# CMS Medicare Manual System
# Pub. 100-6 Financial Management

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

**Transmittal 3** **Date: AUGUST 30, 2002**


| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
|---|---|---|---|
| 3 | | Entire Chapter | |

**CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.**

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

This transmittal includes chapter 3 of the restructured Medicare Financial Management Manual.

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

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

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

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

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

- Page numbers - are not applicable for Internet documents.

- Distribution of printed copies is discontinued.

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

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

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

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

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

# Medicare Financial Management Manual

## Chapter 3 - Overpayments

Table of Contents

**NOTE:** Revision 3, the initial release of this chapter, includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

## Forward - Overpayments Made by the FI or Carrier

**(Rev. 3, 08-30-02)**

This chapter deals with two general types of overpayments.

The first is those overpayments, called aggregate overpayments, that involve the body of a provider's claims, e.g., overpayments discovered at cost-report settlement time or change of FI, overpayments resulting from a pattern of improper application of Medicare coverage provisions, situations involving provider failure to file a cost report, or occasions of fraud or program abuse.

Action to deal with aggregate overpayments is described in §§10 through 30 below and Chapter 4, Debt Collection.

The second category of overpayments (individual overpayments) refers to an incorrect payment for provider or physician services made by the FI or carrier under title XVIII (see §§90ff.).

## 10 - Interest Charges/Payments on Overpayments and Underpayments - General

**(Rev. 3, 08-30-02)**

**A2-2219**

Section 1833(j) of the Social Security Act (the Act) and 42 CFR 405.378 require that interest be charged on Medicare overpayments.

The interest rate on overpayments 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. Nothing in these sections is meant to change any instructions or procedures that are in effect with regard to overpayment collection efforts. (See §20.)

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

### A - Charging of Interest

Interest will be charged on overpayments, and will 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.

**B - Accrual of Interest**

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

## 10.1 - Final Determination - FIs

**(Rev. 3, 08-30-02)**

**A2-2219.1**

The definition of final determination used in conjunction with 42 CFR 405.378ff. is **not** synonymous with the term final determination used in settling provider cost reports when the FI issues a Notice of Program Reimbursement (NPR) under 42 CFR 405.1803. For purposes of this chapter:

A. 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:

   1. An audited final settlement;

   2. Final settlement without audit; or

   3. Reopening for any reason.

B. When an NPR is not utilized, a final determination is deemed to occur upon the issuance of a written determination and a written demand for payment of an overpayment or the issuance of a notice of underpayment to a provider based upon:

   1. Initial retroactive adjustment, with or without desk review; or

   2. Revised initial retroactive adjustment.

   For special requirements concerning demand letters issued as a result of this determination, see §10.5.C.

C. 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.

D. 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. (NOTE: Generally cost reports are due on or before the last day of the fifth month

following the close of the period covered by the report. A single 30-day extension of the due date of the cost report may be granted for good cause.)

## 10.2 - Rates of Interest - FIs and Carriers

**(Rev. 3, 08-30-02)**

**A2-2219.2, B3-7130**

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 rate is published quarterly in the "Federal Register" prior to the first day of each calendar quarter to be applied to determinations made during the succeeding calendar quarter. 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 two consecutive installment payments) 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.

## 10.3 - Interest Accruals

**(Rev. 3, 08-30-02)**

**A2-2219.3**

**A - Overpayments**

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, unless the overpayment is fully paid within 30 days of such notices (§10.1A, B, and C). However, for providers serviced by FIs, there are certain exceptions.

**1 - Untimely Filed Cost Reports, Regarding Final Determinations at §10.1C, and D.**

Interest always accrues for any overpayment on a late filed cost report for the period of delinquency when an overpayment is declared or determined. The overpayment may appear on the cost report, or may be determined later (including increases to overpayment, see (2) below) through desk review or audit. Interest accrues during the period a cost report remains unfiled beyond the due date, and is due and payable following the notice of a final determination even though the overpayment is satisfied at the time of the delayed filing of the report or within the 30-day period after notice of a final determination. 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.

**2 - Increase in Overpayment over the Amount Declared on an Untimely Filed 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 unless fully satisfied within 30 days of the new or revised notice of final determination. These interest charges will be in addition to the interest charges payable under Item 1 above based on the same additional overpayment.

**B - Underpayments**

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

1. An NPR (FI only) and a notice of final determination of an underpayment under §10.1A.

2. A notice of final determination of an underpayment under §10.1B when an NPR is not issued (FI only).

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

## 10.4 - Procedures for Applying Interest During Overpayment Recoupment

**(Rev. 3, 08-30-02)**

**A2-2219.4, B3-7160.3**

### A - General

If a provider is unable to satisfy the overpayment within 30 days from the date of final determination and demand for repayment (§10.1), interest accrues on the unpaid principal balance and is due and payable for each 30-day period, or portion thereof that an overpayment balance is outstanding. The contractor first applies any payments received to the accrued interest charges and then to the overpayment principal. If the provider has more than one overpayment outstanding and a payment is received, the contractor credits the payment to the oldest overpayment first, unless the provider designates otherwise.

### B - Recoupment Through Installment Payments

A provider is expected to repay any overpayment as quickly as possible. If a provider cannot refund the total amount of the overpayment within 30 days after receiving the first demand letter, it should immediately request an extended repayment schedule. (See Chapter 4, Debt Collection, §20 for extended repayment procedures.)

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

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

Generally, the FI or carrier shall calculate interest for a 30-day period as follows:

Principal times Prevailing Interest Rate = Interest for Year

Interest for Year divided by 12 = 30-day Interest

Thus, if a payment is made 31 days from date of determination, two 30-day periods of interest are charged. The FI or carrier applies any payment to accrued interest first and then to principal. For example, an overpayment was determined on June 15, 1999, and no refund was received within 40 days. Offset was put into effect on July 25, 1999, and was applied first to 60 days of interest and the remainder applied to the principal. On or

after August 15, 1999, (the 61st day after determination) any offset amount is applied to an additional 30 days of interest.

Whenever recovery is made in equal installments and over several months, use of an amortization table allows the contractor to dispose of the interest calculation within one operation and eliminates the need to perform time consuming clerical and arithmetical activities upon receipt of each installment payment. Where an amortization table is not available for the particular interest rate assessed, the contractor calculates the equal monthly installment payment which includes the accrued interest by using the following simple interest formula.

MP = Monthly Payment

A= Amount of Loan

i = Monthly Interest Rate

N = Number of Payments

$$MP = \frac{(A)(i)}{1 - \frac{(1)}{(1-i)^N}}$$

**Note:** The contractor may not use this formula where overpayments are collected by offsets or by other than a monthly repayment schedule.

If the contractor assumes that a $5,000.00 overpayment is to be repaid over a period of 36 months at an annual interest rate of 9.5%, the amount of each of the 36 equal monthly payments required to fulfill the repayment agreement is calculated as follows:

A (Amount of loan) = $5,000.00

N (number of payments) = 36 (months)

i (periodic interest rate) = 9.5%/12 (rate per month)

MP (monthly payments = ?

$$MP = \$5{,}000.00 \times \frac{.095}{}$$

$$\frac{}{1 - \frac{(1)}{36}}$$

$$(1 - \frac{.095}{12})$$

MP = $160.15 (Equal Monthly Payment)

Note that this example contains the provisions for offsetting any subsequent underpayment against the outstanding overpayment in order to liquidate the debt as soon as possible. Offset must be made even though the debtor is not in default. Extended repayment schedules call for timely installment payments on the same day each subsequent month, e.g., the first, fifteenth.

**C - Proof of Receipt**

The U.S. Postal Service postmark date is controlling in determining the timely receipt of, for institutional providers serviced by a FI, a cost report or for providers or physicians serviced by either a FI or carrier, 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 the late charge. A provider using a meter postage machine must have a U.S. Postal Service postmark confirming the validity of the postmark date. The date the cost report (institutional providers serviced by FI) or payment is received controls if any other mailing service was used.

## 10.5 - Notification to Providers

**(Rev. 3, 08-30-02)**

**A2-2219.5**

**A - 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 4, Debt Collection, and §§70.1, 70.2 and 70.3, the FI must include the following:

1. 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. 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 subtract the amount of the overpayment from interim payments over the next 30-day period.

**B - Notice of Program Reimbursement (NPR) - FIs**

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

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

**C - Overpayment Demand Letters**

In addition to the requirements of Chapter 4, §10ff., the contractor's written demand for repayment must contain a notice that in accordance with 42 CFR 405.378, interest will be charged on all overpayments determined on or after September 3, 1982, at the prevailing rates.

The interest rate on overpayments 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 contractor may use the following language in explaining how interest will be charged:

> "If payment in full is not received by, (specify a date 30 days from the date of the notification), simple interest at the rate of (___) will be charged on the unpaid balance. For periods of less than 30 days the full monthly interest charge will be applied. Thus, if payment is received 31 days from the date of final determination, two 30-day periods of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will accrue on the remaining principal balance at the prevailing quarterly rate in effect on the date of final determination."

When the contractor issues a demand letter prior to the issuance of the NPR (§10.1.B) the written determination must set out the basis for the overpayment. The contractor will advise the provider that it has 15 days from the date of such notification to contest the

determination regarding the existence or the amount of the overpayment. It must inform the provider that its response must include pertinent evidence supporting its statement why the overpayment is wrong. If there is no timely response or if the response indicates agreement, interest will accrue from the date of the initial retroactive adjustment. Where the response, accompanied by pertinent evidence disputes all or part of the overpayment, interest will not be assessed on the disputed amounts. The contractor must review the evidence submitted and issue a revised determination within 30 days from the receipt of such evidence. Interest will accrue upon the basis and date of the revised determination.

For institutional providers serviced by FIs, if an audit is in process, the resolution of the disputed issues may be delayed until issuance of the NPR. If the contractor proceeds to make a revised determination, it must contain specific findings and explanations as to why the contractor's reimbursement decision differs from the amount the provider claimed. Interest will accrue on undisputed issues from the date of the initial retroactive adjustment. In addition to the above general requirements, FI demand letters issued to institutional providers prior to the NPR must contain the following language:

> "Should you consider that this determination is not in accordance with the provisions of 42 CFR 405.401ff., this is to advise that you have 15 days from date of this notice before suspension of interim payments is initiated to submit any evidence to support a position that the determination is contrary to the principles of reimbursement."

When the NPR is issued with a demand letter the 15-day notice is not to be included. The NPR and/or written determination of an overpayment and demand letters may be combined in one document as long as the requirements of §10.5 B and C are included. The contractor should exercise care to insure that all notices required by §10.5 are dated and mailed on the same day. The first day of the 30-day period is the day following the date of the final determination.

## 10.6 - Waiver and Adjustment of Interest Charges

**(Rev. 3, 08-30-02)**

**A2-2219.6**

### A - Waiver of Interest Charges

Interest charges will 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 will not be waived for the period of time during which the cost report was due but remained unfiled as specified in §10.1.D and E. Also, interest will 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 §10.1.C 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.

**B - Adjustment of Interest Charges**

**1 - Reopenings**

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 charged and recovered interest to reflect the proper interest chargeable under 42 CFR 405.378 and the policies set forth. Interest accrues on the outstanding overpayment during the period of reopening procedures.

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.

**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 charges, including charges for a late filed cost report, 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.

**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 405.454(l) because the provider seeks judicial review of an adverse decision by the PRRB or the decision of the Administrator. Prior to the time that judicial review is sought, interest accrues at the rates specified in 42 CFR 405.378. The FI will make a full or partial reduction in the amount of interest assessed where a decision is made favorable to the provider and it is the final decision in the case.

## 10.7 - Examples of Application

**(Rev. 3, 08-30-02)**

**A2-2219.7, B3-7160.9**

**A - Cost Report Filed On Time**

The provider with a FYE 8/31/1999 submits a cost report on 11/28/1999, showing $10,000 due the program, payment in full accompanies the cost report. On 12/15/1999, the FI completes the desk review and determines an additional $25,000 overpayment. The prevailing interest rate at this time is 9 percent. The provider does not pay the $25,000 additional overpayment until 2/3/2000. Interest, therefore, at a rate of 9 percent per annum accrues on the $25,000 for two 30-day periods. On 6/18/2000, the FI completes its audit and issues an NPR and a written demand showing an additional amount due the program of $16,000. The interest rate at the time the NPR was issued is 12 percent. On 8/15/2000, the provider pays the $16,000 overpayment plus $320.00 interest (two 30-day periods at 1 percent per month.) As a result of a hearing on 12/10/2000, the PRRB reverses the FI's findings and determines that the correct amount due the program was $35,000 ($10,000 when the cost report was filed plus $25,000 determined on desk review.) The $16,000 in principal and $320.00 interest that were charged and collected must be returned to the provider.

Assume the same facts as above, but that as a result of a reopening or a PRRB decision, it was determined that the correct overpayment is $24,000, the $10,000 originally due plus $14,000 due on the desk review. In addition to returning the $16,320, the FI re-computes the interest on $14,000 at 9 percent, (the rate in effect at the time of the desk review); and refunds any principal and interest collected in excess of this amount.

**B - Cost Report Not Filed On Time**

The provider submits its cost report 70 days late and pays the declared overpayment of $50,000 when filing. Interest at the prevailing rate, (assume 12 percent) accrues from the due date until the date filed, or, in this case, three 30-day periods. Interest is charged during the period of delinquency whether or not payment accompanies the cost report. The FI performs a desk review and determines an additional overpayment of $12,000. The rate at this time is 11 percent. Interest at 11 percent is charged on the $12,000 for the three 30-day periods of delinquency. Interest accrues at 11 percent on the $12,000 if payment is not made in 30 days.

A provider with FYE 6/30/1999 submits its cost report late on 11/15/1999, indicating an amount due the program; payment did not accompany the report. Interest is charged for two 30-day periods, from 10/1/1999 through 10/30/1999 and 10/31/1999 through 11/15/1999, the date filed. Do not accrue an additional month's interest based on the fact that payment did not accompany the report. This would result in a double interest assessment. Interest however, accrues on the declared overpayment from the date the cost report is filed to the date the amount due is paid. The interest rate to charge is the rate in effect on the day the cost report became overdue, 10/1/1999. On 3/12/2000, the FI completes the audit and determines an additional overpayment, issuing an NPR and demand letter. Interest will be charged on this additional amount at the rate in effect on 3/12/2000.

Assume the same facts as above. The provider submits payment with the delinquent cost report. The amount received is applied first to any accrued interest and then to principal. The interest rate applicable to the remaining principal is the rate in effect at the time the

cost report became overdue. If only partial payment accompanies the report, the same rule applies.

For any periods of delinquency that began on or after 9/3/82 but prior to 12/6/82, the date 42 CFR 405.378 was published in the "Federal Register," interest will not be charged for the delinquency period based on any subsequent determinations. Interest will be charged in these cases only when full payment of an overpayment is not received within 30 days of a final determination. (See §10.1) Legal notification of the effective date of the regulation will be applied as of the date of publication, 12/6/82.

## 20 - Overpayment for Provider Services - General

**(Rev. 3, 08-30-02)**

**A2-2220, B3-7100**

Overpayments are Medicare funds a provider or physician has received in excess of amounts due and payable under the statute and regulations. Once a determination of overpayment has been made, the amount is a debt owed by the debtor to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must attempt collection of claims of the Federal Government for money arising out of the activities of the agency. While the FI or carrier will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part, as agents of CMS, it must attempt recovery of overpayments in accordance with CMS regulations.

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

In these sections, the term "beneficiary" refers to the patient. The term "physician," includes "supplier," to denote the person (or entity) who rendered services or furnished medical items. Instructions regarding referral to CMS also apply to the RRB if it has jurisdiction.

Medicare classifies overpayments as either “individual” or “aggregate”. For a discussion of individual” overpayments, see §§90ff., below.

The following subsection discusses “aggregate” overpayments.

## 20.1 - Aggregate Overpayments

**(Rev. 3, 08-30-02)**

**A2-2220.2, B3-7150**

**A - Institutional providers serviced by FIs**

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

- A pattern of furnishing and billing for excessive or noncovered services (see Program Integrity Manual);
- Inclusion of non-allowable or excessive costs in the provider's cost report (see §60);
- Excessive interim payments made to the provider §60);
- Failure to repay accelerated payments (§60);
- Failure to file cost reports (§70);or
- Determination of amounts due during desk review, final settlement and reopening of the cost report.

## 20.2 - Physician Offers to Settle on Compromise Basis

**(Rev. 3, 08-30-02)**

**B3-7159**

An overpaid physician may offer to compromise an overpayment. The carrier shall forward all such offers to the RO. It shall accept compromise offers only in exceptional circumstances. It shall obtain approval of the Department of Justice if the overpayment exceeds $100,000, exclusive of interest, or such higher amount as the Attorney General may from time-to-time prescribe.

## 20.3 - Unsolicited Overpayment Refunds

**(Rev. 3, 08-30-02)**

**A2-2220.3**

Actual costs of services cannot be determined until the end of the accounting period because providers are paid on an estimated cost basis during the year. However, when a provider believes that an overpayment has been received and makes an unsolicited overpayment refund, the FI accepts it regardless of the amount. A retroactive adjustment based on actual costs is made at the end of the reporting period.

## 20.4 - Timely Deposit of Overpayment Refund Checks

**(Rev. 3, 08-30-02)**

**A2-2220.4, B3-7114.1**

These instructions are designed to protect the trust fund interest earnings opportunities, and are the same for FIs and carriers.

The FI or carrier promptly deposits refund checks into the Medicare "Federal Health Insurance Benefits Account" in accordance with the following guidelines:

- It deposits receipts of overpayment refund checks of $1,000 or more on a daily basis.

- It may accumulate and deposit receipts of less than $1,000 when the total reaches $1,000.

- It must make deposits no less frequently than weekly regardless of the amount accumulated.

**A - Actions Which Will Satisfy "Deposit" Requirements:**

- If the "Federal Health Insurance Benefits Account" is located in a bank in the same city and in close proximity to the FI or carrier, the FI or carrier deposits the money that day;

- If the account is located in a bank that is not in close proximity, it mails the deposit to the bank;

- If the account is located in a bank that is not in its geographic area, it mails the deposit (express mail overnight delivery if checks total over $10,000); or

- If it maintains a depository account, it makes the deposit the same day (it does not mail it).

**B - Recommended (Not Mandatory) Procedures to Expedite the Deposit of Refund Checks:**

- If cost justified, the FI or carrier establishes a separate post office box for Medicare refund checks to expedite the collection/deposit process;

- It establishes written procedures for the receipt, processing and deposit of refund checks;

- In some instances, it would be appropriate for the FI or carrier to open a "depository account" at a local bank to eliminate the mail float involved in sending the refund check to a bank located in another State. When using this procedure, collected funds at the local bank depository are sent via wire transfer to the bank where the Medicare account is established;

- Where the average monthly deposit of refund checks exceeds several million dollars, the FI or carrier establishes a "lockbox" at its geographic location. A cost analysis will determine whether or not a "lockbox" is warranted.

**NOTE:** Approval from CMS CO and its respective RO is required when the FI or carrier wishes to open either a depository account or a lockbox at a local bank.

## 30 - Determination of Amount of Provider Overpayment

**(Rev. 3, 08-30-02)**

**A2-2221**

The FI is responsible for determining the amount of provider overpayments. The methods for computing these amounts are:

**A - Cost Report Filed and Settled**

The overpayment is the difference between the provider's costs payable under Medicare on the filed cost report and the cost report settled by the FI. The differences may be due to (this list is **not** all-inclusive):

- The claimed program costs are higher than the program costs the FI determined:
- The difference between claimed program utilization and actual covered utilization;
- Inclusion of non-allowable or excessive costs in the cost report;
- Adjustments to claimed pass-through amounts, DRG payments, outlier amounts, interim payments; or
- Correction of errors in the cost report.

**B - Cost Report Filed But Not Settled**

The amount of the overpayment is the sum of:

- The amount the FI determined to be due from the provider for the period for which the cost report was filed (less any amounts recovered);
- Errors in the cost report;
- Amounts the FI determined to have been overpaid as a result of a review of claims because that provider had a pattern of furnishing excessive or noncovered services; and/or

- Adjustments to the provider's claimed pass-through amounts, DRG payments, outlier amounts and interim payments.

**C - Cost Report Overdue**

Where a cost report has not been filed timely, the overpayment is the sum of:

- All interim payments made for beneficiary services rendered during the accounting period for which the cost report has not been filed;
- All interim payments made for beneficiary services rendered subsequent to such accounting period; and
- Any outstanding accelerated payments on account, lump-sum interim payments, and any other interim payments.

**D - Interim Rate Adjustments**

The overpayment is the difference between the amounts that were previously paid and the amounts that should have been paid under the most recent interim rate determination. Overpayments to providers (overpayments arising in other than individual cases) may occur because of (this list is **not** all-inclusive):

- Decrease in the case mix index use in computing the interim rate;
- Fluctuations in utilization, pass-through costs, number of available beds, number of interns and residents;
- Change in services provided which was not timely reported to the FI;
- Lack of timely billing by a PIP provider; or
- Excessive denial rates experienced by the provider.

## 30.1 - Provider Possibly Without Fault

**(Rev. 3, 08-30-02)**

**A2-2221.1**

If the provider alleges that it was without fault with respect to the overpayment, e.g., where it claims that it billed for the services in reliance on misinformation from an official source, or if there is other evidence that the provider was without fault, the FI shall consider relieving the provider of liability under §§100ff. The FI shall explore this issue before pursuing recovery.

Where the provider is determined not to be without fault under the criteria in §100.1, the FI states this in the recovery letter and gives the reasons for the determination. It refers questions as to whether a provider was without fault in a given situation to:

Centers for Medicare & Medicaid Services
Director, CMM
7500 Security Boulevard
Baltimore, MD 21244-1850

Where the provider is determined to be without fault in causing an aggregate overpayment, the FI shall consider whether to recover from the individual beneficiaries in accordance with §§100ff. However, if it appears that the overpayment was due to misinformation from an official source, it submits the case with file to CMS for consideration as to whether the overpayment can be waived.

## 40 - FI Referral to RO of Potentially Uncollectible Provider Overpayments

**(Rev. 3, 08-30-02)**

**A2-2227**

When referral is necessary, the FI shall send the following information:

- The responsible debtors (see §50.A.2), including names and home addresses, and any other information the FI considers useful;
- The amount of the overpayment;
- The provider's cost period ending date(s) in relation to the overpayment (cost report filed and cost report overdue cases only);
- The cause of the overpayment;
- A detailed report of any contact (or attempted contact) with the provider in connection with the overpayment and any reduction or suspension of payment made to date, including the FI's evaluation of the provider's reasons for failing to comply with the repayment schedule;
- The provider's Medicare utilization rate; and
- Whether or not the provider is participating in the Medicaid program.

The RO determines whether additional contacts with the provider will be necessary. Where the RO determines that further efforts would be fruitless or where RO contact is unsuccessful, the RO will request the FI to prepare the case file for referral to the Department of Justice (DJ). The FI shall refer the case to the RO within 15 days of the RO's request.

If changes occur, the FI shall inform the RO at once.

## 50 - Referral to the Department of Justice (DJ)

**(Rev. 3, 08-30-02)**

**A2-2228**

When all attempts to recover an overpayment (see §§70-80) are unsuccessful and the RO determines that further recovery efforts would be unprofitable, it requests the FI to prepare the case file for referral to the DJ. The documentation to provide includes specific information.

**A - General**

The DJ requires the submittal of a Claims Collection Litigation Report (CCLR) for overpayment litigation of claims. The CCLR is a checklist of all administrative collection actions required under the jointly issued GAO and DJ regulations, 4 CFR Part 102, for referred cases. Each case the FI submits must contain a CCLR. It shall supply the following data and material to the RO in quadruplicate.

1 - Index

For each piece of correspondence, it shall show the date of the correspondence, to whom it was addressed, and the name and title of the author. All correspondence must contain the author's signature. For all items beginning with subsection 5, the FI shall index and file all documents related to each cost reporting period in chronological order with the most recent document at the front of the file - each cost report period forms a unit. Each item appears in the following sequence (Items 2-6). The file includes these items when available.

2 - Identity of Debtor

A complete identification of the responsible officials and owners for each cost reporting period for which there is an overpayment. The FI shall include the name, home address, social security number (where available), and credit data (commercial credit information). It shall include the employer's identification number. Where the facility has changed ownership, the FI shall furnish a copy of the sales or lease agreement so that a determination can be made concerning the effective date of change, and the buyer's or the lessee's responsibility for repayment of the overpayment. The FI shall show:

a - Single Proprietorship

The name, home address, credit data and social security number (where available) of the owner and the owner’s spouse. If the owner is deceased, the FI must indicate the name and address of the executor or administrator of the estate.

b - Partnership

The name, home address, credit data and social security number (where available) of each general partner and spouse. The FI shall indicate the extent of each partner's liability, if available. Where feasible, the FI must furnish a copy of the partnership agreement. If one or more partners are deceased, it must indicate the name and address of the executor or administrator of the estate.

c - Corporation

The name, home address, credit data and social security number (where available) of each officer, stockholder, and director. The type of corporation (proprietary or nonproprietary), the State of incorporation and the date thereof, the name and address of the resident agent, the name and address of the provider's legal representative (if applicable), and the names of any and all related companies. Where a change of ownership has occurred or the corporation is defunct, the FI shall refer the case to its **legal counsel,** requesting a legal opinion to show the identity of the liable debtor(s).

d - Bankrupt Provider (Federal proceeding)

In addition:

- The name and address of the trustee in bankruptcy if one has been appointed, or whether the debtor is in possession (acting in its own behalf) in the proceeding; and

- The court of jurisdiction and the case docket number.

e - Receivership Provider (State proceeding)

In addition:

- The name and address of the receiver in receivership; and

- The court of jurisdiction and the equity number.

3 - Identification of Overpayment(s)

The FI shall clearly identify the overpayment for each cost reporting period. Show not only the total overpayment but also each individual part, as in the case of an audit or program review, multiple overpayments have occurred. It shall show any partial payments made by the debtor and clearly identify between principal and interest. It shall base the documentation to support the overpayment determination, (e.g., copies of the cost reports and audits behind their own tab).

4 - Refund Requests

The FI shall include a copy of the demand letter(s) to the provider. It shall include a copy of the postal service registry of the first demand letter and its receipt. It shall notify all responsible officials and owners of the provider as outlined in Subsection A2. Where

demand letters were returned by the postal service, the FI shall document other attempts to secure the address of the debtor(s).

5 - Recovery Efforts

The following are required:

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

6 - Provider's Ability to Refund

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

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

**B - Documentation of Referred Overpayments**

In addition:

1 - Cost Report Information Required - Intermediaries Only

The documentation required differs when a cost report is filed and when a cost report is overdue.

a - Cost Report Filed

If a cost report has been filed, copies of the following are required:

- All correspondence relative to tentative and final settlement and the determination of the overpayment;
- Documents indicating the status of any appeal (request for hearing, notice of hearing, hearing decision);
- Audit adjustment report. (Major adjustments annotated);
- Audited cost report;
- Date audit completed;
- Unaudited cost report;
- Notice of intent to suspend interim payments, provider's reply, and the FI determination; and
- Schedule of monies withheld by the FI, by category:
    - Carry-over beneficiary claims (terminated providers);
    - Emergency claims (emergency providers only); and
    - Beneficiary claim payments listed by reporting period in which the services were rendered.

b - Cost Report Not Filed

Where a cost report has not been filed, the FI shall assemble information relative to each reporting period. It shall file documentation for each unit with the most currently dated item on top. This file consists of, but is not limited to:

- All correspondence, including your internal communications relative to the demand for cost reports, offers of assistance, extension of filing date, etc;
- Schedule of interim payments by reporting period (including periodic interim payments), in the format of a payment register or transaction register;
- Notice of intent to suspend interim payments, the provider's reply, and the FI decision; and
- Schedule of monies withheld by category:
    - Carry-over beneficiary claims (terminated providers);
    - Emergency claims (emergency providers only); and

- Beneficiary claim payments listed by reporting period in which the services were rendered.

c - Some Reports Filed

Where the provider has filed some cost reports but has failed to file others, the FI shall include all items indicated in subsections B-l in descending chronological order with the most current on top.

2 - Specific Non-Cost Report Information Required

Two overpayment situations requiring further documentation are:

a - Overpayment Resulting from Accelerated Payment on account - FI only

Where the provider has an outstanding accelerated payment, the following documentation is required:

- All correspondence, including FI internal communications, relative to the computation of, and supporting documentation for, the accelerated payments on account;
- The provider's request for the accelerated payments on account;
- The RO's approval of the accelerated payment;
- Notice of intent to suspend interim payments, the provider's reply, and the FI decision; and
- Schedule of monies withheld by the FI:
  - Carry-over beneficiary claims (terminated providers);
  - Beneficiary claim payments listed by reporting period in which the services were rendered.

b - Overpayments Resulting from Excessive Utilization

Where overpayments as a result of excessive utilization are discovered, the FI shall document the following:

- All correspondence, including FI internal communications, relative to the development of the sample, explanation of the techniques used, projected statistical sample results, and medical review;
- Provider's acceptance of the sampling techniques and the resulting overpayment determination;

- Documents indicating status of the provider's appeal;
- Notice of intent to suspend interim payments, the provider's reply, the FI decision; and
- Schedule of monies withheld by category:
    - Carry-over beneficiary claims (terminated providers only);
    - Emergency claims (emergency providers only); and
    - Beneficiary claim payments listed by reporting period in which the services were rendered.

## 50.l - Standard Transmittal for Overpayment Case Referral to the DJ

**(Rev. 3, 08-30-02)**

**A2-2228.1**

Each overpayment case prepared for referral to the DJ must include an CMS-3080, Provider Overpayment Case Transmittal. The FI shall prepare the transmittal in triplicate. It shall attach the original and one copy to the cover of the case before referral to the RO. Retain a copy.

The form is available CMS forms web page.

The transmittal identifies pertinent data relating to development of the overpayment. However, the information is not a substitute for the documentation and data required by §50. To complete the transmittal, the FI shall supply the following.

ITEM l. - Provider Identification.

A. Name - Name of indebted provider, including doing business as or also known as information.

B. Provider Number - The assigned provider number. Where there were different periods of ownership, but the same provider number was assigned to both, the FI shall enter the letter "A" after the number to indicate the first ownership, the letter "B" to indicate the second ownership, etc.

C. Address - Current or most recent address of provider.

D. Type of Ownership - The FI shall indicate whether the provider ownership is a proprietorship, partnership, or a nonprofit or proprietary corporation. It shall indicate if the indebted provider is a lessee.

ITEM 2. - FI Identification.

A. Name - FI name.

B. Number - FI identification number.

C. Period - Dates the FI serviced the provider.

ITEM 3. - Date of Program Participation.

A. Entered Program - Date that Health Insurance Benefits Agreement, Form CMS-1561, became effective.

B. Terminated Participation - Date the provider terminated program participation.

ITEM 4. - Chain Organizations

A. Name of Chain - If applicable, the name of the chain. A chain organization consists of a group of 2 or more health care facilities that can be individually owned, leased, or through any other device, controlled by one business entity.

B. Employer Identification Number - EIN of chain organization

ITEM 5 - Submission of Case - Completed by RO as indicated

ITEM 6 - Ownership - FI shall answer questions "A" through "D" if applicable. If answer to "B" is no, the FI shall explain in Item 12.

ITEM 7 - Deceased Owner - FI shall complete only if the type of ownership was a proprietorship or partnership and the owner is deceased.

Name of deceased owner

Date of death

Whether or not Medicare debt is in probate

Name and address of the executor or administrator

ITEM 8 - Corporate Liquidation - The FI shall answer applicable questions

ITEM 9 - Credit Report - The FI shall answer all applicable questions

ITEM 10 - Addresses of Owners - The FI shall answer all applicable questions

ITEM 11 - Overpayments

A - Filed and Non-Filed Cost Reports.

1 - Period Ended

The ending date of the cost reporting period. (Example -March 31, 1999, shown as 033199.)

2 - Overpayment (Underpayment) Per Submitted Cost Report

The amount shown on the initially filed cost report that is due the program. If an amount is due the provider, the FI shows the amount in brackets. If a cost report has not been filed, it indicates the amount of interim payments paid or payable for the cost reporting period. Interim payments paid or payable include amounts withheld and applied to overpayments.

3 - Date Filed (Required to be Filed)

The date the FI received the initial cost report if the provider filed one. If a cost report has not been filed, the FI shall indicate the date the cost report was due. (Example - June 30, 1999, shown as 063099.) If an extension for filing has been granted, the FI shall use the extension due date.

4 - Desk Review (Final)

a - Date Review Finalized - The date the desk review was finalized.

b - Increase (Decrease) to Overpayment - Difference between the amount due the program or provider on the original cost report and the desk review. (Example - Amount due the program on the originally filed costs report was $10,000. Amount due program after desk review was $15,000. The FI shall enter $5,000 in Item 4b.) If a decrease, the FI shall enter the number in brackets.

c - Retroactive Adjustment Payment to FI (Provider) - Amount of the retroactive adjustment paid to the provider. If the retroactive adjustment represents a payment from the provider, the FI shall enter the number in brackets. It shall show the payments made to (by) provider both before and after desk review.

5 - Audit (Final)

a - Date Audit Finalized - If an audit has been conducted, the FI shall indicate the date the field audit was finalized.

b - Increase (Decrease) to Overpayment- This amount is the difference between the findings of a desk review and the audit. (Example - Amount due after audit is $16,000. Amount due after desk review is $15,000. The FI shall enter $l,000 in Item 5b. If a decrease, it shall show the amount in brackets. If a desk review was not performed because an audit was made immediately upon receipt of the cost report, the FI shall show the difference between the original cost report and the audited cost report.

c - Amount Paid by FI (Provider) - The amount the FI paid to the provider after audit. If payment is received from provider, the FI shall show the amount in brackets.

6 - Appeals Hearing

a - Date of FI Decision - The date of a hearing decision under 42 CFR 405.1809.

b - Date of Decision by Provider Reimbursement Review Board - The date of a hearing decision under 42 CFR 405.1835.

c - Decrease to Overpayment - The decrease to the amount shown on the Notice of Program Reimbursement as determined under 42 CFR 405.1803. The FI shall show the amount in brackets.

B - Current Financing Payments - The amount of outstanding current financing deemed to be an overpayment.

C - Accelerated Payments - The amount of accelerated payments deemed to be an overpayment. In Item 12, "Other Information," the FI shall enter the date the statute of limitations bars the right to bring suit.

D - Deductions from Overpayment -

1 - Voluntary Payments from Provider - The amount of voluntary payments made by the provider. The FI shall not include the amounts shown in subsection A, Items "4c and 5c."

2 - Interim Payments Withheld - The amount of interim payments withheld used to reduce the indebtedness.

3 - Offset of Underpayment - The amount of underpayment applied against the overpayment. The FI shall explain the basis for the offset with the case file.

E - Total Indebtedness (Underpayment) -The final amount due the Government or the provider after audit and/or appeal. If an underpayment, the FI shall show the amount in brackets. This amount should agree with the documentation contained in the case file.

F - Date Statute Expires - The date the statute of limitation bars the collection of the overpayment as determined under 28 U.S.C. 2415.

ITEM 12 - Other Information

The FI shall explain any item in detail if necessary. If the case is related to another overpayment case through common ownership, the FI shall indicate the name, address and provider number of the related provider.

## 50.2 - Communication on Cases Sent to RO for DJ Referral

**(Rev. 3, 08-30-02)**

**A2-2228.2**

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

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

## 50.3 - Cases Referred to DJ for Possible Litigation

**(Rev. 3, 08-30-02)**

**A2-2228.3**

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

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

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

- Recommendations of the U. S. Attorney, if any.

The FI shall forward the offer of compromise to the CMS Claims Collection Officer (CCO) through the RO and Division of Overpayment Prevention (DOP).

In most cases, the U.S. Attorney assigned the Medicare overpayment case will not be fully familiar with Medicare procedures, laws, regulations, or reimbursement. The FI may be requested to provide technical information to supplement the U. S. Attorney's knowledge. As cases are readied for litigation, the RO may contact the FI for assistance

in documenting the administrative record, e.g., a list of FI potential witnesses and technical advisors.

## 60 - Recovery of Overpayments, Due to Other Causes, Where a Cost Report Is Filed.

**(Rev. 3, 08-30-02)**

**A2-2230**

## 60.1 - Provider is Participating in Medicare and Medicaid

**(Rev. 3, 08-30-02)**

**A2-2230.1**

When the provider files a cost report indicating that an overpayment has occurred, the FI should receive full refund with the report. Where the provider does not remit the overpayment in full, the FI sends the first demand letter notifying the provider that it will reduce or suspend interim payments in 15 days if the provider does not make repayment arrangements. When an overpayment is determined upon desk review or field audit, the FI sends the first demand letter immediately. The Notice of Program Reimbursement need not occur prior to the mailing of demand letters, although there may be cases where it occurs first. (However, if the determination of program reimbursement would change the facts as stated in prior demand letters, the FI shall include in the NPR an explanation of the revised overpayment amount.)

Where the NPR results in the first demand letter, the two may be sent simultaneously. The demand letter may be sent as a separate document or incorporated into the NPR. Where a NPR has been sent, see Chapter 4, Debt Collection, §40B, exceptions, for notification of suspension of interim payment.

If the provider does not respond within 30 days after the date of the first demand letter, the FI sends a second demand letter notifying the provider of the further adjustment of interim payments. (If payments have not been completely suspended, it will state that interim payments will be completely suspended in 30 days if repayment arrangements are not made.) If appropriate, the FI shall advise the provider that action to withhold its Federal share of Medicaid payments will be initiated. If a satisfactory arrangement still cannot be worked out, the FI shall send a third demand letter 30 days after the date of the second. It shall include notification of the suspension of all interim payments. (See Chapter 4, Debt Collection, §40 to determine if requirements for suspension are met.) Additionally, it shall advise the provider, if applicable, that action to withhold the provider's Federal share of Medicaid payments has been requested.

The FI shall attempt to make personal (or telephone contact) with the provider, 7 days after sending the second demand letter to encourage either a lump-sum refund or a request for an extended repayment schedule. It shall document each contact. If this

contact is not productive and no response is received from the provider within 30 days of the third demand letter, the FI shall refer the case to the RO. (See §40.)

## 60.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid

**(Rev. 3, 08-30-02)**

**A2-2230.2**

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

It shall send the first demand letter. (See Chapter 4, Debt Collection, §10 for an explanation of the procedures of sending the first demand letter and NPR).

It shall send second and third demand letters at 30-day intervals if there is no response from the former provider. If the third letter does not generate a response within 30 days, it shall refer the case to the RO. (See §40.) If the provider agrees to repayment during this process, the FI shall establish a repayment schedule. Any extension requested must be dealt with in accordance with Chapter 4, Debt Collection, §30.

## 60.3 - Provider is No Longer Participating in Medicare But Is Participating in Medicaid

**(Rev. 3, 08-30-02)**

**A2-2230.3**

If the FI discovers an overpayment upon the filing of a cost report, or on determination of the amount of program reimbursement for a former Medicare provider that is still participating in Medicaid, it shall immediately contact the provider, using the first demand letter (see Chapter 4, Debt Collection, §40 and **Column G** of Exhibits l-3) to obtain repayment. Section 60.1 in regard to the **Notice of Amount of Program Reimbursement** also applies. If a lump-sum refund cannot be obtained, it shall work out a repayment schedule not to exceed 12 months from the date of the first demand letter. Any extension beyond 12 months must be approved by the RO.

If there has been no response from the provider within 30 days, the FI shall send a second demand letter, notifying the provider that its Medicare overpayment will be referred to the CMS RO for withholding of the provider's Federal share of Medicaid payments if repayment arrangements are not made within 15 days of the date of this notice.

If, at the end of the 15-day period, the provider has not met the conditions in the second demand letter, the FI shall send copies of all pertinent material to the RO with a recommendation to initiate withholding action. It shall include:

- Copies of the cost report;
- The Notice of Program Reimbursement (if available);
- Invoices or other documentation of the amount(s) due;
- Cost reporting period(s) involved; and
- All correspondence concerning the overpayment, including a summary of the contacts with the provider.

It shall send the third demand letter 30 days following the second where the provider has not responded, even though the procedures for withholding the Federal share of payments in title XIX have been initiated, so that if the RO's recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the DJ.

## 70 - Recovery of Overpayment Due to Overdue Cost Report - FI

**(Rev. 3, 08-30-02)**

**A2-2231**

## 70.1 - Provider is Participating in Medicare and Medicaid

**(Rev. 3, 08-30-02)**

**A2-2231.1**

**A - General**

For a participating provider, the cost report required for each cost report period is due on or before the last day of the fifth month following the end of that particular cost report period. (See Part 1, §2413 of the Provider Reimbursement Manual.) To ensure the timely receipt of the cost report, the FI shall remind a provider of the time limitation for filing by use of a reminder letter. (See Exhibit 9.) It shall send a reminder letter when a provider fails to file a cost report by the last day of the fourth month following the end of the cost report period. It shall inform the provider that the interim payment will be adjusted (reduced or suspended) if the report is not received on or before the last day of the fifth month. It shall state that the provider may request a 30-day extension of the due date (i.e., the provider would have 6 months after the end of the cost report period to file) based upon extenuating circumstances. Upon receipt of such a request, the FI shall determine whether or not the circumstances warrant an extension. If the determination is negative, it shall explain the decision to the provider. If the determination is positive, and the RO has not delegated the granting of extensions for filing cost reports to the FI, it shall send its recommendation, with the request for extension, to the RO. If the RO agrees with the recommendation, it will grant the FI permission to make the final approval on the extension request. When an extension is approved, the FI shall tell the provider that the extension is not automatic and may not be requested repeatedly as a grace period.

If no cost report has been filed by the first day after the due date (including extensions), the FI shall send the first demand letter in Chapter 4, Debt Collection, §10A. Check Column B of Exhibit l for guidance as to specific items to include.

If the provider does not respond within 30 days, the FI shall send the second demand letter. If appropriate, it shall advise the provider that action to withhold the provider's Federal share of Medicaid payments has been requested.

The FI shall make a personal (or telephone) contact with the provider 7 days after mailing the second demand letter. It shall determine any problems the provider might be having in preparing the cost report, and if, and when, the provider expects to complete and submit it. It shall document the provider's response.

If the provider does not respond, the FI shall send the third demand letter. It shall urge the provider to respond within 21 days to avoid RO or DJ involvement. If no response is received within 30 days of the third demand letter, it shall notify the RO. (See §40.)

**B - Interim Payment Has Been Suspended or Reduced**

When a provider's interim payment has been reduced or suspended, the FI shall process bills submitted to the point of payment in the normal manner. It shall compute the reimbursement amount shown on the billing form on the basis of the interim rate currently in effect, reduced by the determined percentage of reduction for suspension (see Chapter 4, Debt Collection, §40C) and pay on that basis (unless all payments have been suspended). Only the amount actually to be paid to the provider may be withdrawn through the letter of credit. The FI shall establish internal procedures to account for the amounts withheld as a result of the interim payment reduction.

**C - Cost Report is Received During Reduction or Suspension Period**

After the overdue cost report is received and desk reviewed (and assuming no overpayment), the FI shall compute a new interim payment as required by Part 1, §2406.5 of the Provider Reimbursement Manual (Interim Payments After Initial Reporting Period). It shall use the new interim payment and make a lump-sum adjustment for the difference between the amount paid the provider during the reduced or suspended payment period and the amount due for services computed at the revised rate.

## 70.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid

**(Rev. 3, 08-30-02)**

**A2-2231.2**

Where the provider's Medicare agreement has terminated, the FI still must receive the cost report. If the cost report is not received timely, it shall immediately send the first demand letter. (Requirements for the demand letters in this situation are in, Debt Collection, §40 and Column D of Exhibits l-3.) The second and third demand letters

follow at 30-day intervals if no response is received. If the third demand letter does not generate a response, the FI shall refer the case to the RO. (See §40.)

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

**(Rev. 3, 08-30-02)**

**A2-2231.3**

Where a provider's agreement under title XVIII has terminated and one or more cost reports have not been submitted the FI shall send the first demand letter. Requirements for this letter are in Chapter 4, Debt Collection, §10 and Column F of Exhibit l. Because this case involves not only a terminated provider but a provider that has failed to meet the basic obligation (submission of a cost report) for the period when it did participate, the first demand letter provides notice that initiation of the procedure for withholding the Federal share of Medicaid payments will begin in 15 days if the FI does not receive the cost report.

When the 15-day period expires without a satisfactory response from the former provider, the FI shall refer the case to the RO for initiation of the withholding process. It shall include:

- Copies of correspondence requesting the cost report;
- A summary of contacts with the provider;
- The results of attempts to obtain the report(s);
- Cost reporting period(s) involved; and
- The amount of interim payments paid during the period(s).

Simultaneously, the FI shall continue sending demand letters to the provider. (Chapter 4, Debt Collection, §10 and Column F of Exhibits 2 and 3 explain the requirements for the second and third demand letters, to be sent at 30-day intervals where the provider has not responded even though the procedures for withholding the Federal share of Medicaid payments have been initiated.) This must be done so that if RO recoupment efforts and the withholding of Medicaid payments are not effective, the case will be ready for referral to the DJ. The second and third demand letters advise the provider of action taken to withhold its Federal share of Medicaid payments.

## Exhibit 9 - Cost Report Due - Provider Still Participating

**(Rev. 3, 08-30-02)**

(FI NAME AND ADDRESS)

**George Wilson, President**
Old Lake Shore Nursing Home
Anytown, State ZIP Code

March 1, 20XX

Dear Mr. Wilson:

We would like to remind you of the obligation of each Medicare provider to submit a cost report at the close of its cost report period. Section 2413 of the Provider Reimbursement Manual explains that this report is due at the FI's office on or before the last day of the fifth month following the end of that period.

Since you have elected the calendar year as your accounting cycle for this purpose, March 31 is the last day available for the timely submission of your cost report. We must inform you that if the cost report is not received by the deadline, we will impose a suspension of the nursing home's current interim payment (see 42 CFR 405.371 for further information). This suspension would be effective April l.

If we can be of any assistance to you in the process of completing and submitting the cost report, please contact us. For example, you may request a 30-day extension of the filing time (if granted this would prevent the reduction of the interim rate) if you feel it is necessary. You should know that this extension is not automatically granted, but is available where extenuating circumstances warrant an extension.

Sincerely,

(name and title)

(This example pertains to a case where the cost report is due, and the provider is still participating in the Medicare program - see §70.1.)

## 80 - Recovery of Overpayments When a Provider Changes Its FI

**(Rev. 3, 08-30-02)**

**A2-2235**

When a provider changes FI, the outgoing FI remains responsible for the recovery of all program overpayments made during the time it serviced the provider. This includes the referral of a potentially uncollectible overpayment to the RO. The outgoing FI must submit information to the RO on the outstanding overpayment amounts and collection efforts (including any collection efforts of the incoming FI) attributable to the overpayment on a quarterly basis as required under the Provider Overpayment Reporting System.

## 80.1 - Action by Outgoing FI

**(Rev. 3, 08-30-02)**

**A2-2235.1**

### A - Notification to Incoming FI

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

- The cost reporting period;
- The date the overpayment was determined;
- Explanation of the type of overpayment, e.g., cost report overpayment - desk review, cost report overpayment - audit; and
- The current status of collection action.

The outgoing FI sends copy of the letter to the RO.

**NOTE:** If more than one RO is involved in servicing an FI (i.e., chain operations), the outgoing FI sends a copy to the appropriate ROs.

### B - Notice of Intent to Suspend Interim Payments

Where the outgoing FI has exhausted the collection actions required by Chapter 4, Debt Collection, §§10ff., and is unable to collect the overpayment, it notifies the provider, in accordance with Chapter 4, §40, that suspension of interim payments will be effected by the incoming FI. The outgoing FI is responsible for assuring that all of the requirements in Chapter 4, §40 are met before suspension is affected. It sends a copy of the notification letter to the RO and the incoming FI.

**C - Notification to the Incoming FI to Suspend Interim Payments**

If the provider does not respond to the written notification of intent to suspend interim payments within the time period specified in the written notification, the outgoing FI notifies the incoming FI to suspend payments. The incoming FI does not suspend interim payments until receipt of the instruction from the outgoing FI. It sends a copy of this notification to the RO.

Where suspension of interim payments is in effect when the provider's change of FI is approved, the outgoing FI notifies the incoming FI to continue the suspension. It sends a copy of the notification to the RO.

## 80.2 - Reduction of Outstanding Overpayment - Change of FI

**(Rev. 3, 08-30-02)**

**A2-2235.2**

Any actions taken by the incoming FI which reduce or eliminate the overpayment made by the outgoing FI is communicated, in writing, to the outgoing FI within 5 working days after the month in which the actions occurred. In addition, unless the provider indicates to the contrary, any collections or payment are applied first to the earliest overpayment. The incoming FI sends a copy of the communication to the RO. See Chapter 5, Accounts Receivable, §90 regarding the treatment of collections for letter-of-credit purposes.

## 80.3 - Extended Repayment Schedules - Change of FI

**(Rev. 3, 08-30-02)**

**A2-2235.3**

Either the incoming or outgoing FI may negotiate an extended repayment schedule. The need for an extended repayment schedule must be documented in accordance with Chapter 4, §§20ff. The FI that negotiates the repayment schedule notifies the other about the terms. Referral to the RO with recommendations is required where the schedule exceeds 12 months. Where the schedule is for 12 months or less, the RO is notified, but recommendations are not required. Payments under the repayment schedule should be made to the FI that negotiated the repayment schedule.

Where an extended repayment schedule is in effect at a change of intermediaries, and the provider later requests a revision in the terms of the existing repayment, either the incoming or outgoing FI may renegotiate the repayment schedule depending upon which receives the provider's request. The need for a revision of the existing repayment schedule must be documented in accordance with Chapter 4, Debt Collection, §§30ff. The FI that renegotiates the repayment schedule notifies the other and the RO about the revised repayment schedule and collects the required payments. Collections received by the incoming FI pursuant to a repayment schedule negotiated by it are reported to the

outgoing FI and RO within 5 working days after the month in which the collections were received.

## 80.4 - Recovery of Overpayment Due to Overdue Cost Report

**(Rev. 3, 08-30-02)**

**A2-2235.4**

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

### A - Reminder Letter

The outgoing FI is responsible for effecting final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter required under §80.1 to ensure the timely receipt of the cost report.

### B - First Demand Letter

If no cost report has been filed by the first day after the due date of the cost report (including extensions), the outgoing FI sends the first demand letter in Chapter 4, Debt Collection, §10, Exhibit l, Column B. It sends copies of the reminder letter and the first demand letter to the RO and incoming FI. Upon receipt of its copy of the letter, the incoming FI suspends the interim payment.

### C - Second Demand Letter

If the provider does not respond within 15 days, the outgoing FI sends the second demand letter notifying the provider that interim payments are further suspended. It sends copies of the letter to the RO and the incoming FI. Upon receipt of its copy of the letter, the incoming FI suspends interim payments.

### D - Third Demand Letter

The outgoing FI is responsible for personal contact with the provider, issuing the third demand letter, and notifying the RO (§70.1).

### E - Receipt of Delinquent Cost Report

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

After the outgoing FI has completed its review of the delinquent cost report, it notifies the incoming FI whether the cost report is acceptable, and the final settlement. The incoming FI, in accordance with §§40.1 and 70.1C, disposes of funds withheld during the suspension of interim payments.

## 80.5 - Incoming FI Unable to Recover Overpayment

**(Rev. 3, 08-30-02)**

**A2-2235.5**

Where the incoming FI has exhausted its collection action and the RO has determined that further recovery effort would be unprofitable (see §40), the RO requests the outgoing and incoming intermediaries to prepare a case file for referral to the DJ. The outgoing and incoming FI document all transactions during the time each served as the servicing FI relevant to the overpayment determination and collection actions. (See §50.) The completion of the transmittal required under §50.1, including the submission of a current credit report, is the responsibility of the outgoing FI. It shall contact the incoming FI for current information required to complete the transmittal such as current address of debtors, or whether any changes in ownership took place since the provider changed intermediaries. Each FI refers the case to the RO within 20 days of the RO's request for such referral.

If changes occur in the status of the overpayment, e.g., claim payments withheld, either the outgoing or the incoming FI, as appropriate, promptly informs the RO.

## 80.6 - Provider Terminated Participation with Overpayments Outstanding

**(Rev. 3, 08-30-02)**

**A2-2235.6**

When a provider, which has changed intermediaries, terminates participation and has outstanding overpayments made by the outgoing FI, it is the responsibility of the incoming FI to recommend that the RO initiate action to determine if suspension of Federal financial participation in title XIX payments is appropriate. The RO notifies the outgoing FI of the provider's termination and requests the outgoing FI to establish whether the former provider is subject to the provisions of Chapter 4, Debt Collection, §50 with respect to overpayments made to it. The implementation of the procedures for suspension of title XIX payments in Chapter 4, §50 is the responsibility of the outgoing FI.

## 90 - Individual Overpayments - General

**(Rev. 3, 08-30-02)**

**A3-3707, A2-2220.1, B3-7100, B3-7142.8**

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

Sections 100-100.6 contain the rules for determining liability for overpayments for items and services furnished beneficiaries.

Sections 110-130 contain instructions for the recovery of individual overpayment cases. Examples of individual overpayment cases are:

- Payment for provider or physician services after benefits have been exhausted, or where the individual was not entitled to benefits.
- Incorrect application of the deductible or coinsurance.
- Payment for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.
- Payment based on a charge that exceeds the reasonable charge.
- Duplicate processing of charges/claims.
- Payment to a physician on a non-assigned claim or to a beneficiary on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-entitlement.

Instructions for FIs to recover aggregate overpayments from the institutional provider are contained in §§20-80.3, and Chapter 4, Debt Collection, §§10-50. The Medicare law contains two provisions (§1870 and §1879) dealing with liability for, and recovery of, overpayments. These provisions are reflected in §§100-110.5 and, for a more extensive treatment, in Medicare Claims Processing, Chapter 31, Limitation On Liability. The following paragraphs summarize the provisions dealing with liability for overpayments to providers, and waiver of recovery of overpayments to providers and beneficiaries.

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

If a provider or physician was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The FI or carrier makes these determinations. This provision forms the basis for policies and instructions in §§100, 100.1, 100.2, 100.4, and 100.6.

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

If an overpaid provider or physician was without fault, or is deemed without fault and therefore not liable for refund, liability shifts to the beneficiary. (If the overpayment involves medically unnecessary or custodial services, the FI or carrier may waive the beneficiary's liability for the overpayment in accordance with C below. If the overpayment does not involve medically unnecessary or custodial services, CMS or SSA may waive recovery from the beneficiary in accordance with D below.) This provision forms the basis for the policies and instructions in §§100.3, 100.4, and 100.6.

**C - Contractor Waiver of Liability Where Provider or Physician and Beneficiary Are Without Fault with Respect to Overpayment for Medically Unnecessary or Custodial Services (§§1879 of the Act)**

When both the provider or physician and the beneficiary are without fault with respect to an overpayment for medically unnecessary or custodial services, the FI or carrier shall waive liability for the overpayment, i.e., take no action to recover the overpayment. This provision forms the basis for the policies and instructions in §§100, 100.3, and 100.2C. (Refer to Medicare Claims Processing, Chapter 31, Limitation On Liability for instructions regarding implementation of §1879.)

**D - CMS or SSA Waiver of Recovery from Beneficiary (§1870(c) of the Act)**

If a beneficiary is liable for an incorrect payment, CMS or SSA may waive recovery if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where an overpayment is discovered subsequent to the third calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.) This section forms the basis for policies and instructions in §§100.4, 100.6, 110.3, and 110.5.

Consideration of waiver is normally contingent upon the beneficiary's request in response to the refund request by the FI, the carrier, or the SSA program service center. However, see §110.3 for cases that the FI or carrier refers to CMS for waiver consideration before taking any recovery action.

## 90.1 - Time Limits on Recovery of Individual Overpayments

**(Rev. 3, 08-30-02)**

**A3-3707.1**

There are two time limitations to consider in deciding whether to recover an overpayment.

**The FI or carrier shall not recover an overpayment not reopened within 4 years (48 months) after the date of payment unless the case involves fraud or similar fault. (See §§120.2B, and Medicare Claims Processing, Chapter 30, Correspondence and Appeals.)**

- The FI or carrier shall not recover an overpayment discovered later than 3 full calendar years after the year of payment unless there is evidence that the provider/physician or beneficiary was at fault with respect to the overpayment. (See §100.4.)

**NOTE:** Where Medicare makes conditional primary payments and a WC plan, no-fault or liability insurer or EGHP (see Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers.) subsequently pays primary benefits for the same services, CMS does not waive recovery solely because the other insurer or plan made its payment subsequent to the third calendar year after the year in which the Medicare payment was made. The statutory language dealing with this waiver provision indicates that it applies only to determinations that a Medicare payment was "incorrect." Since conditional Medicare payments are **correct** payments (which are recovered when another insurer reimburses the provider or beneficiary for the same services), they are not subject to this waiver provision.

Similarly, the 4-year limit on reopening does not apply where another insurer makes payment more than 4 years after a Medicare conditional primary payment was made. The 4-year limit on reopening pertains only to the Government's right to change a determination or decision. Since a conditional Medicare primary payment is a correct determination (and remains correct even after the conditional payment is recovered), a Medicare conditional primary payment may be recovered without regard to the 4-year reopening limit when another insurer, which is primary to Medicare, makes payment.

## 100 - Determining Liability for Overpayments on Claims

**(Rev. 3, 08-30-02)**

**A3-3708, B3-7102**

The FI or carrier shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most FI payments for provider services are made to providers on behalf of the beneficiaries who received the services. If payment is made directly to the beneficiary, liability always lies with the beneficiary. Where the provider or physician has been overpaid, it is liable for the overpayment unless the FI or carrier determines that it was **without fault** with respect to the overpayment.

If the FI or carrier determines that an overpaid provider or physician was without fault, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault. (However, in the case of reasonable charge overpayments made to a without fault physician, the carrier shall refer the case to CMS in accordance with §110.3.)

The FI or carrier does not make decisions concerning beneficiary fault except in the case of overpayments arising from medically unnecessary or custodial services. It waives liability if it finds both the beneficiary and provider or physician without fault, i.e., it takes no action to recover the overpayment. (See §§90.C, 110.2.C, and 110.5.A, and Medicare Claims Processing, Chapter 31, Limitation on Liability.) The question of

beneficiary fault is considered by CMS and SSA in deciding whether to waive recovery from the beneficiary in the case of other overpayments. (See §110.5.B.)

However, CMS may waive recovery if the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

## 100.1 - Provider or Physician Liability

**(Rev. 3, 08-30-02)**

**A3-3708.1, B3-7103**

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

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

- It made full disclosure of all material facts; **and**
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI's attention.

Normally, it will be clear from the circumstances whether the provider or physician was without fault in causing the overpayment. Where it is not clear, the FI or carrier shall develop the issue. (See §100.4 for special rule where the overpayment is discovered more than 3 calendar years after the year it was made.)

## 100.2 - Examples of Situations in Which Provider or Physician Is Liable

**(Rev. 3, 08-30-02)**

**A3-3708.2, B3-7103.1**

In accordance with §§100, and 100.1, the following are examples of situations in which the provider or physician is liable for an overpayment it received.

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

This includes, among others, situations in which a provider or physician failed to request information needed by the FI or carrier to identify cases in which Medicare may be secondary payer, or if it did request such information, it failed to annotate the billing form. (Providers and physicians are instructed to ask beneficiaries for, and to annotate

the claims form with, information needed to help the FI or carrier identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan.) (See Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers.)

**EXAMPLE l:** A beneficiary was involved in a minor automobile accident shortly before entering a hospital for treatment of back pain. The provider billed an automobile no-fault insurer for the treatment. The automobile insurer refused to pay, claiming that the beneficiary's back pain was due to a pre-existing condition. The provider then billed Medicare but failed to annotate the bill that the beneficiary had been involved in an automobile accident.

Following a beneficiary appeal, the automobile insurer agreed that the treatment of this episode of pain was covered under its policy and paid benefits up to the limits of the insurance coverage for services not covered by Medicare. Later, the FI learned that the insurer had changed its decision and asked it to reimburse Medicare. The insurer did not pay because the insurance benefits had been exhausted. The provider is liable for the overpayment because it failed to annotate its bill to Medicare with information that would have enabled the FI to recover Medicare benefits paid for services related to the automobile accident.

**EXAMPLE 2:** A beneficiary fell in a supermarket, breaking her hip. The provider properly billed Medicare (Medicare pays in potential liability cases subject to recoupment if the beneficiary or provider later receives payment from a liability insurer) but failed to annotate the bill that the beneficiary's injuries occurred as a result of an accident other than an automobile accident. The beneficiary subsequently received a liability settlement from the supermarket's insurer, but did not refund the Medicare payments.

Several months later, the FI learned of the settlement but was unable to recover the overpayment from the beneficiary because the beneficiary had died and left no estate. The provider is liable for the overpayment, because, at the time it submitted its bill to Medicare, it failed to furnish information needed by the FI to conduct the development that might have enabled it to recover the Medicare payment from the liability insurer at the time of settlement.

**EXAMPLE 3:** A beneficiary is referred to a physician by an employer for a fracture sustained in a fall at work. The physician billed Medicare and neglected to indicate on the claim form that the injury was work related although he had been given this information by the patient. If Medicare benefits are paid to the physician for the services and the injury was covered by workers' compensation, consider the physician at fault in causing the overpayment because he failed to disclose to you that the injury was work related.

**B - The Provider or Physician Improperly Billed Medicare Instead of Another Insurer or Plan for Primary Benefits Where It Knew, or Should Have Known, That The Other Insurer or Plan Was Primary Payer.**

Providers, physicians, and suppliers are instructed to bill other insurers as primary payers where services can be paid for by automobile medical or no fault insurance, workers' compensation, and, an EGHP in the case of working aged beneficiaries. This includes situations where the provider or physician initially could not have known that another insurer or plan was primary payer but, after being so informed, failed to bill the other insurer or plan as the primary payer.

**EXAMPLE 1:** A beneficiary is referred by an employer to Park Hospital for a fracture received from a fall at work. Park knows that the employer has fewer than 20 employees so the EGHP is not the primary payer. Park checked the work-related box on the billing form affirmatively, but erroneously billed Medicare for the services. The FI mistakenly paid the bill. Park Hospital is at fault because it failed to bill WC as the primary payer.

**EXAMPLE 2:** A beneficiary was injured in an automobile accident and was hospitalized for 60 days. The treatment was covered under automobile no-fault insurance. In addition to the hospital care, the beneficiary received extensive private duty nursing care, which is excluded from Medicare coverage. In view of the total expenses incurred for treatment and the dollar limits contained in the automobile policy, it was doubtful if the automobile insurance would be sufficient to pay for all expenses related to the accident. The beneficiary, therefore, requested the hospital to bill Medicare as the primary payer for Medicare covered services.

The hospital billed Medicare as requested, and primary Medicare benefits were incorrectly paid. The FI later learned that the hospital services could have been paid for by the automobile insurer. The hospital is at fault because it failed to bill the automobile insurer as primary payer.

**NOTE:** Where there is evidence of a deliberate attempt to obtain Medicare payments to which the provider or physician was not entitled, the FI or carrier resolves the fraud issue in accordance with the **Program Integrity Manual**, which can be found at the following Internet address: www.cms.hhs.gov/pubforms/83_pim/pimtoc.htm., before attempting recovery. However, it retains any unsolicited refund that the responsible party makes.

**C - Provider or Physician Receives Duplicate Payments.**

This includes the following situations:

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

- Physician, or supplier received payment from Medicare on the basis of an assignment and a beneficiary received payment on an itemized bill and turned the

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

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

- Provider or physician receives duplicate payments from Medicare and another insurer or plan (directly or through the beneficiary) which is the primary payer, i.e., an automobile medical or no-fault insurer, a liability insurer, a WC insurer, or, under certain circumstances, an EGHP. (See Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers.) The provider or physician is liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer. (See Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers.) However, if the provider or physician turns the other insurance payment over to the beneficiary, the beneficiary is liable.

**D - The Overpayment Resulted Through Misapplication of the Deductible or Coinsurance Requirement or Payment After Exhaustion of Benefits and the Provider Could Have Known From Its Own Records the Beneficiary's Utilization Status.**

Part A Provider is considered liable if it received a remittance record within the 60 days preceding billing indicating deductible and benefit status. This condition is considered met where, within the 60-day period preceding the admission that gave rise to the overpayment, the beneficiary had been a patient in the same institution or the provider could have known the beneficiary's utilization status from its own records.

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

If the FI refers such an overpayment to CMS as uncollectible, it shall include this information in Item 11 of the form CMS-2382.

**EXAMPLE:** John Doe entered University Hospital on January 10, 2000. After using all of his benefit days, including lifetime reserve days, he returned home, but reentered the same hospital in fewer than 60 days and stayed an additional 30 days. University Hospital neglected to check its records and billed the FI for 30 days of inpatient hospital care. The FI made payment. Subsequently, the overpayment was discovered. Since the hospital should have known from its own records that John had exhausted his benefit days, the FI shall seek recovery from the hospital.

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

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

Examples:

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

Mathematical error does not include a failure to assess properly the coinsurance and/or deductible. The FI would determine the liability for coinsurance and deductible overpayments in accordance with D. above. Where payment to a physician was based on a deductible amount, the physician is without fault. Seek recovery from the beneficiary. (See §100.4.)

**F - The Provider or Physician Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.**

**G - The Provider or Physician Does Not Submit Documentation to Substantiate That It Performed the Services Billed to the Program Where There Is a Question as to Whether the Services Were Performed.**

(See the **Program Integrity Manual**, which can be found at the following Internet address: www.cms.hhs.gov/manuals/cmsindex.asp, if fraud is suspected.)

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

For example, the SSO notified the hospital that the individual was not entitled to hospital insurance benefits.

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

1. Services Other Than Medically Unnecessary or Custodial Services, e.g., skilled physical therapy services furnished by a nonqualified physical therapist, or services rendered pursuant to an authorization from the VA. (See Medicare Benefit Policy, Chapter 17, Exclusions.)

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

   - The policy or rule is in the provider manual or in Federal regulations,
   - The FI or carrier provided general notice to the medical community concerning the policy or rule, or
   - The FI or carrier gave written notice of the policy or rule to the particular provider or physician.

   Generally, a provider's, physician's or supplier's allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met. However, there may be other circumstances that justify a finding that the provider or physician was not at fault. The FI or carrier shall consider all of the circumstances, including such factors as whether and to what extent a coverage rule is spelled out in regulations, instructions, or in a CMS notice, and whether a FI or carrier misinformed the provider or physician about the rule; in deciding whether a provider or physician acted reasonably in billing for and accepting payment for noncovered services. (See §110.3D.)

2. Medically Unnecessary or Custodial Services.

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

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

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

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

**L - For Carriers, Overpayment Was for Rental of Durable Medical Equipment and Supplier Billed Under the One-Time Authorization Procedure**.

Pursuant to Medicare Claims Processing, Chapter 20, suppliers of durable medical equipment who have accepted assignment may be reimbursed for rental items on the

basis of a one-time authorization by the beneficiary; i.e., without the need to obtain the beneficiary's signature each month. A supplier using the procedure must have filed with the carrier a statement that it assumes unconditional responsibility for rental overpayments for periods after the beneficiary's death or while he was institutionalized or while he no longer needed or used the equipment.

**M - For Carriers, Items or Services Were Furnished by Practitioner or Supplier not Qualified for Medicare Reimbursement**

Two examples of such services are:

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

## 100.3 - Provider or Physician Protests

**(Rev. 3, 08-30-02)**

**B3-7130.4**

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

a. There was an overpayment;

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

c. The provider or physician is liable for repayment.

If the appeal determination is that the provider or physician is still liable for an overpayment, the FI or carrier shall include in the notification to the provider or physician another request for refund of the overpayment (including all of the information included in the initial refund letter). If the provider or physician does not respond and the overpayment cannot be recovered by offset within 75 days, the FI or carrier shall forward the case to CMS The carrier shall maintain the offset against future Medicare benefits until the overpayment is recovered.

## 100.4 - Beneficiary Liability

**(Rev. 3, 08-30-02)**

**A3-3708.3, B3-7104**

A beneficiary is liable for:

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

  Included are situations in which Medicare pays a provider or physician, and a WC carrier, automobile medical, or no-fault insurer or any liability insurer; or EGHP pays primary benefits to the beneficiary for the same services. The amount for which the beneficiary is liable is the amount Medicare paid as primary payer less the amount Medicare is obligated to pay as secondary payer calculated in accordance with Medicare Claims Processing, Chapter 28, Coordination With Medigap, Medicaid, and Other Complementary Insurers Insurers.

- Overpayments made to the beneficiary.

## 100.5 - Liability for Overpayments Discovered Subsequent to Third Calendar Year after the Year the Payment Was Approved

**(Rev. 3, 08-30-02)**

**A3-3708.4, B3-7106**

The law prescribes special rules that apply when an overpayment is discovered (i.e., it is determined that a "payment was incorrect") subsequent to the third calendar year after the **year** in which the claim was approved. Under these rules, the FI or carrier shall **deem an overpaid provider or physician without fault** without further development, in the absence of evidence to the contrary, i.e., if there is no indication that the provider or physician was at fault. (This provision provides limited relief to providers, physicians, and suppliers, since, in most cases, the facts that bring to light the overpayment are a sufficient basis for determining whether the provider or physician was at fault.) Where the beneficiary is liable, CMS will waive recovery if the beneficiary is without fault. A provider or physician is not deemed without fault with respect to overpayments for noncovered services that are part of a pattern of billing for similar services. In such cases, the FI or carrier initiates any necessary development to establish whether the provider or physician was without fault.

See §§110.3A, 120.3C, and 120.4B for the processing of overpayments discovered subsequent to the third calendar year.

If information indicating the provider or physician was at fault comes to the FI's, or carrier's attention without development within 4 years (i.e., 48 months) after the date of the initial determination (the 4-year time limit on reopening described in Medicare Claims Processing, Chapter 29, Appeals, its determination may be revised. After 4 years, its determination may be reopened only in cases involving fraud or similar fault. (See §110.2B.)

**NOTE:** Where Medicare makes conditional primary payments and a WC plan, automobile medical or no-fault insurer or any liability insurer or EGHP subsequently

pays primary benefits for the same services, CMS does not waive recovery solely because the other insurer or plan made its payment subsequent to the third calendar year after the year in which the Medicare primary payment was approved.

The statutory language dealing with this waiver provision indicates that it applies only to determinations that a Medicare payment was "incorrect." Since conditional Medicare payments are **correct** payments, (which are recovered when another insurer reimburses the provider or beneficiary for the same services) they are not subject to this waiver provision.

Similarly, the 4-year limit on reopening does not apply where another insurer makes payment more than 4 years after a Medicare conditional primary payment was made. The 4-year limit on reopening pertains only to the Government's right to change a determination or decision. Since a conditional Medicare primary payment is a correct determination (and remains correct even after the conditional payment is recovered), a Medicare conditional primary payment may be recovered without regard to the 4-year reopening limit when another insurer, primary to Medicare, makes payment.

## 100.6 - Limitations on Charging Without Fault Beneficiary Where Overpayment for Medically Unnecessary Services or Custodial Care is Discovered Subsequent to the Third Calendar Year

**(Rev. 3, 08-30-02)**

**A3-3708.5**

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

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

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

## 100.7 - How to Determine the Third Calendar Year after the Year the Payment Was Approved

**(Rev. 3, 08-30-02)**

**A3-3708.6, B3-7106.2**

Only the year of the payment and the year it was found to be an overpayment enter into the determination of the 3-calendar year period. The day and the month are irrelevant. With respect to payments made in 1997, the third calendar year thereafter is 2000. For payments made in 1998, the third calendar year thereafter is 2001, etc. Thus, the rules apply to payments made in 1997 and discovered to be overpayments after 2000, to payments made in 1998 and discovered to be overpayments after 2001, etc.

## 110 - Recovery - General

**(Rev. 3, 08-30-02)**

**A3-3709, B3-7114**

After the FI has established who is liable for an overpayment, it shall undertake recovery action as soon as possible, provided the overpayment is not one of the situations listed in §110.2, or 110.3. See §§120ff. for recovery from providers, and §§130ff. for recovery from beneficiaries.

## 110.1 - Offset of Overpayments Against Other Benefits Due

**(Rev. 3, 08-30-02)**

**A3-3709.1**

**A -Benefits Payable Under Part B - FI**

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

**B - Use of Lifetime Reserve Days - FI**

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

## 110.2 - When the FI or Carrier Does Not Attempt Recovery Action and Does Not Refer the Case to CMS

**(Rev. 3, 08-30-02)**

**A3-3709.2, B3-7115**

**A - Total Overpayment Less Than $50)**

The cost of recovering such a small amount ordinarily exceeds the amount recovered. However, the FI or carrier shall accept unsolicited overpayment refunds regardless of the amount. If an individual owes several small overpayments, each of which is less than $50, the FI or carrier shall consider the aggregate amount owed for purpose of this tolerance. Thus, if the overpayments total $50 or more, the FI or carrier shall recover the amount even though each individual overpayment is less than $50.

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

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

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

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

## 110.3 - When the FI or Carrier Does Not Take Recovery Action in Beneficiary Cases but Refers Cases to CMS for Waiver of Recovery Consideration

**(Rev. 3, 08-30-02)**

**A3-3709.3, B3-7116**

Subject to §110.2, the FI or carrier refers the following overpayment cases to CMS for consideration of waiver of recovery from the beneficiary. These are cases in which the beneficiary is liable and the criteria in §110.5.B for waiver of recovery from the beneficiary are likely to be met, i.e., it appears from the circumstances that the beneficiary was without fault and that recovery is against equity and good conscience or defeats the purpose of the Medicare program (i.e., would cause the individual financial hardship). CMS makes the waiver determination. If CMS decides that the information available does not justify waiver, it returns the case for normal recovery efforts from the beneficiary.

**A - Overpayments Made to Without Fault Provider or Physician**

For noncovered services other than medically unnecessary services or custodial care (See §110.2.C for overpayments to without fault providers or physician for medically unnecessary or custodial care.

**B - Discovered subsequent to the third calendar year after the year the payment was approved regardless of the cause of the overpayment.)**

See §110.7 for special information to include on Form CMS-2382.

**C - Overpayments to Beneficiaries for Noncovered Services**

(Including overpayments for medically unnecessary services or custodial care).

CMS refers overpayment cases for which a beneficiary is liable to the appropriate Social Security program service center and that office either recovers the overpayment or waives recovery. In some cases CMS may waive recovery. The Medicare law permits waiver of recovery from a beneficiary if:

1. The beneficiary was without fault in causing and accepting the overpayment; and

2. Recovery would either be against equity and good conscience or would defeat the purpose of the Medicare program or would cause economic hardship.

If the program center is unable to either recover or waive the overpayment, it may report it to the Department of Justice for further recovery action.

**D - Overpayments to Beneficiaries for Other Than Noncovered Services Discovered Subsequent to the Third Calendar Year After the Year Payment Approved**

(Recovery from a without fault beneficiary is waived if the overpayment was discovered after the third calendar year, per §100.4.)

**E - Overpayments Which Resulted From Misinformation From an Official Source Concerning the Medicare Law or Regulations**

For example, where it is determined that the provider was without fault because it relied on incorrect advice from a FI, carrier or CMS concerning the coverage of services.

**NOTE:** This paragraph does not apply to overpayments resulting from an incorrect CWF reply concerning a beneficiary's Part A utilization status or Part B deductible status. An incorrect CWF reply is not considered "misinformation" for this purpose.)

**E - Overpayments to Providers, Physicians, Suppliers or Beneficiaries for Items and Services Rendered During a Period When SSA Records Showed that the Beneficiary Did Not Have Medicare Entitlement**

See §§130.11.A for processing of overpayments from lack of Medicare entitlement.

**F - Effectuation of an Appeal Decision Results in Overpayments for Subsequently Furnished Services- FI**

In some Part A cases, effectuation of a reconsideration, ALJ, AC or Court decision favorable to the beneficiary results in an overpayment to a provider that furnished subsequent services. Such overpayments result, for example, where effectuation causes days previously paid for as full days to become coinsurance days, coinsurance days to become lifetime reserve days, or lifetime reserve days to become "no payment" days. (See Medicare Claims Processing, Chapter 30, Beneficiary Correspondence and Appeals.) In accordance with §100.2B, the overpaid provider is not liable since it had no reason to question the beneficiary's entitlement to benefits.

**G - Overpayments for Services Which Should Have Been Paid for by Another Insurer or Under Another Government Program, e.g., Medicaid or WC, and the Time Period for Claiming Benefits from the Other Program Has Expired**

**H - Overpayments for Which a Medicaid Beneficiary Is Liable and Which the Medicaid Agency Does Not Refund**

Except where it is apparent that the beneficiary knew or should have known that the payment was incorrect.

## 110.4 - Recovery Where Fraud Is Suspected

**(Rev. 3, 08-30-02)**

**A2-3709.4, B3-7117**

If there is reason to believe that the overpayment may have been caused by fraud, the FI or carrier shall make no request for refund until the fraud issue is resolved. However, it shall retain any amount voluntarily refunded pending resolution of the fraud issue. Also, payments may be suspended **with RO concurrence**.

## 110.5 - Waiver

**(Rev. 3, 08-30-02)**

**A3-3709.5, B3-7118**

**A - Waiver by the FI or Carrier**

Where Medicare has paid a provider or physician for services that are later determined to be not reasonable and necessary or custodial, the FI or carrier shall waive liability if the provider or physician and the beneficiary were both without fault, i.e., under the criteria in Medicare Claims Processing, Chapter 31, Limitation on Liability, the parties did not know and could not reasonably have been expected to know that the items or services were not covered. The FI or carrier shall not take recovery action on these cases and shall not refer them to CMS.

Carrier - Consideration of waiver by a carrier in assigned cases involving overpayments for items and services determined to be not reasonable and necessary is automatic, i.e., a waiver determination will be made whether or not either party has directly raised the issue.

**B - CMS or SSA Waiver of Recovery**

The law provides that if a beneficiary is responsible for an overpayment, recovery may be waived by CMS or SSA if:

- The beneficiary was without fault with respect to the overpayment; and
- Recovery of the overpayment would:
  - Defeat the purpose of title II or title XVIII of the Social Security Act by causing financial hardship for the beneficiary; or
  - Be against equity and good conscience.

Consideration of waiver is normally contingent upon the beneficiary's request in response to the FI/Carrier's refund request, or the request of SSA's program service center. However, see §110.3 for cases that the FI/Carrier refers to CMS for waiver consideration before taking any recovery action.

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

**(Rev. 3, 08-30-02)**

**A3-3709.6, B3-7119**

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

## 110.7 - Special Annotation and Additional Information Required for the Overpayment Situations in §110.3

**(Rev. 3, 08-30-02)**

**A3-3712.4, B3-7142.4**

Section 110.3 specifies the types of overpayments to refer to CMS for waiver consideration before undertaking any recovery action.

When referring cases under §110.3, the FI or carrier shall include (Remarks) the following:

- The annotation: "For CMS consideration of waiver per §110.3."
- A recommendation as to whether the beneficiary was without fault with respect to the overpayment and the reason for the recommendation; and
- Sufficient information to enable CMS to determine that one of the conditions in 110.3 is met; for example, if the overpayment was discovered subsequent to the third calendar year after the year of payment:
    - The date the payment in question was approved; and
    - The date the payment was determined to be incorrect. (§100.6 explains how to determine the third calendar year after the year of payment.)

When referring overpayments caused by lack of Medicare entitlement, the FI or carrier shall annotate (Remarks) in red "Non-entitlement Case - for CMS development and/or waiver consideration.

## 110.8 - Refund Offered After Referral to CMS or RRB

**(Rev. 3, 08-30-02)**

**A3-3712.5, B3-7142.7**

After an uncollected overpayment for which a beneficiary is liable has been referred to CMS, the FI shall not start any further action to collect the incorrect payment. In most cases either the overpayment can be deducted from the beneficiary's monthly social security or railroad retirement benefit, or recovery may be waived by CMS or the SSA program service center (or RRB).

In the event that payment is offered after referral, the FI or carrier shall accept it and notify CMS as soon as possible to avoid duplicate collection.

If the uncollected overpayment is one for which a provider or physician is liable, and the debtor tenders a refund, the FI or carrier shall accept it and immediately notify CMS. The FI or carrier shall maintain stops on its records to enable collection by offset after referral to CMS as uncollected.

If offset becomes possible in one of these cases after referral to CMS, the FI or carrier shall make the offset and immediately notify CMS.

## 110.9 - CMS Processing of Provider Overpayments for Which Beneficiary is Liable/CMS Processing of Medical Insurance Overpayments

**(Rev. 3, 08-30-02)**

**A3-3712.6**

CMS refers overpayment cases for which a beneficiary is liable to the appropriate social security program service center and that office either recovers the overpayment or waives recovery. In some cases CMS may waive recovery. The Medicare law permits waiver of recovery from a beneficiary if

- The beneficiary was without fault in causing and accepting the overpayment; and
- Recovery would either be against equity and good conscience, would defeat the purpose of the Medicare program or would cause economic hardship.

If the program service center is unable to either recover or waive the overpayment, it may report it to the Department of Justice for further recovery action.

Overpayments to physicians may be referred by CMS to the Department of Justice for further recovery action.

## 120 - Recovery of Individual Overpayment from the Provider - FI

**(Rev. 3, 08-30-02)**

**A3-3710**

## 120.1 - Participating Provider

**(Rev. 3, 08-30-02)**

**A3-3710.1**

For specific content of demand letters in various situations, see Chapter 4, §10ff.

If the FI determines that an overpayment on an individual claim should be recovered from a participating provider, it shall notify the provider in writing indicating:

- That an overpayment was made;
- The name and HI number of the beneficiary involved;
- The dates and types of services for which the overpayment was made;
- Why the payment was incorrect;

- How the overpayment was calculated;
- Why it is liable for recovery of overpayment (i.e., the reasons for finding the provider at fault);
- The proposed method of recovering the overpayment (i.e., by reduction of subsequent Medicare payments due the provider (offset), or by direct refund);
- If it is proposed to recover the overpayment by offset, that the offset will be put into effect 30 days after the date of the notice:
    - If, within 30 days after the date of the notice informing the provider of the intention to offset, the provider submits a request for reconsideration or hearing, or otherwise protests the offset, the FI shall make an effort to conclude the appeal procedure before the deadline for effectuation of the offset, i.e., the 30th day after the date of notice. However, it shall begin offset 30 days after the initial request for refund, regardless of the status of any appeal request.
- If the overpayment was for medically unnecessary services or for custodial care, and the beneficiary was without fault, and the provider collects the amount of the overpayment from the beneficiary:
    - The beneficiary can be indemnified for this amount by the program and the amount charged to the provider as an overpayment; and
    - The provider has a right to a reconsideration of the decision on recovery of the overpayment, provided it requests it within 60 days of the date of the notice. (See Medicare Claims Processing, Chapter 31, Limitation on Liability.)

## 120.2 - Provider No Longer Participating

**(Rev. 3, 08-30-02)**

**A3-3710.2**

If the provider is no longer participating in the program (and the provider is not involved in bankruptcy proceedings), the FI shall recover an overpayment on individual claims in accordance with the following.

If the provider's final cost report has been received, but the final cost settlement has not been completed, the FI shall adjust the cost report statistics (HI days and HI charges) to properly reflect the amount of the overpayment and notify the provider of the adjustment and the reasons. It shall include in the notice to the provider appropriate data outlined in §120.1.

If final cost settlement has been effected and no further funds are due or owing by the provider, the FI shall send no more than two written requests for refund 30 days apart.

They contain appropriate information outlined in §120.1. In the **second** refund, letter the FI shall state that if the overpayment is not refunded, CMS will refer the overpayment to the Dept. of Justice for collection.

If the provider does not make the refund within 30 days after the second request, the FI refers the overpayment to RO for further recovery efforts as required by §40. Referrals to RO consist of a covering letter containing the information and attachments listed below.

Information required in the FI's overpayment referral letter to the RO:

- An explanation that the letter pertains to an uncollected overpayment due from a provider no longer participating, that the provider's cost report had been received and settled, and that no other monies are due to, or from, the provider;
- The provider's name, address and provider number; and
- The appropriate information outlined in §120.1.

Documentary attachments:

- Copies of the original and corrected billing forms;
- Copies of the initial and follow-up letters sent to the provider; and
- Copies of any other relevant documentation; e.g., the provider's replies to the recovery letters.

If the FI has completed the final cost settlement of the provider's final cost report (or if the provider has failed to submit its cost report) **and** has sent the case to the RO for further collection efforts, it shall notify the RO of the overpayment on the individual beneficiary's claim. It shall identify the adjustment(s) to be made to the cost report statistics in a format that can be used as documentation for the case file.

(If the FI is preparing to send such a cost overpayment case to the RO, it includes the individual overpayment in the aggregate overpayment case file.)

The FI shall make clear to the RO that the case pertains to an uncollected overpayment due from a provider no longer participating, that it has completed the final cost settlement of the provider's final cost report (or that the provider has failed to submit one), and that it had previously sent the case to the RO for further collection efforts. It shall include the same information required in the notice to CMS and specify the adjustment(s) to be made in the cost report data.

If the FI has sent the case to the RO, it shall notify the provider of the overpayment - but **only** with the approval of the RO, since the Government is taking legal action. If it has RO approval, the FI's notification to the provider should contain appropriate items listed in §120.1. It shall indicate that an upward adjustment will be made to the cost report overpayment that had been referred to the RO for collection.

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

**(Rev. 3, 08-30-02)**

**A3-3710.3, B3-7130**

A notice to the beneficiary is required whenever recovery is sought from the provider/physician.

The FI/Carrier shall include in the notification to the beneficiary a copy of the letter sent to the provider or physician unless the letter to the provider or physician refers to matters that do not concern the particular beneficiary; e.g., where the provider was overpaid on behalf of more than one beneficiary. In such cases, a copy of the request for refund sent to the provider or physician should **not** be attached to the beneficiary notice.

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

The notice to the beneficiary should contain the following:

- The name and address of the provider or physician and dates of service for which the overpayment was made.

- A clear explanation of why the payment was incorrect.

- A statement that the provider or physician had been requested to refund the overpayment and, if the provider or physician 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 §100.5 apply, the FI or carrier shall advise the beneficiary that the provider or physician is prohibited, by law, from requesting payment for the services; or

    - If the beneficiary is determined to be without fault, the FI or carrier shall state that if the beneficiary pays for the services, the beneficiary may request that the FI or carrier indemnify the beneficiary for such payment. Any indemnification paid to the beneficiary will be recovered from the provider or physician. (See Medicare Claims Processing, Chapter 31, Limitation on Liability.)

- In all other cases, Medicare law does not prohibit the provider or physician from requesting the beneficiary to pay.

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

## 120.4 - Sample Letter to Beneficiary Where Recovery Is Sought From Provider or Physician

**(Rev. 3, 08-30-02)**

**A3-3710.4, B3-7130.2**

Dear _____:

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

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

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

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

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

(See Medicare Claims Processing, Chapter 30, Limitation On Liability)

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) did have knowledge 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, physician's, supplier's name**) except for any charges for services or items never covered by Medicare. If you (the beneficiary) have (has) paid (**provider's, physician's, supplier'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 (physician's, supplier's) name), your cancelled check, or any other evidence showing that you (the beneficiary) have (has) already paid (provider's (physician's, supplier'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**

(See NOTE in §100.)

(**Provider's, physician's, supplier's name**) has been requested to refund this overpayment because it has been found to be at fault in causing it. Under the Medicare law, (**provider's, physician's, supplier's name**) is prohibited from billing you, or any other source, for these noncovered services. If (**provider's, physician's, supplier'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, physician's, supplier's name**) has been requested to refund the overpayment because it has been found to be at fault in causing it. Since the above services are not covered by Medicare, (**Provider's, physician's, supplier's name**) may ask you to pay for them. However, if you are billed, this is a matter between you and (**Provider's, physician's, supplier'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 30, Beneficiary Correspondence and Appeals.

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

**(Rev. 3, 08-30-02)**

**B3-7130.3**

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

If the reply to the letter indicates that the estate will not refund the overpayment, or if a reply is not received within 30 days, the case should be forwarded to CMS in accordance

with §§120ff. When referring such overpayments, the carrier shall include any information about the appointment of a legal representative, the size of the estate, etc., and copies of any correspondence with survivors or others concerning the overpayment.

## 130 - Recovery Where the Beneficiary Is Liable for the Overpayment

**(Rev. 3, 08-30-02)**

**A3-3711, B3-7120**

When the FI or carrier has determined the beneficiary to be liable for the overpayment, it shall initiate recovery efforts in accordance with the following sections, as appropriate.

## 130.1 - Recovery Where Beneficiary Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental

**(Rev. 3, 08-30-02)**

**A3-3711.1, B3-7120.1**

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

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

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

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

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

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

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

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

If efforts to recover the overpayment are not successful, or if the FI or carrier is certain that the other plan or program will not refund a particular overpayment, it shall seek recovery from the beneficiary in accordance with §130.2. It shall explain in the notice to the beneficiary that the other plan or program will not make payment directly to it. However, if the beneficiary is a Medicaid recipient, the FI or carrier shall not attempt recovery from the beneficiary. Instead it shall refer the overpayment to CMS in accordance with §40 .

## 130.2 - Recovery From the Beneficiary

**(Rev. 3, 08-30-02)**

**A3-3711.2, B3-7120.2, B3-7120.3**

The FI or carrier shall initiate recovery from the beneficiary by sending a letter containing the information in §130.5 if the overpayment is $50 or more. (See model language in §§130.6 and 130.7.

If the refund letter does not result in a refund, the FI or carrier shall send a follow-up letter and arrange to offset the overpayment against any Medicare payments that become due the beneficiary, unless one of the conditions in §130.3 is met.

If, within 2 months after sending the follow-up letter, the overpayment has not been recovered and the individual has not requested a reconsideration, review, carrier fair hearing, ALJ hearing or waiver, the FI or carrier shall refer the case to CMS for possible recovery from the individual's social security benefits. However, if the HI number has a T or M suffix, the FI or carrier shall not refer the case to CMS since those beneficiaries are not entitled to monthly social security benefits. Offset should be continued in the case of beneficiaries whose HI number ends in T or M until the overpayment is recovered, or if carrier records show that the beneficiary has died, the carrier shall maintain the offset until the time period for filing claims on behalf of the deceased has expired.

If the beneficiary protests following the receipt of a notification of overpayment, the FI or carrier shall handle the protest in accordance with §130.11.

It shall not initiate further recovery action after referring a beneficiary overpayment to CMS since, in most cases, the overpayment will be deducted from the individual's monthly social security or railroad retirement benefits or recovery of the overpayment will be waived. However, if payment is offered after referral to CMS, it shall accept the payment, and notify CMS immediately to avoid duplicate collection efforts.

## 130.3 - When to Suspend Efforts to Recover From the Beneficiary Following Initial Letter

**(Rev. 3, 08-30-02)**

**A3-3711.3, B3-7120.4**

The FI or carrier shall suspend its efforts to recover from the beneficiary if:

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

The FI or carrier shall make no further recovery efforts until it disposes of the appeal request. (See §130.11.)

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

(See §110.5 for the qualifying conditions for waiver of recovery.) If the overpayment was for reasons other than services found to be not reasonable and necessary or custodial care, the FI or carrier shall refer the case to CMS unless recovery of the

overpayment is still pending with a State welfare department or other third party. If the overpayment was for services found to be not reasonable and necessary or custodial care, the FI or carrier shall determine whether the beneficiary's liability can be waived in accordance with Medicare Claims Processing , Chapter 30, Limitation on Liability, and notify the beneficiary of its finding. If it determines that the conditions for waiver of liability under this provision are not met, it shall refer the case to CMS.

**C - The Beneficiary Is Receiving Welfare Benefits**

If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, the FI or carrier shall ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. (See §130.1.) If the welfare agency does not refund the overpayment in full, the FI or carrier shall not attempt recovery from the beneficiary, unless the exception in 110.3.H applies.

**D - It May Be Possible To Recover From Another Health Insurance Plan or Governmental Program**

If, after initiating recovery efforts from the beneficiary, the FI or carrier learns that the beneficiary is covered by other health insurance or another governmental program, it shall ascertain whether the other plan or program will reimburse Medicare for all, or part of, the overpayment. It shall not send a follow-up letter to the beneficiary until its efforts to recover from the other plan have been completed. (See §130.1.)

## 130.4 - Computation of Overpayment When Recovery Is From Beneficiary - FI

**(Rev. 3, 08-30-02)**

**A3-3711.4**

Subject to the recovery limitations in §§110.2 and 110.3, the amount to be recovered from a beneficiary who is liable for a provider overpayment under §100.3 is calculated as follows:

**A - Providers Reimbursed on the Basis of Reasonable Cost**

1. Overpayments Due to Erroneous Payment of Cash Deductibles and/or Coinsurance Amounts

   Where the overpayment resulted because the FI erroneously reimbursed the provider for some or all of the beneficiary's inpatient deductible, SMI deductible, or coinsurance obligation, the beneficiary is requested to refund the amount of the actual erroneous payment. (See paragraph C, Example 1, below.)

Where the overpayment resulted from erroneous payment for un-replaced deductible blood under Part A or Part B, the beneficiary is requested to refund the amount the provider would have charged for the blood in question if it had not been paid for under Medicare. This conforms with the manner in which reimbursement is made for un-replaced blood.

2. General Rule for Other Overpayment Cases

   Where the overpayment was caused by reasons other than those specified in 1, above, the amount the beneficiary is asked to refund will be determined as follows. (See 3, below for exception.)

   - Where interim reimbursement to the provider is determined on the basis of a percentage of billed charges, the FI shall request the beneficiary to refund the amount of interim reimbursement incorrectly paid the provider;

   - Where interim reimbursement to the provider is determined on some basis other than a percentage of charges, the FI shall determine the product of the charges that were initially billed by the provider but subsequently determined to be noncovered, by the ratio which the provider's total Medicare reimbursable costs for covered services bears to the provider's total Medicare charges for covered services as reflected in the provider's cost report for the fiscal year in which the beneficiary's stay began. The beneficiary is requested to refund this amount less any applicable deductible or coinsurance amount. If the ratio for the appropriate fiscal year is unobtainable, the FI shall use the ratio from the most recent cost report available. (See paragraph C, Example 1, below.)

3. Exception to the General Rule Where Medicare Payment Exceeds Provider's Customary Charges

   The beneficiary will be requested to refund the provider's customary charges for the erroneously reimbursed services (less any applicable deductible or coinsurance) in any situation where this amount is less than the amount determined under 2 above (e.g., where the provider is a public provider and is reimbursed on the basis of fair compensation because its charges to the public are nominal). This is because a beneficiary is liable for the Medicare overpayment only to the extent that the beneficiary benefited from that payment.

**B - Providers Reimbursed Under Prospective Payment System.**

Over-payments Due to Erroneous Payment of Inpatient Deductible and/or Coinsurance Amounts

Where the overpayment resulted because the FI erroneously reimbursed the provider for some or all of the beneficiary's inpatient deductible or coinsurance obligation, the beneficiary is requested to refund the amount of the actual erroneous payment. (See paragraph C, Example 2, below.)

Where the overpayment resulted from erroneous payment for unreplaced deductible blood under Part A, the beneficiary is requested to refund the amount the provider would have charged for the blood in question if it had not been paid for under Medicare.

General Rule for Other Overpayment Cases

The beneficiary will be requested to refund the lower of the PPS payment (determined in accordance with §§2405 of the Provider Reimbursement Manual) or the provider's customary charges less any applicable deductible or coinsurance. (See paragraph C, Example 3, below.)

**C - Examples of How Much to Recover from Beneficiary**

Example 1 illustrates a case in which an overpayment was based in part on misapplication of the deductible and coinsurance amounts (§130.4.A.1 and in part on payment for services after benefits were exhausted (§130.4.A.2.b) where the hospital is reimbursed on the basis of reasonable cost; Example 2 illustrates a case in which an overpayment is based on misapplication of the inpatient coinsurance amount where a hospital is reimbursed under PPS (§130.4.B.1); Example 3 illustrates a case in which an overpayment is based on non-entitlement where the hospital is reimbursed under PPS (§130.4.B.2).

**EXAMPLE 1: Provider Reimbursed on Basis of Reasonable Cost:**

A beneficiary is hospitalized for 20 days during 2001. The total covered charges are $14,000.

The FI receives and approves the bill. The CWF response indicates that the stay is the beginning of a spell of illness. Since the provider's interim reimbursement formula is $602 per diem, the FI made payment of $11,248 (20 days X $602 per day minus $792 deductible).

Subsequently, the FI learns that the original CWF response was incorrect and at the time of admission the beneficiary had only 8 lifetime reserve days available. Consequently, the provider submits a corrected bill showing $5,600 in covered charges and $8,400 in noncovered charges.

The amount which the beneficiary will be requested to refund will be calculated as follows:

1 The beneficiary's liability for the first 8 days of the stay, i.e., the period for which payment was based on misapplication of the deductible and coinsurance, is calculated as follows:

| | | |
|---|---|---|
| A | amount of coinsurance which should have been applied (8 lifetime reserve days at $396 per day): | $3,168 |

| | | | |
|---|---|---|---|
| | B | amount of deductible actually applied: | -$792 |
| | C | amount for which the beneficiary is liable: | $2,376 |
| 2 | The beneficiary's liability for the last 12 days of the stay, i.e., after benefits were exhausted, is calculated as follows: | | |
| | A | charges initially allowed but subsequently determined to be noncovered: | $8,400 |
| | B | ratio of provider's total Medicare reimbursable costs for covered services to provider's total Medicare covered charges as reflected on cost report for year of admission: | X 86% |
| | C | amount for which the beneficiary is liable (product of a and b): | $7,224 |
| 3 | Total amount for which the beneficiary is liable: (sum of amount determined under l and 2 above). | | $10,392 |

**EXAMPLE 2: Provider Reimbursed Under PPS:**

A beneficiary is hospitalized for 20 days during 1996. The outlier threshold is day 23. The query reply indicated that 27 days of full benefits were available, and that the deductible had been met previously. On that basis, the FI reimbursed the hospital its full Medicare payment rate (determined in accordance with §§2405 of the Provider Reimbursement Manual). The FI subsequently discovered that at the time of admission the beneficiary had only 8 lifetime reserve days available. Therefore, the Medicare payment should have been reduced by 8 days of lifetime reserve coinsurance, or $2,944 (8 X $368). That is the amount for which the beneficiary is liable. There is no overpayment due to benefits being exhausted, since an entire stay that is within the day outlier threshold is covered under PPS as long as the beneficiary has at least one benefit day remaining at the time of admission.

**NOTE:** Day outliers became obsolete after FY 1997.

**EXAMPLE 3: Provider Reimbursed Under PPS:**

A hospital is incorrectly paid $8,908 ($9,700 Medicare payment rate (determined in accordance with §§2405 of the Provider Reimbursement Manual) minus $792 deductible) for services rendered in 2001 to an individual who was not entitled to Medicare. The provider had no basis to question the individual's entitlement. The provider's charges for otherwise covered services are $9,000. The individual is requested to refund $8,208, the lower of the hospital's PPS payment or its charges less the $792 deductible.

## 130.5 - Content of Request for Refund Letter

**(Rev. 3, 08-30-02)**

**A3-3711.5, B3-7120.5**

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment that is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the FI or carrier determination. Clarity is important because CMS and SSA may eventually use the letter for further recovery attempts. The FI or carrier letter and the referral form (Form CMS 2382 - FI, CMS-1932 - carrier) are usually the only sources available to CMS and the SSA for information regarding the overpayment.

The following is the minimum information the FI or carrier shall include in refund letters sent to a beneficiary:

- The name and address of the provider/physician;
- Dates and type of services for which the overpayment was made;
- A clear explanation of why the payment was not correct;
- The amount of the overpayment and how it was calculated;
- If necessary, a statement that the provider was without fault and that the individual is responsible for refunding overpayments where the provider was without fault;
- The refund should be by check or money order and how it should be made out (enclose preaddressed envelope);
- The refund can be made by installments (see §130.9);
- That unless a refund is made, the overpayment will be referred to SSA for further recovery action;
- Possible recovery from other insurance (if applicable),
- An explanation of the beneficiary's right to a reconsideration or hearing as appropriate; and
- An explanation of the CMS/SSA waiver of recovery provisions. (See §110.5.)

## 130.6 - Sample Request for Refund Letter

**(Rev. 3, 08-30-02)**

**A3-3711.6**

The FI or carrier may use or adapt the following model letter for requesting refunds of overpayments:

"Dear Mr. _____:

**A - Opening Paragraph:**

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

The FI or carrier shall include a clear and complete explanation of how the overpayment arose (see §§130.7 and Medicare Claims Processing, Chapter 23, Remittance Notices to Providers) for some suggested explanations), the amount of the overpayment and how it was calculated,)

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

**B - Liability of Beneficiary**

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

**C - Request for Refund**

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

**D - Possible Offset**

"If other Medicare benefits become payable to you and you have not refunded the incorrect payment we will withhold the amount you owe from those benefits." (In the initial letter the FI or carrier shall add: "beginning 30 days from the date of this letter.")

**E - Possible Referral to Social Security Administration**

"If you do not repay this amount, this overpayment will be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action that, among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled."

**F - Installment Payments**

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

**G - Possible Recovery from Other Insurance**

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

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

**H - Notification of Appeal Rights**

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

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

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

**I - Notification of Waiver of Recovery Provision**

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

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, **and**

- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses **or** would be unfair.

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

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

## 130.7 - Optional Paragraphs for Inclusion in Refund Letters

**(Rev. 3, 08-30-02)**

**A3-3711.7**

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

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

#### 1 - General - FI

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

#### 2 - Deductible Overpayment

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

#### 3 - Coinsurance Overpayment

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

### B -Deductible Not Properly Assessed -Carrier

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

**C - Payment Made Under WC Law**

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

**D - Beneficiary Not Entitled to Medicare Benefits**

"The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your Medicare Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (FI or carrier name). Therefore, if you disagree with this decision, or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you."

## 130.8 - Recovery Where Beneficiary Is Deceased

**(Rev. 3, 08-30-02)**

**A3-3711.8, B3-7120.8**

Where a beneficiary who is liable for an overpayment dies, the FI or carrier shall attempt to recover from such sources as State welfare agencies, or private insurance plans (see §130.1), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative.

If the entire overpayment cannot be recovered by the above methods, it shall send a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative if known, or to the last known address of the deceased. It shall include the basic information in §130.5, but shall not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The FI or carrier shall not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. It shall not recover by offset against underpayments

payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

If a refund is not received within 30 days after writing to the estate, the FI or carrier shall determine if a transfer to the Social Security Administration is warranted. When forwarding the overpayment to SSA, the FI or carrier shall notify any party that responded to its recovery letter that the case is being transferred to the Social Security Administration and that further recovery action will be taken by the agency.

**Model Refund Request to Estate of Deceased Beneficiary (FI or carrier shall adapt to Fit the Situation)**

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

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

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

(FI or carrier shall include:

- A clear and complete explanation of how the overpayment arose (see §140.6 for some suggested explanations),
- The amount of the overpayment,
- How it was calculated, and
- Why the payment was not correct.)

The FI or carrier shall add if applicable:

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

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

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

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

“If we do not hear from you within 30 days, we will be required to refer this matter to the Social Security Administration (or Railroad Retirement Board) for further recovery action.

**NOTE:** The FI or carrier shall undertake notification of appeal rights in accordance with the reopening rules in Medicare Claims Processing, Chapter 30, Beneficiary Correspondence and Appeals.

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

## 130.9 - Beneficiary Wishes to Refund in Installments

**(Rev. 3, 08-30-02)**

**A3-3711.9, B3-7120.9**

**A - General**

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

Normally, the installments should be large enough to effect recovery within 3 years; however, the FI or carrier shall allow a longer installment period if the beneficiary is willing to refund at least $50 per month. In notifying a beneficiary that they can refund an overpayment by installments, the FI or carrier shall specify the amount (not less than $10) and the number of monthly installments necessary to recovery the overpayment. (See §130.6D.)

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

The FI or carrier shall exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that they cannot afford an installment of at least $10 per month, or that they can afford installments of $10 to $50 per month but the overpayment is so large that recovery would take substantially more than 3 years, the FI or carrier shall treat such statement as a request for waiver. It shall refer it to CMS, and annotate Item 13, Remarks, of the form CMS-2382 with the phrase, "FOR CONSIDERATION OF WAIVER -BENEFICIARY ALLEGES HARDSHIP."

The FI or carrier shall notify the beneficiary that their file has been forwarded to CMS for further consideration and that they will be notified of the decision. The following paragraph is suggested for use in notifying a beneficiary:

"Because you have stated that you cannot afford to pay the monthly installment amount that we require, we have sent your file to the Centers for Medicare and Medicaid Services for further consideration. The Centers for Medicare and Medicaid Services will contact you if additional information is needed and it will also notify you of the decision made in your case."

**B - Notification of Installment Schedule**

When agreement is reached with a beneficiary for refund by installments, the FI or carrier shall notify the beneficiary of the installment schedule. It may, at its option, ask the beneficiary to sign an installment agreement such as the one in paragraph C below. It shall give one copy of the agreement to the beneficiary, and retain the other.

**C - Suggested Installment Agreement**

_____ _____

Name of Overpaid Beneficiary Health Insurance Claim Number

Beneficiary's Address

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

| **DATE PAYMENT DUE (Month, Day, Year)** | Amount of Payment |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____

Signature of Beneficiary

_____

Date

**D - Beneficiary Fails to Remit Installments**

If the beneficiary fails to remit two installments (not necessarily consecutive), or after remitting the overdue installments, fails to remit any subsequent installments, the FI or carrier shall ask the beneficiary the reason for the lapse. If it does not receive a response within 30 days, or is informed that the beneficiary is unable to continue paying any installments, it shall refer the case to CMS. (If the beneficiary states that they can afford a lesser installment amount, see paragraph E below.) If the FI or carrier learns that the beneficiary is deceased, see §130.8. When referring defaulted cases, the FI or carrier shall annotate the overpayment referral form (CMS-2382) to that effect, specifying the amount of the installments that were agreed upon, and the amount refunded by the beneficiary.

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

If the beneficiary notifies the FI or carrier that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the FI or carrier shall set up a new agreement, provided the new installment is at least $10 per month, **and** large enough to effect recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement. If the beneficiary cannot afford such an amount, the FI or carrier shall refer the case CMS, and annotate the overpayment referral form (CMS-2382) as in A above.

## 130.10 - Recording Overpayment Cases in Which the Provider is Not Liable- FI

**(Rev. 3, 08-30-02)**

**A3-3711.10**

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

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

## 130.11 - Beneficiary Protests

**(Rev. 3, 08-30-02)**

**A3-3711.11, B3-7120.11**

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

**A - Protests To Treat As Requests Administrative Appeal**

The FI or carrier shall consider a beneficiary's reply a request for administrative appeal (Part A reconsideration, Part B review, Part B fair hearing, or ALJ hearing (both A & B), as applicable) if the beneficiary protests the existence of an overpayment, the amount of the overpayment, or if the nature of the protest is unclear. (See B below for which protests the FI or carrier shall consider requests for waiver.) It shall take no further recovery action in such cases until the administrative appeal process is completed. (See Medicare Claims Processing, Chapter 30, Beneficiary Correspondence and Appeals.) The FI or carrier shall tell the beneficiary that the request is being considered (or has been forwarded to the Office of Hearings and Appeals, if a hearing request) and that no action is necessary until further notice. If the overpayment case has been referred to CMS, the FI or carrier shall inform CMS of the appeal so that recovery action by CMS may be suspended pending the results of the appeal.

If the appeal determination is that the beneficiary is liable for an overpayment, the FI or carrier shall send the beneficiary another request for refund of the overpayment (including all information in §130.5), unless the beneficiary has also requested waiver. In that event, see B below. If the beneficiary does not reply within 30 days, the FI or carrier shall forward the case to CMS.

The FI or carrier shall annotate Item 13, "Remarks" of the CMS-2382 in red "NONENTITLEMENT CASE - For CMS Development and/or Waiver Consideration."

An individual may protest a Medicare overpayment determination at a local SSO. That office helps the individual to complete an appeal request. If the overpayment involves an issue other than entitlement to benefits, the SSO forwards the request using form CMS-2649 (Part A) or form CMS-1964 (Part B), to the FI or carrier. If the overpayment resulted from a decision that the individual was not entitled to Medicare during the period in which the services were rendered, the SSO uses form CMS-561 and sends the original to its Program Service Center for reconsideration. It sends the FI or carrier an informational copy so it can suspend recovery action pending the outcome of the appeal. When the reconsideration is complete, the Program Service Center sends the FI or carrier a copy of its determination. The FI or carrier shall either resume or terminate recovery action as appropriate, and notify the beneficiary when the recovery is terminated or resumed.

**B - Protests To Treat As Requests for Waiver**

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

**NOTE:** If the beneficiary has also requested appeal, the FI or carrier shall conduct the appeal prior to the referral; and if the original decision is affirmed, advise the beneficiary that the matter has been referred to SSA for consideration of the claim that refunding the overpayment would be a hardship for the beneficiary and/or would be unfair.