Medicare

Renal Dialysis Facility Manual (Non-Hospital Operated)

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

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REFER TO CHANGE REQUEST: 2810

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
324.1 – 325.7 (Cont.)	3-17 - 3-18.6b (10 pp.)	3-18 - 3-18.6 (8 pp.)

NEW/REVISED MATERIAL—*EFFECTIVE DATE*: September 8, 2003
IMPLEMENTATION DATE: September 8, 2003

THE CHANGES LISTED BELOW DO NOT REQUIRE ANY SYSTEM CHANGES.

Section 325, Renal Health Clinic Manual, Credit Balance Reporting Requirements- General Provisions, changes HCFA to CMS. This change applies throughout these revisions. Adds a reminder that "Only Medicare Credit Balances are reported on the CMS-838".

Section 325.2 Completing the CMS-838, Column 11, changes "request" to "claim" as submission of the CMS-838 by itself does not constitute an adjustment.

Section 325.3 Payment of Amounts Owed Medicare, dds more detailed/specific requirements for payment and provides revised instructions regarding recovery demands and interest.

Exhibit I – Medicare Credit Balance Report Certification Page, revised certification page approved in 2002.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Refunds

324. REFUND OF MONIES INCORRECTLY COLLECTED

Renal dialysis facilities bill Medicare for dialysis treatments, except for the deductible and coinsurance. Bill the Medicare patient directly only for the Part B deductible and coinsurance. Furthermore, coinsurance billed to the patient for covered dialysis services must be based on the charge determined by Medicare to be the reasonable charge. Coinsurance amounts along with Medicare payment for the covered dialysis service must not exceed what has been determined to be the facility's reasonable charge. (See §318 (15I) for a discussion of Medicare reimbursement amounts and how they are determined.)

Amounts incorrectly collected and not refunded represent improper charges for covered services. Money incorrectly collected are amounts in excess of allowable charges and deductible and coinsurance amounts, if applicable, paid to a facility by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program. A majority of incorrect collections are made inadvertently and may involve a simple error on the part of the facility in billing a beneficiary. However, there are other situations which lend themselves to the possibility of an incorrect collection. Shown below are some examples:

- In a retroactive entitlement case, where the beneficiary (or other person) paid for covered services and later becomes entitled to have payment made for them by Medicare;

- Where an intermediary (carrier) has initially denied payment and a subsequent finding is made (e.g., as the result of a reconsideration or hearing decision) that payment for all or part of the services may be made;

- Where the beneficiary or other person has protested a direct charge by a facility and the intermediary determines that the beneficiary is entitled to have program payment made on his behalf for all or part of the services.

The intermediary ensures that facilities refund monies incorrectly collected. Therefore, in the situations described above (and other similar situations recognized by the intermediary), the intermediary (carrier) determines, on an individual case basis, whether the facility has already received reimbursement for covered services from the individual or other person (e.g., relatives, other insurance carriers, or welfare) before making Medicare payment. If the facility advises, in writing, that it has not been reimbursed by the individual or other person for covered services, payment can be made. (See §324.1 for proper disposition and §324.2 for time limit within which refund or other disposition is to be accomplished.)

Where the intermediary knows that a facility has overcollected deductible and coinsurance amounts, direct refund is made by the intermediary to the beneficiary.

324.1 Return or Other Disposition of Monies Incorrectly Collected.--A facility in possession of any incorrect collection is required to refund or make final disposition of the money in accordance with applicable State law. If refund or final disposition will be delayed for a prolonged period, the facility is required to set aside the money in a separate account until refund or final disposition can be made. Until the facility advises, in writing, that it has properly refunded or disposed of the money or, as necessary, set aside the money, the intermediary will withhold an amount equal to such incorrect collection against amounts otherwise due.

A. Refund.--Refund is to be made to the beneficiary (or any other person) from whom the facility collected the monies. If the beneficiary or other person cannot be located after the facility has made a reasonable effort (including contact by mail at the last known address), ask the intermediary to check HCFA's records. If the individual to whom refund is to be made still cannot be located or has died, make final disposition of the monies in accordance with State law.

B. Monies Set Aside.--In some situations refund or final disposition may be delayed for a prolonged period (e.g., where the beneficiary's whereabouts is being developed or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual). When such a delay in making refund or final disposition is encountered, notify the intermediary and set the funds aside in a separate account identified by the name of the individual to whom the payment is due. Carry these amounts on the records until refund or final disposition, as provided in A above, is made.

324.2 Appropriate Time Limits Within Which Facility Must Dispose of Sums Incorrectly Collected.--Refund or final disposition in accordance with applicable State law of sums incorrectly collected should be accomplished promptly. In any event, the refund, final disposition, or, as necessary, setting funds aside in a separate account, should be accomplished within a period of 60 days after notification of incorrect collection.

324.3 Former Facility.--Once a facility is in the Medicare program, it remains responsible, notwithstanding subsequent withdrawal of program approval or voluntary participation, for the required refund or final disposition of any monies incorrectly collected for covered services furnished to Medicare beneficiaries during the effective period of its program participation.

325. CREDIT BALANCE REPORTING REQUIREMENTS – GENERAL

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses this information. In accordance with sections 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, complete a Medicare Credit Balance Report (CMS-838), to ensure that monies owed to Medicare re repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed, or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance or amounts;
- A hospital which bills and is paid for outpatient services included in a beneficiary's inpatient claim. Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program

Only Medicare Credit Balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, . Refer to §§300 and 301 that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

325.1 Submitting the CMS-838.--Submit a completed CMS-838 to your intermediary within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

325.2 Completing the CMS-838.--The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. The detail page provides space to address 17 claims. You may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you report. An electronic file (or hard copy) of the detail page is available from your FI.

You may submit the detail page(s) on a diskette furnished by your contractor or by a secure electronic transmission as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE: Part B pertains only to services you provide that are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Complete the CMS-838 providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;
- The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- The month, day and year of the reporting quarter, e.g., 12/31/02;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1- The last name and first initial of the Medicare beneficiary, (e.g., Doe, J.).

Column 2- The Medicare Health Insurance Claim Number (HICN) of the Medicare beneficiary.

Column 3- The 1-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

Column 4- The 3-digit number explaining the type of bill, e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions, §§320-321.)

Columns 5/6- The month, day and year the beneficiary was admitted and discharged, if an inpatient claim, or "From" and "Through" dates (date service(s) were rendered) if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 1/1/02).

Column 7 - The month, day and year (e.g., 1/1/02) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and ICN number correspond to the most recent payment.

Column 8 - An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)

Column 9 - The amount of the Medicare credit balance that was determined from your patient/accounting records.

Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the CMS-838 to your intermediary.)

Column 11 - A "C" when you submit a check with the CMS-838 to repay the credit balance amount shown in column 9, a "A" if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the CMS-838, and a "Z" if payment is being made by a combination of check and adjustment bill with the CMS-838. Use an "X" if an adjustment bill has already been submitted electronically or by hard copy.

Column 12 - The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if you make full payment.

Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons". Provide an explanation on the detail page for each credit balance with a "3".

Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability. For code description, see §620.)

12 - Working Aged
13 - End Stage Renal Disease
14 - Auto No Fault/Liability
15 - Workers' Compensation
16 - Other Government Program
41 - Black Lung
42 - Department of Veterans Affairs (VA)
43 - Disability
44 - Conditional Payment
47 - Liability

Column 15 - The name and billing address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report.

325.3 Payment of Amounts Owed Medicare.— Providers must pay all amounts owed Medicare (column 9 of the report) at the time the credit balance is submitted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a separate claim adjustment, electronic or hard copy, for all individual credit balance that pertain to open cost reporting periods. The FI will ensure that the monies are not collected twice.
- Submission of the detailed information on the CMS-838 will not be accepted by the FI as a claims adjustment.
- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).

- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20 (h) state that "if a provider receives payment from both Medicare and another payer that is primary to Medicare", the provider must identify MSP related credit balance in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60–day period into consideration.

- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, contact your FI regarding an extended repayment schedule.

325.4 Records Supporting CMS-838 Data.--Develop and maintain documentation that shows that each patient record with a credit balance (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether or not the patient is an eligible Medicare beneficiary;
- Identify other liable insurers and the primary payer
- Adhere to applicable Medicare payment rules; and
- Ensure that the credit balance is due and refundable to Medicare

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your intermediary will review your documentation during audits/reviews performed for cost report settlement purposes.

325.5 Provider-Based Home Health Agencies (HHAs).--Provider-based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it may be different from the intermediary servicing the parent facility.

325.6 Exception for Low Utilization Providers.--Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, §2414.4B, or files less than 25 Medicare claims per year.

325.7 Compliance with MSP Regulations.--MSP regulations at 42 CFR 489.20 require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a CMS-838 and adherence to CMS's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a

reporting quarter, in accordance with the 60-day requirement, do not include it in the CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.

EXHIBT I

FORM CMS-838
Medicare Credit Balance Report
Certification Page
MEDICARE CREDIT BALANCE REPORT CERTIFICATION

The Medicare Credit Balance Report is required under the authority of Sections 1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER (S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared
by

_____ _____
Provider Name Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

(Sign) _____
Officer or Administrator of Provider

(Print) _____
Name and Title

(Print) _____
Date

CHECK ONE:
[ ]Qualify as a Low Utilization Provider.
[ ]The Credit Balance Report Detail Page(s) is attached.
[ ]There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached.)

_____ _____
Contact Person Telephone Number

FORM APPROVED
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The Medicare Credit Balance Report
(CMS-838)