copies should be dated and mailed the same day as the electronic transmission. The hard copy must be signed by the CFO of Medicare Operations. Include a preprinted address label with the hard copy for the return of approved CNC recommendations.

ROs are responsible for approval or denial of all recommendations for CNC based upon the criteria set forth in these instructions. RO approval will be by the Assistant Regional Administrator (ARA) for Financial Management. ROs will complete their review of the Medicare contractors' recommended CNC and return their approval or denial of such reclassifications by the first of the last month of each quarter (December 1, March 1, June 1, and September 1). ROs may return an electronic copy annotated to show approval or denial by the RO ARA for Financial Management in order to meet the required time frame for approval, but this will be followed by a hard copy which was signed and dated by the ARA for Financial Management. (ROs will also send copies of the signed RO approval or denial each quarter to CMS CO to the attention of: 1) Chief, MSP Operations Branch, Division of Financial Integrity, Office of Financial Management; and 2) Chief, Financial Reporting and Oversight Branch, Division of Accounting, Office of Financial Management).

The CNC action should not be taken nor should any changes be made to the MSP A/R on any systems (Medicare contractor systems or other systems which Medicare contractors have responsibility for updating) for CNC until the recommendation for CNC has been processed by CMS, approved in writing, and returned to the Medicare contractor. The listing of approved CNC will be returned to the contractors by the ROs. Receipt of this approval authorizes the Medicare contractor to reclassify the MSP A/R, and update the MSP A/R and associated case in all appropriate systems. Where the RO does not approve a recommended CNC for a particular debt, the RO will annotate this clearly on the returned form. This information will be clearly shown on both the advance electronic copy of the approval, as well as the hard copy signed by the ARA for Financial Management. When the MSP A/R is reclassified as CNC, the associated case file must be annotated to show that a particular MSP A/R was reclassified as CNC and the

date/quarter of the action. Reclassification as CNC **does not** close the associated case. MPaRTS (Mistaken Payment and Recovery Tracking System) does not need to be updated for Data Match debt when the MSP A/R is reclassified as CNC.

The CMS approval of MSP A/R reclassified as CNC must be retained and available upon request (from the Office of the Inspector General or any other internal or external review organization) in accordance with retention procedures in the Medicare Intermediary and Carrier Manuals. Medicare contractors are also reminded that under the Department of Justice's requested records freeze, all records must be retained indefinitely. This CMS approval must also be annotated by the Medicare contractor to indicate the date/quarter when the MSP A/R was reclassified.

Exhibit 20 - Attachment I

MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC

Medicare Contractor Name and Number:
Medicare Contractor Contact Person/Phone/Fax/E-mail Address:
Medicare Contractor Mailing Address:

Part A-HI, or Part B-SMI - as applicable (show which)
Intermediaries report Part A and/or Part B
Carriers report Part B only

Type of MSP Debt	Bene. HICN	Bene. Name	Debtor Name	Debtor Type	Date of Initial Demand	Original AR Amount	Current Principal Balance (HI)	Current Interest Balance (HI)	Current Principal Balance (SMI)	Current Interest Balance (SMI)	Total Principal and Interest	Date of Last Payment, Offset, Recoup. Or Adjustment	TIN of Current Debtor

(Provide totals for each column if applicable)

CFO of Medicare Operations:_____ (signature required)
(Signature constitutes certification that all CMS specified criteria for CNC reclassification are met.)

Associate Regional Administrator/Division of Financial Management: (signature required) ___ Concur ___NonConcur

Date of Referral to RO : _____
Date of RO decision: _____
Date/quarter when approved MSP A/R were reclassified as CNC: _____

Attachment II

This is an exact duplicate of Attachment 1, "MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC" for Part B Intermediary Claim Activity. The heading at the top of the spreadsheet is "Part B of A" - SMI, instead of "Part A - HI." Intermediaries report their SMI data on this report.

Attachment II

This is an exact duplicate of Attachment 1, "MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC" for Part B Intermediary Claim Activity. The heading at the top of the spreadsheet is "Part B" - SMI, instead of "Part A - HI." Carriers report their SMI data on this report.

400.21 - Exhibit 21 - CMS Policy for Recognizing Accounts Receivable

A1-1960.21, B1-4960.21

CMS Policy for Recognizing Accounts Receivable

Overview

The majority of the Medicare accounts receivable balances reported by CMS in its financial statements are comprised of overpayments made to providers, physicians, suppliers, beneficiaries, insurers, employers and other entities. The primary responsibility for identifying, recording, collecting, and reporting overpayments lies with CMS's Medicare contractors. CMS defines an "overpayment" as Medicare funds that a provider, physician/supplier, beneficiary, insurer, employer, or other entity has received in excess of amounts due and payable under the Medicare statute and regulations. Once a determination of an overpayment has been made, the amount so determined is a debt that is owed to the Medicare program. For financial reporting purposes, this overpayment or debt must be recognized as an accounts receivable and reported as an asset in CMS's financial statements.

CMS has adopted the financial reporting definition for the recognition of an accounts receivable set forth by the Federal Accounting Standards Advisory Board (FASAB). The FASAB recommends generally accepted accounting standards and principles for the Federal Government. The FASAB sets these standards and principles so that Federal agencies' financial reports include understandable, relevant, and reliable information about the financial position, activities, and results of operations of the United States government and its component units.

According to the FASAB's Statement on Federal Financial Accounting Standard Number 1 (SFFAS No.1), "Accounting for Selected Assets and Liabilities,"

> "Accounts receivables are amounts that an entity claims for payment from others. They arise from claims to cash or other assets." Additionally, the FASAB recommends, "A receivable should be recognized when a Federal entity establishes a claim to cash or other assets against other entities, either based on legal provisions, such as a payment due date (e.g., taxes not received by the date they are due), or goods or services provided. If the exact amount is unknown, a reasonable estimate should be made."

For financial reporting purposes, recognition means the process of formally recording an item into the financial statements of an entity as an asset, liability, revenue, expense, or the like. In the case of Medicare contractors, recognition would equate to recording the accounts receivable on Form CMS-H750A/B and Form CMS-H751A/B Contractor Financial Reports.

Recognition Policy

CMS and its Medicare contractors will recognize and report an accounts receivable as of the date a demand letter is sent to the debtor. Specifically, contractors will recognize and record an accounts receivable (Non-Medicare Secondary Payer (MSP) and MSP overpayments) as of the date of the demand letter on Line 2a, New Receivables of Form CMS-H751A/B Status of Accounts Receivable Report. The act of sending out the demand letter is the event that triggers the recognition of an accounts receivable. The purpose of the demand letter is to notify the debtor of the existence of the overpayment, and to request payment. Chapter 4, Debt Collection, §§10 and 130 outline the language and information that, at a minimum, a demand letter must contain. A demand letter must contain the name and address of the debtor, the amount of the overpayment, terms of how interest will be assessed, date when repayment is due, and the debtor's rights to appeal. All these items are consistent with the definition recommended by the FASAB as outlined above.

It is important for Medicare contractors to ensure that they retain copies of a demand letter(s) sent. The demand letter provides documentation or evidence of the actual debt and recovery efforts taken. It must be kept in each case file with other associated case documents or correspondence if the case is referred to the Department of Justice; referred for debt cross-servicing; requested by CMS, Office of Inspector General (OIG) or General Accounting Office (GAO) during audits/reviews. This information is necessary and needed to support the debt.

Unless otherwise specifically noted, this policy is applicable to both non-MSP and MSP overpayments. The following are specific circumstances where application of this policy will not apply, i.e., when an accounts receivable would be recognized even though a demand letter has not been issued or, vice versa, where sending a demand letter would not necessarily require the recognition of an accounts receivable.

- Accounts Receivables Due to Unfiled Cost Reports; and
- Consent Settlement Agreements.

These two circumstances are not all inclusive. If there is a specific situation that is not described above, Medicare contractors should consult CMS for further guidance.

Accounts Receivable Due to Unfiled Cost Reports

Through analysis of Federal financial accounting standards and regulations, CMS believes that recognition of a receivable prior to the filing of a cost report significantly overstates net assets and ultimately net position. Furthermore, CMS believes that current accounting procedures for recognizing accounts receivables due to a provider's failure to file a cost report timely does not adhere to the accounting principles articulated in Statement of Federal Financial Accounting Standards Number (SFFAS No.) 1 - Accounting for Selected Assets and Liabilities, SFFAS No. 5 - Accounting for Liabilities of the Federal Government, and SFFAS No. 7 - Nonexchange Revenue (Measurement & Recognition), as well as Generally Accepted Accounting Principles (GAAP) of

conservatism and matching. Based on this analysis, the failure to file a cost report does not complete the earnings process, and accordingly, no accounting event has occurred. As such, the recognition of a receivable prior to the completion of the earnings process (receipt or filing of a cost report) is poor matching. In addition, SFFAS Nos. 5 and 7 states that liabilities and nonexchange revenue should only be recognized when a past event or exchange transaction has occurred, use of resources (inflow or outflow) are probable and can be reasonably estimated or measured. Without the actual submission of the cost report, CMS cannot reasonably estimate the amount of the receivable, as required by SFFAS No. 1.

Therefore, unfiled cost report receivables will no longer be reported on the Form CMS-H750 Contractor Financial Report and Form CMS-H751, Status of Accounts Receivable Report. CMS's current financial reporting instructions require Medicare fiscal intermediaries to place providers who have not filed a timely cost report on 100 percent penalty withhold, and recognize and demand a receivable based on the value of all interim payments made to the provider in, and subsequent to, the cost reporting period, without considering the value of actual services performed during that period. Federal debt collection regulations allow CMS to demand repayment of the full amount paid to a provider during a cost reporting period if a provider fails to comply with the requirements to file a cost report in a timely manner. However, for financial reporting purposes, CMS recognizes that the entire amount being demanded does not truly represent funds owed to CMS. Since the provider has performed services, the true economic value of the receivable demanded is overstated. In fact, CMS may have a liability upon settlement. Cost report receivables should not be accrued until related cost reports are received, and CMS can support the existence of a receivable through provider agreement, such as filing a cost report, filing a cost report without sufficient payment, or a court ruling in favor of CMS.

As a result, for financial reporting purposes, CMS is revising its policy for reporting unfiled cost reports as an accounts receivable, unless the fiscal intermediary is aware of a unique situation where recording an accounts receivable would be appropriate. Fiscal intermediaries will continue to reflect an overpayment on the Provider Overpayment Reporting (POR) system based on the value of all interim payments made to the provider in, and subsequent to, the cost reporting period.

However, **effective for the March 31, 2001 reporting period, accounts receivable for unfiled cost reports will no longer be reported on Form CMS-H750 and Form CMS-H751.** CMS will continue to monitor and manage the status of unfiled cost reports through the POR system, without overstating accounts receivable on the financial statements. All other processes related to unfiled cost reports remain unchanged. Fiscal intermediaries must continue to: (1) Place the providers on 100 percent penalty withhold, (2) Demand the submission of delinquent cost reports from providers based on current debt collection regulations, and (3) Refer the debt in accordance with the requirements of the Debt Collection Improvement Act of 1996.

Fiscal intermediaries must ensure that Line 7, Ending Balance, of Form CMS-H751 does not include any receivables due to unfiled cost reports. If accounts receivables due to unfiled cost reports were included in the December 31, 2000 Form CMS-H751, these receivables must be zeroed out by recording a downward adjustment for these amounts on Line 5a, Reclassified/Adjustments, on Form CMS-H751 and provide a specific footnote in the remarks section of the report identifying the nature and amount of the adjustment.

Consent Settlement Agreements Resulting from Comprehensive Medical Reviews (CMRs)

Typically, postpayment reviews of claims are conducted for a specified provider/physician/supplier or group in order to evaluate their billing patterns over a selected period of time. CMRs are performed to determine whether a suspected provider/physician/supplier or groups are providing noncovered or medically unnecessary services. A CMR is a thorough analysis of a sample of processed claims and all pertinent data (such as medical record, beneficiary payment history, etc.) for selected providers/physicians/suppliers for a specified time period. CMRs are usually targeted to providers/physicians/suppliers who have demonstrated aberrant billing and/or practice patterns.

If a CMR determines that an incorrect amount of money has been paid to the provider/physician/supplier, the contractor must assess an overpayment based on instructions outlined in the contractor manuals. Per Chapter 3, Overpayments, there are three different types of overpayments that result from a CMR: Actual overpayment, projected overpayment, and limited projected overpayment. The type of sample used during a CMR determines how Medicare contractors are to assess and demand money back from the provider or physician/supplier who was overpaid.

An actual overpayment is, for the actual claims reviewed, the sum of the payments (based on the amount paid to the provider/physician/supplier and Medicare approved amounts) made to a provider/physician/supplier for services which were determined to be not medically necessary or incorrectly billed. If an actual overpayment is assessed, Medicare contractors must send a demand letter for the amount of the actual overpayment and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

A projected overpayment is defined as the numeric overpayment obtained by projecting an overpayment from a statistically valid random sample (SVRS) to all similar claims in the universe under review. Medicare contractors must notify the provider or physician/supplier of the overpayment, and refer the case to the Medicare contractor's overpayment staff to demand and collect the overpayment. Medicare contractors must send a demand letter for the amount of the projected overpayment and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

A limited projected overpayment is the numeric overpayment obtained by projecting an overpayment from a limited sample or limited SVRS subsample to all similar claims in

the universe under review. If this type of overpayment is assessed, Medicare contractors have three overpayment assessment options. The Medicare contractor can assess an actual overpayment; a projected overpayment based on a SVRS by performing an expanded CMR; or can offer the provider or physician/supplier a consent settlement based on the potential projected overpayment amount. Again, if an actual or project overpayment is assessed, Medicare contractors must send a demand letter, and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

If a consent settlement is offered to the debtor, the consent settlement document must carefully explain what rights a debtor waives by accepting the consent settlement. It must contain a binding statement that a debtor agrees to waive any rights to appeal the decision regarding the potential overpayment determination. If this option is used, the Medicare contractors **must not** recognize an account receivable until a consent settlement is signed and agreed to by the debtor and CMS.

400.22 - Exhibit 22 - Accounts Receivable Trending Analysis Procedures

A1-1960.22, B1-4960.15

The Centers for Medicare & Medicaid Services (CMS) utilizes contractors to manage and administer the fee-for-service portion of the Medicare program. Medicare contractor financial reports provide a method of reporting financial activities by the contractors as required by the Chief Financial Officers (CFO) Act of 1990. The Medicare contractors are required to maintain accounting records in accordance with federal government accounting principles and applicable government laws and regulations and are required to use double entry bookkeeping and accrual basis accounting. The financial reports are due 21 calendar days after the end of each quarter via the Contractor Administrative and Financial Management (CAFM) system.

The financial reports consist of a Statement of Financial Position (Form CMS-750) and a Status of Accounts Receivable (Form CMS-751). The system accumulates and reports by each trust fund, as there are separate reports for Part A Hospital Insurance (HI) and Part B Supplementary Medical Insurance (SMI). The accounts receivable activity is reported for the fiscal year-to-date for the period of the report. Medicare Secondary Payer (MSP) accounts receivable activity is reported on Form CMS-M751 report. This activity is combined with the Non-Medicare Secondary Payer (Non-MSP) accounts receivable activity on Form CMS-H751. There is no separate Form CMS-751 report for Non-MSP accounts receivable.

Account receivables represent amounts owed by health care providers, insurers, third party administrators, beneficiaries, employers, and other government agencies. Medicare accounts receivable is comprised of various components with the balance derived from MSP and Non-MSP receivables, as well as miscellaneous amounts owed the program from various sources. On Form CMS-H750, the majority of HI Non-MSP accounts receivable balances consist of or are due to cost report settlements, claims accounts receivable, periodic interim payments (PIP) and other overpayments. The detailed activity for these components is included in Form CMS-H751 report. Also on Form CMS-H750 Status of Financial Position, HI MSP accounts receivable balances consist of receivables specific to Data Match, non-Data Match, liability (including workers compensation (WC), auto, no-fault) and MSP beneficiary debts. The detailed activity for these components is included in Form CMS-M751 report.

Contractors must maintain and make available lead schedules and detailed documentation to support all amounts reported.

Objective

To ensure that accounts receivable balances reported are reasonable, Medicare contractors are required to perform trending procedures. Trending procedures can be used as an important tool to identify potential errors, system weaknesses, or inappropriate patterns of accounts receivable accumulation, collections, transfers or write-offs.

Trending procedures involve comparisons of recorded amounts to expectations developed by the Medicare contractors. To properly apply trending procedures, it is necessary to take the following steps:

Compare Current Year Amounts with Comparative Financial Data

In comparing current-period financial results with prior-period financial results, there is an implied assumption that the volume of activity in the two periods is comparable. If there has been a substantial change in volume, it is necessary to take this change into account and to quantify the change, when making the comparisons. For example, if a contractor's accounts receivable balance has increased by 10 percent, it is necessary to determine and document the reason for the increase. The increase may be the result of transitions of providers, new legislation, etc.

Understand Identified Variances and Document the Results

Medicare contractors must identify and provide an explanation for variances that meets the thresholds outlined in these procedures. Typically, this will be accomplished primarily through inquiry of operations personnel in the Audit and Reimbursement, MSP, Medical Review, and other areas that report and track accounts receivable balances. If an explanation does not adequately describe the variance, the Medicare contractors must perform additional procedures such as review of detail transactions to identify the underlying cause(s) of any unusual changes.

The causes for the variances should be quantified. For example, if the change was mainly attributable to a contractor transition, then the total amount of receivables transitioned should be identified and included in the Medicare contractors' work papers.

Methodology

Trending & Comparative Analysis for Accounts Receivables

The primary emphasis for performing trend analysis is focusing on the change in the ending principal accounts receivable balance. The ending principal accounts receivable balance is comprised of Non-MSP and MSP accounts receivables. For FIs, the Non-MSP overpayments section consist of four major components (cost report settlements, PIP, claims accounts receivable, and credit balances). For carriers, the Non-MSP overpayment section consists of two main areas: 1) amounts owed from beneficiaries and 2) amounts owed from physicians/suppliers. These two areas consist of two major components (claims accounts receivable and credit balances). For both FIs and carriers, the MSP section consists of three major components (Data Match, non-Data Match, and liability (including WC, auto, no-fault)). In order to properly identify and understand variances, an analysis must be performed at the component level. **Although the instructions specify ending principal accounts receivable balance, Medicare contractors must have available an explanation of any significant change in the ending interest accounts receivable balance and any other sections of the Forms**

CMS-750/751 that meets the thresholds. The explanation should be available for review by CMS, Office of the Inspector General, General Accounting Office and /or other related parties.

Prior to the certification and submission of the Forms CMS-750/751 reports, each Medicare contractor must perform the following steps on a quarterly basis, beginning with the quarter ending June 30, 2002. **The CFO for Medicare Operations' certification of these reports is indicative that trending procedures have been performed.**

Accounts Receivable Trending Analysis Procedures

Step (1) Compare the current quarter Non-MSP overpayments section of Form CMS-H750A/B for FIs (Form CMS-H750B for carriers) component line items to the same component line items in the prior quarter (i.e. 06/30/02 versus 03/31/02) and the current quarter to the prior year's quarter (i.e. 06/30/02 versus 06/30/01). Calculate the dollar and percentage difference for each component line item. (See Attachments I & I-A for the required format)

NOTE: For FIs, due to the seasonal nature of the cost report settlements, PIP, etc., independent quarter activity in the current year should not be the only analysis compared to the preceding quarter. Comparisons should always be performed from current period year-to-date activity to prior period year-to-date activity for the same period of time (i.e. 06/30/01 versus 06/30/02)

Step (2) Compare the current quarter MSP section of Form CMS-H750A/B for FIs (Form CMS-H750B for carriers) component line items to the same component line items in the prior quarter and prior year. Calculate the dollar and percentage difference for each component line item. (See Attachments II & II-A for the required format)

Step (3) Verify that the dollar amount for each component line item is supported by lead schedules and/or detailed documentation. Any errors or misstatements identified as a result of this analysis must be corrected prior to the submission of Forms CMS-750/751 reports.

Step (4) The sum of the components for the Non-MSP overpayments sections (See Attachments I & I-A) plus the sum of the components for the MSP sections (See Attachments II & II-A) must equal the ending balances reported on Line 7, of Form CMS-H751A/B for FIs, (Form CMS-H751B for carriers) (See Attachments III & III-A) for the current and prior quarters. The sum of the components for the Non-MSP overpayments sections must equal the ending balances reported on Line 7, of Attachments IV and IV-A for the current and prior quarters. The sum of the components for the MSP sections must equal the ending balances reported on Line 7, of Form CMS-M751A/B for FIs (Form CMS-H751B for carriers) (See Attachments V & V-A) for the current

and prior quarters.

Step (5) Provide explanations for each component line item where the amount changed meets the threshold of +/-15 percent and the amount changed is +/- 5 percent of the components ending balance. (See Attachments I, I-A, II & II-A)

II - Supporting Analysis

Step (1) Ensure the current year beginning balance is the same amount as the prior year's ending balance and the beginning balance for the prior year's quarter is the same as the beginning balance of the final quarterly report for that FY (i.e., 06/30/01 and 09/30/01). Additionally, for the second through fourth quarter periods, ensure that the beginning balances are unchanged from the amount reported as the first quarter beginning balances.

Step (2) Compare the current quarter Form CMS-H751/M751 line items to the same line items in the prior quarter and prior year. Calculate the dollar and percentage difference for each line item for Section A of Form CMS-H751/M751. (See Attachments III & III-A)

NOTE: The Medicare contractors are not required to perform trending procedures or provide variance explanations on the line items of Forms CMS-H751/M751. However, the above steps should be used to assist the Medicare contractor in identifying the reasons for the variances identified in Attachments I, I-A, II & II-A.

Overall Summary

Step (1) Document conclusions in a summary memorandum (See Attachment VI) to be included with Attachments I, I-A, II & II-A and submit to the CFO for Medicare Operations for sign off approval.

For example, the Medicare contractor must identify any external and/or internal factors that attributed to the variances.

External factors might include (1) Medicare contractor transitions from the Medicare program, (2) seasonal variances such as provider year-ends, (3) new legislation impacting reimbursement policies, MSP policies, etc., (4) current economic conditions (provider termination, bankruptcy, extended repayment schedules, etc.).

Internal factors might include (1) turnover of key personnel, (2) changes in accounting guidance or CMS priorities/initiatives, (3) reporting system modifications, (4) number of contractor processing sites.

Step (2) A signed approved copy of the summary memorandum (See Attachment VI)

along with Attachments I, I-A, II & II-A will be submitted to the regional office for final approval.

NOTE: The summary memorandum (See Attachment VI) and the analysis schedules (Attachments I, I-A, II & II-A) will be reviewed and approved by the CFO for Medicare Operations and the region's Associate Regional Administrator, Division of Financial Management (ARA/DFM). The ARA/DFM will review the trend analysis submitted by the Medicare contractor and either approve or request additional explanation and/or documentation. The ARA/DFM must notify the Medicare contractor by phone, email or fax no later than February 15, May 15, August 15, and November 8 as to the approval/disapproval. The ARA/DFM must allow the Medicare contractor no less than two days (upon receipt of the request) to provide the additional documentation needed to support their variance. Upon receiving the request, the Medicare contractor has no more than four days to provide the additional documentation to the ARA/DFM. The ARA/DFM must contact the central office (CO) (by phone, email or fax) when a Medicare contractor has been notified to submit additional documentation and a date the trend analysis will be forwarded to the CO.

III. Due Date

The analysis must be submitted to each contractor's respective regional office on February 8, May 8, August 8, and November 1. The ARA/DFM must review and approve the Medicare contractors' submissions and forward them to CO by February 15, May 15, August 15, and November 8. If that date occurs on a holiday or a weekend, the report is due the following Federal workday. The Medicare contractor and the ARA/DFM may email or fax the analysis by the due dates and immediately follow up with a signed approved hard copy.

NOTE: The ARA will submit the signed approved copy of the Medicare contractors' summary memorandums and the analysis schedules to the Central Office, Division of Financial Oversight. The CO will review the summary memorandums and the analysis schedules. The CO **is not** responsible for approving or denying the Medicare contractors' trend analysis. The CO may request additional explanation and/or documentation to support the Medicare contractors' analysis schedules. The CO will notify the ARA/DFM (by phone, email or fax) when a request for any additional documentation is needed.

Attachment I - FI

Attachment I

CMS MEDICARE ACCOUNTS RECEIVABLE NON-MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750A
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	06/30/01	$ Change	% Change	Note
Cost Report Settlements	36,836,000	20,145,000	16,691,000	82.85%	(1)
Claims	3,517,000	3,827,500	(310,500)	-8.11%	NER
PIP	40,455,000	48,946,000	(8,491,000)	-17.35%	(2)
Credit Balance	170,000	155,700	14,300	9.18%	NER
Other	3,000,000	2,980,400	19,600	0.66%	NER
Total Non-MSP	83,978,000	76,054,600	7,923,400	10.42%	
5% of Combined Ending Balance	4,198,900	(83,978,000 x 5%)			

No Explanation Required (NER)

(1) Cost Report Settlements - The ending balance increased by approximately $17 million which is a combination of transfers in from XYZ in the amount $10 million of as well as an increase in cost report settlement activity of $7 million.

(2) PIP- The ending balance decreased primarily due to a system error in the prior year that caused the balance to be overstated by $8.0 million.

Note: Column A - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the prior year's quarter (06/30/01).

Attachment I - Carrier

Attachment I

CMS MEDICARE ACCOUNTS RECEIVABLE NON-MSP (PART B)

CONTRACTOR ABC

(PRINCIPAL)

SOURCE: H750B

SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

			(A - B)	(C / B x 100%)	
	A	B	C	D	
	06/30/02	06/30/01	$ Change	% Change	Note
Physician/Supplier Overpayments	9,210,000	6,049,700	3,160,300	52.24%	(1)
Beneficiaries	858,600	958,900	(100,300)	-10.46%	NER
Total Non-MSP	10,068,600	7,008,600	3,060,000	43.66%	
5% of Combined Ending Balance	503,430	(10,068,600 x 5%)			

No Explanation Required (NER)

(1) Physician/Supplier Overpayments - The ending balance increased by approximately $3 million which is primarily due to transfers in from contractor XYZ and claims accounts receivables (adjustments).

Note: Column A - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the prior year's quarter (06/30/01).

Attachment I-A - FI

Attachment I-A

CMS MEDICARE ACCOUNTS RECEIVABLE NON-MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750A
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

			(A - B)	(C / B x 100%)	
	A	B	C	D	
	06/30/02	03/31/02	$ Change	% Change	Note
Cost Report Settlements	36,836,000	31,310,600	5,525,400	17.65%	(3)
Claims	3,517,000	3,014,571	502,429	16.67%	NER
PIP	40,455,000	33,099,545	7,355,455	22.22%	(4)
Credit Balance	170,000	165,000	5,000	3.03%	NER
Other	3,000,000	2,872,917	127,083	4.42%	NER
Total Non-MSP	83,978,000	70,462,634	13,515,366	19.18%	
5% of Combined Ending Balance	4,198,900	(83,978,000 x 5%)			

No Explanation Required (NER)

(3) Cost Report Settlements - The ending balance increased by approximately $6 million due to receiving tw o cost reports settlements that w ere due on March 31, 2002 and transfers in from contractor MNO.

(4) PIP- The ending balance increased by $7.4 million primarily due to the quarterly PIP review .

Note: Column A - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year prior quarter (03/31/02).

Attachment I-A - Carrier

Attachment I-A

CMS MEDICARE ACCOUNTS RECEIVABLE NON-MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750B
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	03/31/02	$ Change	% Change	Note
Physician/Supplier Overpayments	9,210,000	7,875,707	1,334,293	16.94%	(2)
Beneficiaries	858,600	888,396	(29,796)	-3.35%	NER
Total Non-MSP	10,068,600	8,764,103	1,304,497	14.88%	
5% of Combined Ending Balance	503,430	(10,068,600 x 5%)			

-

No Explanation Required (NER)

(2) Physician/Supplier Overpayments - The ending balance increased by approximately $1.3 million which is primarily due to transfered in from contractor MNO.

Note: Column A - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable Non-MSP section of the H750 reports for the current year prior quarter (03/31/02).

Attachment II - FI

Attachment II

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750A
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	06/30/01	$ Change	% Change	Note
Data Match	18,338,500	87,195,000	(68,856,500)	-78.97%	(5)
Non-Data Match	12,743,100	48,637,000	(35,893,900)	-73.80%	(6)
MSP Provider/Phys/Supplier/Ben.	-	-	-	0.00%	NER
MSP Beneficiary (Liability)	-	-	-	0.00%	NER
Other MSP (Liability)	8,460,000	7,838,000	622,000	7.94%	NER
Total MSP	39,541,600	143,670,000	(104,128,400)	-72.48%	
5% of Combined Ending Balance	1,977,080	(39,541,600 x 5%)			

No Explanation Required (NER)

(5) Data Match - The balance decreased by approximately $69 million w hich resulted mainly from transfers to CNC.

(6) Non-Data Match - The balance decreased by approximately $36 million w hich resulted mainly from transfers to CNC.

Note: Column A - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable MSP section of the H750 reports for the prior year's quarter (06/30/01).

Attachment II - Carrier

Attachment II

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750B
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	06/30/01	$ Change	% Change	Note
Data Match	3,723,000	6,481,000	(2,758,000)	-42.56%	(3)
Non-Data Match	124,000	217,000	(93,000)	-42.86%	NER
MSP Provider/Phys/Supplier/Ben.	-	-	-	0.00%	NER
MSP Beneficiary (Liability)	-	-	-	0.00%	NER
Other MSP (Liability)	255,000	165,000	90,000	54.55%	NER
Total MSP	4,102,000	6,863,000	(2,761,000)	-40.23%	
5% of Combined Ending Balance	205,100	(4,102,000 x 5%)			

No Explanation Required (NER)

(3) Data Match - The balance decreased by approximately $2.8 million which resulted mainly from transfers out to CNC.

Note: Column A - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable MSP section of the H750 reports for the prior year's quarter (06/30/01).

Attachment IIA - FI

Attachment II-A

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750A
SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	03/31/02	$ Change	% Change	Note
Data Match	18,338,500	23,578,071	(5,239,571)	-22.22%	(7)
Non-Data Match	12,743,100	15,928,875	(3,185,775)	-20.00%	(8)
MSP Provider/Phys/Supplier/Ben.	-	-	-	0.00%	NER
MSP Beneficiary (Liability)	-	-	-	0.00%	NER
Other MSP (Liability)	8,460,000	7,251,429	1,208,571	16.67%	NER
Total MSP	39,541,600	46,758,375	(7,216,775)	-15.43%	
5% of Combined Ending Balance	1,977,080	(39,541,600 x 5%)			

No Explanation Required (NER)

(7) Data Match - The balance decreased by approximately $5.3 million which resulted mainly from transfers to CNC.

(8) Non-Data Match - The balance decreased by approximately $3.2 million which resulted mainly from from transfers to CNC and cash collections.

Note: Column A - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year prior quarter (03/31/02).

Attachment II-A - Carrier

Attachment II-A

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H750B

SCOPE: If percentage change is greater than +/- 15% and amount of change +/- 5% of the combined component ending balances.

	A	B	(A - B) C	(C / B x 100%) D	
	06/30/02	03/31/02	$ Change	% Change	Note
Data Match	3,723,000	4,964,000	(1,241,000)	-25.00%	(4)
Non-Data Match	124,000	242,314	(118,314)	-48.83%	NER
MSP Provider/Phys/Supplier/Ben.	-	-	-	0.00%	NER
MSP Beneficiary (Liability)	-	-	-	0.00%	NER
Other MSP (Liability)	255,000	306,000	(51,000)	-16.67%	NER
Total MSP	4,102,000	5,512,314	(1,410,314)	-25.58%	
5% of Combined Ending Balance	205,100	(4,102,000 x 5%)			

No Explanation Required (NER)

(4) Data Match - The balance decreased by approximately $1.2 million which resulted mainly from transfers out to CNC and offset collections.

Note: Column A - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year's quarter (06/30/02).

Column B - Enter the amounts from the accounts receivable MSP section of the H750 reports for the current year prior quarter (03/31/02).

Attachment III - FI

Attachment III

CMS MEDICARE ACCOUNTS RECEIVABLE COMBINED (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751A

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	329,345,200	264,386,000	64,959,200	24.57%
2a.	New Receivables	80,050,600	76,494,000	3,556,600	4.65%
2b.	Accrued Receivables	40,455,000	48,946,000	(8,491,000)	-17.35%
3.	Interest Earned	0	0	0	0.00%
4a.	Cash/Check Collections	(218,697,200)	(41,183,200)	(177,514,000)	431.03%
4b.	Offset Collections	(424,000)	(104,030,700)	103,606,700	-99.59%
4c.	Collections Deposited at Another Location	(50,000)	0	(50,000)	100.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(4,409,000)	(8,700,000)	4,291,000	-49.32%
	Auditor/Consultants Adjustments	(5,617,400)	(9,100,000)	3,482,600	-38.27%
5b.	Transfers In from other Medicare Contractor(s)	10,242,000	0	10,242,000	100.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(160,000)	(2,620,000)	2,460,000	-93.89%
5d.	Transfers In from other CMS Locations, POR	304,000	0	304,000	100.00%
5e.	Transfers Out from other CMS Locations, POR	(247,600)	0	(247,600)	100.00%
5f.	Transfers In from other CMS Locations,Not POR	126,000	4,200,000	(4,074,000)	-97.00%
5g.	Transfers Out to other CMS Locations, Not POR	(150,000)	(8,357,500)	8,207,500	-98.21%
5h.	Waivers	(292,000)	(200,000)	(92,000)	46.00%
6a.	Amounts Written-off (Bad Debts)	(536,000)	(110,000)	(426,000)	387.27%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(106,420,000)	0	(106,420,000)	100.00%
7.	Ending Balance	123,519,600	219,724,600	(96,205,000)	-43.78%
a.	Current	92,639,700	142,820,990	(50,181,290)	-35.14%
b.	Non-current	30,879,900	76,903,610	(46,023,710)	-59.85%
8.	Allowance for Uncollectable Accounts	(28,042,000)	(123,274,000)	95,232,000	-77.25%
9.	Total Receivables Net of Allowance	95,477,600	96,450,600	(973,000)	-1.01%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP (Attachment IV) and MSP (Attachment V) analysis, and determine whether such variances are appropriate.

Attachment III - Carrier

Attachment III

CMS MEDICARE ACCOUNTS RECEIVABLE COMBINED (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751B

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	12,015,000	10,085,000	1,930,000	19.14%
2a.	New Receivables	10,803,000	9,366,000	1,437,000	15.34%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(3,939,000)	(3,240,000)	(699,000)	21.57%
4b.	Offset Collections	(896,000)	(718,000)	(178,000)	24.79%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(3,500,000)	(1,500,000)	(2,000,000)	133.33%
	Auditor/Consultants Adjustments	(94,000)	(84,000)	(10,000)	11.90%
5b.	Transfers In from other Medicare Contractor(s)	3,042,000	242,000	2,800,000	1157.02%
5c.	Transfers Out to Other Medicare Contractor(s)	(40,000)	(30,000)	(10,000)	33.33%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	144,600	10,600	134,000	1264.15%
5g.	Transfers Out to other CMS Locations, Not POR	(137,000)	(131,000)	(6,000)	4.58%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	(37,000)	(67,000)	30,000	-44.78%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(3,191,000)	(62,000)	(3,129,000)	5046.77%
7.	Ending Balance	14,170,600	13,871,600	299,000	2.16%
a.	Current	9,636,008	9,710,120	(74,112)	-0.76%
b.	Non-current	4,534,592	4,161,480	373,112	8.97%
8.	Allowance for Uncollectable Accounts	(8,360,654)	(8,184,244)	(176,410)	2.16%
9.	Total Receivables Net of Allowance	5,809,946	5,687,356	122,590	2.16%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP (Attachment IV) and MSP (Attachment V) analysis, and determine whether such variances are appropriate.

Attachment III-A - FI

Attachment III-A

CMS MEDICARE ACCOUNTS RECEIVABLE COMBINED (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751A

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	329,345,200	329,345,200	0	0.00%
2a.	New Receivables	80,050,600	69,923,100	10,127,500	14.48%
2b.	Accrued Receivables	40,455,000	33,099,545	7,355,455	22.22%
3.	Interest Earned				
4a.	Cash/Check Collections	(218,697,200)	(205,340,211)	(13,356,989)	6.50%
4b.	Offset Collections	(424,000)	(424,000)	0	0.00%
4c.	Collections Deposited at Another Location	(50,000)	(50,000)	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(4,409,000)	(4,409,000)	0	0.00%
	Auditor/Consultants Adjustments	(5,617,400)	(5,617,000)	(400)	0.01%
5b.	Transfers In from other Medicare Contractor(s)	10,242,000	0	10,242,000	100.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(160,000)	(110,000)	(50,000)	45.45%
5d.	Transfers In from other CMS Locations, POR	304,000	0	304,000	100.00%
5e.	Transfers Out from other CMS Locations, POR	(247,600)	0	(247,600)	100.00%
5f.	Transfers In from other CMS Locations,Not POR	126,000	0	126,000	100.00%
5g.	Transfers Out to other CMS Locations, Not POR	(150,000)	(100,000)	(50,000)	50.00%
5h.	Waivers	(292,000)	(200,000)	(92,000)	46.00%
6a.	Amounts Written-off (Bad Debts)	(536,000)	(110,000)	(426,000)	387.27%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(106,420,000)	(98,786,625)	(7,633,375)	7.73%
7.	Ending Balance	123,519,600	117,221,009	6,298,591	5.37%
a.	Current	92,639,700	76,193,656	16,446,044	21.58%
b.	Non-current	30,879,900	41,027,353	(10,147,453)	-24.73%
8.	Allowance for Uncollectable Accounts	(28,042,000)	(26,612,064)	(1,429,936)	5.37%
9.	Total Receivables Net of Allowance	95,477,600	90,608,945	4,868,655	5.37%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP (Attachment IV-A) and MSP (Attachment V-A) analysis, and determine whether such variances are appropriate.

Attachment III-A - Carrier

Attachment III-A

CMS MEDICARE ACCOUNTS RECEIVABLE COMBINED (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751B

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	12,015,000	12,015,000	0	0.00%
2a.	New Receivables	10,803,000	6,817,274	3,985,726	58.47%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(3,939,000)	(2,626,000)	(1,313,000)	50.00%
4b.	Offset Collections	(896,000)	(537,600)	(358,400)	66.67%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(3,500,000)	(1,500,000)	(2,000,000)	133.33%
	Auditor/Consultants Adjustments	(94,000)	(84,000)	(10,000)	11.90%
5b.	Transfers In from other Medicare Contractor(s)	3,042,000	2,042,000	1,000,000	48.97%
5c.	Transfers Out to Other Medicare Contractor(s)	(40,000)	(40,000)	0	0.00%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	144,600	144,600	0	0.00%
5g.	Transfers Out to other CMS Locations, Not POR	(137,000)	(97,857)	(39,143)	40.00%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	(37,000)	(37,000)	0	0.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(3,191,000)	(1,820,000)	(1,371,000)	75.33%
7.	Ending Balance	14,170,600	14,276,417	(105,817)	-0.74%
a.	Current	9,636,008	9,707,963	(71,955)	-0.74%
b.	Non-current	4,534,592	4,568,453	(33,861)	-0.74%
8.	Allowance for Uncollectable Accounts	(8,360,654)	(8,423,086)	62,432	-0.74%
9.	Total Receivables Net of Allowance	5,809,946	5,853,331	(43,385)	-0.74%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP (Attachment IV-A) and MSP (Attachment V-A) analysis, and determine whether such variances are appropriate.

Attachment IV - FI

Attachment IV

CMS MEDICARE ACCOUNTS RECEIVABLE Non-MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751A & M751A
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	188,945,200	113,686,000	75,259,200	66.20%
2a.	New Receivables	57,500,600	50,694,000	6,806,600	13.43%
2b.	Accrued Receivables	40,455,000	48,946,000	(8,491,000)	-17.35%
3.	Interest Earned	0	0	0	0.00%
4a.	Cash/Check Collections	(202,697,200)	(24,783,200)	(177,914,000)	717.88%
4b.	Offset Collections	(424,000)	(101,030,700)	100,606,700	-99.58%
4c.	Collections Deposited at Another Location	(50,000)	0	(50,000)	100.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(2,319,000)	(4,700,000)	2,381,000	-50.66%
	Auditor/Consultants Adjustments	(5,617,400)	(2,300,000)	(3,317,400)	144.23%
5b.	Transfers In from other Medicare Contractor(s)	10,242,000	0	10,242,000	100.00%
5c.	Transfers Out to Other Medicare Contractor(s)	0	(2,300,000)	2,300,000	-100.00%
5d.	Transfers In from other CMS Locations, POR	304,000	0	304,000	100.00%
5e.	Transfers Out from other CMS Locations, POR	(247,600)	0	(247,600)	100.00%
5f.	Transfers In from other CMS Locations,Not POR	126,000	0	126,000	100.00%
5g.	Transfers Out to other CMS Locations, Not POR	(150,000)	(2,157,500)	2,007,500	-93.05%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	0	0	0	0.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(2,089,600)	0	(2,089,600)	100.00%
7.	Ending Balance	83,978,000	76,054,600	7,923,400	10.42%
a.	Current	62,983,500	49,435,490	13,548,010	27.41%
b.	Non-current	20,994,500	26,619,110	(5,624,610)	-21.13%
8.	Allowance for Uncollectable Accounts	(19,065,080)	(17,266,273)	(1,798,807)	10.42%
9.	Total Receivables Net of Allowance	64,912,920	58,788,327	6,124,593	10.42%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the Non-MSP section (Attachment I) of the H750A/B. (For example, the net increase in Non-MSP is primarily due to cost report settlement activity (Line 2a), the PIP accrual (Line 2b) and transfers in from other contractors (Line 5b). This analysis supports the explanation provided by the contractor.)

Attachment IV - Carrier

Attachment IV

CMS MEDICARE ACCOUNTS RECEIVABLE Non-MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751B & M751B

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	3,440,000	2,690,000	750,000	27.88%
2a.	New Receivables	7,430,000	5,305,000	2,125,000	40.06%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(1,339,000)	(1,147,000)	(192,000)	16.74%
4b.	Offset Collections	0	0	0	0.00%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(1,885,000)	0	(1,885,000)	100.00%
	Auditor/Consultants Adjustments	(94,000)	0	(94,000)	100.00%
5b.	Transfers In from other Medicare Contractor(s)	3,042,000	242,000	2,800,000	1157.02%
5c.	Transfers Out to Other Medicare Contractor(s)	0	0	0	0.00%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	144,600	10,600	134,000	1264.15%
5g.	Transfers Out to other CMS Locations, Not POR	0	(30,000)	30,000	-100.00%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	(37,000)	0	(37,000)	100.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(633,000)	(62,000)	(571,000)	920.97%
7.	Ending Balance	10,068,600	7,008,600	3,060,000	43.66%
a.	Current	6,846,648	4,906,020	1,940,628	39.56%
b.	Non-current	3,221,952	2,102,580	1,119,372	53.24%
8.	Allowance for Uncollectable Accounts	(5,940,474)	(4,135,074)	(1,805,400)	43.66%
9.	Total Receivables Net of Allowance	4,128,126	2,873,526	1,254,600	43.66%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Procedures Manual Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the Non-MSP section (Attachment I) of the H750B. (For example, the net increase in Non-MSP is primarily due to claims accounts receivables (Line 2a), internal adjustments (Line 5a) and transfers from other contractors (Line 5b). This analysis supports the explanation provided by the contractor.)

Attachment IV-A - FI

Attachment IV-A

CMS MEDICARE ACCOUNTS RECEIVABLE Non-MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751A & M751A
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	188,945,200	188,945,200	0	0.00%
2a.	New Receivables	57,500,600	49,773,100	7,727,500	15.53%
2b.	Accrued Receivables	40,455,000	33,099,545	7,355,455	22.22%
3.	Interest Earned	0	0	0	0.00%
4a.	Cash/Check Collections	(202,697,200)	(191,390,211)	(11,306,989)	5.91%
4b.	Offset Collections	(424,000)	(424,000)	0	0.00%
4c.	Collections Deposited at Another Location	(50,000)	(50,000)	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(2,319,000)	(2,319,000)	0	0.00%
	Auditor/Consultants Adjustments	(5,617,400)	(5,617,000)	(400)	0.01%
5b.	Transfers In from other Medicare Contractor(s)	10,242,000	0	10,242,000	100.00%
5c.	Transfers Out to Other Medicare Contractor(s)	0	0	0	0.00%
5d.	Transfers In from other CMS Locations, POR	304,000	0	304,000	100.00%
5e.	Transfers Out from other CMS Locations, POR	(247,600)	0	(247,600)	100.00%
5f.	Transfers In from other CMS Locations,Not POR	126,000	0	126,000	100.00%
5g.	Transfers Out to other CMS Locations, Not POR	(150,000)	(100,000)	(50,000)	50.00%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	0	0	0	0.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(2,089,600)	(1,455,000)	(634,600)	43.62%
7.	Ending Balance	83,978,000	70,462,634	13,515,366	19.18%
a.	Current	62,983,500	45,800,712	17,182,788	37.52%
b.	Non-current	20,994,500	24,661,922	(3,667,422)	-14.87%
8.	Allowance for Uncollectable Accounts	(19,065,080)	(15,996,758)	(3,068,322)	19.18%
9.	Total Receivables Net of Allowance	64,912,920	54,465,876	10,447,044	19.18%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the Non-MSP section (Attachment I-A) of the H750A/B (For example, the net increase in Non-MSP is primarily due to cost report settlement activity (Line 2a), the PIP accrual (Line 2b) and transfers in from other contractors (Line 5b). This analysis supports the explanation provided by the contractor.)

Attachment IV-A - Carrier

Attachment IV-A

CMS MEDICARE ACCOUNTS RECEIVABLE Non-MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: H751B & M751B

SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	3,440,000	3,440,000	0	0.00%
2a.	New Receivables	7,430,000	3,901,503	3,528,497	90.44%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(1,339,000)	(676,000)	(663,000)	98.08%
4b.	Offset Collections	0	0	0	0.00%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(1,885,000)	465,000	(2,350,000)	100.00%
	Auditor/Consultants Adjustments	(94,000)	(84,000)	(10,000)	100.00%
5b.	Transfers In from other Medicare Contractor(s)	3,042,000	2,022,000	1,020,000	50.45%
5c.	Transfers Out to Other Medicare Contractor(s)	0	0	0	0.00%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	144,600	144,600	0	0.00%
5g.	Transfers Out to other CMS Locations, Not POR	0	0	0	0.00%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	(37,000)	(37,000)	0	100.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(633,000)	(412,000)	(221,000)	53.64%
7.	Ending Balance	10,068,600	8,764,103	1,304,497	14.88%
a.	Current	6,846,648	6,134,872	711,776	11.60%
b.	Non-current	3,221,952	2,629,231	592,721	22.54%
8.	Allowance for Uncollectable Accounts	(5,940,474)	(5,170,821)	(769,653)	14.88%
9.	Total Receivables Net of Allowance	4,128,126	3,593,282	534,844	14.88%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Procedures Manual Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the Non-MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the Non-MSP section (Attachment I-A) of the H750B. (For example, the net increase in Non-MSP is primarily due to transfers in from other contractors (Line 5b). This analysis supports the explanation provided by the contractor.)

Attachment V - FI

Attachment V

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: M751A
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	140,400,000	150,700,000	(10,300,000)	-6.83%
2a.	New Receivables	22,550,000	25,800,000	(3,250,000)	-12.60%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(16,000,000)	(16,400,000)	400,000	-2.44%
4b.	Offset Collections	0	(3,000,000)	3,000,000	-100.00%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(2,090,000)	(4,000,000)	1,910,000	-47.75%
	Auditor/Consultants Adjustments	0	(6,800,000)	6,800,000	-100.00%
5b.	Transfers In from other Medicare Contractor(s)	0	0	0	0.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(160,000)	(320,000)	160,000	-50.00%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	0	4,200,000	(4,200,000)	-100.00%
5g.	Transfers Out to other CMS Locations, Not POR	0	(6,200,000)	6,200,000	-100.00%
5h.	Waivers	(292,000)	(200,000)	(92,000)	46.00%
6a.	Amounts Written-off (Bad Debts)	(536,000)	(110,000)	(426,000)	387.27%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(104,330,400)	0	(104,330,400)	100.00%
7.	Ending Balance	39,541,600	143,670,000	(104,128,400)	-72.48%
a.	Current	29,656,200	93,385,500	(63,729,300)	-68.24%
b.	Non-current	9,885,400	50,284,500	(40,399,100)	-80.34%
8.	Allowance for Uncollectable Accounts	(8,976,920)	(106,007,727)	97,030,807	-91.53%
9.	Total Receivables Net of Allowance	30,564,680	37,662,273	(7,097,593)	-18.85%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the MSP section (Attachment II) of the H750A/B. (For example, the net decrease in MSP is primarily due to transfers out to CNC (Line 6c). This analysis supports the explanation provided by the contractor).

Attachment V - Carrier

Attachment V

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: M751B
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	06/30/01	$ Change	% Change
1.	Begin FY Balance	8,575,000	7,395,000	1,180,000	15.96%
2a.	New Receivables	3,373,000	4,061,000	(688,000)	-16.94%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(2,600,000)	(2,093,000)	(507,000)	24.22%
4b.	Offset Collections	(896,000)	(718,000)	(178,000)	24.79%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(1,615,000)	(1,500,000)	(115,000)	7.67%
	Auditor/Consultants Adjustments	0	(84,000)	84,000	-100.00%
5b.	Transfers In from other Medicare Contractor(s)	0	0	0	0.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(40,000)	(30,000)	(10,000)	33.33%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	0	0	0	0.00%
5g.	Transfers Out to other CMS Locations, Not POR	(137,000)	(101,000)	(36,000)	35.64%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	0	(67,000)	67,000	-100.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(2,558,000)	0	(2,558,000)	100.00%
7.	Ending Balance	4,102,000	6,863,000	(2,761,000)	-40.23%
a.	Current	2,789,360	4,804,100	(2,014,740)	-41.94%
b.	Non-current	1,312,640	2,058,900	(746,260)	-36.25%
8.	Allowance for Uncollectable Accounts	(2,420,180)	(4,049,170)	1,628,990	-40.23%
9.	Total Receivables Net of Allowance	1,681,820	2,813,830	(1,132,010)	-40.23%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Procedures Manual Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the MSP section (Attachment II) of the H750B. (For example, the net decrease in MSP is primarily due to transfers out to CNC (Line 6c). This analysis supports the explanation provided by the contractor.)

Attachment V-A - FI

Attachment V-A

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART A)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: M751A
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	140,400,000	140,400,000	0	0.00%
2a.	New Receivables	22,550,000	20,150,000	2,400,000	11.91%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(16,000,000)	(13,950,000)	(2,050,000)	14.70%
4b.	Offset Collections	0	0	0	0.00%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(2,090,000)	(2,090,000)	0	0.00%
	Auditor/Consultants Adjustments	0	0	0	0.00%
5b.	Transfers In from other Medicare Contractor(s)	0	0	0	0.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(160,000)	(110,000)	(50,000)	45.45%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	0	0	0	0.00%
5g.	Transfers Out to other CMS Locations, Not POR	0	0	0	0.00%
5h.	Waivers	(292,000)	(200,000)	(92,000)	46.00%
6a.	Amounts Written-off (Bad Debts)	(536,000)	(110,000)	(426,000)	387.27%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(104,330,400)	(97,331,625)	(6,998,775)	7.19%
7.	Ending Balance	39,541,600	46,758,375	(7,216,775)	-15.43%
a.	Current	29,656,200	30,392,944	(736,744)	-2.42%
b.	Non-current	9,885,400	16,365,431	(6,480,031)	-39.60%
8.	Allowance for Uncollectable Accounts	(8,976,920)	(10,615,306)	1,638,386	-15.43%
9.	Total Receivables Net of Allowance	30,564,680	36,143,069	(5,578,389)	-15.43%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Note:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the MSP section (Attachment II-A) of the H750A/B. (For example, the net decrease in MSP is primarily due to cash collections (Line 4a) and transfers out to CNC (Line 6c) This analysis supports the explanation provided by the contractor.)

Attachment V-A - Carrier

Attachment V-A

CMS MEDICARE ACCOUNTS RECEIVABLE MSP (PART B)
CONTRACTOR ABC
(PRINCIPAL)

SOURCE: M751B
SCOPE: NO FORMAL ANALYSIS REQUIRED SEE MSP AND NON-MSP WORKSHEETS

		06/30/02	03/31/02	$ Change	% Change
1.	Begin FY Balance	8,575,000	8,575,000	0	0.00%
2a.	New Receivables	3,373,000	3,187,714	185,286	5.81%
2b.	Accrued Receivables	0	0	0	0.00%
3.	Interest Earned				
4a.	Cash/Check Collections	(2,600,000)	(1,950,000)	(650,000)	33.33%
4b.	Offset Collections	(896,000)	(806,400)	(89,600)	11.11%
4c.	Collections Deposited at Another Location	0	0	0	0.00%
5a.	Adjusted Amounts				
	Internal Adjustments	(1,615,000)	(1,965,000)	350,000	-17.81%
	Auditor/Consultants Adjustments	0	0	0	0.00%
5b.	Transfers In from other Medicare Contractor(s)	0	0	0	0.00%
5c.	Transfers Out to Other Medicare Contractor(s)	(40,000)	(20,000)	(20,000)	100.00%
5d.	Transfers In from other CMS Locations, POR	0	0	0	0.00%
5e.	Transfers Out from other CMS Locations, POR	0	0	0	0.00%
5f.	Transfers In from other CMS Locations,Not POR	0	0	0	0.00%
5g.	Transfers Out to other CMS Locations, Not POR	(137,000)	(101,000)	(36,000)	35.64%
5h.	Waivers	0	0	0	0.00%
6a.	Amounts Written-off (Bad Debts)	0	0	0	0.00%
6b.	Transfers In from CNC	0	0	0	0.00%
6c.	Transfers Out to CNC	(2,558,000)	(1,408,000)	(1,150,000)	81.68%
7.	Ending Balance	4,102,000	5,512,314	(1,410,314)	-25.58%
a.	Current	2,789,360	3,858,620	(1,069,260)	-27.71%
b.	Non-current	1,312,640	1,653,694	(341,054)	-20.62%
8.	Allowance for Uncollectable Accounts	(2,420,180)	(3,252,265)	832,085	-25.58%
9.	Total Receivables Net of Allowance	1,681,820	2,260,049	(578,229)	-25.58%
10	Cash/Offsets Received for Receivables at Another Location	0	0	0	0.00%

Procedures Manual Notes:

Although no formal analysis is required, the contractor should use this analysis to validate the variance explanations. In this example, the contractor experienced variances in most activity lines in Section A. The contractor should question the nature of the variances before beginning the MSP analysis and determine whether such variances are appropriate. The variances must support the explanations provided on the trend analysis of the MSP section (Attachment II-A) of the H750B. (For example, the net decrease in MSP is primarily due to offset collections (Line 4b) and transfers out to CNC (Line 6c). This analysis supports the explanation provided by the contractor.)

Attachment VI - FI - CMS Medicare Accounts Receivable Trend Analysis

CMS MEDICARE ACCOUNTS RECEIVABLE
TREND ANALYSIS - ABC Part A
For Quarter Ending _____

The following represents the summary for the changes in the accounts receivable balance for the current quarter. The following descriptions outline the underlying reasons for the changes in the accounts receivable balances:

Current Quarter to Prior Quarter (06/02 versus 03/02)

1 - The cost report settlements (Non-MSP) increased by $5 million primarily due to the receipt of two (2) cost reports settlements due March 2002 and transfers from MNO.

2 - The $7.4 million increase in the PIP accrual (Non-MSP) was due to quarterly reviews.

3 - The $8 million decrease in Data Match and non-Data Match (MSP) is primarily due to debt over 180 days being approved and transferred to currently not collectible (CNC) and cash receipts.

4 - The combined ending balance increased by $6 million or 5% primarily due to a $6 million increase in cost report settlements, a $7 million increase in PIP and a $8 million decrease in MSP.

Current Quarter to Prior Year Quarter (06/02 versus 06/01)

5 - The cost report settlements (Non-MSP) increased by $17 million primarily due to two (2) providers transferring from XYZ in the amount of $10 million and an increase in cost report settlement activity of $7 million.

6 - The PIP accrual (Non-MSP) decreased by approximately $8 million due to a systems error in the prior period that excluded claims for the period.

7 - The Data Match and non-Data Match (MSP) decreased by $105 million primarily due to debt over 180 days being approved and transferred to CNC.

8 - The combined ending principal balance decreased from $220 million at June 30, 2001 to $124 million at June 30, 2002, which is a decrease of approximately of $96 million or 44%. This occurred due to significant transfers out to CNC of $105 million, a PIP adjustment for a prior period system error of $8 million, and cost report settlement activity of $17 million.

Prepared by: _____ Date: _____

CFO for Medicare Operations approval: _____ Date: _____

ARA/DFM approval: _____ Date: _____

Attachment VI - Carrier - CMS Medicare Accounts Receivable Trend Analysis

CMS MEDICARE ACCOUNTS RECEIVABLE
TREND ANALYSIS - ABC Part B
For Quarter Ending _____

The following represents the summary for the changes in the accounts receivable balance for the current quarter. The following descriptions outline the underlying reasons for the changes in the accounts receivable balance.

Current Quarter to Prior Quarter (06/02 versus 03/02)

1 - The $1.2 million increase in the physician/supplier overpayments (Non-MSP) is primarily due to claims adjustments for two providers

2 - The $1.2 million decrease in Data Match and non-Data Match (MSP) is due to transfers to currently not collectible (CNC).

Current Quarter to Prior Year Quarter (06/02 versus 06/01)

1 - The physician/supplier overpayments (Non-MSP) increased by $3.0 million primarily due to five (5) providers transferring in from contractor XYZ.

2 - The Data Match and non-Data Match (MSP) decreased by $2.8 million primarily due to debt over 180 days being approved and transferred to CNC.

3 - The combined ending principal balance increased by $299,000 or 2.2 %. This occurred due to transfers out to CNC of $2.8 million and transfers in from other contractors of $3.0 million.

Prepared by: _____ Date: _____

CFO for Medicare Operations approval: _____ Date: _____

ARA, DFM approval: _____ Date: _____