

Medicare Financial Management

Chapter 4 - Debt Collection

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For purposes of these instructions, the term Provider, Physician and other Supplier will be referred to as “Provider”.

The following collection activities are the minimum requirements the Medicare contractor (contractor) shall follow for all Non-MSP provider overpayments. Where additional information is located elsewhere in the manual chapter, an annotation of the specific section is included. (See Medicare Financial Management Manual, Publication 100-06, Chapter 3, §40).

1. Initial Demand letter

The contractor shall send an initial demand letter within established timeframes of the identification or notification of an overpayment. The contractor shall ensure the date of the initial demand letter is the date the AR is established and the date the letter is mailed. The initial demand letter shall include all required language and shall meet timeliness standards as outlined in chapter 3 §200 and/or chapter 4 §§20 and 90.

a. Dollar threshold

The threshold amount to send the initial demand letters is \$25 (principal). The contractor shall aggregate all of the overpayments to the provider to meet the threshold amount for the initial demand letter.

b. Undeliverable demand letter

If the contractor receives the initial demand letter back as undeliverable, the contractor shall attempt to reach the provider by telephone within 10 business days of receiving the undeliverable letter.

If the contractor is unsuccessful at reaching the provider by telephone, the contractor shall at the minimum attempt to locate the provider through other means including:

- Querying the Provider Enrollment Change of Ownership System (PECOS) to determine if there is updated contact information (including an email address) for the provide);
- Contacting the medical review staff or fraud and abuse staff for possible updates on the debtor’s whereabouts;
- Conducting research to see if the provider is in bankruptcy or litigation, and by using the name of the owners, partners, or the corporation officers;
- Conducting an internet search site, including using Lexis-Nexis® or a similar program;
- Contacting the servicing regional office (RO) for assistance or further guidance, if the contractor does not have access to a search engine.

The contractor shall document in the case file all attempts to contact the provider.

2. Recoupment

The contractor shall initiate recoupment of the debt, or any remaining balance of the debt, as outlined below, except when the debt is in the following status: (1) appeal subject to the Limitation on Recoupment provisions (redetermination/reconsideration), (2) bankruptcy, (3) Extended Repayment Schedule (ERS) or (4) a pending ERS request.

For Part A (Non-935 Overpayments)

- Recoupment shall begin 16 days from the date of initial demand letter if the debt is not subject to Limitation on Recoupment provisions of Section 935(f)(2) of the MMA. (See chapter 3, §200)

For Part B (935 and Non-935) and Part A 935 Overpayments

- Recoupment shall begin 41 days from the date of the initial demand letter.
- Recoupment shall continue until the debt is collected in full or is in a status that excludes recoupment.

3. Interest

If the overpayment is not paid in full 30 days from the date of the initial demand letter, contractors shall ensure that interest is assessed beginning on day 31. Simple interest shall be charged on the outstanding principal balance of the debt starting with the date of the initial demand letter and for every 30-day period thereafter, until the debt is paid in full. Refer to chapter 4, §30 and 42 CFR 405.378 for additional information.

4. Telephone Contacts:

Contractors shall attempt to contact providers by phone, at least twice, as follows:

a. First telephone contact

- **Providers who have been terminated/revoked/ or have withdrawn from the Medicare program:**
 - The telephone contact shall be made within 10 business days of the contractor's notification of termination/revocation/withdrawal.
- **Active Providers:**
 - The telephone contact shall be made when the debt is at least 60 days delinquent (90 days from the date of the demand letter) and is not in an appeal, litigation, ERS, or bankruptcy status.
 - The telephone contact may be made sooner if the contractor believes that earlier contact may result in a collection.
 - In situations where the provider cannot be reached by telephone the contractor shall leave a voicemail as needed.
- **Successful Phone Contact:**
 - The contractor shall inform the provider of repayment options (e.g. ERS) and explain that any unpaid delinquent debt will be referred to Treasury for further collection activity. If the provider has a surety bond, the contractor shall inform the provider that the debt will be collected through the surety, and any remaining balance will be referred to Treasury.
 - If the first call is successful, (second call would not be necessary) document the contact.
- **Unsuccessful Phone Contact**
 - The contractor shall discontinue telephone efforts when a provider's number is disconnected.

- The contractor shall at the minimum attempt to locate the provider through other means as listed in discussion of undeliverable demand letters, section 1(b), above.

b. Second Phone Contact

The second phone call is only necessary if the contractor was unable to directly communicate with the provider on the first call.

- The contractor shall make a second phone call to the provider at least 7 business days before referring the debt to Treasury.
- The contractor shall leave a voicemail where the call is directed to voice messaging.
- Leaving the second voicemail message shall be sufficient for attempting to reach the provider by telephone.

The contractor shall document, in the case file, all attempts to contact the provider.

5. Extended Repayment Schedule (ERS)

If the provider submits an application for an ERS, the contractor shall follow the instructions in Chapter 4 §50. An ERS application may be requested at any time during the collection process.

6. Intent to Refer (ITR) letter

For providers who have been terminated/revoked or have withdrawn from the Medicare program:

The contractor shall send the ITR letter:

- If the initial demand letter was returned undeliverable and a better address cannot be located (see below for Instructions Summary for Undeliverable Letters), or
- When the contractor has verified in PECOS or Provider Enrollment that the provider is terminated or out of business.
 - The contractor utilizing HIGLAS shall manually update the accounts receivable (AR) status code to 'PROVIDER-TERMINATED' if the ITR has not been issued and the contractor learns that the provider is terminated or out of business. HIGLAS will not allow the AR status code to be updated to 'PROVIDER-TERMINATED' if the existing AR status code is exempt from Treasury referral.
 - The contractor utilizing HIGLAS shall manually add a comment to the AR status indicating that the provider has been terminated or out of business, when a provider has been terminated or is out of business and has an AR with a status code that is ineligible for Treasury referral"
 - The contractor not utilizing HIGLAS shall manually create the ITR letter and send it as soon as possible if an ITR letter has not been issued and the contractor learns that the provider is terminated or out of business.

For active providers:

The contractor shall send the ITR letter when the debt is **at least** 30 days delinquent (60 days from the determination date)* and is not in a status excluded from debt referral.

NOTE: In all cases, the contractor shall ensure that the ITR letter is sent in enough time to allow the debtor 60 days' notice prior to referral to Treasury. In accordance with provisions of the Digital Accountability and Transparency Act of 2014 (DATA Act) which amended the Debt Collection Improvement Act of 1996 (DCIA), eligible delinquent debts must be referred to Treasury by the 120th day of delinquency. (Refer to chapter 4, §70 for further detail.)

* The Healthcare Integrated General Ledger Accounting System (HIGLAS) adds an additional 5 grace days when determining when to generate the ITR letter to allow for interest accruals to appear on the ITR letter; therefore, the ITR letter will be system generated on day 66.

* **Instructions Summary for Undeliverable Letters**

1. If the contractor utilizing HIGLAS cannot locate a better address within 10 business days of receipt of the undeliverable demand letter, the contractor shall manually update the status code to 'LTR-UNDL-1ST.'
2. If the contractor locates a better address for the undeliverable initial demand letter, the contractor shall send the provider a manual undeliverable demand notification letter, with the initial demand letter attached, to the better address. The original initial demand letter date shall remain in effect.
3. If the contractor not utilizing HIGLAS cannot locate a better address within 10 business days of receipt of the undeliverable initial demand letter, the contractor shall manually create the ITR letter immediately and send it as soon as possible.
4. If the ITR letter is returned as undeliverable and a better address cannot be located within 10 business days of receipt, the contractor utilizing HIGLAS shall update the status code to 'LTR-UNDL-ITR.'
5. If the contractor locates a better address for the undeliverable ITR letter, the contractor shall send the provider a manual undeliverable ITR notification letter, with the original ITR letter attached, to the better address. The original ITR letter date shall remain in effect.

Note: The HIGLAS logic will review the letter history and the debt will become eligible for referral to Treasury 66 days from the ITR letter date.

7. Surety Bond

Prior to referral to Treasury, DME contractors shall refer to instructions outlined in Medicare Program Integrity Manual, Publication100-08, chapter 15, §21.7.1.

8. Record Keeping

The contractor shall keep records of all collection activities through all stages of the debt collection process. This record shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes.

10.1 - Required Timeframes for Debt Collection Process for Provider Overpayments (Rev. 259, Issued: 01-15-16 Effective: 02-16-16, Implementation: 02-16-16)

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 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. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)

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. The initial demand letter shall be sent by first class mail, secured email, or fax.
4. The initial demand letter is an explanation of the nature of the overpayment, how it was established, a bankruptcy notice, and the amount determined.
5. 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).
6. 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.)
7. If payment in full is not received within 30 days, interest will be charged.
8. The initial demand letter includes Debt Collection Improvement Act (DCIA) Intent Language for referral to the Treasury Department for cross servicing.
9. 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.
10. 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 15 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. The provider or supplier may submit a cost report, make a refund, arrange for immediate recoupment, or request an ERS, as applicable.
9. The percentage of withhold shall be indicated whenever an adjustment (reduction or suspension) of interim payments has been imposed.
10. 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.)
11. The cost report letters shall include DCIA Intent Language for referral to the Treasury Department for cross servicing.
12. 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.

20.1 - Number of Demand Letters

(Rev. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)

In general, the contractor sends one overpayment Initial (1st) demand letter to a provider or supplier. The contractor shall have at all times access to copies of the demand letters generally housed in the case file, bulk PDF, or in HIGLAS. When the demand letter has been sent and returned as undeliverable, the contractor shall attempt to locate the provider or supplier (see Chapter 4, §10). If the contractor is unable to locate the provider or supplier and the overpayment is eligible for referral to the Department of Treasury, the contractor shall immediately send the ITR demand letter, which shall include the intent to refer language.

Where a repayment schedule has been established after the Initial (1st) demand letter has been sent **and** the provider or supplier defaults on the repayment schedule, the contractor shall count that 1st demand letter as one of the two letters (1st and ITR) normally sent to an overpaid provider or supplier.

20.2 – Sample Demand Letters All Providers or Suppliers

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

It is CMS' responsibility to protect the Trust Fund and replenish any overpaid funds. In this section, contractors are given templates to model when sending providers and suppliers a request for payment.

EXHIBIT 1- INITIAL DEMAND LETTER - NON-935–

(Rev .316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)

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.

D. 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 of the 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. **This is not an appeal of the overpayment determination.** Our office will advise you of our decision 15 days from the mailroom-stamped receipt date of your request.

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:

If Provider is enrolled in 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_16 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.

If Provider is NOT enrolled in 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 {MAC site} for the Immediate Recoupment Request instructions.

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

You may contact this office for information on how to fax your request. (Immediate recoupment already in effect for Part A non-935.)

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. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)

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. **This 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 [&CONTRACTOR_URL] for ERS instructions and forms.**

Immediate Recoupment:

If Provider is enrolled in 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_16 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.

If Provider is NOT enrolled in 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 {MAC site} for the Immediate Recoupment Request instructions.

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

This process is voluntary and for your convenience. Your request must specifically state you understand you are waiving potential receipt of interest payment pursuant to § 1893(f) (2) for the overpayments.

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. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)**

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.

Medicaid Offset

If this matter is not resolved within fifteen (15) days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of 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 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 _____ at _____. We expect to hear from you shortly.

Sincerely,

(Name and Title)

Enclosure
(Name and Title)

Enclosure

EXHIBIT 4- INITIAL DEMAND LETTER – UNFILED COST REPORT
(Rev. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)

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

1. (APROVNONCRASF1.pdf): Part-A Non As-Unfiled Cost Report Initial Demand Letter

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

(Mailed 7 calendar days after cost report was

due.) Date:

INITIAL DEMAND LETTER

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

RECEIPT CONFIRMATION REQUESTED

RE: Late Medicare Cost

Report Provider Name: [DBA

Name] Provider Number:

[xxxxxxx]

Fiscal Year End: [Month, Day, Year]

Dear [Title] [Last Name]

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

(Unfiled Cost Report)

We have not received the cost report for [DBA Name], provider number [xxxxxxx] for the period ending [month/day/year]. Under Title 42 Code of Federal Regulations (CFR), § 413.24, cost reports are due by the last day of the fifth (5th) month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS&R) reports from the contractor, whichever is later. Your report is now late, as it was due [month/day/year].

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.

(Home Office Cost Report is Unfiled)

We have not received the home office cost statement from_____. According to our records, ___ serves as the home office for your facility. Since the home office cost statement remains unfiled, the amount stated on your filed cost report for the fiscal year ending__ for home office costs has been disallowed. This disallowance will continue until the home office submits the home office cost statement.

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.

Deemed Overpayment:

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

If full payment is not received or arrangements made for an extended repayment schedule, we will take all action(s) necessary to recover the full amount. You can visit our website at [&CONTRACTOR_URL] for ERS instructions and forms.

Suspension:

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

Interest Charges:

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

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

Interest Computation:

The interest rate in effect at the time your cost report was due is [xx.xxx%]. This rate is applicable to any overpayments related to the untimely filing of your cost report. Under Title 42 CFR § 405.378 (b) (2),

interest charges are assessed in thirty (30)-day periods. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be assessed and for each full 30-day period until the debt is paid in full.

Cost Report Submission:

Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report, together with any amounts due (principal and interest); (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty (30) days of the date of this letter; or (3) A request for a repayment schedule of all interim payments, the deemed overpayment, within fifteen (15) days of the date of this letter. Checks are to be made payable to [Contractor]. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

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

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

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.

Medicaid Offset:

If this matter is not resolved within fifteen (15) days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, § 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.

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.

Termination of Medicare Provider Agreement:

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

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

Sincerely,

[Title] [Name] [Position Title]

Intent to Refer Letters:

**EXHIBIT 5- INTENT TO REFER LETTER- NON-935 –
(Rev. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)**

Contractors shall use the appropriate template below:

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

1. (BPROV3.pdf) Part B Provider Intent to Refer
2. (APROV3.pdf) Part A Aggregate Claims Intent to Refer

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

Note: Contractors shall use this template for manual letters and shall scan all letters for easy access.

Date: &LETTER

&LETTER_HEADER1 &LETTER_HEADER2
&LETTER_HEADER3 &LETTER_HEADER4

Letter Number: &LETTER_NUMBER

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

RE: Overpayment Amount: &HINVOICE_AMOUNT Outstanding Balance:
&DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

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

Dear Sir/Madam:

On &DATE_OF_ORIGINAL_DEMAND_LETTER, we sent a letter requesting that you refund an overpayment made to you in the amount of &HINVOICE_AMOUNT that resulted from claim(s) accounts receivable(s). As of the date of this letter, we have not yet received payment, an application for an extended repayment schedule, or have sufficient assigned Medicare claims been submitted for collection of

the balance. The outstanding amount due for this overpayment is &DEMAND_AMOUNT, which includes a principal amount of &INVOICE_BALANCE_AMOUNT and interest assessed in the amount of &INTEREST_BALANCE_AMOUNT.

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

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.

Repayment

Your debt will not be referred to the Department of Treasury if you make payment in full. The past due amount of &DEMAND_AMOUNT owed to the Medicare Program as of &LETTER_DT includes interest accrued through &LAST_INTEREST_ACCRUAL_DATE. Interest is accrued monthly and is added to the balance of the debt.

Your check or money order for the amount due should be made payable to Medicare and sent with a copy of this letter to:

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

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement if you are eligible under the requirements at 42 C.F.R. 401.607(c)(2). If you are interested in an extended repayment agreement, please contact this office. Refer to your initial demand letter to determine your rights to an appeal.

Referral To The U.S. Department of The Treasury for Collection

If your debt remains unpaid 60 days from the date of this letter, your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. 3711(g). The Treasury's Debt Management Services will use various tools to collect the debt, including offset of federal payments, demand letters, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation.

Due Process

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

For Individual Debtors Filing a Joint Federal Income Tax Return

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

Overpayments from Debtors Who 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.

Federal Salary Offset

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

Medicaid Offset

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, per Title 42 CFR, § 447.30. These recoveries will be in addition to any recoupment from other Medicare funds due you until the full amount owed to Medicare is recovered.

Bankruptcy

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

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 look forward to hearing from you shortly.

Sincerely,

Medicare Recovery Unit

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

1. (APROV9353.pdf) Part A 935 Aggregate & Adjustment Claims Intent to Refer
2. (APROVRAC2.pdf) Part A 935 RAC Adjustment Claims Intent to Refer
3. (BPROV9353.pdf) Part B 935 Adjustment Claims Intent to Refer
4. (BPROVRAC2.pdf) Part B 935 RAC Adjustment Claims Intent to Refer

B. Contractors shall use the appropriate first paragraph below.

RE: Medicare Overpayment and Notice of Intent to Refer Debt to the Department of Treasury's Debt Collection Center for Cross Servicing and Offset of Federal Payments and Certain Eligible State Payments - MMA 935

Provider Name: &HPROVIDER_NAME Provider Number:
&HPROVIDER_NUMBER Outstanding Balance:
&DEMAND_AMOUNT

Dear Sir/Madam:

Part A and B overpayments subject to 935 (excluding RAC overpayments)

On &DATE_OF_ORIGINAL_DEMAND_LETTER, we sent a letter requesting that you refund an **overpayment subject to 935**, Limitation on Recoupment. As of this date, we have not yet received payment, a 935 appeal request, or an application for an extended repayment schedule and insufficient assigned Medicare claims have been submitted for collection of the balance. The outstanding amount due for this overpayment is &DEMAND_AMOUNT, which includes a principal amount of &INVOICE_BALANCE_AMOUNT and interest assessed in the amount of &INTEREST_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 and B 935 RAC Adjustment Claims

On &DATE_OF_ORIGINAL_DEMAND_LETTER, we sent a letter requesting that you refund a **Recovery Auditor-identified** overpayment subject to 935, Limitation on Recoupment. As of this date, we have not yet received payment, a 935 appeal request, or an application for an extended repayment schedule and insufficient assigned Medicare claims have been submitted for collection of the balance. The outstanding amount due for this overpayment is &DEMAND_AMOUNT, which includes a principal amount of &INVOICE_BALANCE_AMOUNT and interest assessed in the amount of INTEREST_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.

[Contractors shall include the following language in all ITR-935 letters after the first paragraph.]

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt will be referred to the Department of Treasury's Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments. This could occur should the amounts recovered through withholding (offset)

of your claims be insufficient to satisfy the monthly amount of your extended repayment schedule or the amount needed to be current on the extended repayment schedule. Your debt will be referred under provisions of federal law, title 31 of the United States Code, § 3720A, which is a provision of the Debt Collection Improvement Act of 1996.

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

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

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

For Individual Debtors Filing a Joint Federal Income Tax Return

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

Overpayments from Debtors Who 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.

Federal Salary Offset

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

Medicaid Offset

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 recoupment from other Medicare funds due you until the full amount owed to Medicare is recovered.

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

Due Process

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

Repayment

Your debt shall not be referred to the Department of Treasury if you make payment in full. The past due amount owed to the Medicare Program as of the date of this letter includes current accrued interest. Interest is accrued monthly and is added to the balance of the debt. Your check or money order for the amount due should be made payable to:

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

Include a copy of this letter with your payment.

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement if you are eligible under the extended repayment requirements at 42 C.F.R. 401.607(c)(2). If you are interested in an extended repayment agreement, please contact this office.

Bankruptcy

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

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. Any repayment schedule (where one is approved) would run from the approval date.

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

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

Should you have any questions, please contact 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 look forward to hearing from you shortly. Sincerely,

Supervisor, Part A Overpayments &CONTRACTOR_NAME

**EXHIBIT 7- INTENT TO REFER LETTER - UNFILED COST REPORTS ONLY -
(Rev. 316, Issued: 05-24-19, Effective: 10-01-19, Implementation: 10-07-19)**

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

1. (APROVCRUNF3.pdf) Part A Unfiled Cost Report Intent to Refer

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

RE: Intent to Refer Letter Provider or Supplier Name: Provider/Supplier Number: &
Overpayment Amount: &HINVOICE_AMOUNT Outstanding
Balance: &DEMAND_AMOUNT

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

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

**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.**

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

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

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

For Individual Debtors Filing a Joint Federal Income Tax Return

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

Federal Salary Offset

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

Medicaid Offset

As authorized in 42 CFR 447.30, and Section 1914 of the Social Security Act, CMS **may** instruct the State Medicaid Agency to offset the Federal share of any Medicaid payments due to you, your agency and/or related facilities. At that time, the offset **shall** remain in effect until the Medicare overpayment is paid in full.

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

Due Process

You have the right to request an opportunity to inspect and copy records relating to the **unfiled cost report debt**. This request must be submitted in writing to the address listed below. You have the right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter.

You must submit any evidence that the debt is not owed or legally enforceable within **60 calendar** days of the date of this letter. If, after sixty (60) calendar days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, **may** be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset. **NOTE: Unfiled Cost Report debts (including new ones) may be transferred to Treasury for cross servicing/offset, upon approval from CMS central/regional offices.**

Repayment

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

Your check or money order for the amount due, made payable to: Medicare

Contractor
Address 000 Street
Anywhere USA 00000-0000

Include a copy of this letter with your payment.

If you cannot make the payment in full, you **may** be allowed to enter into an **extended repayment agreement**.

If you are interested in an extended repayment agreement, please contact this office.

Bankruptcy

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

If you have any questions concerning this debt, please contact _____
at _____.

Sincerely,

[Signature of Certifying Official]

30 - Interest Assessment/Payment on Overpayments and Underpayments

(Rev. 29, 01-02-04)

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

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

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

30.1 - Final Determination

(Rev. 29, 01-02-04)

For purposes of this chapter:

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

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

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

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

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

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

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

30.2 - Rates of Interest - FIs and Carriers

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

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

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

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

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

30.3 - Interest Accruals

(Rev. 41, 04-30-04)

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

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

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

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

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

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

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

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

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

The carrier discovers that an overpayment for \$795.45 exists and sends a demand letter on 09/30/04. (The determination date of this overpayment is prior to the effective date of the revision to 42 CFR 405.378). The provider does not remit payment on the overpayment until 11/14/2004 (45 days after the date of the initial demand letter). Therefore, interest accrues on the \$795.45 for two full 30-day periods.

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

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

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

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

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

Examples of Application when cost report not filed on time

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

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

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

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

C. Accrual of Interest; Rejected Cost Report

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

Example of Interest Accrual When the Cost Report is Rejected

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

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

overpayment amount, interest accrues on the difference between the check and the overpayment listed on the revised cost report. The interest rate is the rate that was in effect on the day the cost report was due.

D. Underpayments

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

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

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

30.4 - Procedures for Applying Interest During Overpayment Recoupment

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

A. General

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

B. Recoupment Through Installment Payments

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

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

Interest rates remain constant based upon the initial rate assessed unless the provider defaults, i.e., **misses one consecutive installment payment following a delinquent status** of an extended repayment agreement. Interest on the principal balance of the debt may be changed to the current prevailing rate if (a) the provider **has defaulted** on its installment payments and (b) the current prevailing rate in effect on the date the

installment becomes overdue is higher than the rate specified in the agreement. (For FISS and APASS users only.) Each payment is applied first to accrued interest and then to principal. After each payment interest will accrue on the remaining unpaid principal balance.

C. Proof of Receipt

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

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

A. Cost Report Reminder Letters

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

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

2. Assessed Interest- If a cost report is filed on time and indicates an amount is due CMS, interest will accrue on that overpayment from the date the cost report is due, unless full payment accompanies the report or the provider and the contractor agree in writing, in advance, to recoup the amount of the overpayment from interim payments over the next 30-day period.

B. Notice of Program Reimbursement (NPR)

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

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

C. Overpayment Demand Letters

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

30.6 - Waiver and Adjustment of Interest Charges

(Rev. 41, 04-30-04)

A. Waiver of Interest Charges

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

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

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

B. Adjustment of Interest Charges

1. Reopenings-FI

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

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

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

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

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

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

Example of Application

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

As a result of a hearing on 12/10/05, the PRRB reverses the intermediary's findings and determines that the correct amount due the program was \$4,000. The excess \$12,000 in principal and the accrued interest on \$12,000 that was assessed and collected must be returned to the provider.

3. Judicial Review

The policies and procedures of this section do not apply to the time period for which interest is payable under 42 CFR 413.64(j) because the provider seeks judicial review of an adverse decision by the PRRB or the decision of the Administrator. Section 1878(f) of the Social Security Act authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis. The interest rate assessed is the rate on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. This rate of interest can be found at <http://cms.hhs.gov/statistics/trust-fund-interest-rates/>. If the FI withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider. However, if the Medicare program had recovered any of the amount in controversy interest would be payable from the time of recovery through the date of payment.)

40 – Withholds and Suspensions **(Rev. 29, 01-02-04)**

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

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

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

40.1 – Recoupment by Withholding Payments **(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)**

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 15 days following the date of the notification to submit such a statement.

C. Cost Report Overpayments Percentage of Withhold

Some percentage of withhold shall begin 15 days after the date of the first demand letter (day 16) if the overpayment has not yet been liquidated or an extended repayment plan has not been requested. The matrix

below shall be utilized to determine the percentage of withhold for an overpayment determined from a cost report that has been filed (as filed cost report, tentative settlement, or final settlement), a PIP review, or an interim rate review. See Chapter 3, §30.1 when a cost report remains unfiled.

Day 16	No word from provider	100 % withhold
Day 16	Provider has submitted Extended Repayment Schedule (<i>ERS</i>) application	No withhold <i>if</i> provider submitted a <i>good faith</i> payment along with <i>ERS</i> application. <i>Good faith</i> payments must continue on a monthly basis until provider receives written approval or denial of the <i>ERS</i> request. If <i>good faith</i> payment is not received with the application request, withhold shall be initiated at 30%.
Day 16	Provider has submitted <i>ERS</i> application but it is incomplete	No withhold as long as provider submitted a first <i>good faith</i> payment along with <i>ERS</i> application. If <i>good faith</i> payment is not received with the application request, withhold shall be initiated at 30%. Once a completed application is submitted, <i>good faith</i> payments <i>or 30% withholding</i> must continue on a monthly basis until provider receives written approval or denial of the <i>ERS</i> request. If completed information is not received within an allotted amount of time (rarely more than 30 days) withhold shall be initiated at 100%.
Day 16	Provider has said that it is planning to submit an <i>ERS</i> application	30% withhold- when <i>ERS</i> application is received, cease withhold if <i>a good faith</i> payment accompanies the application request; maintain 30% withhold if payment does not accompany application.
Day 30	Still no word from provider	<i>Withhold at 100%.</i>
Day 30+	<i>ERS</i> application is being reviewed by RO or CO	No withhold as long as provider continues to submit appropriate <i>good faith</i> payments on a monthly basis under the terms of the application request. If provider did not submit a first <i>good faith</i> payment or does not submit subsequent payments, withhold shall be 30% <i>of payments</i> unless RO or CO gives alternative instructions.
Day 30	Provider said an <i>ERS</i> 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 <i>or refer to RO for direction.</i>
Day 45+	No <i>ERS</i> application and no payment by provider	<i>Withhold at 100%</i>

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.

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

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

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

- Fraud or willful misrepresentation exists;
- An overpayment exists but the amount of the overpayment is not yet determined;
- The payments to be made may not be correct; or

- The provider fails to furnish records and other requested information. (Some examples include cost reports, credit balance reports, and form CMS-91.)

50 - Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP))

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

For purposes of these instructions, the term Provider, Physician and other Supplier will be referred to as “Provider.”

For purposes of these instructions, the term *Medicare Administrative Contractor (MAC)* may be referred to as “Contractor.”

For the purposes of these instructions, the following definitions apply; See 42 C.F.R. §401.607(c)(2) and (3):

Hardship exists when the total amount of all outstanding overpayments (principal and interest) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made for: (1) the cost reporting period covered by the most recently submitted cost report; or (2) the previous calendar year for a non-cost report provider (see below ‘additional factors to consider’ when determining eligibility).

Extreme Hardship exists when a provider qualifies as being in “hardship” as defined in the previous paragraph and a 36 month to 60 month extended repayment schedule (ERS) is deemed eligible for approval consideration by Medicare.

Additional Factors to Consider:

The contractor shall evaluate the request, based on the definitions written above, in conjunction with the requirements found in sections 50-50.3 of this chapter. For a provider whose situation does not meet the definitions written above, the contractor shall evaluate the ERS request based on the requirements found in sections 50-50.3 of this chapter and consider the information in (i) – (iii) below, when deciding whether to grant an ERS.

The contractor shall determine the number, amount, and frequency of installment payments based on the information submitted by the debtor and on other factors such as:

- Total amount of the claim (overpayment);
- Provider's ability to pay; and
- Cost to CMS of administering an installment agreement.

The contractor shall document evaluation factors, including communication with CMS, used during the decision-making process.

A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a “hardship” on the provider, a request for an ERS should be submitted immediately. However, if the overpayment is outstanding and not referred to Treasury, the provider shall request an ERS beyond 30 days, and the contractor shall review that request. Instructions on how to apply for an ERS shall be available on the contractors’ website for provider reference. Medicare demand letters shall refer providers to the contractors’ website for detailed ERS instructions. Contractors shall include in the ERS instructions a form in which the provider can elect to have their underpayments or manual refunds automatically applied to their overpayment (see section B below). Providers shall be given the option to request a paper copy.

A. The following steps shall be implemented upon receipt of an ERS:

1. A provider shall submit a signed ERS request which includes:
 - i. the specific overpayment for which an ERS is being requested;
 - ii. the number of months requested;
 - iii. CMS required documents (see sections 50.1-50.2) and a good faith payment equaling one month's payment of the providers requested terms with its request (ex. 36 month request = 1/36th minimum). *Good faith payments shall not be considered monthly payments for the MAC approved ERS, but instead, shall be applied to reduce the overall balance of the overpayment.*

This is what constitutes a complete ERS.

2. Contractors shall evaluate all providers' requests for an extended repayment schedule up to 60 months, *and* shall only approve/disapprove ERS requests up to *60* months.
3. Contractors should consider ERS requests for *6-15* months on a case-by-case basis. Approval should only be for cases where it is clear that the debt can be repaid in this short period. Requests for *6* -15 month ERSs do not require submitting financial documentation if the provider meets the hardship qualifications and does not fall within a scenario found in section 50.3(1).
4. *When deemed appropriate*, contractors *may* refer ERS requests that need *additional* guidance to *the* Regional Office (RO), along with a recommendation.
5. The RO *will* evaluate ERS requests *as needed or requested by the contractor for further direction*. (see 42 CFR 401-607(c)(2)(vi)).
6. CMS Central Office (CO) will evaluate ERS requests as needed or requested by the RO.
7. All ERS requests shall be reviewed and evaluated for approval, disapproval, or referral to RO/CO within 30 *calendar* days of receipt of the complete request.
8. Providers *may* request for *an ERS under 16* months without submitting financial documentation if they meet the hardship qualifications and do not fall within a scenario found in section 50.3(1).
9. The Provider shall submit financial documentation for ERS request *16* months or longer.
10. The contractor shall determine eligibility qualifications and the duration of the ERS based on its review of the provider's documentation and any other information acquired (such as fraud information, claims data, overpayment history, etc.).
11. If an ERS is approved and a provider misses *one consecutive* installment payment *following a delinquent status*, the provider is in default. (refer to 42 CFR §401.607(2)(v)). *Delinquent loan status is when a provider misses one installment payment. Default loan status is when a provider misses one consecutive installment payment, following a delinquent loan status.* The contractor shall send a notice of default to the provider within 5 *calendar* days, suspend the ERS agreement, and immediately resume normal debt collection procedures.
12. The contractor shall consider a providers' request to reinstate the ERS, even after default. If reinstated, the provider shall be required to submit new documentation to determine eligibility. The contractor shall determine to reinstate the original ERS agreement or revise the schedule, if approved. If revised, the contractor shall ensure that the revised terms do not extend the original and revised schedule beyond 60 months. The ERS will be closed with no reopening, if the provider

were to default again on the reinstated request.

13. The contractor should not grant an ERS to a provider where there is a previously defaulted ERS that was not resolved (reinstated, paid up to date, or paid in full).

B. The following steps shall be implemented when reviewing and establishing an ERS:

1. If a complete ERS request and a good faith check payment (see note a. below) are received, the contractor shall start reviewing the request immediately. The contractor shall accept the good faith payment(s) and suspend any recoupment during the review of the ERS.
2. Contractors shall review the complete ERS package to make a final decision within 30 *calendar* days of receipt. If the contractor needs additional time to review an ERS request, it shall work with their RO to determine a reasonable timeframe to complete.
3. If an ERS request is received with all documentation but no good faith payment, (see note a. below) the contractor shall immediately place the provider on 30% recoupment during the review of the ERS.
4. Contractors shall review the ERS documents in detail to determine if there are any other documents needed. If additional documents are needed the contractors shall request additional documentation.
5. *If an incomplete ERS request is received, the contractor shall review the submitted documentation, determine and request all missing documents. If a good faith payment was not received, the MAC shall immediately place the provider on no less than 30% recoupment. If the contractor requests additional documentation and the information is not received by the 16th calendar day after the contractor's request, the contractor should close the request and resume normal collect activities.*
6. Contractors shall review the ERS documents in detail to determine if there are any other documents needed. If additional documents are needed the contractors shall request additional documentation.
7. Contractors should extend an additional 15 calendar days to receive the documentation from the provider before closing the request. Upon receipt, the contractor shall complete its review of the additional documentation within 5 *calendar* days.
8. Contractors shall ensure that requesting additional documentation will not unnecessarily extend the decision-making period.
9. If the contractor needs additional time to conduct the review, they shall work with their RO to determine a reasonable timeframe to complete.
10. Contractors shall **NOT** refund any payments received or recouped that occurred while processing an ERS, but shall apply such amount(s) to the outstanding overpayment(s) (apply to interest first then principal), unless CMS directs otherwise.
11. If the ERS request is approved, the contractor shall establish an ERS to recover the remaining balance of an overpayment.
12. Pre-accrued interest shall be recovered first before applying any payments to principal. Pre-accrued interest can either be recovered in one lump sum or over multiple months (not to exceed 3 months, unless directed by CMS), depending on a provider's ability to pay in full or over time.
13. Contractors shall ensure that interest continues to accrue on the overpayment until it is paid in full. While recovering the pre-accrued interest amounts, the contractor shall also recover the interest

that continues to accrue on the outstanding principal balance.

14. Once the pre-accrued interest is paid in full, the ERS (recovering principal and accruing interest) shall begin.
15. Approved ERS requests will run from the ERS approval date.
16. If the ERS request is denied, the contractor shall continue with normal debt collection activities. Providers shall be permitted one additional ERS request for an overpayment, where a previous ERS was denied.
17. If both ERS requests are denied, any additional ERS requests for that overpayment (that a contractor deems should be considered) shall be forwarded to the RO for review.
18. Contractors shall include in the ERS instructions an option in which the provider can elect to have all of its underpayments or manual refunds automatically applied to its overpayment. Subject to section B below, a provider can rescind its consent to automatic recoupment or offset of underpayments and manual refunds, with further written notice to the contractor.
19. Any underpayments or manual refunds applied to an overpayment shall reduce the term of the ERS and shall not affect the installment amounts due under any amortization schedule.
20. Unless the provider has submitted a request asking the MAC to automatically apply underpayments and manual payments to the ERS payments, contractors shall not automatically apply an underpayment due to a cost report or a manual refund due to over collection to the ERS overpayment.
21. If the contractor determines a Medicare underpayment or manual refund after establishing an ERS, the contractor shall notify the provider in writing of the underpayment or manual refund.
22. The contractor shall permit the provider 15 calendar days following the date of notification to submit a request (with justification) to refund the underpayment.
23. If the provider does not respond in the required timeframe or has not submitted a form asking the contractor to automatically apply the underpayment or manual refund to the ERS payments, the contractor shall immediately apply this amount to the ERS payments (with the exception of #20 above).
24. If the provider responds timely, the contractor has 15 calendar days from the receipt date to determine if the provider's justification is in the best interest of the Medicare program. The contractor should either apply the underpayment or refund the amount to the provider.
25. If a provider does not submit such a justification, the contractor shall deny the request and shall immediately apply this amount to the ERS payments.
26. If the provider fails to provide accurate current financial information, including certifying that no material change has occurred, the contractor shall apply the underpayment or manual refund to the ERS.
27. If a refund request is denied, the contractor shall send written notice of the determination to the provider, explaining the rationale for the determination. The determination is not an initial determination and is not appealable.

NOTE(S):

- a. Good faith payments are monthly payments submitted by the provider while an ERS is in review. They should equal one (1) month's payment of the providers requested terms; ex., 36-month request = 1/36th minimum good faith payment. Payments less than this amount are not considered a good faith payment. Payments shall continue to be submitted monthly while the ERS is being reviewed.
- b. If under a 935 appeal, the provider shall continue to submit good faith payments or ERS *installment* payments. These payments are considered voluntary payments and not 935 recoupments.

50.1 – ERS Required Documentation --Physician is a Sole Proprietor

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

- A. The contractor shall require that the provider (physician/sole proprietor) furnish the following for *Extended Repayment Schedule (ERS)* request of *15* months or *less*:
 1. **Signed Proposed Amortization Schedule** – The CMS requires a signed request, including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.
 2. **Good Faith Payments** – The CMS requires the provider to submit the first *good faith* payment (per the proposed amortization schedule) *with the ERS application*, along with any future payments due, while under review. Providers shall submit a good faith payment each month until the ERS review is decided.
- B. The contractor shall require that the provider (physician/sole proprietor) furnish the following for an ERS request of *16* months or more:
 1. **Signed Proposed Amortization Schedule** – The CMS requires a signed request, including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.
 2. **Good Faith Payments** – The CMS requires the provider to submit the first *good faith* payment (per the proposed amortization schedule), along with any future payments due while under review. Providers shall submit a good faith payment each month until the ERS review is decided.
 3. **CMS-379 Form** - a completed CMS -379 Form. The information requested on this form is necessary for the contractor to determine if the physician/sole proprietor will be able to make installment payments on a claim.
 4. **Financial Statements** - of Debtor.
 5. **Income Tax Return** - a copy of the provider's income tax filing for the most recent calendar year.

50.2 - ERS Required Documentation– Provider is an Entity Other Than a Sole Proprietor

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

- A. The contractor shall require that the provider (NOT a physician/sole proprietor) furnish the following for an Extended Repayment Schedule (ERS) request of *15* months or less:
1. **Signed Proposed Amortization Schedule** – The CMS requires a signed request, including a proposed monthly term and payment installment schedule, as a provider’s agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.
 2. **Good Faith Payments** – The CMS requires the provider to submit the first *good faith* payment (per the proposed amortization schedule), along with any future payments due while under review. Providers shall submit a good faith payment each month until the ERS review is decided.
- B. The contractor shall require that the provider (NOT a physician/sole proprietor) furnish the following for ERS request of *16* months or more:
1. **Signed Proposed Amortization Schedule** – The CMS requires a signed request, including a proposed monthly term and payment installment schedule, as a provider’s agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.
 2. **Good Faith Payments** – The CMS requires the provider to submit the first *good faith* payment (per the proposed amortization schedule), along with any future payments due while under review. Providers shall submit a good faith payment each month until the ERS review is decided.
 3. **Balance sheets** - the provider’s most current balance sheet and the balance sheet for the last complete Medicare cost reporting period (or the most recent fiscal year).

NOTE:

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

4. **Income statements** - related to the balance sheets. The CMS requires that both the balance sheets and income statements include similar agreement language:

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

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

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

Signed

Officer/Administrator of Provider(s) Title

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

Date

5. **Cash flow statements** - for the periods covered by the balance sheets (see Exhibit 3 for recommended format). If the date of the provider's request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement shall be provided for all months between that date and the date of the request.
6. **Projected cash flow statement** - from the date of the request and covering the remainder of the fiscal year. If fewer than 6 months remain, the provider shall include a projected cash flow statement for the following year. (See Exhibit 3 for recommended format.)
7. **List of restricted cash funds** - by amount as of the date of request and the purpose for which each fund is to be used (if applicable).
8. **List of investments** - by type (stock, bond, etc.), amount and current market value as of the date of the report (if applicable).
9. **List of notes and mortgages payable** - by amounts as of the date of the report, and their due dates (if applicable).
10. **Schedule showing amounts** - due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations/persons, TIN and NPI numbers. It shall also show where the amounts appear on the balance sheet-- such as Accounts Receivable, Notes Receivable, etc.
11. **Schedule showing types** - amounts of expenses (included in the income statements) paid to related organizations. The schedule shall show names of the related organizations, TIN and NPI numbers.
12. **The percentage of occupancy**- by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods the income statements cover.

All financial records must be for the business participating in the program. It should not be for the owner if the business is a partnership or a corporation. If an outside facility manages the financial aspects of the business, the provider shall submit individual financial records, as well as the financial records of the outside facility.

50.3 - ERS Approval Process

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

Contractors shall not approve any Extended Repayment Schedule (ERS) if any of the following apply:

1. When there is reason to suspect that the provider may:
 - a) file for bankruptcy;
 - b) cease to do business;
 - c) discontinue participation in the program; or
 - d) when there is an indication of fraud or abuse committed against the program.
2. When any of the following is not submitted with request:

- a) a signed request agreement;
- b) all required documents;
- c) a proposed term and installment schedule; and
- d) the first installment payment (per the proposed installment schedule).

15 months or less ERS

The contractor shall review and confirm that none of the scenarios listed above apply. The contractor shall review 12 months of claims and payment history and consider whether it supports full payment of the overpayment within *15 months or less*. Once the contractor determines ability to repay, it shall examine the status of any outstanding overpayments, cost report settlements, advanced payments and accelerated payments. In the case any of these overpayments are excessive, in default or delinquent, the contractor shall determine if an ERS for *15 months or less* is appropriate.

16 months or more ERS

The contractor shall review and confirm that none of the scenarios listed in the beginning of this section apply. The contractor shall analyze the financial data submitted by the provider to determine the availability of cash, marketable securities, accounts receivable, restricted and unrestricted endowment funds, or special funds, and considers whether these funds could be used for partial or full payment of the overpayment (see Exhibits 1-4 below).

The contractor shall review 12 months of claims and payment history, and considers whether it supports full payment of the overpayment within the requested months. Once the contractor determines ability to repay, it shall examine the status of any outstanding overpayments, cost report settlements, advanced payments and accelerated payments. In the case any of these overpayments are excessive, in default or delinquent, the contractor shall determine if an ERS is appropriate. The contractor shall reference and complete the ERS protocol sheet (see Exhibit 1) while reviewing and once a decision is made.

The contractor should alter the length of time when approving an ERS request, based on its analysis of the provider's submitted documentation. For example, if a provider requests 24 months, but the contractor determines that 12 months is sufficient, the contractor can deny the 24 month request and extend an offer of a 12 month repayment plan.

The contractor should request additional financial information from the provider, if needed. It should also request financial information from the owner if the owner is requesting to submit personal capital to help repay the Medicare debt.

The contractor shall provide a recommendation to the RO; shall deny or approve for terms under its authority; or shall request additional information from the provider within 30 days of receipt of the completed ERS request.

If the provider is unable to furnish all of the required documentation listed in 50.1 and 50.2 of this chapter, a full explanation shall be provided as to why this is the case. All documentation shall be received within 30 days of the date of the request (see § 50(2) of this chapter). Where the provider's explanation is reasonable and the documentation is otherwise acceptable, the contractor shall forward the request for extended repayment to the RO with its recommendation, within 30 days receipt of the completed request. The contractor shall comply with Chapter 4 §40 regarding recouping the overpayments pending receipt of the provider's documentation and the contractor's decision on the extended repayment request.

If the provider is able to furnish all of the required documentation listed in 50.1 and 50.2 of this chapter timely, the contractor shall *approve, counter or deny the request* within 30 days receipt of the completed request.

If the contractor determines that the provider **DOES** meet the requirements for an ERS, it shall:

- a) notify the provider in writing, within 5 *calendar* days of making the decision;
- b) include the amortization schedule showing principal and interest payment amounts and dates payments are due; and
- c) include approval information on the quarterly report (see § 50.4 of this chapter).

If the contractor determines that the provider **DOES NOT** meet the requirements for an ERS, it shall:

- a) notify the provider in writing, within 5 *calendar* days of making the decision; and
- b) include the denial reason, in the notification.

In the case the provider:

Rejects: If a provider rejects the approved terms, it shall submit a written and signed rejection notice to the contractor. In this case, the contractor shall close out the request and follow normal recoupment policy and procedures, at a recoupment rate of 100% of the provider's payments.

Disagrees: If a provider requests additional month(s) due to hardship, the contractor shall elevate the request to the RO for further review. When needed, the RO should contact CO for additional guidance.

No Response: If the provider has not responded, the contractor shall proceed with the ERS as outlined in the approved schedule.

Exhibit I – Protocol for Reviewing Extended Repayment Schedule (ERS)

Provider _____

Provider Number _____

(Part A Only) Cost Report _____

FYE (Part B Only) Date(s) _____

Overpaid Overpayment _____

Amount \$ _____

Date of Demand Letter _____

No. of Months Requested for ERS _____

Date of Request Received _____

Bankrupt ___ Terminated ___ Suspended ___ Revoked ___ Fraud ___ Documented ___

Decision Date (36 Months or less) _____ (36 or more) _____ # of Mos. Apprvd. _____

Date Referred to RO for Consideration _____

Name of Contractor _____

Decision Reason _____

Reviewed By _____

Contractor Analyst _____

Supervisor Review _____

Date _____

1. Contractor shall summarize the major reasons why the overpayment occurred.
2. Contractor shall review the documentation the provider submits to determine whether it is complete. (Refer to §50.1 and 50.2 for required documentation.) Contractor analyzes the financial data submitted (for an ERS over 12 months) to determine the availability of cash, marketable securities, accounts receivable, restricted and unrestricted endowment funds, or special funds, and considers whether these funds could be used for partial or full payment of the overpayment.
3. Contractor shall perform the following calculations by using the most current financial data that the provider submitted to determine whether the provider qualifies for an ERS.

(a) Current Ratio

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

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

This ratio defines the number of dollars held in current assets per dollar of current liabilities (e.g., it relates current assets to current liabilities).

Multiple coverage of liabilities is desirable. Generally, high values for the current ratio imply a good ability to pay short-term obligations and, thus, a low probability of technical insolvency.

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

(b) Quick Ratio

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

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

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

Normally, the contractor considers a quick ratio of 1.5:1 adequate to meet current liabilities. However, a provider with a high quick ratio can have short-term payment problems if it has excessive amounts of slow-paying or doubtful accounts receivable, which it cannot turn into cash soon enough to meet maturing current liabilities. Conversely, a low quick ratio might not imply a future liquidity crisis if current liabilities include terms that will not require payment from existing current assets.

4. The contractor for institutional providers shall determine whether there are any settlements (interim rate adjustments or cost report) in process which could be used to offset the outstanding overpayment.
5. Based upon the previous steps, the contractor shall summarize whether or not it should approve or deny, or recommend approval of a repayment plan. If it recommends approval, it indicates the number of months, how it calculated the monthly payment and the reason(s) for the approval. If it recommends denial, it indicates the reason(s).

Exhibit 2 - Cash Flow Statement Period Covered

CASH FLOW STATEMENT FOR THE PERIOD _____

Cash provided by:

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

**CASH FLOW STATEMENT
FOR THE PERIOD _____**

Cash applied to:

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

- - Cash at end of period (date)	\$XXXX
Less: Cash at beginning of period (date)	<u>XXXX</u>
Increase (Decrease) in Cash	<u>XXXX</u>

**Exhibit 3 - Projected Cash Flow Statement Cash from Operations
(Schedule A) Period Covered**

**PROJECTED CASH FLOW
CASH FROM OPERATIONS (SCHEDULE A)**

Net Income (or Net Loss)

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

Decrease in Accounts Payable	XXXX
Decrease in Prepaid Income	XXXX
Others	<u>XXXX</u>
<u>XXXX</u> Net Cash from Operations	<u>XXXX</u>
	\$XXXX

Requirements to be Completed Before Approval or Denial	<i>15 Months or Less</i>	<i>16 Months or More</i>
Received and Reviewed <u>all</u> required documentation	X	X
Received and Applied submitted payments while under review	X	X
Complete ERS Protocol (See Exhibit 1)		X
Analyzed Financial Statements		X
Reviewed last 12 months Claim History	X	X
Reviewed last 12 months Payment History	X	X
Reviewed status of Additional Outstanding Overpayments	X	X
Confirmed No Active Bankruptcy	X	X
Confirmed Enrollment Status is not– Terminated, Revoked, Suspended	X	X
Reviewed status of Outstanding Advance/Accelerated Payments	X	X
Part A- Reviewed status of Outstanding Cost Report Settlements	X	X
Confirmed No Outstanding Fraud Investigations <i>with CPI Staff</i>	X	X
Sent to RO/CO for opinion (if needed)	X	X

50.4 – Sending the ERS Request to the Regional Office (RO)
(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

After the contractor has reviewed the provider's supporting documentation and determines that a referral *to the RO* is needed, it shall send its recommendation to the RO for consideration of approval. The contractor shall submit the following:

1. A copy of all information the provider submitted.
2. The date of the initial contact between the contractor and the provider regarding the overpayment.
3. Copies of all correspondence, including demand letters and the complete Extended Repayment Schedule (ERS) request. Also include notes of telephone conversations, if any.
4. Part A - The amount of the overpayment; cost report year in which it occurred; dates and amounts of any repayments; dates and amounts of payments (interim or retroactive) held in account.
5. Part B - The amount of the overpayment, claim paid date, dates and amounts of any repayment.
6. Part A - The cost reports in which the overpayments appeared or were found. The contractor shall furnish any information it has on the financial status of related organizations, as determined through audits and other sources, such as mercantile reports.
7. Documentation reflecting current enrollment status along with any bankruptcy, fraud and abuse and other litigation cases.
8. Amount repaid to date on pending ERS request along with current status on any additional outstanding overpayments.
9. The provider's proposed repayment plan and rationale.
10. The contractor's recommendation and supporting rationale including a completed ERS protocol (See Exhibit 1) and the last 12 months' claim and payment history.
11. The contractor's opinion, based on experience, as to the reliability of the financial data.

The RO will grant a provider an ERS of:

- (a) Up to 36 months if repaying an overpayment in full will constitute a "hardship," as defined in section 50 of this chapter.
- (b) 37 months up to 60 months if repaying an overpayment in full will constitute an "extreme hardship," as defined in section 50 of this chapter. See also 42 CFR 401-607(c)(2)(vi).

If the contractor receives no response from the RO in 30 days, the contractor shall follow up with the RO for a status update.

NOTE: An ERS shall be repaid through recoupment, unless a provider supplies a valid reason why the ERS shall *be paid by another method, such as payment by check.*

50.5 - Monitoring an Approved Extended Repayment Schedule (ERS) and Reporting Requirements

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

MACs have access to the CMS HIGLAS ERS Activity dashboard/report in HIGLAS Business Intelligence (HBI) using the BI Update AR User Responsibility. This report has a comprehensive view of the ERS portfolio by each MAC jurisdiction. It also helps identify at risk ERS which are delinquent or in default status by showing risk criteria such as provider average billing and provider non-ERS debt balances. The data is refreshed daily each morning. MACs can view/search specific ERS data as well as export the record(s) as required. MACs shall continue to verify the Program Integrity checks in PECOS and with CPI staff, such as, Terminated/Revoked statuses, before approving an ERS request.

MACs shall provide ERS status updates to CMS upon request using this activity report.

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

(Rev. 12346; Issued:11-01-23; Effective:10-30-23; Implementation:10-30-23)

When approving/denying an Extended Repayment Schedule (ERS) request, the contractor is making a subjective decision concerning the provider's ability to repay. All complete ERS requests shall be reviewed by the contractor. This includes ERS requests from terminated providers and requests received for debts where the contractor has already sent an Intent to Refer (ITR) letter.

Terminated Providers:

If a terminated provider submits an ERS request, the MAC shall consider the provider's ability to repay the debt over time.

The contractor shall refer requests to the RO if it determines that an ERS is in the best interest of the Medicare program prior to denying the request, based on the requirements in section 50.3. In addition, if the contractor has a reason to believe that a provider will terminate the program, they should research this issue and refer the request to the RO for a decision.

Debts that are Pending Referral to Department of Treasury:

If a contractor has sent an ITR letter and the contractor has *received* an ERS *request* prior to referral, the *contractor shall review and process the request first to determine eligibility. If the request is approved, the contractor shall establish the ERS and shall not refer the debt to Treasury.* If denying an ERS request will result in the immediate referral of an active provider to the Department of Treasury, the contractor shall contact the RO to determine if an alternative exists.

It is preferred to recoup payments from present and future claims payments. If recoupment of payments is not possible, the contractor shall accept monthly checks in the full amount agreed. If the provider misses

one payment (*delinquent loan status*), the contractor shall continue with normal debt collection (including discontinuing the ERS, pursuing the full balance owed, and/or referral to Treasury).

NOTE: The requirements set forth in the Debt Collection Improvement Act of 1996 still apply.

60 - Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments **(Rev. 29, 01-02-04)**

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

60.1 - Withholding the Federal Share of Medicaid Payments to Recover Medicare Overpayments **(Rev. 29, 01-02-04)**

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

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

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

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

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

If they determine that it is not feasible, they notify the FI/carrier, citing the reason for not processing the collection request.

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

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

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

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

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

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

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

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

60.2 - Withholding Medicare Payments to Recover Medicaid Overpayments (Rev. 29, 01-02-04)

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

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

- The amount of the Medicare payments to which the institution would otherwise be entitled;

- The total Medicaid overpayment.

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

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

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

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

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

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

70.1 - Background

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

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

70.2 - Cross Servicing

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

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

70.3 - Treasury Offset Program (TOP)

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

The TOP is a program that compares Federal payments and eligible state payments with Federal debt. When a match occurs, the payment is offset to collect the debt. When the Taxpayer Identification

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

70.4 Definition of Delinquent Debt

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

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

70.5 - Referral Requirements

(Rev. 259, Issued: 01-15-16 Effective: 02-16-16, Implementation: 02-16-16)

The Centers for Medicare & Medicaid Services (CMS) is mandated to refer all eligible debt, 120 days delinquent, for cross servicing and/or TOP. Additionally, the CMS has the option of referring such debt before it is 120 days delinquent.

70.6 - Debt Ineligible for Referral

(Rev.

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

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

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

Contractors shall monitor debt previously ineligible for referral that become eligible for referral. If the status of the debt changes to an eligible status, contractors shall determine whether an ITR letter has been sent. If the ITR letter has been sent, and at least 60 days have passed since the date of the ITR letter (including the ITR letter returned undeliverable), contractors not utilizing HIGLAS shall refer the debt by utilizing the Debt Referral Form within ten calendar days of the status change making the debt eligible for referral. If the ITR letter has not been sent, contractors shall send the ITR letter within ten calendar days of the status change making the debt eligible for referral, and follow the normal debt referral process.

70.7 - Intent to Refer Letter

(Rev.11787;

Issued: 01-19-23; Effective: 04-21-23; Implementation: 04-21-23)

To comply with the DCIA requirements to provide specific notice to debtors before referring a debt for cross servicing and/or TOP, contractors shall send an Intent to Refer (ITR) letter as their final demand letter for all eligible delinquent debt. The contractor shall send the “final demand letter”, which is defined as the last letter routinely sent to debtors to request payment, when or before the debt is 30 to 61 days delinquent (60 to 91 days from the determination date). A sample ITR letter is included in Exhibit 1 of this section.

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

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

Contractors sending manual ITR letters should use their own language in the opening paragraphs to explain the reason for the overpayment and the current balance, including interest accrued and the interest rate.

The ITR letter shall be signed by the contractor official who routinely signs the demand letters. The language in the ITR letter shall include a sentence that says: “If, after sixty calendar days from the date of this letter we have not received such evidence, your debt, if it is still outstanding and eligible for referral, shall be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset.”

70.8 - Response to Intent to Refer Letter

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

The ITR letter provides debtors with 60 calendar days to respond. If, by day 61 the debtor has not responded to the ITR letter, the contractor not utilizing HIGLAS shall refer the debt immediately by using the Debt Referral Form. For contractors utilizing HIGLAS, the debt will be systematically referred to Treasury 66 days from the ITR letter date. Debt for which less than full payment was received, or there is a current repayment agreement that is in default, are eligible for referral for cross servicing and/or TOP. Where there has been a partial recoupment or collection, but the collection is not the result of a current extended repayment agreement, the balance (if principal and interest balance is greater than or equal to \$25) shall still be referred for cross servicing and/or TOP. The contractor shall not refer debts to Treasury that are ineligible for referral or exempt from referral to cross servicing and/or TOP.

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

If the ITR letter is returned as undeliverable, contractors shall follow established procedures to locate a better address. (See Chapter 4, §§ 10 and 80) If a better address is obtained, the contractor shall send the provider/supplier a manual ITR notification letter, with the original ITR letter attached, to the better

address. The original ITR letter date shall remain in effect. If the ITR letter is returned as undeliverable and a better address cannot be located within 10 business days:

- the contractor not utilizing HIGLAS shall refer the debt to Treasury by entering the debt into the Debt Referral Form 60 calendar days from the date of the original letter.
- the contractor utilizing HIGLAS shall update the status code to 'LTR-UNDL-ITR.' HIGLAS will systematically refer the debt to Treasury 66 days from the ITR letter date.

70.9 - Reserved for Future Use

70.10 - Reserved for Future Use

70.11 - Actions Subsequent to Debt Referral

(Rev.

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

Once the debt is referred for cross servicing, active collection efforts by the contractors and/or CMS shall cease. However, debt referred for cross servicing and/or TOP shall still be maintained in HIGLAS or in the contractors' internal systems for financial reporting, interest accrual, and possible internal recoupment. The contractor not utilizing HIGLAS shall be responsible for updating all the applicable systems. The contractor shall utilize the Debt Referral Form for the manual change of the status and the balance of the debt at Treasury.

70.12 - Transmission of Debt

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

Prior to the weekly transmission of debts to Treasury, the contractor shall certify its debts by the close of business on the day before transmission. When CMS transmits debts to Treasury, CMS shall generate an CMS Debt Management (CMSDM) Outbound Debt Referral Report that will list the debts transmitted that week. The contractor utilizing HIGLAS shall use the appropriate responsibility to retrieve the report that will list its debts only. The contractor not utilizing HIGLAS shall update its internal systems with the debts' transmission status and send a transmitted debt report to CMS with 15 business days. The contractors shall review the reports to ensure that debts transmitted remain valid and amounts are accurate.

70.13 - Update after Debt Transmission

(Rev.11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

The contractors shall update HIGLAS or the Debt Referral Form (contractors not utilizing HIGLAS), within ten business days of the notification of the change to the debt if the contractors discover an error, collection (by check or recoupment), or receive information establishing that the debt is ineligible for cross servicing (i.e., bankruptcy, appeal),

If Treasury or a Private Collection Agency (PCA) discovers an error, collects on the debt, or receives information, that would render the debt ineligible for cross servicing, Treasury shall notify CMS and its contractors via the CMS Debt (CMSDM) Management Inbound Acknowledgment, Treasury Dispute

Timer, or Collections Report. The contractor not utilizing HIGLAS shall update its internal records, as appropriate. The contractor shall return the completed CMSDM Treasury Dispute Timer Reports to CMS within 30 calendar days.

If Treasury or the PCA receives a dispute from the debtor or obtains additional information regarding the debt that requires CMS or contractor intervention, a Treasury Cross-Servicing Dispute Resolution Form shall be sent to CMS. The CMS shall maintain a report of all debt in dispute and forward the information to the contractors for review and decision. The contractors shall have 30 calendar days to respond to Treasury and update their internal systems if applicable, and shall copy CMS RO and CO on their response. The contractor shall recall the debt if it is determined that the dispute is valid.

If Treasury does not receive the response to the dispute timely, the debt may be returned to agency (RTA) with the reason “dispute timer expired.”

70.14 - Collections

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

70.14.1 – Background

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

Collection reports from the Department of the Treasury (Treasury) as a result of cross servicing efforts are received by CMS central office (CO) through the Intra-governmental Payment and Collection (IPAC) system multiple times per month. Collections may be received as a result of collection efforts by Treasury’s Servicing Center or by a Treasury contracted Private Collection Agency (PCA) including installment payments on Treasury approved extended repayment schedules or from offsets from the TOP.

70.14.2 - Intra-governmental Payment and Collection (IPAC) System

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

The collection report generated from the IPAC system includes a break out of principal and interest collected on individual debts; however, the report does not show the balance and the status of the debt after the collection. Treasury calculates interest on a daily basis while CMS calculates interest monthly. Therefore, the amount of interest collected by Treasury or its PCAs may not equal the amount of interest shown as accrued by the contractors.

70.14.3 - CMS Debt Management Collections Interface and Report

(Rev.

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

The CMS Debt Management (CMSDM) Collections Interface reports collections back to HIGLAS on debts that were referred to Treasury. The contractor shall view its Roundtrip Status Report every Monday to determine if the CMSDM Treasury Collections Report is available from the Friday HIGLAS cycle. The contractor shall use the appropriate HIGLAS responsibility to generate the CMSDM Treasury Collections Report which is the result of processing the interface and is available three times per month.

For each debt listed on the CMSDM Treasury Collections Report, contractors not utilizing HIGLAS shall apply the collection to principal and interest amounts as indicated. For collection of interest only, contractors not utilizing HIGLAS shall post the interest as shown on the CMSDM Treasury Collections Report. An interest adjustment is not required prior to posting the collection. For collection of principal and interest, contractors not utilizing HIGLAS shall manually adjust the amount of interest accrued in its

internal system to the amount of interest collected as listed on the CMSDM Treasury Collections Report. This will make the amount of the accrued interest equal to the amount of interest collected which is listed on the CMSDM Treasury Collections Report. Contractors not utilizing HIGLAS shall then post the collection. Interest shall continue to accrue on the remaining principal balance. Contractors not utilizing HIGLAS shall use the current date as the date of collection to post the Treasury collections to their systems. Contractors not utilizing HIGLAS shall complete and return to CMS the CMSDM Treasury Collections Report within 15 business days of receipt.

Contractors utilizing HIGLAS shall complete/update their adjustments/refunds within 15 business days of receipt of the CMSDM Treasury Collections Report. CMS shall run a CMSDM Treasury Collections Report on day 16 to determine if there are any unapplied debts. If there are any unapplied debts CMS shall create a report listing those debts and send to the MAC via email. The contractor shall take immediate corrective action and send an Excel spreadsheet back to CMS showing the updates. If a refund is not resolved, the contractor shall have an additional 15 business days to resolve the refund.

70.14.4 - Reserved for Future Use

70.14.5 - Reserved for Future Use

70.14.6 - Reserved for Future Use

70.14.7 - Excess Collections

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

70.14.8 - Applying Excess Collections

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

Contractors shall apply the excess collection to the debt listed on the CMSDM Collection Report in order to bring the balance to zero. Contractors shall then determine if the debtor has any other outstanding debts including interest to which the excess collection may be applied.

70.14.8.1 - If the Debtor Has Other Outstanding Debt

(Rev.

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

If the debtor has other outstanding debt, the excess collection shall then be applied to the oldest debt first (then next oldest), in accordance with established procedures for applying excess collections against a debtor's overpayments. The breakout of principal and interest on the CMSDM Treasury Collections Report does not apply when the excess collection is applied to another outstanding debt.

70.14.8.2 - If the Debtor Has No Other Outstanding Debt

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

If there are no other outstanding debts, the excess portion of the collection, after bringing the debt listed on the spreadsheet to a zero balance, shall be refunded. The amount of the refund shall be annotated on the CMSDM Treasury Collections Report. The contractor shall process the refund within 15 business days. A copy of the report, with the appropriate annotations regarding the refund, shall be kept in the debtor file for audit trail purposes. The contractor shall make appropriate adjustments in HIGLAS or its internal systems, for contractors not utilizing HIGLAS, to reflect the refund activity.

70.15 - Financial Reporting for Debt Referred

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

70.15.1 - Financial Reporting for Non-MSP Debt

(Rev. 11787;

Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

The contractor not utilizing HIGLAS shall continue to accrue and report interest in its internal systems on a debt after the debt has been referred for cross servicing.

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

70.15.2 - Reserved for Future Use

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

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

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

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

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

For contractors who have transitioned to the Healthcare Integrated General Ledger Accounting System (HIGLAS), collections reported and posted to the debts on the CMSDM Treasury Collections Report shall be reported on the Treasury Report on Receivables and Debt Collection Activities Report (TROR), Part I,

Section A, Line (4)(D), Collections by Treasury through Offset and Cross-Servicing and in Part II, Section C, Line (1)(G), By Treasury/Designated Debt Collection Center Cross-Servicing. If the debt is in a Currently Not Collectible (CNC) status, the amounts collected shall be reported in Part I, Section A, on Line (4) (D), Collections by Treasury Through Offset and Cross-Servicing, and Line (5) (E), Written-Off Debts Reinstated for Collections and also in Part II, Section C, Line (1) (G), By Treasury/Designated Debt Collection Center Cross-Servicing.

70.15.4 - Financial Reporting for Debts Returned to Agency (RTA) (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

Debts RTA shall be reported in the appropriate line of the CMS Form 751 (contractors not utilizing HIGLAS) and the Treasury Report of Receivables and Debt Collection Activities (TROR) Reports (contractors utilizing HIGLAS). Details regarding debts RTA are outlined in Section 70.17 herein.

70.15.4.1 - Debts RTA for Bankruptcy (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

H751 Reporting

Section B

(4)(B)(1) In Bankruptcy

TROR Reporting

Section B

(1)(D)

70.15.4.2 - RTA and other Debts, Pending Final Disposition (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

Debts RTA for the following reasons: uncollectible, out of business, miscellaneous dispute, dispute timer expired, recall approved, manual RTA, and certain debts that have not been referred to Treasury shall be reported as follows:

H751Reporting

Section B

4(B)(9) Pending Request Waiver/Compromise – for those debts waiting write off approval.

Section B

(4)(B)(11) Other Exclusions – for those debts not yet eligible for write off due to age or past collections.

Section A

Line 6.A. Amounts Written-Off (Bad Debts) – for those debts approved for Write off Closed.

TROR Reporting

Section B

Line (3)(G) Debt Returned from Cross-Servicing – for those debts not yet eligible for write off due to age or past collections. The HIGLAS Accounts Receivable status code DR-RTN-CS (Debts Returned from Cross-Servicing) is mapped to line (3)(G). The receivable balance detail extract can be used to validate the detail of debts reported to this line.

Part II, Section B, Line (1)(G) – “Other – must footnote” - HIGLAS Accounts Receivable status codes beginning with “REQ” (request) are mapped to this line. A footnote(s) will be required for all balances on this line. The footnote(s) should include the dollar amount and number of debts for all debts containing the “REQ” status codes (i.e. pending ERS request, pending RO WOC approval, etc.)

Section A, Line (6) (B) Written Off and Closed Out – for those debts approved for Write off Closed that are not in CNC Status. For debts approved for write off closed already in CNC status:

Section D

Line (2) CNC Debts Closed Out During the Current FY

70.15.4.3 - Debts RTA Because Dispute Timer Expired (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

H751 Reporting

Section B

4(A) Referred for Cross Servicing OR

Section B

(4)(B)(1)- (11) As appropriate.

TROR Reporting

Section B

Line (3) (J) Debt Referred to Treasury or a Designated Debt Collection Center for Cross-Servicing – for those debts resubmitted to Treasury. OR

Debts ineligible for referral shall be reported in the appropriate line as an exclusion to debt referral.

70.15.4.4 - Debts RTA Paid in Full or Satisfied Payment Agreement or Satisfied Compromise (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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

H751 Reporting

Section B

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

TROR Reporting

Section B

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

70.16 - Debt Close-Out

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

An agency closes out a debt when it determines that further debt collection actions are prohibited or the agency does not plan to take any future actions (either active or passive) to try to collect the debt.

Contractors shall submit the following debts for close-out (termination of collection action).

- Non-MSP provider/supplier debts with a combined principal and interest balance of less than \$25. The HIGLAS Auto Write-Off Program (AWOP) will systematically close-out these particular debts based on non-excluded transaction types that are 180 days old (from the demand letter/determination date) with no collections within the last 60 days.
- MSP debt with a combined principal and interest balance of less than \$25. The HIGLAS AWOP will systematically close-out these MSP debts that are at least 120 days old (from the demand letter/determination date) with no collections within the last 60 days.
- MSP debt where the debtor is deceased. The contractor shall not close-out these debts when the debtor is deceased and the estate is still open or when the MSP claim arises from a wrongful death, survival or other cause of action claiming medical damages incurred by the beneficiary where the settlement, judgment or award is awarded to an individual or entity other than the beneficiary's estate. The contractor shall also not terminate collection action or close-out debts that are in litigation and/or under negotiation by the Office of General Counsel (OGC) or the Department of Justice (DOJ).
- Non-MSP beneficiary debts with a principal balance less than \$50.
- Non-MSP beneficiary debts with principal balance between \$50 and \$999.99, over 425 days old, the last payment date is greater than 365 days old, and the contractor has verified there are no other collections for the same beneficiary.
- Non-MSP beneficiary debts greater than or equal to \$1,000, have been referred to the Social Security Administration (SSA), have no collections, over 425 days old, and the last payment date is 365 days old.
- Debts greater than six years old that have been returned to agency (RTA) by Treasury and the contractor has performed the required steps to resolve and/or research the debt to confirm the RTA status. Debts with a combined principal and interest balance less than \$25 do not require any research. This includes debts that have been returned to agency (RTA'd) with a combined principal and interest balance less than \$25 but later exceeds \$25 as a result of accrued interest while awaiting close-out review.

- Certain debts that have not been referred to Treasury (non-RTA) for various reasons such as bankruptcy or litigation. The contractor shall submit the justification and supporting documentation, including OGC correspondence for such debt close-outs.
- Debts, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and close-out. For example, when debts are received as a result of a contractor transition where no electronic or paper records are available, and other debts where no records are available to support the balances. The contractor shall make a concerted effort to validate the debts before selecting this option. A listing of this debt shall be forwarded to the Office of Financial Management/Financial Services Group/Division of Financial Services and Debt Management (OFM/FSG/DFSDM) Director for approval. The list should contain the reason for termination of collection action and close-out recommendation that provides reasonable evidence to substantiate that the claim is no longer available.

Delegations of Authority for Closing-Out Debts Less Than \$25

- CMS has authority to terminate collection action and close-out debts that have a combined principal and interest balance less than \$25.
- The contractor not utilizing HIGLAS shall recommend termination of collection activity of debts, once the debt is 180 days old (that is, 150 days delinquent) with no collection activity within the past 60 days.

Delegations of Authority for Closing-Out Debt That Was Not Eligible for Referral to Treasury (Non-RTA) and Non-Uncollectible (RU)/Out of Business (RN) RTA Debt

This delegation of authority only applies to debts not eligible for Treasury referral, such as, bankrupt issuers/health plans/contributing entities or issuer/health plan/contributing entity debts and debts returned to agency (RTA) with a code other than RU/RN (non-RU/RN).

- **Debts with amounts \$100,000 or less (exclusive of interest)** may be approved for termination of collection activity and close-out by CMS.
- **Debts with amounts in excess of \$100,000 (exclusive of interest)** must be referred to the CMS with the Office of General Counsel (OGC) concurrence for the approval process as described by 42 CFR 401.601(c).

Delegations of Authority for Closing-Out Returned to Agency Debt that is RU/RN

- **Returned to Agency Debts classified as RU or RN with amounts of \$500,000 or less (exclusive of interest)** may be approved by the CMS without OGC's concurrence.
- **Returned to Agency Debts classified as RU or RN greater than 6 years old and in excess of \$500,000 (exclusive of interest)** must be referred to the CMS with OGC concurrence for the approval process as described by 42 CFR 401.601(c).

Fraud Checks

A fraud check must be completed for ALL providers/suppliers who have a valid National Provider Identifier (NPI) and has debts submitted for close-out. Before any debts can be submitted to the CO or RO, the contractor shall submit a fraud check request to the Center for Program Integrity (CPI). Fraud checks shall be performed through CPI's Unified Case Management (UCM) system for providers/suppliers that have an NPI.

The contractor shall use the following instructions for requesting fraud check reports.

1. The contractor shall create an Excel spreadsheet listing the NPIs and names of the providers/suppliers. The NPIs and provider/supplier names shall be obtained from the related debt close-out spreadsheet. The contractor shall use the naming format FraudChk_Contractor-Jurisdiction_Reviewer_Period Ending (example – FraudChk_ABC-J2_RO_FY19Q4) when naming/saving the file(s).
2. The contractor shall email its fraud check request spreadsheet along with a completed CPI data request form to CPIFraudcheck-OFMDebt@cms.hhs.gov with the subject line “Contractor/Jurisdiction Fraud Check Request” (example – ABC/J2 Fraud Check Request).
3. The contractor shall expect to receive the fraud check report from CPI within one week of sending the fraud check request to CPI. The contractor shall use the fraud check report to determine if the provider/supplier has an open fraud case. Please note the following:
 - The NPI is listed in column A (PRVDR_NPI_NUM).
 - Column B (UCM_FRAUD_CHECK) will indicate a “Y” if the NPI was found in UCM. An “N” in column B will indicate that there are no records listed for the NPI. Therefore, all other fields will be blank.
 - If there is a “Y” in column B, proceed to column P (RFRL_OPEN_IND) to determine if the case is open or closed. If there is a “Y”, the case is open which means that the provider's/supplier's debts are not eligible for close-out. An “N” indicates that the provider's/supplier's fraud case is closed.
 - If there are more than one open and/or closed fraud case for a given provider/supplier, filter column P with the “Ys” only to get only those providers/suppliers with open fraud cases. If all entries for a given NPI have an “N” in columns B or P, then the debt is eligible for RO or CO close-out review/approval. However, if one or more of a given provider/supplier NPI's entries has a “Y” in column P, the NPI's debts are not eligible to be submitted for RO or CO close-out review/approval.

The contractor shall include a copy of the fraud check report for the NPIs that are included on the particular debt close-out spreadsheet that is sent to the CO or RO.

Debt Close-out Request Submission

The contractor shall submit two separate quarterly debt close-out reports utilizing the Debt Close-Out Request template/spreadsheet. These reports shall be submitted to CMS no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). If this day falls on a weekend or federal holiday, the next business will be the due date. The contractor utilizing HIGLAS shall only include new debts with a combined principal and interest balance greater than or equal to \$25. The contractor not utilizing HIGLAS shall include all eligible debts. Each debt shall be considered a separate

identifiable debt and shall not be aggregated with other debts. The contractor shall only include provider/supplier debt that is associated with a valid National Provider Identifier (NPI).

The contractor shall include in the first report, debts that are not eligible for Treasury referral (e.g., beneficiary, deceased provider/supplier), referred to as non-Return to Agency (non-RTA) debts, and non-RU /RN debts (other than bankruptcy debts) with principal balances up to \$100,000 and RU/RN debts with principal balances up to \$500,000. The debts listed on this report will be reviewed and approved by the RO (CMS CO for Medicare Secondary Payer (MSP) debts).

The contractor shall include in the second report, which is for debts that will be reviewed by OGC, non-RTA and non-RU/RN debts (other than bankruptcy debts) with a principal balance greater than \$100,000 and RU/RN debts with a principal balance greater than \$500,000, provided that all categories of debts are greater than 6 years old.

Debts that will be reviewed by OGC shall also include the following documentation:

Part A Debts

1. Notice of Program Reimbursement (NPR) - **(cost report debts only)**
2. Initial demand letter
3. Final appeal decision letter sent from contractor's appeals department to overpayments department (decision only, exhibits not required)
4. Intent to Refer (ITR) letter
5. Most recent Extended Repayment Schedule (ERS) – **(if applicable)**
6. A report from PECOS and/or copies of 855 Forms showing:
 - i. date the debtor's Medicare enrollment ended; or
 - ii. identifying information on all owners/managing employees/directors; and
 - iii. whether there are owners/managing employees/directors of the debtor company who are affiliated with a provider/supplier that is still operating in the Medicare program. If so, the MAC shall also include identifying information from PECOS about the company with which he or she is affiliated, including the interest he or she has in that company.

Part B and MSP Debts

(Not required if the provider/supplier has more than more than ten debts requested to be closed out during a quarter. But required for all extrapolated overpayments.)

1. Initial demand letter
2. Intent to Refer (ITR) letter
3. Final appeal decision letter sent from contractor's appeals department to overpayments department (decision only, exhibits not required)
4. Most recent Extended Repayment Schedule (ERS) – **(if applicable)**
5. A report from PECOS and/or copies of 855 Forms showing:
 - i. date the debtor's Medicare enrollment ended; or
 - ii. identifying information on all owners/managing employees/directors; and
 - iii. whether there are owners/managing employees/directors of the debtor company who are affiliated with a provider/supplier that is still operating in the Medicare program. If so, the MAC shall also include identifying information from PECOS about the company with which he or she is affiliated, including the interest he or she has in that company.

For debts that are submitted to CMS that CMS in turn may forward to OGC with CMS's recommendation, the contractor shall provide a separate debt close-out report and certification statement signed by its Chief Financial Officer in accordance with Financial Management Manual, Ch. 4, § 70.17.2 for the debts serviced by a particular OGC Regional Office (RO). The certification statement must state that it covers the listed debts and then list: (1) the number of debts; (2) the total principal balance of the debts; and (3) total interest balance of the debts. The MAC shall use the provider's/supplier's address to determine the OGC RO. Below is the list of the OGC ROs and the states that each RO services. The list can also be found at <https://www.hhs.gov/about/agencies/ogc/key-personnel/regional-offices/index.html>.

- Region I (Boston) - Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- Region II (New York) - New Jersey, New York, Puerto Rico, Virgin Islands
- Region III (Philadelphia) - Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
- Region IV (Atlanta) - Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
- Region V (Chicago) - Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
- Region VI (Dallas) - Arkansas, Louisiana, New Mexico, Oklahoma, Texas
- Region VII (Kansas City) - Iowa, Kansas, Missouri, Nebraska
- Region VIII (Denver) - Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
- Region IX (San Francisco) - American Samoa, Arizona, California, Guam, Hawaii, Nevada
- Region X (Seattle) - Alaska, Idaho, Oregon, Washington

CMS shall respond within 30 days after receipt of the close-out request, except for cases exceeding the CMS' delegated authority. For those cases exceeding the CMS authority, the CMS shall forward the case to the Office of General Counsel (OGC) with the CMS' recommendation, within 30 days of receipt of the contractor's request.

70.17 - Debts Returned to Agency (RTA) by the United States Department of the Treasury (Treasury) (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

The Treasury returns to agency (RTA) debts to the Centers for Medicare & Medicaid Services (CMS) using the following reasons:

RTA Debt Status Code	Federal Debt Return Description (FDRETDSC)	HIGLAS AR Status Code
RB	In Bankruptcy	RTA-RB
RC	Small Balance	RTA-RC
RC	Account Settled/Compromise	RTA-RC
RC	Satisfied Compromise	RTA-RC
RD	Congressional Dispute	RTA-RD
RD	Debt Amount Incorrect	RTA-RD
RD	Other	RTA-RD
RD	Manual RTA	RTA-RD
RD	Proof of Debt Validated	RTA-RD

RD	Recalled	RTA-RD
RD	Miscellaneous Dispute	RTA-RD
RD	VDPP - Previously Paid	RTA-RD
RD	Complaint	RTA-RD
RD	Wrong Debtor	RTA-RD
RD	Disability/Inability to Pay	RTA-RD
RD	Recall Approved	RTA-RD
RN	Entity Out of Business	RTA-RN
RP	Satisfied Payment Agreement	RTA-RP
RP	Previously Paid	RTA-RP
RP	Paid in Full	RTA-RP
RP	Previously Resolved	RTA-RP
RU	Uncollectible	RTA-RU
RU	Debtor Death	RTA-RU
RU	Inability to Pay	RTA-RU
RX	Claim Not Substantiated	RTA-RX
RX	No Disposition Desc Found	RTA-RX

HIGLAS shall systematically update an RTA debt's AR status code with the appropriate temporary HIGLAS AR RTA Status Code. The contractor shall use the appropriate HIGLAS responsibility to generate the weekly RTA report.

The contractor not utilizing HIGLAS shall also download the report, add a column, and indicate what status the debt was updated to and post in a secure drive where CMS can access the updated spreadsheet. The contractor shall also add any applicable comments to the spreadsheet.

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

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

Debts in bankruptcy status are ineligible for cross-servicing. The contractors are responsible for obtaining bankruptcy documentation to support the bankruptcy status code listed on the RTA report. Once the contractors obtain the documentation, they shall update HIGLAS or their internal records to reflect the appropriate code for bankruptcy. The contractors shall follow established procedures regarding debts in bankruptcy status. The contractors shall properly report the status of these debts in their quarterly financial reports to CMS CO. (See Pub. 100-06, chapter 3, section 140.)

The Treasury no longer routinely sends bankruptcy documents to creditor agencies. Therefore, contractors shall follow established procedures, including contacting the CMS Regional Office (RO), to obtain bankruptcy documentation. It is the contractor's responsibility to obtain the bankruptcy documentation. If the contractors cannot obtain bankruptcy documentation through established procedures, including asking the RO for assistance, the contractors may contact Treasury to obtain documentation for RTA debts in bankruptcy. If the contractors are unable to obtain bankruptcy documentation through established procedures or through the assistance of the RO, they shall request bankruptcy documentation from Treasury via email to CrossServicing.Questions@fms.treas.gov. The subject line of the email request

shall be entitled, "Request for Bankruptcy Information". If the contractors do not receive a confirmation from Treasury within 2 business days of the request, the contractor shall re-send the email or make another request to Treasury via fax number 205-912-6353. The contractors shall include the following information; the Cross-Servicing Next Generation (CSNG) number, debtor name and the contractor's contact information on each request via email or fax.

If the CMS Regional Office of General Counsel (OGC) advises the contractor that debts are not discharged in bankruptcy and are still eligible for referral, the contractor shall submit a new referral to Treasury.

70.17.2 - Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN) (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

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).

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.
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:

<p><u>Contractor Validation:</u> 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. <u>Total debts recommend for Write-Off-Closed:</u> Number of Debts: _____ Principal Balance: _____ Interest Balance: _____</p> <p>Signature of Medicare Contractor CFO: _____ Date: _____</p>
--

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.

**70.17.3 - Debts RTA by Treasury as Dispute Response not Received Timely (RX)
(Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)**

The Treasury returns debts with this status code because the dispute response was not received timely. The contractor shall research and resolve the debts in a RX status that have a combined principal and interest balance greater than or equal to \$25 within 30 business days in order to determine the current status of the debts. No further action is necessary if the debts are already in a recalled status. The contractors shall add a comment on the HIGLAS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

RX debts that have a combined principal and interest balance of less than \$25

- **Contractor Utilizing HIGLAS** shall allow HIGLAS to systematically change the status code to 'DR-RTN-CS' (Debt Returned from Cross-Servicing) which will allow the debt to be identified and written off by the HIGLAS Auto Write-Off Program.

- **Contractors NOT Utilizing HIGLAS** shall submit these debts for close-out.

If the debts are still valid and eligible for referral to Treasury, the contractors shall re-refer the debts to Treasury, even if a response to the disputes were previously submitted to Treasury. The contractors shall not issue a second Intent to Refer (ITR) letter.

70.17.4 - Debts RTA by Treasury as a Miscellaneous Dispute, a Manual RTA, Complaint or as Recall Approved (RD) (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

The contractor shall research and resolve debts in a RD RTA status code greater than or equal to \$25 and within 30 calendar days update HIGLAS or its internal system with the final disposition of the debts. If any debts are still valid and eligible for referral to Treasury, the contractors shall change the status code of the debts from RD to R-DCS (Debt Resubmitted to Cross-Servicing) to be resubmitted to Treasury. The contractors shall not issue a second Intent to Refer (ITR) letter for the debts.

RD debts that have a combined principal and interest balance of less than \$25

- **Contractor Utilizing HIGLAS** shall allow HIGLAS to systematically change the status code to 'DR-RTN-CS' (Debt Returned from Cross-Servicing) which will allow the debt to be identified and written off by the HIGLAS Auto Write-Off Program.
- **Contractors NOT Utilizing HIGLAS** shall submit these debts for close-out.

70.17.5 - Debts RTA by Treasury as Paid in Full (RP), Satisfied Payment Agreement (RP) or Satisfied Compromise (RC) (Rev. 11787; Issued:01-19-23; Effective: 04-21-23; Implementation:04-21-23)

- If a debt is returned to agency (RTA) as paid in full (RP), satisfied payment agreement (RP), or compromise (RC) and a principal balance less than \$100 remains after the receipt has been applied, contractors not utilizing HIGLAS shall adjust down the remaining balance. HIGLAS shall systematically adjust down these balances to \$0.00 for contractors utilizing HIGLAS.
- If a debt is returned to agency (RTA) as paid in full (RP) or satisfied payment agreement (RP), and a principal balance greater than or equal to \$100 remains after the receipt has been applied, the contractor shall research all activity on the debt to determine if the receipts were appropriately applied and take any action, if needed. If all receipts were applied appropriately, the contractor shall then adjust down the remaining balance to \$0.00.
- If a debt is returned to agency (RTA) as satisfied compromise (RC) the contractor shall research all activity on the debt to determine if the receipts were appropriately applied and take any action, if needed. The contractor shall adjust down the balance to \$0.00 using the appropriate adjustment/write-off code.

If it is determined a refund is valid, the contractors shall follow procedures for applying excess collections and update HIGLAS or their internal systems to reflect any refund given (see CMS Pub. 100-06, chapter 4, section 70.14.8).

Exhibit 1- Intent to Refer (ITR) Letter

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Intent to Refer Letter

Background

The DCIA requires Federal agencies to refer debt that is 120 days delinquent to the Department of Treasury or a Treasury designated Debt Collection Center for cross servicing.

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

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

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

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

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

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

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

The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it may be reported to the IRS as potential taxable income. During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

For Individual Debtors Filing a Joint Federal Income Tax Return

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

Federal Salary Offset

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

Medicaid Offset

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

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

Due Process

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

Repayment

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

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

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

Include a copy of this letter with your payment.

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

Bankruptcy

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

If you have any questions concerning this debt, please contact _____
at _____.

Sincerely,

Signature of Certifying Official

Official Position

Exhibit 5

(Rev. 315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

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

Treasury Cross-Servicing Dispute Resolution

DMS Request Date: Total Number of Pages: _____

SBU

FedDebt Case ID.: Principal Amt: \$

Creditor Agency Debt ID: PCA Code:

Debtor:

Program:

For CMS Use Only:

Creditor Agency Contact Name:

Medicare beneficiary identifier:

Creditor Agency Contact Phone:

Beneficiary Name:

Creditor Agency Facsimile:

Dispute Number:

Dispute request reason: Miscellaneous Dispute

Additional comments:

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

Creditor Agency (CA) Dispute Resolution Section: Please indicate a response by checking one of the following reasons: Please attach supporting documentation.	
DAIC	___ CA agrees. Debt amount is incorrect. Requires financial adjustment.
DACC	___ CA disagrees. Debt amount is correct. Continue collection efforts.
MDAA	___ CA agrees. Miscellaneous dispute, stop collection activity.
MDFF	___ CA agrees. Miscellaneous dispute. Requires financial adjustment, continue collection efforts.
MDDD	___ CA disagrees. Miscellaneous dispute. Continue collection efforts.
VDWD	___ CA agrees. Wrong debtor, stop collection activity.
VDRD	___ CA disagrees. This is not the wrong debtor, continue collection efforts.
VDPP	___ CA agrees. Previously paid, stop collection activity.
VDNP	___ CA disagrees. Not previously paid, continue collection efforts.
VDPR	___ CA agrees. Previously resolved, stop collection activity.
VDNR	___ CA disagrees. Not previously resolved, continue collection efforts.
Financial Adjustment Information (To Be Completed By Creditor Agency):	
Principal Amount	\$ _____
Interest Amount	\$ _____
Penalty Amount	\$ _____
Admin Cost Amount	\$ _____
Total Balance Owed	\$ _____
Please check one of the following:	
<input type="checkbox"/> Adjustment reflects the total balance currently owed by the debtor, and has been made by our Agency.	
<input type="checkbox"/> Adjustment has not been made in FedDebt by the Agency, and should be made by DMS.	
Creditor Agency Response Date: _____ Creditor Agency Response Contact:	

Additional Comments By Creditor Agency:	

80 – Recovery of Non MSP Overpayments from the Beneficiary
(Rev. 235, Issued: 05-14-14, Effective: 07-07-14, Implementation: 07-07-14)

80.1 – Reserved for Future Use

(Rev. 235, Issued: 05-14-14, Effective: 07-07-14, Implementation: 07-07-14)

80.2 – Immediate Recoupment Requirements for NON-935 Overpayment Recovery from the Physicians and Other Suppliers

(Rev. 205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

Medicare contractors shall offer providers the opportunity to request immediate recoupment.

Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate recoupment pays the debt in full before day 31. If providers request an immediate recoupment they must understand that it is considered a voluntary repayment.

A. Medicare contractors shall offer two options.

- A one-time request on the specific overpayment and all future overpayments. Or
- A request on the specific overpayment addressed in demand letter.

B. Medicare contractors shall incorporate the following minimum information related to “immediate recoupment” information on its website:

- This option is for demanded debts only.
- The request must be in writing, and may be submitted using regular mail, facsimile, or email.
- The request must include the following:
 1. Provider Name and contact number
 2. Provider’s Medicare Number and/or the National Provider Identification (NPI)
 3. Provider’s or the CFO’s signature
 4. Letter number
 5. Which option the provider is requesting

C. Medicare contractors shall post to the website the language in the demand letter related to the immediate recoupment option.

D. Medicare contractors shall consider all written requests for an immediate recoupment as a payment arrangement that constitutes a voluntary payment.

E. Medicare contractors shall inform providers that going through the immediate recoupment process is considered voluntary payments. Refer to chapter 3 section 200 for overpayments subject to 935.

- F. Medicare contractors demand letter and website shall explain, when there is a remaining principal balance after the initial immediate recoupment you shall continue recoupment and other collection activities.
- G. Medicare contractors' website shall include instructions for providers currently in an immediate (offset) arrangement to submit a new request to continue the immediate recoupment process.
- H. Medicare contractors shall allow previous immediate offset agreements to continue when requested awaiting the submission of the new request.
- I. Medicare contractors shall update each AR associated to the request within 10 business days from the mailroom stamped receipt date. Refer to Chapter 4 §90.2.
- J. As applicable, Medicare contractors shall use the new functionality in HIGLAS which allows user to set the flag to immediate recoupment for multiple ARs instead of one AR.
- K. Medicare contractors shall update individual or multiple AR's in the shared systems when a provider requests the immediate recoupment option.
- L. Medicare contractors shall accept a written request to discontinue participation in the immediate recoupment process at anytime.
- M. Medicare contractor shall discontinue the recoupment process per providers' written request.
 - You shall stop this process within 10 business days from the mailroom stamped receipt date.

80.3 – Overpayment Recovery from Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(Rev. 208, Issued: 04-20-12, Effective: 05-20-12, Implementation: 05-20-12)

Certain DMEPOS suppliers are required to have surety bonds. Medicare contractors shall follow instructions in Pub.100-08, chapter 15, §15.21.7.1, related to collecting claims against surety bonds, if applicable, in addition to normal debt collection activities.

90 – Physician/Supplier Overpayment Demand Letters - Carrier

(Rev. 29, 01-02-04)

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

90.1 – Part B Overpayment Demand Letters to Beneficiaries

(Rev. 29, 01-02-04)

See chapter 3, §§100 and 110ff

90.2 - Part B NON-935 Overpayment Demand Letters to Physicians/Suppliers

(Rev. 205; Issued: 02-09-12, Effective: 07-01-12, Implementation: 07-02-12)

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

A. Overpayment Amount Is At Least \$10

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

B. Overpayment Demand Letter

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

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

A. Content of Demand Letters

- Sent to the physician/supplier.
- For a first request, mail within seven (7) calendar days of determination of the overpayment.
- Each demand letter is an explanation of the nature of the overpayment, how it was established, in addition, the amount determined.
- The Medicare contractor shall include the model immediate recoupment process language within the content of the Part B non-935 overpayment demand letters to physicians and other suppliers for the Part B Non-MSP overpayment demand letters.
- The demand letter shall offer the physician and other supplier the opportunity to request an immediate recoupment. Refer to section 80.2.

- The demand letter shall offer the physician/supplier the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be approved using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter.
- The demand letter constitutes a request to the physician/supplier to refund the overpaid amount.
- The demand letter informs physicians/suppliers that the carrier will recover the overpayment through the recoupment of current payments due or from future claims submitted unless the carrier receives repayment or the physician/supplier provides a statement within 15 days of the date of the letter of why this action should not take place. The demand letter shall also inform physicians/suppliers that this recoupment will begin on the 41st day from the date of the letter.
- The demand letter informs physicians/suppliers that interest will accrue on the overpayment if payment in full is not received by the 31st day from the date of the letter. The demand letter shall also inform physicians/suppliers of the applicable interest rate that will accrue if payment in full is not received by the 31st day from the date of the letter.
- The demand letter informs physicians/suppliers that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) A review is available for disputed overpayments of any amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least \$100.
- Bankrupt providers. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.

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

B. Recovery by Recoupment

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

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

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

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

C. Follow-up Request

If the initial demand letter for an overpayment of \$10 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

D. Physician Appeals Within 30 Days of Notification of the Intent to Recoup

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

E. Demand Letter to Physician Returned as Undeliverable

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

F. Direct Contact with Physician

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

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

EXHIBIT 1- SAMPLE DEMAND LETTERS

Exhibits I through VI include: the initial demand letter with optional opening paragraphs and the follow-up letter. It also includes a limited set of optional paragraphs to be used in specific situations, e.g., medical necessity denials, and installment payments. The carrier shall follow these formats, with the optional paragraphs, when preparing demand letters.

This section also includes standard letters to be used when the physician/supplier voluntarily submits a check to the carrier. These letters are optional if the carrier uses the remittance advice to inform physicians/suppliers of receipt of their refund checks.

EXHIBIT 1 - INITIAL Non-935 DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code
Date

Dear Dr. Smith:

Contractors should use the appropriate paragraph:

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

or

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

or

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

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

Why you are responsible:

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

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below.

(Applicable Authorities: Section 1870(b) of the Social Security Act; §§ 405.350 - 405.359 of Title 42, §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.)

What you should do:

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

Carrier Name

Address

City, State and Postal ZIP Code

Immediate Recoupment request:

“You may elect to have your overpayment(s) repaid through the “immediate recoupment” process and avoid paying by check or waiting for the standard recoupment that begins on day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than 16 days from the date of initial demand letter. You must specify whether you are submitting:

1. A one-time request for the current overpayment and all future overpayments, or
2. A request for the current overpayment addressed in this demand letter only.

This process is voluntary and for your convenience.

Visit our website at www._____. or call (USA MEDICARE CONTRACTOR Name) at (XXX) XXX-XXXX for additional information and instructions for “**Immediate Recoupment**”.

You may fax your request to XXX-XXX-XXXX.

If you do not refund in 30 days:

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

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

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

If you wish to appeal this decision:

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

Address of Redetermination Department

If you have filed a bankruptcy petition:

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

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

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

Sincerely,

(name and title)

Enclosure

EXHIBIT 2 - FOLLOW UP DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Dear (Name of Physician/Supplier):

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

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

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

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

Sincerely,

(Name of individual)

Enclosure

EXHIBIT 3- INTENT TO REFER LETTER

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

EXHIBIT 4 - OPTIONAL OVERPAYMENT CUSTOMIZING PARAGRAPHS

A1 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."

Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because (i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community).

(Applicable Authorities: Section 1879 of the Social Security Act; §§411.404 and 411.406 of Title 42 of the United States Code of Federal Regulations.)

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

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary.

This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge.

The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

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

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

NOTE: The above paragraphs are not all-inclusive.

EXHIBIT 5 - SAMPLE LETTER - CHECK INCLUDED FOR CORRECT AMOUNT

Dear (Name of Physician/Supplier):

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

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

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

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

Sincerely,

(Name of individual)

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

Dear (Name of Physician/Supplier):

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

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

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

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

Sincerely,

(Name of individual)

Enclosure

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

(Rev. 70, Issued: 05-27-05; Effective and Implementation dates: 06-27-05)

When a claim adjustment creates an overpayment the beneficiary who received the services will normally receive a Medicare Summary Notice (MSN) notifying the beneficiary about the specifics of the adjustment and the beneficiary's appropriate appeal rights. The MSN uses codes with accompanying descriptions to update the beneficiary. Through a MSN code, the MSN can also be used to inform the beneficiary that the provider may be requested to repay the difference in the amount paid and the adjustment to Medicare.

In situations where the claim adjustment creates an overpayment and a MSN is generated, a separate notice to the beneficiary is **not** required whenever recovery is sought from the provider.

However, if a MSN is not generated a separate notice to the beneficiary is required whenever recovery is sought from the provider. Some reasons a MSN may not generate include, but are not limited to, if the claim has been purged from the system or if the overpayment is because of a mass adjustment. In these situations a separate notice to the beneficiary is required whenever recovery is sought from the provider. (See Chapter 3, §§100 & 110ff when recovering from the beneficiary.)

The following instructions apply if a separate notice to the beneficiary is required.

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

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

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

- The name and address of the provider and dates of service for which the overpayment was made.
- A clear explanation of why the payment was incorrect.
- A statement that the provider has been requested to refund the overpayment and, if the provider is liable for medically unnecessary services or (FIs only) custodial care, the following additional information, as applicable:
 - If the error is discovered subsequent to the third calendar year after the year the payment was approved, and the other conditions described in Chapter 3, §80 apply, the Contractor shall advise the beneficiary that the provider is prohibited, by law, from requesting payment for the services; or
 - If the beneficiary is determined to be without fault, the Contractor shall state that if the beneficiary pays for the services, the beneficiary may request that the Contractor indemnify the beneficiary for such payment. Any indemnification paid to the beneficiary will be recovered from the provider. (See Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.)
- In all other cases, Medicare law does not prohibit the provider from requesting the beneficiary to pay.

An explanation of the beneficiary's appeal rights. (See Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions.) In the notice to the beneficiary, however, the Contractor shall not mention waiver since there is no provision for waiver when the physician is liable for the overpayment.

90.4 - Sample Letter to Beneficiary Where Recovery Is Sought From Provider (Rev. 70, Issued: 05-27-05; Effective and Implementation dates: 06-27-05)

A notice to the beneficiary is required whenever a provider is requested to repay Medicare because of an overpayment determined as a result of services provided to the beneficiary. If a MSN is generated the appropriate notice codes shall be utilized informing the beneficiary that the provider may be requested to repay Medicare. If this occurs no further action needs to be taken. However, if a MSN is not generated notice shall be sent to the beneficiary. Below is a sample letter to a beneficiary where recovery is sought from the provider.

Dear _____:

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

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

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

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

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

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

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

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

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt from (provider's name), your cancelled check, or any other evidence showing that you (the beneficiary) have (has) already paid (provider's name) for the services at issue.

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

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

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

C. All Other Cases

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

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

110 - Confirmed Identity Theft

(Rev. 336: Issued: 02-07-20: Effective:05-08-20: Implementation; 05-08-20)

The Centers for Medicare & Medicaid Services (CMS) is addressing instances of identity theft confirmed by the Investigating Unit (IU) through a CMS-approved identity theft victim validation and remediation process. For purposes of this instruction, the IU is the Unified Program Integrity Contractor (UPIC) and the CMS Center for Program Integrity (CPI).

When the IU confirms, by letter, to the contractor that a victim's overpayment(s) resulted from identity theft:

- The contractor shall immediately discontinue ALL collection efforts on the overpayment(s). These collection efforts shall include recoupments, sending demand letters, and referring the overpayment(s) to Treasury.
- Contractors not utilizing the Healthcare Integrated General Ledger Accounting System (HIGLAS) shall recall the overpayment(s) if it was referred to Treasury.
- The contractor shall update the Shared System, HIGLAS, and ViPS Medicare System (VMS), as appropriate, for all affected claims and accounts receivables (ARs) within 5 business days from the confirmation receipt date.
- Contractors utilizing HIGLAS shall adjust down the AR(s) with the "DELETE/ADJ TO ZERO" activity code and close the AR(s) by changing the AR status code "CLO-ERR." The "DELETE/ADJ TO ZERO" activity code will systematically recall the overpayment(s) if it was referred to Treasury.
- Contractors not utilizing HIGLAS shall adjust down the related AR(s) to \$0.00 and change the status to closed.
- The contractor shall refund any monies within 30 calendar days that were recouped or paid to satisfy the overpayment(s).
- The contractor shall request CMS to provide a revised (corrected) IRS Form(s) 1099-C if the original IRS Form(s) 1099-C included the overpayment(s).
 - The contractor shall send the request to MedicareOverpayments@cms.hhs.gov with "Corrected IRS Form(s) 1099-C Request for Confirmed ID Theft" in the subject field.
 - The contractor shall include in its request, a copy of the IU identity theft confirmation letter and the amount(s) that shall be corrected.
 - The contractor shall issue the revised (corrected) IRS Form(s) 1099-C to the victim.
- The contractor shall issue a revised (corrected) IRS Form 1099-MISC if the original IRS Form 1099-MISC issued to the victim contained amounts related to confirmed identity theft.
- The contractor shall notify the victim, by letter, of all activity associated with the overpayment(s) of the confirmed identity theft case. This activity shall include items such as notice of the

rescission of the overpayment(s), the revision of the IRS Forms 1099-C and/or 1099-MISC, and the recall of the overpayment(s) from Treasury. The letter shall also include all claim/document control numbers of all affected claims and all original accounts receivable amounts (principal and interest) that were adjusted down.

110.2 - Seized Monies Received from Law Enforcement

(Rev. 199, Issued: 11-04-11, Effective: 12-05-11, Implementation: 12-05-11)

The contractor shall apply any seized monies received (e.g., Treasury check) from the perpetrator of the identity theft to the fraudulent debt in accordance with the Medicare Financial Management Manual, Publication, 100-06, Chapter 5.

120 – Monitoring Accounts Receivable that are in a Redetermination or Reconsideration Status

(Rev. 261, Issued: 01-29-16, Effective: 03-01-16, Implementation: 03-01-16)

The MAC shall develop controls to monitor accounts receivable (ARs) that are in the first (redetermination) or second (reconsideration) level of appeal. ARs that are in either level of appeal are subject to limitations on recoupment as mandated by Section 935(f)(2)(a) of the Medicare Modernization Act of 2003. The MAC shall monitor these ARs to make sure the “days in status” are not greater than 120. If the “days in status” are greater than 120, the MAC shall research the appeal to determine the status/decision of the appeal and update the AR’s status accordingly.

130 –Federal Payment Levy Program – IRS Tax Levy Requests

(Rev. 11462; Issued: 06-23-22; Effective: 07-25-22; Implementation: 07-25-22)

In coordination with the Internal Revenue Services’ Federal Payment Levy Program (FPLP), under Internal Revenue Manual, Part 5, Chapter 11, Section 7, CMS receives automated Notice of Levy to collect delinquent debts owed to the federal government. Automated FPLP interfaces with the Bureau of Fiscal Services’ (BFS) Treasury Offset Program (TOP). CMS shall comply with automated FPLP requests under 26 U.S.C. §6331(a);(h), which requires:

- (1) A Levy shall extend only to property possessed and obligations existing at the time thereof, in accordance to 26 USC §6331(b);
- (2) Any Federal payment owed to the taxpayer shall be levied on a continuous basis, until such levy is satisfied, as determined by the Secretary of Treasury; 26 USC §6331(h)(1)
- (3) Any such levy shall be applied at the rate of 100% for any payment(s) due to a Medicare provider or supplier under Title XVIII of the Social Security Act. 26 USC §6331(h)(2)

For the purposes of operationalizing the CMS’s obligations under the FPLP, specifically in identifying “an obligation existing at the time thereof” under 26 USC §6331(a) the Social Security Act, § 1816(c)(3)(A)&(B), and 1842(c)(3)(A)&(B):

- (4) “No payment shall be issued, mailed, or otherwise transmitted with respect to any claim

submitted under this title within the applicable number of calendar days after the date on which the claim is received.” SSA §1816(c)(3)(A)&(B); and

- (5) “Applicable number of calendar days” means with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and with respect to claims submitted otherwise, 28 days. SSA§ 1842(c)(3)(A)&(B)

The Medicare Claims Processing Manual, Chapter 1, Section 80.2.1.2, Payment Floor Standards, describe the method of calculation of the applicable calendar days as described in SSA §1816(c)(3) & §1842(c)(3). For the purpose of implementing this section, the Payment Floor Date, as described in Chapter 1, Section 80.2.1.2, is the earliest day after receipt of the clean claim that payment may be made. Any claims payment amounts owed to the provider of services, hospital, or supplier, which are held on the payment floor, but have not yet reached the Payment Floor Date, regardless of date of submission, shall be considered “obligation(s) existing at the time thereof” the IRS Levy is received by CMS.

Under Internal Revenue Manual (IRM) 5.11.6.7.2, and in addition to automatic levies through FPLP, payments to Medicare providers and suppliers may be general levies, also referred to as paper levies, received on form 668a.

A. Medicare payment to providers and suppliers are subject to withhold due to receipt of a general or paper tax levy on form 668a when:

1. A tax levy is served by the Internal Revenue Service (IRS) at the Medicare Administrative Contractor, or

2. In rare circumstances, received by the CMS.

- CMS as a responsible party shall promptly notify the appropriate MAC if a general or paper levy is served to the CMS.

B. Once received, the contractor shall implement the general or paper tax levy to recoup funds against current Medicare claims payments on behalf of the IRS.

C. Contractors shall be responsible to setup the paper levy as a Third-Party Payment (TPP) Debt.

1. Once a paper levy has been end-dated and sufficient paperwork is returned, it is possible for the provider to receive a new levy for the same provider, with new dates.

2. It is also possible to have more than one paper levy served on a provider (not a duplicate) at the same time.

- Contractors shall decline the additional 668a tax levy and return it to the IRS with instruction to resend when the existing debt is finished collecting.

D. General or paper tax levies received on IRS form 668a are not continuous levies.

- If the provider or supplier for whom the paper levy is received is already subject to FPLP, the paper levy is setup as a TPP and collected according to the HIGLAS hierarchy.
- Any provider claims received after the general or paper levy IRS FORM 668a has been served shall not be added to the obligated amount due to the provider.

E. Contractors shall follow these steps for general or paper tax levies received on IRS form 668a:

1. The amount shall be held at 100% up to the total amount reflected on the IRS form 668a general levy;

2. After the claims clear the payment floor, up to the amount of the levy, the amount shall be transmitted to the Treasury Department as requested; however:

- If the amount due the provider on the day the levy was served, and

- The total amount due the provider for the claims on the floor is not enough to cover the levy amount (once all the obligated claims clear the floor, no later than the number of calendar days specified in the IRS form 668a general levy).

3. The entire amount withheld shall be released to the Treasury Department.

F. Contractors shall have the number of calendar days specified in the IRS form 668a levy to collect funds from the date the third-party transaction is set up.

- Contractors shall add an inactive date to the third-party transaction when the full amount is not collected in full within the required timeframe.

G. Contractors shall complete the back section on the IRS 668a form as requested by the IRS.

1. Send back the form to the IRS, after the number of calendar days specified in the IRS form 668a general levy and the total amount is collected.
2. Report the tax levies as a withholding on the Remittance Advice (RA).

H. Contractors shall setup the TPP offset form for non-tax FPLP withholdings in the Medicare Provider Payment Offset process which are collected in the hierarchical order below:

1. Medicare Accounts Receivable debt,
2. FPLP Offsets for Federal Tax debt at 100% maximum of the payable amount,
3. Administrative Offsets for Federal Non-Tax debt at 100% of the payable amount,
and
4. TPP

Refer to <https://www.irs.gov/businesses/small-businesses-self-employed/federal-payment-levy-program> for additional information on the Tax Levy Program.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R12346FM</u>	11/01/2023	Revisions and Deletions to the Internet Only Manual (IOM), Publication 100-06, Chapter 4, Debt Collection Related to Extended Repayment Schedules (ERS) and Debt Management	10/30/2023	13358
<u>R12323FM</u>	10/20/2023	Revisions and Deletions to the Internet Only Manual (IOM), Publication 100-06, Chapter 4, Debt Collection Related to Extended Repayment Schedules (ERS) and Debt Management- Rescinded and replaced by Transmittal 12346	10/30/2023	13358
<u>R12262FM</u>	09/28/2023	Revisions and Deletions to the Internet Only Manual (IOM), Publication 100-06, Chapter 4, Debt Collection Related to Extended Repayment Schedules (ERS) and Debt Management - Rescinded and replaced by Transmittal 12323	10/30/2023	13358
<u>R11787FM</u>	01/19/2023	Publication (Pub.) 100-06, Chapter 4, Section 70 Revision (Removal of Debt Collection System References and Corresponding Updates) and Inclusion of Existing Debt Close-Out (Termination of Collection Action) Instructions	04/21/2023	12858
<u>R11462FM</u>	06/23/2022	Federal Paper Tax Levy	07/25/2022	12481
<u>R10821FM</u>	05/24/2021	Pub. 100-06, Chapter 4, Section 10 Revision (New Accounts Receivable (AR) Status Codes for Undeliverable Initial Demand Letters and Terminated/Out of Business Providers	04/26/2021	11832
<u>R10527FM</u>	12/23/2020	Pub. 100-06, Chapter 4, Section 10 Revision (New Accounts Receivable (AR) Status Codes for Undeliverable Initial Demand Letters and Terminated/Out of Business Providers)- Rescinded and replaced by Transmittal 10821	04/26/2021	11832
<u>R336FM</u>	02/07/2020	Pub. 100-06, Chapter 4, Section 110 (Confirmed Identity Theft) Revision	05/08/2020	11486
<u>R330FM</u>	11/06/2019	The Medicare Fee-for-Service Recovery Audit Program	11/04/2019	11464

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R328FM</u>	10/18/2019	Updates to Medicare Financial Management Manual Chapter 4, Section 50-50.6 Extended Repayment Schedules	10/07/2019	11128
<u>R326FM</u>	10/04/2019	The Medicare Fee-for-Service Recovery Audit Program- Rescinded and replaced by Transmittal 330	11/05/2019	11464
<u>R316FM</u>	05/24/19	Updates to Medicare Financial Management Manual Chapter 4, Section 20 and 20.1 Demand Letters	10/07/2019	10776
<u>R312FM</u>	04/05/2019	Updates to Medicare Financial Management Manual Chapter 4, Section 50-50.6 Extended Repayment Schedules- Rescinded and replaced by Transmittal 328	10/07/2019	11128
<u>R315FM</u>	05/17/2019	Update to Publication (Pub.) 100-06 to Provide Language-Only Changes for the New Medicare Card Project	06/18/2019	11211
<u>R296FM</u>	12/08/2017	Cessation of MAC Validation of Recovery Audit Program New Issues	01/02/2018	10349
<u>R286FM</u>	06/09/2017	Medicare Financial Management Manual Chapter 4, Section 20 Demand Letter Updates	07/03/2017	10023
<u>R285FM</u>	06/02/2017	Pub. 100-6, Chapter 3 and 4 Revisions	07/01/2017	10079
<u>R264FM</u>	02/12/2016	Extended Repayment Schedule (ERS) Manual Updates	03/14/2016	9423
<u>R261FM</u>	01/29/2016	Monitoring Accounts Receivable that are in a Redetermination or Reconsideration Status	03/01/2016	9470
<u>R259FM</u>	01/15/2016	Internet Only Manual Pub.100-06, Chapter 4 Revisions to Reflect the New Debt Referral Requirements Mandated by the Digital Accountability and Transparency Act of 2014 (DATA Act)	02/16/2016	9469
<u>R246FM</u>	11/26/2014	Recovery Auditor Appeal Adjustments with "RI" Indicator	12/29/2014	8973
<u>R244FM</u>	10/17/2014	Treasury Report on Receivables (TROR) Reporting	11/18/2014	8936
<u>R241FM</u>	09/26/2014	Recovery Audit Program Tracking Appeals and Reopenings	10/07/2014	8411

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R235FM</u>	05/14/2014	Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 4, Debt Collection (Section 10)	07/07/2014	8315
<u>R233FM</u>	04/04/2014	Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 4, Debt Collection (Section 10) – Rescinded and replaced by Transmittal 235	07/07/2014	8315
<u>R226FM</u>	09/06/2013	Recovery Audit Program Tracking Appeals and Reopenings – Rescinded and replaced by Transmittal 241	10/07/2013	8411
<u>R224FM</u>	08/02/2013	Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS)	09/03/2013	8347
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