CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13899	**Date: August 7, 2026**
	Change Request 14457

SUBJECT: Extending the Default Recoupment Date for Part A Cost Report Overpayments and Revision of the Medicaid Check Criterion for Debts Submitted for Close-Out

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to:

- extend the Healthcare Integrated General Ledger Accounting System (HIGLAS) default recoupment date for Part A cost report overpayments; and
- revise the Medicaid check criterion for debts submitted for close-out.

EFFECTIVE DATE: January 4, 2027
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2027

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.1/Part A Provider is Participating in Medicare and Medicaid
R	3/20.2/Provider is No Longer Participating in Medicare and Not Participating in Medicaid
R	3/20.3/Provider is No Longer Participating in Medicare But Is Participating in Medicaid
R	4/20/Demand Letters
R	4/20.2/Exhibit 1
R	4/20.2/Exhibit 2
R	4/20.2/Exhibit 3
R	4/40.1/Recoupment by Withholding Payments
R	4/70.17.2/Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 13899	Date: August 7, 2026	Change Request: 14457

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to:

- extend the Healthcare Integrated General Ledger Accounting System (HIGLAS) default recoupment date for Part A cost report overpayments; and
- revise the Medicaid check criterion for debts submitted for close-out.

II. GENERAL INFORMATION

A. Background: To alleviate financially burdensome administrative processes in the Medicare program that increase costs and reduce efficiency, the Centers for Medicare & Medicaid Services (CMS) will extend the HIGLAS default recoupment date for Part A cost report overpayments from 16 calendar days to 41 calendar days after the demand date. This change will more closely align to the schedule for other recoupments, such as Part A and Part B claim overpayments, which begin on day 41.

Medicare overpayments have a Statute of Limitations (SOL) period of 6 years. However, the SOL does not apply to legal defenses against a claim, such as recoupment. Therefore, a debt with an age greater than 6 years is **not** eligible for Medicaid offset because the collection activity is not considered recoupment.

B. Policy: If not paid in full by day 40, recoupment begins for overpayments subject to Limitation on Recoupment provisions of Section 935(f)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, unless in an excluded category (Extended Repayment Schedule (ERS) Request, an approved ERS, appeal or bankruptcy).

Medicare overpayments have a SOL period of 6 years.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14457.1	HIGLAS shall change the default recoupment date for Part A Cost Report and Interim Rate Review Overpayments from day 16 after the demand letter date to day									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	41.									
14457.2	HIGLAS shall make the following transaction types associated with **APROVCRASF1** (Part-A As-Filed Cost Report Initial Demand letter) and **APROVNONCRASF1** (Part A Cost Report Initial Letter – Tentative Settlement) demand letters available for immediate recoupment by updating the existing lookup type configuration. • APROV-CR-ASF • APROV-CR-FNLAU • APROV-CR-FNLDR • APROV-CR-REOP • APROV-CR-RVSDFNL • APROV-CR-RVSDTEN • APROV-CR-TEN • APROV-IRR • APROV-IRR-HOSPICE • APROV-IRR-PASS • APROV-IRR-PIP • APROV-HOSPICE-CAP									HIGLAS
14457.3	HIGLAS shall update the APROVCRASF1 (Part-A As-Filed Cost Report Initial Demand letter) demand									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	letter template as identified in red italics on the attached updated APROVCRASF1 demand letter template.									
14457.4	The contractor shall only conduct Medicaid payment inquiries for debtors who have returned to agency uncollectible (RU) and/or out-of-business (RN) debts that are less than 6 years old and are being reviewed for close-out.	X	X	X	X					BCRC, CRC, HITECH, IPC, RRB-SMAC

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	• The default recoupment date for Part A Cost Report Overpayments will change from day 16 after the demand letter date to day 41. • Cost report debts that are associated with Part-A As-Filed Cost Report Initial Demand letter) and Part A Cost Report Initial Letter – Tentative Settlement will be available for immediate recoupment.

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Financial Management
Chapter 3 - Overpayments

(Rev.13899; Issued:08-07-26)

20.1 - Part A Provider is Participating in Medicare and Medicaid

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

When the provider files a cost report indicating an overpayment, a final determination is deemed to have occurred if the cost report is not accompanied by payment in full. Where the provider does not remit the overpayment in full, the *contractor* sends the first demand letter notifying the provider that it will reduce or suspend interim payments in *40* days if the provider does not make repayment arrangements.

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

When the Notice of Program Reimbursement (NPR), which is sent at the conclusion of an audit, results in an overpayment a first demand letter must also be sent. The NPR and the first demand letter may be sent simultaneously, the first demand letter may be sent as a separate document or the first demand letter may be incorporated into the NPR. If the issuance of the NPR changes the facts as stated in prior demand letters, the *contractor* shall include in the NPR an explanation of the revised overpayment amount.

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

If the provider does not respond within 30 days after the date of the first demand letter, the *contractor* sends a second demand letter notifying the provider of the *contractor's* intent to recoup the overpayment from interim payments. (If the current percentage of withhold is less than 100%, the demand letter shall state that interim payments will be withhold at 100% in 30 days if repayment arrangements are not made.) If appropriate, the *contractor* shall advise the provider that action to withhold its Federal share of Medicaid payments has been requested. The *contractor* shall attempt to make personal (or telephone contact) with the provider, 15 days after sending the second demand letter to encourage either a lump-sum refund or a request for an extended repayment plan. It shall document each contact. (See Chapter 4, §10-20)

If there is no response or if the overpayment is still outstanding 30 days after the date of the second demand letter the *contractor* shall send a third demand letter. If eligible, the third demand letter shall include notification of the intent to refer the entire debt to the Department of Treasury for additional collection action. (See Chapter 4, §20)

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

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

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

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

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

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

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

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

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

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

The first demand letter must provide notice (See Chapter 4, §10-20 and §60) that action to withhold its Federal share of Medicaid payments will be requested if repayment arrangements are not made within 15 days of the date of this notice. The second demand letter must provide notice that action to withhold its Federal share of Medicaid payments has been requested and will be initiated if repayment arrangements are not made. The *contractor* shall send the third demand letter 30 days following the second where the provider has not responded, even though procedures for withholding the Federal share of payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury.

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

Medicare Financial Management
Chapter 4 - Debt Collection

(Rev.13899; Issued:08-07-26)

10.1 - Required Timeframes for Debt Collection Process for Provider Overpayments

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

Listed below are the general timeframes for most overpayment debt collection activities. There may be instances, due to specific circumstances related to the debt, where these timeframes will not apply.

Timeframes (Based on Date of Demand Letter)	Medicare Contractor
Day 1	The accounts receivable (AR) is created, the initial demand letter sent. Contractors shall ensure that the dates for establishing the AR, creating the demand letter and mailing the letter are the same.
Day 15	Deadline for provider rebuttal request. A rebuttal does not delay recoupment.
Day 16	Immediate Recoupment, if requested by the provider starts by day 16.
Day 16	Recoupment shall begin for overpayments not subject to Limitation on Recoupment provisions of Section 935 (f)(2) of the MMA unless the debt is in an excluded category (ERS Request, an approved ERS, appeal or bankruptcy).
Day 31	Interest shall begin to accrue if overpayment is not paid in full by day 30.
Day 41	If not paid in full by day 40, recoupment begins for *certain Part A Cost Report (As-Filed Cost Report Initial Demand, Initial Letter –Tentative Settlement, and Interim Rate Review) overpayments and* overpayments subject to Limitation on Recoupment provisions of Section 935(f)(2) of the MMA unless in an excluded category (ERS Request, an approved ERS, appeal or bankruptcy).
Day 90	The contractor shall attempt to contact the provider by telephone if the debt is 60 days delinquent and not in a status excluded from referral to Treasury.
Day 61-90	The contractor shall send the ITR on **eligible** delinquent debts.
Day 126-150	Eligible delinquent debt shall be referred to Treasury.
At least 7 days prior to referral to Treasury	The contractor shall make a second call to the provider before the debt is referred to Treasury.
Prior to Referral to Treasury (DME Only)	The DME contractor shall follow instructions in IOM Pub. 100-8, Chapter 15, related to surety bond collection requirements.

20 – Demand Letters

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

There are two overpayment demand letters, an Initial Demand Letter and an Intent to Refer Letter (ITR) (this does not include notification letters or response letters) used in the debt collection process. The purpose of an overpayment demand letter is to notify the providers and suppliers of the existence and amount of an overpayment, and to request repayment. Every demand letter, regardless of the cause of the overpayment or the status of the provider or supplier, shall meet certain requirements as to form and content.

Below is a detailed list of the requirements for the basic overpayment demand letters to use in various overpayment situations (it is not all-inclusive).

Non-Cost Report Overpayment Demand Letters:

1. The initial demand letter shall be sent to the provider or supplier within 7 calendar days of the determination of the overpayment.

2. The letters shall be labeled either Initial Demand Letter or The Intent to Refer Letter (ITR).

3. All letters shall be scanned or copied into the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to include a copy of manual letters.

4. The initial demand letter shall be sent by first class mail, secured email, or fax.

5. The initial demand letter is an explanation of the nature of the overpayment, how it was established, a bankruptcy notice, and the amount determined.

6. The initial demand letter includes language to request the provider or supplier to submit a refund or arrange for immediate recoupment or file an appeal (with exception of Requests for Anticipated Payment (RAP) claims that shall not receive appeal rights, see 100-06 Chapter 3 Section 200.1.2).

7. The initial demand letter offers the provider or supplier the opportunity to apply for an Extended Repayment Schedule (ERS) if repayment of the debt will cause financial hardship. (An ERS shall be analyzed using the criteria set forth in Chapter 4, §50. Any approved ERS would run from the approval date.)

8. If payment in full is not received within 30 days, interest will be charged.

9. The initial demand letter includes Debt Collection Improvement Act (DCIA) Intent Language for referral to the Treasury Department for cross servicing.

10. The ITR letter is sent to the provider or supplier at least 60 days after the date of the initial, final or revised demand letter, if it is not in a status excluded from debt referral, and shall include the initial demand letter number.

11. All correspondence, including demand letters, addressed to a provider or supplier in bankruptcy proceedings, shall be submitted to the Regional Office (RO), which has the lead in the bankruptcy proceedings, for approval prior to release.

Cost Report Overpayment Demand Letters:

1. When a provider files a cost report without payment for the amount due from the provider, the contractor shall send a demand letter to the provider. The demand letter shall inform the provider that the contractor will recoup (reduce or withhold) Medicare payments if it does not receive the overpayment amount, or a request for a repayment schedule along with the first month's payment within *40* days of the date of the demand letter.

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

3. In addition to the suspension of future Medicare payments for failure to file a cost report, contractors shall deem all interim and lump-sum payments made for the fiscal period and all interim and lump-sum payments made in a subsequent period as an overpayment. These overpayments shall be immediately due and payable to CMS if the cost report is not received timely.

4. The contractor shall ensure that recoupment of Medicare payments does not start until the cost report demand letter is generated.

5. The initial cost report demand letters may be delivered certified mail, electronic mail (e-mail), or through a secured portal and shall include a receipt confirmation.

6. The initial cost report demand letters shall be sent to the provider or supplier on the 7th day after the due date or extended due date of the cost report, if not received.

7. The initial cost report demand letters shall include the explanation of the overpayment determination and the amount due or Notice of Program Reimbursement (cost report).

8. All letters shall be scanned or copied into the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to include a copy of manual letters.

9. The provider or supplier may submit a cost report, make a refund, arrange for immediate recoupment, or request an ERS, as applicable.

10. The percentage of withhold shall be indicated whenever an adjustment (reduction or suspension) of interim payments has been imposed.

11. The cost report letters shall offer the provider the opportunity to apply for an ERS if repayment of the debt will cause financial hardship. (An ERS shall be analyzed using the criteria set forth in Chapter 4, §50. Any approved ERS would run from the approval date.)

12. The cost report letters shall include DCIA Intent Language for referral to the Treasury Department for cross servicing.

13. The ITR letter shall be mailed to the provider 60 days after the date of the Initial Demand letter, if it is not in a status excluded from debt referral.

EXHIBIT 1- INITIAL DEMAND LETTER - NON-935–

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

Contractors shall use the appropriate template below:

A. Contractors on HIGLAS shall use the list below for the appropriate system generated letters.

1. (BPROV1.pdf) Part B Provider/Supplier Initial Demand Letter
2. (BPROV1VA.pdf) Provider/Supplier Voluntary Returned Check 1st demand letter
3. (BPROV1N.pdf) Part B Provider/Supplier Notify Initial Demand Letter
4. (BPROV1V.pdf) Part B Provider/Supplier Voluntary Refund 1st Demand Letter
5. (APROV1.pdf) Part A Aggregate Claims Demand Letter
6. (APROV-CLA.pdf) Part A No Appeal

B. Contractors not on HIGLAS and Manual letters shall use this letter as your template.

RE: Initial Demand Letter
Provider/Supplier Name:
Provider/Supplier Number:
&
Overpayment Amount:
&HINVOICE_AMOUNT
Outstanding Balance:
&DEMAND_AMOUNT

C. Contractors shall use the appropriate first paragraph below:

Dear Sir/Madam:

PART B Provider or Supplier Demand Letter (BPROV1.pdf in HIGLAS)

This is to let you know that you have received a Medicare payment in error, which has resulted in an overpayment to you of &HINVOICE_AMOUNT. The attached documentation explains how this happened.

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

Or,

PART B Provider or Supplier Notify 1st Demand Letter (BPROV1N.pdf in HIGLAS)

We appreciate your recent inquiry regarding a Medicare payment that you believe was paid in error. Our analysis found that the overpaid amount was &DEMAND_AMOUNT. The attached documentation explains how this happened. We thank you for bringing this overpayment to our attention.

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

Or,

PART B Provider or Supplier Voluntary Returned/Refund 1st Demand, (BPROV1VA.pdf in HIGLAS) or (BPROV1V.pdf in HIGLAS)

We have received your check in the amount of &INVOICE_RECEIPT_AMOUNT. We thank you for

bringing this overpayment to our attention. While we appreciate you submitting payment to us, our review found that the overpaid amount was &HINVOICE_AMOUNT. The attached documentation explains how this happened. Please remit the additional &INVOICE_BALANCE_AMOUNT.

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

Or,

PART A (Non-935) Aggregate Claims Demand Letter (APROV1.pdf in HIGLAS)

Claims adjustments were entered in our system under provider &HPROVIDER_NAME. Additional adjustments were made to the claims, and a balance in the amount of &DEMAND_ AMOUNT has been outstanding for 60 days. As this amount has not been recouped through claims submission, the purpose of our letter is to request that this amount be repaid to our office. The attached documentation explains how this happened.

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

Or,

PART A No Appeal Claims Demand Letter (APROVNOAPPEAL1.pdf in HIGLAS)

Claims adjustments were entered in our system under provider &HPROVIDER_NAME and a balance in the amount of &DEMAND_ AMOUNT is due. The purpose of our letter is to request that this amount be repaid to our office. The attached documentation explains how this happened.

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

B. Contractors shall include the following language below in all initial letters after the first paragraph.

Why you are responsible:

You are responsible for following correct Medicare filing procedures and must use care when billing and accepting payment. You are responsible for repayment in this matter based upon one or both ofthe following criteria:

1. You billed and/or received payment for services for which you should have known you were not entitled to receive payment. Therefore, you are not without fault and are responsible for repaying the overpayment amount.

2. You received overpayments resulting from retroactive changes in the Medicare Physician Fee Schedule and/or changes mandated by legislation.

If you dispute this determination, please follow the appropriate appeals process listed below. (Applicable authorities: § 1870(b) of Social Security Act; sub§ 405.350 - 405.359 of Title 42, sub§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.) [This appeal paragraph is to be excluded in No-Appeal demand letters.]

Rebuttal Process:

Under our existing regulations 42 CFR § 405.374, providers and suppliers will have **15 days from the date of this demand letter** to submit a statement of rebuttal. The rebuttal process provides the debtor the opportunity, before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. A rebuttal is not intended to request a review of supporting medical documentation nor to express disagreement with the overpayment decision. A rebuttal shall not duplicate the redetermination process. T**his is not an appeal of the overpayment determination.** Our office will advise you of our decision 15 days from the mailroom-stamped receipt date of your request.

Interest Assessment:

If you do not refund in 30 days:

In accordance with 42 CFR 405.378, simple interest at the rate of &AR_INTEREST_RATE % will be charged on the unpaid balance of the overpayment, beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance, at the rate of &AR_INTEREST_RATE %. In addition, please note that Medicare rules require that payment be either received in our office by &LETTER_DATE_29 (United States Postal Service Postmark) for the payment to be considered timely. A metered mail postmark received in our office after &LETTER_DATE_29 will cause an additional month's interest to be assessed on the debt.

Payment by Recoupment:

If payment in full is not received by &LETTER_DATE_40 (&LETTER_DATE_15 for Part A non-935), payments to you can be recouped (recoupment) until payment in full is received if you haven't submitted an acceptable ERS request, an immediate recoupment request, and/or a valid and timely appeal is received.

Make a payment or Arrange for payments:

What you should do:

Please return the overpaid amount to us by &LETTER_DATE_29 and no interest charge will be assessed. Make the check payable to Medicare Part A and send it with a copy of this letter to:

&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

In addition, please note that Medicare rules require that payment be either received in our office by, &LETTER_DATE_29, or United States Postal Service postmark by that date, for the payment to be considered timely. A metered mail postmark received in our office after &LETTER_DATE_29 will cause an additional month's interest to be assessed on the debt.

If you are unable to make refund of the entire amount at this time, advise this office immediately with a request for an extended repayment schedule (ERS) so that we may determine if you are eligible for

one. Any repayment schedule (where one is approved) would run from the approval date. **You can visit our website at [&CONTRAC TOR_URL] for ERS instructions and forms.**

Immediate Recoupment:

NO FURTHER ACTION IS REQUIRED BY YOU. You have previously elected to have your overpayment(s) repaid through the **Immediate Recoupment** process. Based on this, payments to you will begin to be recouped on &LETTER_DATE_*15* until payment is received in full. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.

Immediate Recoupment:

TO SIMPLIFY THE REPAYMENT PROCESS, reduce the extra work and cost associated with mailing your repayment each time, you may elect to have automatic immediate recoupments for ALL overpayments by requesting the **Immediate Recoupment** process for All Current and Future Accounts Receivable. This will automatically begin recoupment starting on day 16 for ALL future accounts receivable. When the initial request is received after day 16 the debt shall be placed in an immediate recoupment status. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.

You must specify whether you are submitting:

1. A request on the current demanded overpayment (all accounts receivables within this demand letter) and ALL FUTURE OVERPAYMENTS; or

2. A one-time request on this current demanded overpayment (all accounts receivables) addressed in this demand letter only.

This process is voluntary and for your convenience.

You can visit our website at *&CONTRACTOR_URL* for the Immediate Recoupment Request instructions.

You may contact this office for information on how to fax your request.

If you wish to appeal this decision: [This appeal paragraph is to be excluded in No-Appeal demand letters.]

If you disagree with this overpayment decision, you may file an appeal. Please refer to the original remittance advice for additional instruction. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

&CONTRACTOR_NAME &REVIEW_ADDRESS1 &REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

Medicaid Offset:

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

Right to Inspect Records Prior to Referral to Treasury:

In the event an ITR letter is sent, you have the right to inspect and copy all records pertaining to your debt. In order to present evidence or review the CMS records, you must submit a written request to the address below. Your request must be received within 60 calendar days from the ITR letter date. In response to a timely request for access to CMS' records, you will be notified of the location and time when you can inspect and copy records related to this debt. Interest will continue to accrue during any review period. Therefore, while review is pending, you will be liable for interest and related late payment charges on amounts not paid by the due date identified above.

For Individual Debtors Filing a Joint Federal Income Tax Return:

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

For Debtors that Share a Tax Identification Number(s):

Section 1866(j)(6) of the Social Security Act authorizes the Secretary of Health and Human Services (the Secretary) to make any necessary adjustments to the payments of an applicable provider or supplier who shares a TIN with an obligated provider or supplier, one that has an outstanding Medicare overpayment. The Secretary is authorized to adjust the payments of such a provider or supplier regardless of whether it has been assigned a different billing number or National Provider Identification Number (NPI) from that of the provider or supplier with the outstanding Medicare overpayment.

Federal Salary Offset:

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

If You Have Filed a Bankruptcy Petition:

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

Should you have any questions, please contact your overpayment representative at the following number:

CONTACT_PHONE_NUM_

We look forward to hearing from you shortly.

Sincerely,

Medicare A or B Recovery Unit

Enclosures: How This Overpayment Was Determined

EXHIBIT 2- INITIAL DEMAND LETTER - 935

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

A. Contractors on HIGLAS shall use the list below for the appropriate system generated letters.

1. (APROV9351.pdf): Part-A Adjustment Initial Claims Demand letter
2. (BPROV9351.pdf): Part-B 935 Adjustment Initial Claims Demand letter
3. (APROVAGG9351.pdf): Part-A Aggregate Closure Initial Demand Letter
4. (BPROVAGG9351.pdf): Part-B Aggregate Closure Initial Demand Letter
5. (APROVRAC1.pdf): Part-A 935 RAC Adjustment Claims Demand Letter
6. (BPROVRAC1.pdf): Part-B 935 RAC Adjustment Claims Demand Letter
7. (APROVRACAGG1.pdf): Part-A 935 RAC Adjustment Claims Initial Demand Letter
8. (BPROVRACAGG1.pdf): Part-B 935 RAC Adjustment Claims Initial Demand Letter

B. Contractors not on HIGLAS shall use this letter as your template.

Letter Number: Date:

&HPROVIDER_NAME
&HPROVIDER_ADDRESS1
&HPROVIDER_CITY, &HPROVIDER_STATE
HPROVIDER_POSTAL_CODE

INITIAL REQUEST
[Contractors shall use the appropriate reference below for demanded 935 overpayments.] RE: MMA 935 –
Overpayment Amount

Dear Sir/Madam,

Contractors shall use the appropriate first paragraph below for all Initial Demands letters except Recovery Audit Contractors (RAC).

This letter is to inform you that you have received a Medicare payment in error, which has resulted in an overpayment subject to § 935(f) (2) of the Medicare Modernization Act (MMA), § 1893(f) (2) of the Social Security Act, Limitation on Recoupment, in the amount & DEMAND_ AMOUNT. **The purpose of this letter is to request that this amount be repaid to our office. The attached explains how this happened.**

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

(RAC Demand Letter Language only)

This finding was a result of a Recovery Audit Program review. If you have any questions relating to this letter or the recoupment process, you should contact us at: &CONTRACT_STATE_TOLL_FREE_ &CONTRACT_STATE_TOLL_FREE_NUM. If you have any questions relating to the review rationale or you feel that this finding is in error and would like to submit additional documentation or discuss the issue further, please contact the Recovery Auditor.

If you are unable to locate the name and contact information for the Recovery Auditor from prior correspondence, please contact the Medicare Administrative Contractor, which is located at the bottom of this page, for further information.

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

How This Overpayment Was Determined:

[When applicable on a Manual Letter, include explanation of the overpayment determination.]

[Contractor shall explain the authority for reopening the claims (i.e., consistent with 42 CFR 405.980 and Publication 100-04, Medicare Claims Processing Manual, chapter 34) and explain how the facts of the case allowed you to reopen within the timeframes established in those sections.]

Why You Are Responsible:

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

This amount is subject to § 935(f) (2) of the Medicare Modernization Act (MMA) (section 1893(f) (2) of the Social Security Act), Limitation on Recoupment (42 CFR 405.379).

Rebuttal Process:

Under our existing regulations at 42 CFR § 405.374, Providers or Suppliers will have **15 days from the date of this demand letter** to have an opportunity for rebuttal by submitting a statement. The rebuttal process provides the debtor the opportunity, before the suspension of payment, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. A rebuttal is not intended as a request for the review supporting medical documentation nor to express disagreement with the overpayment decision. A rebuttal shall not duplicate the redetermination process. T**his is not an appeal of the overpayment determination. The limitation on recoupment under** § 1893 (f) (2) (a) of the Social Security Act **does not apply to rebuttal requests.** Our office will advise you of our decision 15 days from the mailroom-stamped receipt date of your request.

Interest Assessment:

If you do not pay the full amount in 30 days:

In accordance with 42 CFR 405.378, simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpaid balance of the overpayment, beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time.

Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance, at the rate of &AR_INTEREST_RATE percent. A metered mail postmark received in our office after &LETTER_DATE_29 will cause an additional month's interest to be assessed on the debt.

In addition, please note that Medicare rules require that payment be either received in our office by

&LETTER_DATE_29 or United States Postal Service Postmark by that date for the payment to be considered timely.

Suspended Funds Applied To The Overpayment and Has a Remaining Outstanding Balance:

If the suspended funds are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR § 405.379 "Limitation on Recoupment" provision under §1893(f) (2) of the Act, then the provider or supplier is subject to 935 Appeals rights and will be available for offset after 41 days on the remaining balance still owed to CMS. (See 42 CFR § 405.372(e) for more information.)

Payment by Recoupment:

If payment in full is not received by &LETTER_DATE_29 **(date of the notification),** payments to you can be recouped (recoupment) until payment in full is received if you haven't submitted an acceptable ERS request, an immediate recoupment request, and/or a valid and timely appeal is received.

Make a Payment or Arrange for Payments:

What You Should Do:

Please return the overpaid amount to us by &LETTER_DATE_29 and no interest will be assessed. We request that you refund this amount in full.

Make the check payable to Medicare [**Part A] or [Part B]** and send it with **a copy of this letter** to:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

If you are unable to make refund of the entire amount at this time, advise this office immediately with a request for an extended repayment schedule (ERS) so that we may determine if you are eligible for one. Any repayment schedule (where one is approved) would run from the approval date. **You can visit our website at [&CONTRAC TOR_URL] for ERS instructions and forms.**

Immediate Recoupment:

NO FURTHER ACTION IS REQUIRED BY YOU. You have previously elected to have your overpayment(s) repaid through the **Immediate Recoupment** process. Based on this, payments to you will begin to be recouped on &LETTER_DATE_*15* until payment is received in full. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.

Immediate Recoupment:

TO SIMPLIFY THE REPAYMENT PROCESS, reduce the extra work and cost associated with mailing your repayment each time, you may elect to have automatic immediate recoupments for ALL overpayments by requesting the **Immediate Recoupment** process for All Current and Future Accounts Receivable. This will automatically begin recoupment starting on day 16 for ALL future accounts receivable. When the initial request is received after day 16 the debt shall be placed in an immediate recoupment status. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.

You must specify whether you are submitting:

1. A request on the current demanded overpayment (all accounts receivables within this demand letter) and ALL FUTURE OVERPAYMENTS; or

2. A one-time request on this current demanded overpayment (all accounts receivables) addressed in this demand letter only.

This process is voluntary and for your convenience.

You can visit our website at *&CONTRACTOR_URL* for the Immediate Recoupment Request instructions.

You may contact this office for information on how to fax your request.

Note: Such interest may be payable for certain overpayments reversed at the ALJ level or subsequent levels of appeal.

If You Wish To Appeal This Decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claims. The first level of appeal is called a redetermination. You must file your request for a redetermination 120 days from the date of this letter**.**

However, if you wish to avoid recoupment from occurring, you need to file your request for redetermination within 30 days from the date of this letter, as described above. Unless you show us otherwise, we assume you received this letter within 5 days of the date of this letter.
Please send your request for redetermination to:

&CONTRACTOR_NAME - 935 APPEALS
REDETERMINATION &REVIEW_ADDRESS1
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

How to Stop Recoupment:

Even if the overpayment and any assessed interest has not been paid in full, you can temporarily stop Medicare from recouping any payments. **If you act quickly and decidedly,** Medicare will **stop recoupment** at two points.

First Opportunity: We must receive a valid and timely request for a redetermination within 30 days from the date of this letter. We will stop or delay recoupment pending the results of an appeal. To assist us in expeditiously stopping the recoupment process, we request that you clearly indicate on your appeal request that this is a 935 overpayment appeal for a redetermination.

Second Opportunity: If the redetermination decision is (1) **unfavorable,** we will begin to recoup no earlier than the 60th day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter); or (2) if the decision is **partially favorable**, we will begin to recoup no earlier than the 60th day from the date of the Medicare revised overpayment Notice/Revised Demand Letter. Therefore, it is important to act quickly and decidedly to limit recoupment by submitting a valid and timely request for reconsideration within 60 days of the appropriate notice/letter. The address and details on how to file a request for reconsideration will be included in the Redetermination decision letter.

What Happens Following a Reconsideration By a Qualified Independent Contractor (QIC):

Following a **decision or dismissal** by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level, Administrative Law Judge (ALJ).

NOTE: Even when recoupment is stopped, interest continues to accrue.

Medicaid Offset:

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

Right to Inspect Records Prior to Referral to Treasury:

In the event an Intent to Refer (ITR) letter is sent, you have the right to inspect and copy all records pertaining to your debt. In order to present evidence or review the CMS records, you must submit a written request to the address below. Your request must be received within 60 calendar days from the ITR letter date. In response to a timely request for access to CMS's records, you will be notified of the location and time when you can inspect and copy records related to this debt. Interest will continue to accrue during any review period. Therefore, while review is pending, you will be liable for interest and related late payment charges on amounts not paid by the due date identified above.

For Individual Debtors Filing a Joint Federal Income Tax Return:

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

For Debtors That Share a Tax Identification Number (TIN):

Section 1866(j)(6) of the Social Security Act authorizes the Secretary of Health and Human Services (the Secretary) to make any necessary adjustments to the payments of an applicable provider or supplier who shares a TIN with an obligated provider or supplier, one that has an outstanding Medicare overpayment. The Secretary is authorized to adjust the payments of such a provider or supplier regardless of whether it has been assigned a different billing number or National Provider Identification Number (NPI) from that of the provider or supplier with the outstanding Medicare overpayment.

Federal Salary Offset:

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

If You Have Filed a Bankruptcy Petition:

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

Should you have any questions, please contact your overpayment consultant at the following:

&BUSINESS_PURPOSE_1
&CONTRACT_CONTACT_PHONE_NUM_
1

We look forward to hearing from you shortly.

Sincerely,

SELECT

Supervisor, Part A Overpayments &CONTRACTOR_NAME

Or,

Medicare Part B Recovery Unit

Enclosures

How This Overpayment Was Determined

EXHIBIT 3- INITIAL DEMAND LETTER- COST REPORTS FILED –

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

A. **Contractors on HIGLAS shall use the list below for the appropriate system generated letters.**

1. (APROVCRASF1.pdf): Part-A As-Filed Cost Report Initial Demand letter
2. (APROVNONCRASF1.pdf): Part A Cost Report Initial Letter – Tentative Settlement

B. **Contractors not on HIGLAS shall use this letter below as your template.**

C. **Use the appropriate reference below for the first paragraph.**

INITIAL REQUEST

RECEIPT CONFIRMATION REQUESTED

RE: Initial Demand Letter Provider or Supplier Name:
Provider/Supplier Number: &
Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: & DEMAND_AMOUNT

Date:

Dear Mr. Smith:

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

(NPR Issued)
On July 26, 20xx, we received your cost report for the fiscal year ending June 30, xxxx. We have fully reviewed this report, and the results of our review have been incorporated in the enclosed copy of your

Notice of Program Reimbursement (dated August 21, 20xx). As explained in the Notice, we find that the Valley Convalescent Center has been overpaid $_____for the past fiscal year.

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

(Tentative Settlement)

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

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

(As Filed Cost Report)

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

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

PLEASE MAIL TO:

&CONTRACTOR_NAME &CHECK_ADDRESS1 &CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

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

If payment in full is not received, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur, you must notify [contractor]. We will review your documentation, but will not delay recoupment.

This is not an appeal of the overpayment determination.

Immediate Recoupment:

NO FURTHER ACTION IS REQUIRED BY YOU. *You have previously elected to have your overpayment(s) repaid through the* ***Immediate Recoupment*** *process. Based on this payments to you will begin to be recouped on &LETTER_DATE_15 until payment is received in full. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.*

Immediate Recoupment:

TO SIMPLIFY THE REPAYMENT PROCESS, *reduce the extra work and cost associated with*

mailing your repayment each time, you may elect to have automatic immediate recoupments for ALL overpayments by requesting the ***Immediate Recoupment*** *process for All Current and Future Accounts Receivable. This will automatically begin recoupment starting on day 16 for ALL future accounts receivable. When the initial request is received after day 16 the debt shall be placed in an immediate recoupment status. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.*

You must specify whether you are submitting:

1. *A request on the current demanded overpayment (all accounts receivables within this demand letter) and ALL FUTURE OVERPAYMENTS; or*

2. *A one-time request on this current demanded overpayment (all accounts receivables) addressed in this demand letter only.*

This process is voluntary and for your convenience.

You can visit our website at &CONTRACTOR_URL for the Immediate Recoupment Request instructions.

You may contact this office for information on how to fax your request.

Medicaid Offset

If this matter is not resolved within *forty* (*40*) days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of Title XIX of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, § 447.30(g). These recoveries will be in addition to any recoupments from other Medicare funds due you until the full amount owed to Medicare is recovered. The appeal process is detailed in the Notice of Program Reimbursement (NPR).

Interest Assessment:

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

Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance, at the rate of___.

Extended Repayment Request:

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

If You Have Filed a Bankruptcy Petition:

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

For Debtors That Share Tax Identification Numbers:

Section 1866(j)(6) of the Social Security Act authorizes the Secretary of Health and Human Services (the Secretary) to make any necessary adjustments to the payments of an applicable provider or supplier who shares a TIN with an obligated provider or supplier, one that has an outstanding Medicare overpayment. The Secretary is authorized to adjust the payments of such a provider or supplier regardless of whether it has been assigned a different billing number or National Provider Identification Number (NPI) from that of the provider or supplier with the outstanding Medicare overpayment.

Should you have any questions please contact_____at_____. We expect to hear from you shortly.

Sincerely,

(Name and Title)

Enclosure
(Name and Title)

Enclosure

40.1 – Recoupment by Withholding Payments

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

A. General

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

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

B. Requirements for Withhold

Comply with the following conditions to withhold interim payments:

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

C. Cost Report Overpayments Percentage of Withhold

100% of withhold shall begin *40* days after the date of the first demand letter (day *41*) if the overpayment has not yet been liquidated or an extended repayment plan has not been *fully recovered*. The matrix below shall be utilized to determine the percentage of withhold for an overpayment determined from a cost report that has been filed (as filed cost report, tentative settlement, or final settlement), a PIP review, or an interim rate review. See Chapter 3, §30.1 when a cost report remains unfiled.

Day *40*	**Still no word from provider**	**Withhold at 100%.**
Day *40+*	ERS application is being reviewed by RO or CO	No withhold as long as provider continues to submit appropriate good faith payments on a monthly basis under the terms of the application request. If provider did not submit a first good faith payment or does not submit subsequent payments, withhold shall be 30% of payments unless RO or CO gives alternative instructions.
Day *40*	Provider said an ERS application was forthcoming but has not been received to date	Increase withhold to 100%. If provider calls with an acceptable reason for the delay, make a judgment call to leave at 30% until day 45 or refer to RO for direction.
Day *40+*	**No ERS application and no payment by provider**	**Withhold at 100%**

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

D. Physician/Supplier Overpayments- Withhold of Payments

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

NOTE: Additional Information for MACs

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

The payment submitted with the ERS application shall be one month's payment based on the amortization schedule submitted with the ERS application. The amortization schedule shall not exceed 60 months, shall include principal and interest and the minimum monthly payment shall not be less than 1/60th of the overpayment. If the provider requests an ERS in excess of 60 months the good faith payment submitted

shall be 1/60th of the overpayment. If the good faith payment submitted is not 1/60th of the overpayment, the MAC shall contact the provider (in writing or a documented telephone call with the appropriate personnel at the provider's place of business) requesting additional funds. If the provider does not submit additional funds within 15 days of the date of the request, the MAC shall initiate a 30% withhold.

Until a final decision is made regarding the ERS the provider should submit monthly good faith payments based on the amortization schedule. If the provider does not continue to submit monthly good faith payments, the MAC shall contact the provider requesting the payment. If the provider does not submit the monthly payment within 15 days of the date of the request, the MAC shall initiate a 30% withhold until a decision is made.

E. Disposition of Withheld Funds

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

F. Duration of Withhold

The withhold shall remain in effect until:

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

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

(Rev.13899; Issued: 08-07-26; Effective: 01-04-27; Implementation: 01-04-27)

The temporary HIGLAS RTA Status Code for all debts that are returned to agency as Uncollectible (RU) or Out of Business (RN) shall be systematically updated, by HIGLAS, to 'DR-RTN-CS' (Debt Returned from Cross-Servicing).

The contractor **not** utilizing HIGLAS shall re-refer to Treasury all debts RTA'd as RU/RN that are:

- Less than or equal to $500,000 (principal balance) and less than 3-years old; or
- Greater than $500,000 (principal balance) and less than 6-years old.

However, if Treasury returns these same debts before the 3 or 6-year age after they have been re-referred one time, the contractor not utilizing HIGLAS shall **not** re-refer the debts to Treasury. The contractor's weekly RTA Report will allow the contractor to easily assess whether a debt qualifies for close-out or re-referral to Treasury.

(**For contractors utilizing HIGLAS:** HIGLAS functionality will systematically re-refer debts that have been initially RTA'd as RU/RN and do not meet the aforementioned age requirements.)

For RU and RN debts with a combined principal and interest balance less than $25:

- Contractors utilizing HIGLAS shall allow the HIGLAS Auto Write-Off Program to identify these debts and systematically write them off.
- Contractors not utilizing HIGLAS shall submit for close-out review.

The contractors shall use the RTA report to research the RU or RN debts with a combined principal and interest balance greater than or equal to $25 in order to determine the current status or final disposition. The debts already in a recalled status are included so that the contractors will know that Treasury considers the debts uncollectible or out of business.

The contractors shall determine whether collection by litigation is a viable option for debts with a combined principal and interest balance greater than or equal to $25 showing a status code of RU or RN. If so, follow established procedures for referring the debts for litigation (See CMS Pub. 100-06, chapter 3, section 120).

The contractors shall also consider whether all other appropriate actions to collect debts with a combined principal and interest balance greater than or equal to $25 have been taken before recommending debts for Write-Off Closed (WOC), including the criteria listed below:

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

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

3. Is the debtor receiving Medicaid funds? If so, the contractor shall not recommend the debt for WOC. The contractor shall instead contact the CMS RO to institute an offset and shall continue collection efforts. ***(This criterion only applies to debts that are less than 6 years old)***

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

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

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

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

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

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

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

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

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

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

9. Does the debtor have any open appeal(s)? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await the final determination on the appeal(s), and apply any funds due from a favorable decision to any outstanding debts first, before releasing any funds.
10. Does the debtor have an active fraud case? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall forward the debt to the appropriate Unified Program Integrity Contractor (UPIC) or CMS Centers for Program Integrity that has the open fraud case.

If the contractors have considered all of the above criteria above and are recommending the debts for WOC, the contractors shall submit a request to the CMS RO for approval. The contractor shall submit these debts as instructed in Chapter 4, § 70.16. The contractor shall include the Contractor Validation Statement below with each close-out request submission:

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

Signature of Medicare Contractor CFO: _____
Date: _____

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

Once CMS approves the debts for WOC, the contractors shall complete the WOC process including changing the status to the appropriate Write-Off/Approved/Closed status code, making the appropriate adjustments in HIGLAS or internal system, and making all appropriate adjustments on CMS Form 751 or the TROR.

Letter Number:

Date: &LETTER_DT

&HPROVIDER_NAME
&HPROVIDER_ADDRESS1
&HPROVIDER_ADDRESS2
&HPROVIDER_CITY, &HPROVIDER_STATE &HPROVIDER_POSTAL_CODE
&HPROVIDER_COUNTRY

INITIAL REQUEST

RECEIPT CONFIRMATION REQUESTED

RE : Cost Report - As Filed Cost Report
Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

Dear Sir/Madam,

On &INVOICE_DATE, we received your cost report for the fiscal year ending &FYE_DATE. The cost report, as filed, reflects an overpayment of &DEMAND_AMOUNT for this fiscal year. The Provider Reimbursement Manual (PRM) Part 1, Chapter 24, section 2409.A (2) states that, when a cost report is filed indicating an overpayment, a full refund shall accompany the cost report submission.

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

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

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

If payment in full is not received, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that withhold should not occur, you must notify &CONTRACTOR_NAME. We will review your documentation, but will not delay recoupment.

This is not an appeal of the overpayment determination.

Immediate Recoupment:

NO FURTHER ACTION IS REQUIRED BY YOU. *You have previously elected to have your overpayment(s) repaid through the* ***Immediate Recoupment*** *process. Based on this, payments to you will begin to be recouped on &LETTER_DATE_15 until payment is received in full. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.*

Immediate Recoupment:

TO SIMPLIFY THE REPAYMENT PROCESS, *reduce the extra work and cost associated with mailing your repayment each time, you may elect to have automatic immediate recoupments for ALL overpayments by requesting the* ***Immediate Recoupment*** *process for All Current and Future Accounts Receivable. This will automatically begin recoupment starting on day 16 for ALL future accounts receivable. When the initial request is received after day 16 the debt shall be placed in an immediate recoupment status. If the debt is not collected in full before day 31, interest will continue to accrue until the debt is collected in full.*

You must specify whether you are submitting:

1. *A request on the current demanded overpayment (all accounts receivables within this demand letter) and ALL FUTURE OVERPAYMENTS; or*

2. *A one-time request on this current demanded overpayment (all accounts receivables) addressed in this demand letter only.*

This process is voluntary and for your convenience.

You can visit our website at &CONTRACTOR_URL for the Immediate Recoupment Request instructions.

You may contact this office for information on how to fax your request.

Medicaid Offset:

If this matter is not resolved within *forty (40)* days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of Title XIX of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, section 447.30(g). These recoveries will be in addition to any recoupments from other Medicare funds due you until the full amount owed to Medicare is recovered. The appeal process is detailed in the Notice of Program Reimbursement (NPR).

Interest Assessment:

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

Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance, at the rate of &AR_INTEREST_RATE percent.

Extended Repayment Request:

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

If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Nothing in this letter should be considered as a request or demand for payment. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under, the docket number, and the district where the bankruptcy is filed.

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

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

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

For Debtors That Share a Tax Identification Numbers:

Section 1866(j)(6) of the Social Security Act authorizes the Secretary of Health and Human Services (the Secretary) to make any necessary adjustments to the payments of an applicable provider or supplier who shares a TIN with an obligated provider or supplier, one that has an outstanding Medicare overpayment. The Secretary is authorized to adjust the payments of such a provider or supplier regardless of whether it has been assigned a different billing number or National Provider Identification Number (NPI) from that of the provider or supplier with the outstanding Medicare overpayment.

Should you have any questions, please contact your overpayment consultant at the following:

&BUSINESS_PURPOSE_1
&CONTRACT_CONTACT_PHONE_NUM_1
&BUSINESS_PURPOSE_2
&CONTRACT_CONTACT_PHONE_NUM_2
&BUSINESS_PURPOSE_3
&CONTRACT_CONTACT_PHONE_NUM_3
&BUSINESS_PURPOSE_4
&CONTRACT_CONTACT_PHONE_NUM_4
&BUSINESS_PURPOSE_5
&CONTRACT_CONTACT_PHONE_NUM_5

We expect to hear from you shortly.

Sincerely,

Medicare &MEDICARE_TYPE Recovery Unit
&CONTRACTOR_NAME

Enclosure

How This Overpayment Was Determined