Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents
(Rev. 47, 06-25-04)

Bankruptcy Attachments

NOTE: Revision 3 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 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 - Overpayments Determined by the FI or Carrier

(Rev. 29, 01-02-04)

Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an 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. 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, however once an intermediary or carrier determines an overpayment has been made 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 addition, The Debt Collection Improvement Act of 1996 requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and offset. CMS is mandated to refer all eligible debt over 180 days delinquent for cross servicing and offset.

This chapter deals with two general types of overpayments.

Aggregate overpayments involve a group or all of a Part 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, overpayments resulting from a periodic interim payment adjustment, situations involving provider failure to file a cost report, or occasions of fraud or program abuse. Aggregate overpayments are described in §10.1, §20 and §30 of this chapter and Chapter 4, Debt Collection.

Individual overpayments refer to incorrect claims payment for services under Part A or Part B. Individual overpayments are described in §10.2, §80ff and Chapter 4, Debt Collection. Medicare Secondary Payer (MSP) instructions can be found in the Medicare Secondary Payer Manual, CMS Publication 100-5.

10.1 - Aggregate Overpayments

(Rev. 29, 01-02-04)

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;
- Excessive interim payments made to the provider;
- Failure to repay accelerated payments;
- Failure to file cost reports (Chapter 3, §30);or
- Determination of amounts due upon filing the cost report, during desk review, final settlement and reopening of the cost report.

10.2 - Individual Overpayments

(Rev. 29, 01-02-04)

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

Examples of individual overpayment cases are:

- Payment for provider, supplier 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.

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

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

$$(1-i)$$

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 = ?

$$MP = \$5{,}000.00 \times \frac{\frac{095}{12}}{1 - \frac{(1)}{36}}$$

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

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 the Program Integrity Manual and 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. 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 - Recovery of Cost Report Overpayments- Cost Report Filed

(Rev. 29, 01-02-04)

Providers of services under Part A of the Medicare program are normally required to submit a cost report. A cost report must be submitted for each cost reporting year or upon termination of the Medicare agreement.

20.1 - Part A Provider is Participating in Medicare and Medicaid

(Rev. 29, 01-02-04)

When the provider files a cost report indicating an overpayment, a final determination is deemed to have occurred if the cost report is not accompanied by payment in full. Where the provider does not remit the overpayment in full, the 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.

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

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

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

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

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

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

(Rev. 29, 01-02-04)

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

If the 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 terminated provider to obtain a refund in a lump-sum, if it has not been made.

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

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

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

(Rev. 29, 01-02-04)

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 to obtain a refund in a lump sum, if it has not been made.

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

The first demand letter must provide notice (See Chapter 4, §10-20 and §60) that action to withhold its Federal share of Medicaid payments will be requested if repayment arrangements are not made within 15 days of the date of this notice. The second demand letter must provide notice that action to withhold its Federal share of Medicaid

payments has been requested and will be initiated if repayment arrangements are not made. The FI shall send the third demand letter 30 days following the second where the provider has not responded, even though procedures for withholding the Federal share of payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury.

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

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 - Recovery of Cost Report Overpayments - Overdue Cost Report

(Rev. 29, 01-02-04)

When a provider fails to submit a cost report by the due date the FI shall take recovery action to notify the provider that submission of the cost report is required and that additional collection action will continue until an acceptable cost report is submitted.

30.1 - Provider is Participating in Medicare and Medicaid

(Rev. 29, 01-02-04)

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. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

If no cost report has been received by the seventh day after the due date (including extensions), the FI must send the first demand letter in Chapter 4, §20. (The seven-day timeframe allows for processing and mail time.) In addition the FI must initiate 100% suspension of all Medicare payments on day seven if the cost report has not been received, an extension request has not been received and approved or a reduction in the rate of suspension has not been approved. (See Chapter,)

If the provider does not respond within 30 days of the first demand letter, the FI shall send the second demand letter. (See Chapter 4, §20)

The FI shall make a personal (or telephone) contact with the provider 15 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 within 30 days of the second demand letter, the FI shall send the third demand letter. (See Chapter 4, §20)

30.2.-.Provider is No Longer Participating in Medicare and Not Participating in Medicaid

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

(Rev. 29, 01-02-04)

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, §20. Since this

situation 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.

The FI shall continue sending demand letters to the provider. (Chapter 4, §20 for the requirements for the second and third demand letters) The demand letters must 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 recoupment efforts and the withholding of Medicaid payments are not effective, the case will be ready for referral to the Department of Treasury.

40 – Recovery of Claims Accounts Receivables from the Provider - FI
(Rev. 29, 01-02-04)

Intermediary claims A/R arises from adjustments in the intermediary's claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). Some of the reasons these adjustments occur include the duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, a determination by the intermediary that an adjustment was required, or an adjustment created from a credit balance report, CMS-838. These adjustments are normally recovered through the recoupment of future claims and the recovered amounts are included in the remittance advices to the providers. For additional information see Chapter 4, §70.15.2.

40.1 – Demand Letter Contents
(Rev. 29, 01-02-04)

The FI will demand an overpayment resulting from a claims adjustment if the claims adjustment has had no recoupment in the past 60 days.

The demand letter must include the following information:

- That an overpayment was made;
- That interest will begin to accrue if the overpayment is not paid in full within 30 days;
- The name and HI number of the beneficiary involved;
- The dates and types of services for which the overpayment was made to include sufficient information for the provider to identify the overpayment;
- How the overpayment was calculated;
- Why it is liable for recovery of overpayment (i.e., the reasons for finding the provider at fault);
- That recoupment of the overpayment from all available payments is occurring;
- A reference to the Appeals rights in the remittance advice;

40.2- Sample Demand Letter for Claims Accounts Receivables
(Rev. 41, 04-30-04)

Below is a sample demand letter that FIs may use when demanding Claims Accounts Receivables. The Extended Repayment Plan enclosure can be found at Chapter 4, §20, Exhibit 2.

Date

Certified Mail

Name/Address

Re: Provider Number
Claims Accounts Receivable

Dear _____:

On _____, a claim adjustment was entered in our system under provider _____ for $_____. Since then, adjustments were made to the claim and a balance in the amount of $_____ has been outstanding for 60 days. As this amount has not been recouped through claims submission, the purpose of our letter is to request that this amount be repaid to our office. For your reference, a copy of the Claims Accounts Receivable Transaction Summary is enclosed. (Insert the name of the detailed summary report enclosed. This report should include sufficient information needed by the provider to identify the overpayment).

Please submit your check payable to _____, to the following address:

In order to ensure that your check is credited to this overpayment, please enclose a copy of this letter with your payment.

Until payment in full is received or an acceptable extended repayment request is received all payments due to you are being withheld. (This includes claims, settlement amounts, or interim payments.) If you have reason to believe that withhold should cease you must notify our office before _____ and provide documentation as to why this withholding action should not continue. We will review your documentation, but will not delay recoupment during the review process. This is not an appeal of the overpayment determination.

In addition, in accordance with 42 C.F.R. §405.378, simple interest at the rate of ____% will be charged on the unpaid balance of the overpayment, beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of this letter, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and the remaining amount to principal.

Additional interest of $___ will be assessed against the principal balance on ____ and will continue to assess at the rate of ___% a year for each 30-day period the principal amount remains unpaid. In addition, please note that Medicare rules require that payment be either received in our office by ___ or United States Postal Service postmarked by that date in order for the payment to be considered timely. A metered mail postmark received in our office after ___ will cause an additional month's interest to be assessed on the debt.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, please advise our office immediately so that we may determine if you are eligible for a repayment schedule (See enclosure for details). Any repayment schedule (where one is approved) would run from the date of this letter. If we do not hear from you, your interim payments will continue to be withheld and applied towards the outstanding overpayment balance. Any amount withheld will not be refunded.

If you feel you have reason to appeal this adjustment, please refer to the original remittance advice dated _____ for additional instruction.

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

If you have a question regarding why these adjustments were made, please contact our _____at _____. If we can assist you further in the resolution of this matter, we will be glad to do so. We look forward to hearing from you shortly.

Sincerely,

(name and title)

50 - Recovery of Overpayments When a Provider Changes Its FI- FI Only

(Rev. 29, 01-02-04)

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.)

50.1 Action By Outgoing FI

(Rev. 29, 01-02-04)

The outgoing FI is responsible for effectuating final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter to ensure the timely receipt of the cost report as well as any NPRs and demand letters. The outgoing FI is also responsible for assuring that the incoming FI is aware of the outstanding overpayment and that recoupment is initiated by the withholding of interim payments, if necessary. If the overpayment remains uncollected, the outgoing FI is responsible for initiating the withholding of Title XIX payments (Medicaid) and for referring the overpayment to the Department of Treasury. The outgoing FI must copy the incoming FI on all correspondence with the provider to ensure a timely collection process.

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;

- The current status of collection action, including any withhold that is currently in place to recoup the overpayment; and
- The original balance of the overpayment and the current principal and interest balance of the overpayment.

The outgoing FI should also notify the incoming FI of future settlements that will be occurring and of any unfiled cost reports.

B - Notice of Intent to Suspend Interim Payments

If at the time of the change of FI the outgoing FI is recouping an overpayment by the withholding of interim payments the incoming FI will continue the withhold. The outgoing FI must notify the provider that the withhold will be continued by the incoming FI until the overpayment is liquidated or an acceptable ERS is approved. In addition, the outgoing FI must notify the incoming FI of the details of the withhold.
If after the change of FI occurs the outgoing FI determines that an overpayment exists the outgoing FI must notify the provider in accordance with normal procedures. The current FI should receive a copy of all NPRs and demand letters. The outgoing FI must contact the current FI to make sure that recoupment begins when necessary.

50.2 – Action by Incoming FI

(Rev. 29, 01-02-04)

The incoming FI is responsible for effectuating final settlements for the cost report periods after the change of FI becomes effective. If the FI receives a cost report from a prior period it should forward it to the outgoing FI to make the final settlement. If the outgoing FI is no longer participating in the Medicare program, the incoming FI shall contact the RO for further instructions.

After the outgoing FI has completed its review of the cost report, it notifies the incoming FI whether the cost report is acceptable, and the final settlement. The incoming FI, in accordance with Ch. 4, §40, disposes of funds withheld during the suspension of interim payments (for an unfiled cost report) and initiates recoupment by the withhold of interim payments if necessary.

While overpayments are outstanding at the outgoing FI, the incoming FI must keep the outgoing FI up to date regarding the provider's location and participation in the Medicare program. If the incoming FI learns of a provider's termination from the Medicare program it must notify the outgoing FI so that it may act accordingly.

A. Reduction of Outstanding Overpayment

Any actions taken by the incoming FI which reduce or eliminate the overpayment made by the outgoing FI shall be 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. See Chapter 5, Financial Reporting for instructions on transferring any payment(s) between FIs.

50.3 - Extended Repayment Plan - Change of FI

(Rev. 29, 01-02-04)

Either the incoming or outgoing FI may negotiate an extended repayment plan. The need for an extended repayment plan must be documented in accordance with Chapter 4, §50. The FI that negotiates the repayment plan notifies the other about the terms. Referral to the RO with recommendations is required where the plan exceeds 12 months. Payments under the repayment plan should be made to the FI that negotiated the repayment plan.

Where an extended repayment plan 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 plan depending upon which receives the provider's request. The need for a revision of the existing repayment plan must be documented in accordance with Chapter 4, §50. The FI that renegotiates the repayment plan notifies the

other about the revised repayment plan within 5 working days and collects the required payments. Collections received by the incoming FI pursuant to a repayment plan negotiated by it are reported to the outgoing FI and RO within 5 working days after the month in which the collections were received.

60- Interim Rate Adjustments and Periodic Interim Payment Adjustments – FI only

(Rev. 29, 01-02-04)

The interest provisions of Chapter 4, §30 do not apply to FI overpayments or underpayments determined as a result of interim rate and periodic interim payment (PIP) adjustments or utilization reviews. If necessary, an interim rate or periodic interim payment adjustment shall occur prior to the end of the cost reporting year. When this occurs, the interim rate or periodic interim rate is adjusted for the remainder of the cost reporting year in order to have aggregate payments approximate total allowable costs. This adjustment is based on any overpayment or underpayment determined as a result of the interim review. Since payments are adjusted, this overpayment or underpayment should not exist at the end of the cost reporting year.

If the adjustment of the payments would provide a hardship to the provider and an extended repayment plan is requested instead, interest shall accrue on the overpayment. The interest rate charged shall be the rate in effect on the date the notice of payment adjustment was sent to the provider unless a specific instruction is issued as in the case of Interim Payment System (IPS) recoveries for FY 1998 & 1999 (Transmittal A-99-47). This is true for any entity that is reimbursed in such a way that interim rate adjustments and/or periodic interim payment adjustments are required.

If the review is completed after the end of the cost reporting year or after the cost report is filed, adjustments to the interim or periodic rate are not possible. In this case any determined overpayment or underpayment shall be considered in conjunction with the final settlement. By taking the overpayment or underpayment into consideration with the tentative or final settlement the FI will issue a tentative settlement payment, tentative settlement demand letter, or Notice of Program Reimbursement. When a demand letter or Notice of Program Reimbursement is issued, interest will be assessed if necessary, and the provider will be notified of it's appeal rights. Any determined overpayment shall then be recouped.

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 1-3) 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 – Determining Liability and Waiver of Recovery for Overpayments

(Rev. 29, 01-02-04)

The Medicare law contains three provisions (§1870, §1879 and §1842(l)) dealing with liability for, and recovery of, individual overpayments. These provisions do not cover cost report overpayments. These provisions are reflected below and, for a more extensive treatment, in Medicare Claims Processing, Chapter 31, Limitation On Liability.

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 unless recovery is waived under the limitation of liability provision. 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 and therefore not liable for the overpayment, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault.

However, recovery from the beneficiary may be waived if you determine 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.

70.1- 1879 Determination – Limitation of Liability

(Rev. 29, 01-02-04)

Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, practitioners, and other suppliers who acted in good faith in accepting or providing services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision applies to all Part A/Part B claims decisions where claims are denied or reduced (prepay or postpay) under §1862(a) (9) and §1879 (e) and (g) of the Act. Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary. (See PIM Exhibits, §14.1)

A. Limitation on Liability – Indemnification Procedures for Claims Filed under Part B – Section 1879(b) of the Act provides that, when a physician/supplier is held liable for the payment of expenses incurred by a beneficiary for items or services determined to be excluded and such physician/supplier requests and received payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program will indemnify the beneficiary or other person(s) for any payments made to the liable physician/supplier (including deductible and coinsurance payments). Further, any such indemnification payments are considered overpayments to the physician/supplier. (See PIM Exhibits, §14.1)

B. Limitation on Liability Where Physician and Beneficiary Did Not Have Prior Knowledge With Respect to Services Found To Be Not Reasonable And Necessary Services (§1879 of Act).--When both the physician and the beneficiary did not have prior knowledge with respect to services found to be not reasonable and necessary, permit Medicare payment to be made under the limitation on liability provision. (See PIM Exhibits, §14.1)

An overpayment does not exist if a determination is made that the limitation of liability provision applies. The

claim decision must incorporate a limitation of liability determination.

70.2 - 1842(l) Determination

(Rev. 29, 01-02-04)

For denials of nonassigned claims based on §1862(a)(1) involving physician services, the carrier must make a determination under §1842(l) of the Act regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for postpayment denials. (See PIM Exhibits, §14.3)

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment

(Rev. 29, 01-02-04)

Once the contractor has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a §1870(b) determination regarding whether the provider/beneficiary was without fault with respect to the overpayment. Once this determination has been made, then waiver of recovery of the overpayment from the provider/beneficiary should be considered per §1870(c).

Carriers make a §1870 determination for all assigned and non-assigned claims, however, §1870 (b) or (c) of the Act, does not apply to the provider on non-assigned post-payment §1862(a)(1) denied claims. However, it can apply to the beneficiary meaning that the beneficiary was not at fault in causing the overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims denied under §1862(a)(1) of the Act for not being reasonable and necessary. Section 1870 is the framework for determining who is liable for the overpayment and whether the overpayment recovery can be waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived per 1870(c), the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. Section 1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim and this is the basis for the overpayment.

Examples of §1870 determinations

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

If a provider 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.

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 was without fault, or is deemed without fault and therefore not liable for refund, liability shifts to the beneficiary. If the overpayment involves services that are not reasonable and necessary, you should have made a §1879 determination regarding the beneficiary's liability for the overpayment. If the overpayment does not involve medically unnecessary services, then limitation on liability does not apply.

C – Contractor Waiver of Recovery from Beneficiary (§1870(c) of the Act)
If a beneficiary is liable for an incorrect payment, recovery may be waived 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.)

If §1879 of the Act is applicable, then §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was lack of knowledge by both the beneficiary and the provider.

80 – Individual Overpayments Discovered Subsequent to the Third Year

(Rev. 29, 01-02-04)

There are special rules that apply when an overpayment is discovered subsequent to the third year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary. In the absence of evidence to the contrary, the FI or carrier will not recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See PIM, Chapter 3.)

Example 1: On May 9, 2003 Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On January 6, 2007 the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The FI or carrier will not recover this overpayment as long as there is no evidence to the contrary because it was determined subsequent to the third year after notification of payment. (Any determination date later than Jan. 1, 2007 will not be recovered.)(If evidence to the contrary existed, recoupment may be initiated. The PIM should be referenced and if necessary the appropriate Benefits Integrity unit at the contractor for guidance.)

Example 2: On May 9, 2003 Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On September 20, 2006 the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The FI or carrier will attempt recovery of the overpayment. (Any determination dates up to Dec. 31, 2006 will be recovered.)

80.1 How to Determine the Third Calendar Year after the Year the Payment Was Approved

(Rev. 29, 01-02-04)

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 2000, the third calendar year thereafter is 2003. For payments made in 2001, the third calendar year thereafter is 2004, etc. Thus, the rules apply to payments made in 2000 and discovered to be overpayments after 2003, to payments made in 2001 and discovered to be overpayments after 2004, etc.

Where an overpayment to a provider, or a physician assignee for medically unnecessary services or custodial care is discovered (i.e., demanded) 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.

Reopenings (See Medicare Claims Processing Publication 100-4, Chapter 29 Appeals of Claims Decisions for additional information)

Your initial, or review determination or a decision by a Hearing Officer may be reopened under the following conditions:

- Within 12 months after the date of the determination or decision it may be reopened for any reason;
- After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or
- At any time, if:

- Such initial or review determination was procured by fraud or similar fault of the beneficiary or some other person.

If an overpayment is determined based on a reopening outside of the above parameters, the FI or carrier will not recover the overpayment.

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, Financal Reporting, §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 §80.1C, 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 - Provider Liability

(Rev. 29, 01-02-04)

A provider 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 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 or carrier's attention.

Normally, it will be clear from the circumstances whether the provider was without fault in causing the overpayment. Where it is not clear, the FI or carrier shall develop the issue.

90.1 - Examples of Situations in Which Provider Is Liable
(Rev. 29, 01-02-04)

In accordance with §90 the following are examples of situations in which the provider is liable for an overpayment it received.

A - The Provider 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 failed to report any additional payments he may have received from the beneficiary and situations in which a provider failed to request applicable information from the beneficiary including, but not limited to, 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 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 1: A provider submitted an assigned claim showing total fees of $600. The provider did not indicate on the CMS-1500 that any portion of the bill had been paid. After the deductible and coinsurance you determined the amount owed to the provider was $480 on the assumption that the provider had received no other payment. You later learned that the beneficiary had paid the provider $200 before the provider submitted his claim. Thus, the payment should have been split; i.e., $400 should have been paid to the provider and $80 to the beneficiary. The physician was at fault in causing the $80 overpayment since he failed to inform you of the amount he had received from the beneficiary.

B - Provider Receives Duplicate Payments.

This includes the following situations:

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

- Provider 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 provider. The provider is liable for only the portion of the total amount paid in excess of the provider's portion of the allowable amount. The beneficiary is liable for the balance of the overpayment. However, if the beneficiary paid any portion of the coinsurance to the provider, the provider is liable for that amount also. If the provider protests recovery of the overpayment on the grounds that the provider applied all or part of the check received from the beneficiary to amounts the beneficiary owed the provider for other services, the beneficiary, rather than the provider, 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 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 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 and/or Medicare Secondary Payer Manual.) However, if the provider turns the other insurance payment over to the beneficiary, the beneficiary is liable.

C - 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.

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 Mr. Doe 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.

D - 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 in calculating charges, or
- Overlapping or duplicate bills.

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

E - The Provider Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

F - The Provider 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.)

G - 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 Social Security Office notified the hospital that the individual was not entitled to hospital insurance benefits.

H - The Provider Billed, or Medicare Paid the Provider for Services that the Provider 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 should have known about 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.

   Generally, a provider'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 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 about the rule; in deciding whether a provider acted reasonably in billing for and accepting payment for noncovered services.

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 should have known that the services were not covered.

I - 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.
J - For Carriers, The Physician Was Paid but Did Not Accept Assignment.

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

K - 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.

L - 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.

90.2 - Provider Protests Its Liability

(Rev. 29, 01-02-04)

A provider's reply to a notification that the provider 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 whether,

c. The provider is liable for repayment.

NOTE: Receipt of an appeal request does not delay or stop collection efforts on the overpayment.

100 - Beneficiary Liability

(Rev. 29, 01-02-04)

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, was without fault. (See Medicare Claims Processing, Chapter 30, Limitation on Liability.)
- Situations in which Medicare pays a provider, 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. (See Medicare Secondary Payer Manual)
- Overpayments made to the beneficiary.

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 §110.4 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 1: 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 Program Integrity Manual 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 allowed amount 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 allowed amount. 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 Secondary MAnual) 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. 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 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.

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.)

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

There was an overpayment;

The amount of the overpayment was correctly calculated; and

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 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, §50.25), 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 Where the Beneficiary Is Liable for the Overpayment

(Rev. 29, 01-02-04)

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. The chart below is meant to be a guide. The actual sections shall be reviewed for additional guidance.

MEDICARE BENEFICIARY NON-MSP OVERPAYMENTS

O/P Amount	Overpayment Notice	Level of Pursuit	Waiver Requests
$0-$49.99	No- refer to Ch. 3 §110.2	None	N/A
$50-$999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. If case is in offset status for one year with no collection activity, refer case to RO with a recommendation to terminate collection action.	Review all waiver requests and make a decision to approve or deny the waiver based on Ch. 3 §70.
$1000-$19999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and make a decision to approve or deny the waiver based on Ch. 3 §70.

$20000 and over	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and make a recommendation to approve or deny the waiver based on Ch. 3 §70. If the recommendation is for approval, refer the waiver request to the Regional Office for concurrence.

110.1 - Recovery Where the Beneficiary Is Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental

(Rev. 29, 01-02-04)

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, TRICARE, 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 overpayments, it shall arrange with the other plan or program to make payment to overpaid provider upon the FI's or carrier's request, (even though the

provider 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 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 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 (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 §110.2. 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.

110.2 - Recovery From the Beneficiary

(Rev. 29, 01-02-04)

To recover a Non-MSP overpayment from a beneficiary, follow the recovery procedure below. If the beneficiary protests following the receipt of a notification of overpayment, handle the protest in accordance with §110.9.

A. Non-MSP Overpayment Is Less Than $50.--Take no further recovery action. Do not send a recovery letter, or attempt recoupment. Also do not refer case to CMS for further collection efforts. See §160.2 for termination of collection procedures.

B. Non-MSP Overpayment Amount Is $50 or More.--Upon discovering an overpayment of $50 or more, send the beneficiary a recovery letter containing the information in §110.4.

If there is no response within 30 days after sending the initial recovery letter and none of the conditions in §110.3 are present:

1. Send a follow-up letter to the beneficiary, and

2. Arrange to begin recoupment of the overpayment against any Medicare payments that become due the beneficiary on day 60.

C. Referral to SSA-

To be considered for SSA referral the overpayment amount must be $1000 or more and the beneficiary must be in current pay status. If, within 90 days of sending the initial demand letter, the overpayment has not been recovered and the individual has not requested a reconsideration, hearing or waiver (see §110.9) Prepare the case for referral to SSA for possible recovery from the individual's social security benefits.

However, if the HI number has a T or M suffix, do not refer the case to SSA 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. If appropriate, the instructions for termination of collection action (See 110.3D for additional instructions.) should be followed.

The FI or Carrier should not refer an overpayment to SSA if it has knowledge that the beneficiary is deceased.

When preparing the case for referral to SSA the following must be included in the case file:

- Referral Form- contains the address of the referring agency (The Centers for Medicare and Medicaid Services (CMS) Central Office, CMS Regional Office, or the Medicare Contractor and information pertaining to the case; and
- Return Notice- for SSA use in recording information for crediting the CMS Trust Fund; and
- Waiver Determination- if the Medicare Contractor or CMS RO determines the beneficiary was at fault for the overpayment.

NOTE: The contractor's file must contain all overpayment notification letters and correspondence from the beneficiary and/or representative. Contractors may retrieve copies of the relevant forms from the servicing regional office or by accessing SSA's Program Operations Manual System at http://policy.ssa.gov/poms.nsf/poms. Access the HI section for Health Insurance and then the section number HI 022 titled Medicare Overpayments. Then access HI 02201 - Methods of Recovery for Title XVIII Overpayments and finally HI 02201.015 titled Appeal Requests and Refunds. The Beneficiary Overpayment Referral Notice is Exhibit A.

When an individual or his/her authorized representative receives notice from SSA that a Medicare overpayment will be withheld from title II benefits and protests the withholding, the protest applies only to the deduction from his/her title II benefits. It does not apply to the Medicare overpayment because the Medicare contractor has determined that the overpayment must be recovered.

If SSA receives an appeal and/or waiver request, they must stop the process of recovery. If the Medicare Contractor, CMS RO, or the Administrative Law Judge has previously denied a waiver request, SSA will then process the overpayment in accordance with current operating procedures. If the individual has not requested waiver with the contractor but files a waiver request with SSA, then SSA must return the overpayment package to the appropriate contractor for processing.

When an individual or his/her representative goes to SSA to request a waiver and/or an appeal of the Medicare Overpayment withholding, SSA must complete the following forms, depending on the request:

- Waiver- Form 632-BK (Request for Waiver of Overpayment and Recovery of Change in Repayment Rate)
- Appeal of Withholding – SSA-795 (Statement or Claimant or Other Person) since the rate of the withholding is not an initial determination, does not use the SSA-561 (Request for Reconsideration) or HA-501 (Request for Hearing).

NOTE: The referral of a Non-MSP beneficiary debt to SSA occurs regardless of the classification of the debt for financial reporting. Thus, a referral to SSA should occur even if the debt has been reclassified to Currently Not Collectible(CNC).

D. Beneficiary "Write-Off" between $50- $999.99 –If there has been "No Activity"(i.e. no recoupment) within a 12 month period of a beneficiary Non-MSP overpayment that is between $50-$999.99, verify that no collections are being made on any other older debts for the same beneficiary before you make a recommendation for write-off to the Regional Office. At the end of each Quarter compile a list of all beneficiary Non-MSP overpayments between $50-$999.99 to the Regional Office for Write-Off.

Please submit this information, including the status of probate, if applicable, with an explanation for the beneficiary Non-MSP overpayment Write-off.

Example:

Region #	Carrier #	Bene. Hic #	Claim #
xx	xxxxx	xxxxxxxxxx	xxxxxxxxxxxxxxxx

Claim paid date	Demand letter date	Det. date.	$ amt.
xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxx

The Regional Office will be responsible for approval or denial of all recommendations for "write-off", based on the information submitted by Carrier.

NOTE: The write off of a Non-MSP beneficiary debt between $50-$999.99 occurs regardless of the classification of the debt for financial reporting. Thus, a request to write off Non-MSP beneficiary debt between $50-$999.99 should occur even if the debt has been reclassified to Currently Not Collectible (CNC).

NOTE: Beneficiary overpayments that are greater than $1000 may be recommended for write-off following the above instructions if the Medicare Contractor has verified from SSA that the beneficiary is not in a current pay status.

110.3 - When to Suspend Efforts to Recover From the Beneficiary Following the Initial Demand Letter

(Rev. 29, 01-02-04)

Efforts to recover from the beneficiary should be suspended if any of the following conditions exist:

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 §110.9.)

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

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 §110.1.) If the welfare agency does not refund the overpayment in full, the FI or carrier shall not attempt recovery from the beneficiary, unless it is apparent that the beneficiary knew or should have known that the payment was incorrect.

Note: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

110.4- Content of Demand Letter to Beneficiary

(Rev. 29, 01-02-04)

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment which 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 carrier's determination. Clarity is also important because the letter may eventually be used by CMS for further recovery attempts.

The following is the minimum information which shall be included in all overpayment refund letters sent to a beneficiary:

A. Name and address of physician, date and type of service, charges, date of check, amount of check, and name of payee.

B. A clear explanation of why the payment was not correct.

C. The amount of the overpayment and how it was calculated.

D. The beneficiary is required to refund the overpayment.

E. The refund should be by check or money order, and how it should be made out (enclose a pre-addressed envelope).

F. The refund can be made by installments. (See §110.8.)

G. Unless a refund is made, the overpayment may be withheld from other Medicare benefits payable to the beneficiary, and may be referred to the Social Security Administration for further recovery action.

H. Possible recovery from other insurance (if applicable).

I. An explanation of the beneficiary's right to a review or hearing as appropriate.

J. An explanation of the CMS/SSA waiver of recovery provisions. (See §170.3.)

110.5 - Sample Demand Letter to Beneficiary

(Rev. 29, 01-02-04)

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

"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 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 When Payment Made to Physician or Supplier

If payment was made to the physician, add the following:

"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 60 days from the date of this letter.")

E - Possible Referral to Social Security Administration
If the overpayment is over $1000, add the following:

"If you do not repay this amount, this overpayment may 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 of Claims Decisions.

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."

110.6 - Optional Paragraphs for Inclusion in Demand Letters

(Rev. 29, 01-02-04)

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 you are responsible for the deductible and 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 approved 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 Workers’ Compensation 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.”

110.7 - Recovery Where Beneficiary Is Deceased

(Rev. 29, 01-02-04)

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 §110.1), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative. (See 42 CFR 424.60)

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 §110.5, 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.

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 _____)."

(This paragraph should include a clear and complete explanation of how the overpayment

arose, 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.

If payment was made to the physician, add the following:

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.

NOTE: The FI or carrier shall undertake notification of appeal rights in accordance with the reopening rules in Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.

"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."

110.8 - Beneficiary Wishes to Refund in Installments

(Rev. 29, 01-02-04)

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.

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. (See §110.9)

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. Request 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 consecutive installments, 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 the statement should be treated as a waiver request. If the FI or carrier learns that the beneficiary is deceased, see §110.7.

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.

110.9 - Beneficiary Protests

(Rev. 29, 01-02-04)

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 Pub. 100-4, Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) 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 SSA, the FI or carrier shall inform SSA of the appeal so that recovery action by SSA 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 §110.5), unless the beneficiary has also requested waiver. In that event, see B below.

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. Discontinue collection efforts and make a waiver determination if necessary. If the beneficiary offers evidence of financial condition, the FI or carrier shall include 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 waiver determination.

110.10 - When the FI or Carrier Does Not Take Recovery Action in Beneficiary Cases but Considers Whether Waiver of Recovery is Applicable

(Rev. 29, 01-02-04)

The FI or carrier shall consider whether waiver of recovery from the beneficiary is applicable. If the beneficiary is liable and the criteria 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), the FI or carrier makes a waiver determination.

The FI or carrier shall first determine if the beneficiary was without fault see §70.3. If it appears that the beneficiary was without fault the FI or carrier shall then determine if recovery would be against equity and good conscience or if recovery would defeat the purpose of title II or title XVIII of the Social Security Act.

- For recovery to be against equity and good conscience an individual must have changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that a payment would be made or because of the overpayment itself. (See 20 CFR §404.509)
- For recovery to defeat the purpose of title II or title XVIII of the Social Security Act the beneficiary must need all of his or her current income to meet ordinary and necessary living expenses. (See 20 CFR §405.508)

The FI or carrier shall make waiver of recovery determinations for individual Non-MSP overpayments up to $20,000. If an individual Non-MSP overpayment is greater than $20,000, and the FI or carrier believes that the waiver of recovery is appropriate the FI or carrier shall make a recommendation to the regional office for approval to waive the recovery. If there is a situation that involves several beneficiaries where the aggregate total of all waiver determinations exceeds $40,000, the regional office shall be notified. The regional office shall provide guidance as to who shall approve the waiver of recovery determinations.

If the FI or carrier decides that the information available does not justify waiver, it proceeds with normal recovery efforts from the beneficiary.

Note: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

120 - Referral to the Department of Justice (DOJ)

(Rev. 29, 01-02-04)

If the FI/Carrier's attempts to recover an overpayment are unsuccessful and the FI/Carrier believes that the overpayment may be recovered through litigation the FI/Carrier should informally refer the overpayment to the RO to explore the possibility of litigation. If the RO, in conjunction with the Office of General Counsel, believes litigation is necessary it will request the FI/Carrier to prepare the case file for referral to the DOJ. The RO will inform the FI/Carrier of all elements to include in the case file.

A - General

The DOJ 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. If need be the RO can assist the FI/Carrier in obtaining a copy of the CCLR. The FI/Carrier will follow the advice received by their RO's OGC in completing the CCLR. -

In addition to completing the sections of the CCLR as much as possible the FI/Carrier must provide any relevant information to help DOJ. If applicable, the FI/Carrier must notify DOJ if there has been a change of ownership, if there have been any bankruptcy proceedings, and all necessary information concerning the identification of any outstanding overpayments regardless of the determination date. The following guidelines exist for providing information relevant to the identification of overpayments. However, the RO may request additional documents if they are relevant to the overpayment and/or provider.

Identification of Overpayment(s)

The FI/Carrier shall clearly identify the overpayment(s). Cost report overpayments should be identified for each cost reporting period, by total overpayment amount and each individual overpayment amount if multiple overpayments have occurred (tentative and final settlements, interim rate adjustments…). It shall show any partial payments made by the debtor and clearly distinguish between principal and interest. It shall include

documentation to support the overpayment determination. This includes copies of the cost reports, audits, and reviews, copies of all correspondence, and any other information relevant to the overpayment.

Refund Requests

The FI/Carrier shall include a copy of the demand letter(s) to the provider. Where demand letters were returned by the postal service, the FI/Carrier shall document other attempts to secure the address of the debtor(s).

Recovery Efforts

The following are required:

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

Provider's Ability to Refund

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

- 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.

120.1 - Communication on Cases Sent to RO for DOJ Referral
(Rev. 29, 01-02-04)

If the FI/Carrier 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 DOJ, 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 DOJ, the RO notifies the FI/Carrier, who will take no further collection actions except for withheld amounts that may become available. The FI/Carrier shall forward any communications received from the provider to the RO.

120.2 - Cases Referred to DOJ for Possible Litigation
(Rev. 29, 01-02-04)

After a provider overpayment case has been referred to DOJ, the FI/Carrier shall not contact or negotiate with the provider, unless authorized to do so by the DOJ 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 DOJ. If the DOJ contacts the RO with such a request, the RO forwards the information to the FI/Carrier for provider notification. If the provider offers a compromise, the FI/Carrier 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/Carrier shall forward the offer of compromise to the CMS Claims Collection Officer (CCO) through the RO.

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

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 §100.5.)

(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 – Change of Ownership (CHOW)

(Rev. 29, 01-02-04)

When a provider undergoes a CHOW, the provider agreement is automatically assigned to the new owner unless the new owner rejects assignment of the provider agreement. The paragraphs below describe the impact of assignment on overpayment recovery.

Assignment of Medicare Provider Agreement:

Automatic assignment of the existing provider agreement to the new owner means the new owner is subject to all the terms and conditions under which the existing agreement was issued. (See State Operations Manual, §3210)

With assignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless fraud was involved. In addition, the new owner receives benefits of assuming the Medicare provider agreement, such as receiving underpayments discovered after the CHOW.

When a provider undergoes a CHOW where the new provider accepts assignment of the previous owner's Medicare agreement, the responsibility for repaying any outstanding and future overpayments resides with the new owner. Exception: If any of the overpayments determined for a fiscal year when the previous owner had assignment were discovered due to fraud the responsibility for the repayment of the overpayments does not shift to the new provider. It stays with the old provider.

A sales agreement stipulating that the new owner is not liable for the overpayments made to the previous owner is not evidence enough for recovery from the new owner to not occur. Medicare was not a part of the sales agreement. That is a civil matter and it would be up to the new owner to enforce the sales agreement. If the new owner assumes assignment of the Medicare agreement, Medicare will attempt to recover from the new/current owner regardless of the sales agreement.

The intermediary should attempt collection from the new owner. If this is not successful and the FI/Carrier has reasonable evidence that the previous owner can repay the overpayment it should refer the case to the regional office. The regional office will then confer with the regional OGC and decide if this case warrants collection from the previous owner. This should be completed before the debt is transferred to the Department of Treasury.

Nonassignment of a Medicare provider agreement:

If the new owner refuses to accept assignment of the Medicare agreement, the new owner must enter into its own Medicare agreement. In this case there would be no CHOW of the Medicare agreement and the previous owner would still be responsible for any outstanding overpayments.

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

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.

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.)

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 §§2405ff 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 §§2405ff 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 §§2405ff 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 Manual 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 §130.6.D).

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.

140 - Bankruptcy -
(Rev. 12, 10-18-02)

This section contains actions that the contractors must take to safeguard the Medicare Trust Funds when a provider files for bankruptcy. This section does not address bankruptcy issues involving debts arising under the MSP provisions. (Although this Manual will usually use the term "provider," its provisions also apply to suppliers, including physicians). However, use of the term "provider" does not mean that the Medicare program considers suppliers and physicians to be providers. It also explains how to report accurately the Centers for Medicare & Medicaid Services' (CMS) accounts receivable balances and support CMS's efforts to effectively evaluate and manage bankruptcy cases.

This Manual will guide contractor staff through the initial stages of a provider bankruptcy. It is not intended to be, and cannot be, a step by step process from beginning to end. Bankruptcy is litigation. Bankruptcy law and the bankruptcy court affect all the actions CMS and its contractors take concerning a bankrupt Medicare provider. Therefore, contractor staff must consult closely with the Regional Office (RO) before taking, omitting, continuing or discontinuing actions regarding a bankrupt provider. In some cases, attorneys from the Department of Justice (DOJ) in Washington, D.C. or United States Attorney's Offices will work directly with RO staff. However, in most cases, the RO will be in contact with Regional Counsel.

This section consists of eight subsections which are listed in the Table of Contents.

140.1 - Glossary of Acronyms
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(Rev. 12, 10-18-02)

ARMG - Accounting and Risk Management Group
CMS - Centers for Medicare & Medicaid Services
DME - Durable Medical Equipment
DMERC - Durable Medical Equipment Regional Carrier

DMSO - Division of Medicaid and State Operations
DFRDR - Division of Financial Reporting and Debt Referral
DCC - Debt Collection Center
DOJ - Department of Justice
FI - Fiscal Intermediary
NPR - Notice of Program Reimbursement
POR - Provider Overpayment Report
PORS - Provider Overpayment Reporting System
PSOR - Physician/Supplier Overpayment Report
RC - Regional Chief Counsel's Office - the regional office component of the Office of the General Counsel
RO - Regional Office of the Centers for Medicare and Medicaid Services

140.2 - Basic Bankruptcy Terms and Definitions

(Rev. 12, 10-18-02)

140.2.1 - Bankruptcy is Litigation

(Rev. 12, 10-18-02)

An individual or company declares bankruptcy by filing a petition for bankruptcy in a United States Bankruptcy Court. The Bankruptcy Court then opens a bankruptcy case. The Bankruptcy Court closely monitors the affairs of the individual or company (the debtor) including the creditors' treatment of the debtor. Bankruptcy may appear to be "business as usual" for a debtor, but it is not. You should not take any action for or against a debtor until you consult the Regional Office who will consult with the Regional attorney handling the bankruptcy. Do not share any information about bankruptcy strategy or activities with the bankrupt provider.

140.2.2 - Types of Bankruptcies

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(Rev. 12, 10-18-02)

Title 11 of the United States Code (the Bankruptcy Code) identifies four types of bankruptcies that may involve Medicare providers: Chapter 7, 9, 11 and 13. We briefly describe each type here to familiarize you with these types of bankruptcy. However, these general descriptions do not replace your attorney's specific advice in a particular bankruptcy case.
1. Chapter 7 - Debtors file Chapter 7 bankruptcies to obtain discharge of their debts. Companies that file under Chapter 7 generally close. A court-appointed trustee accumulates the assets of the debtor, sells them, and distributes the money among those whom the debtor owes (the creditors).
2. Chapter 9 - Chapter 9 bankruptcies involve municipalities such as a hospital district. Chapter 9 provides for reorganization, much like Chapter 11.
3. Chapter 11 - Debtors file Chapter 11 to reorganize the debtor individual or business. To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan"). The Plan indicates the amount and schedule for payments to creditors. Creditors vote on the Plan, and the Court must confirm it. Recovery amounts vary. The Bankruptcy Code provides for discharge of the remainder of the debt.
4. Chapter 13 - Chapter 13 bankruptcies adjust the debts of individuals (including sole proprietorships) with a regular income. Generally, debtors must file a debt adjustment plan within 15 days after filing.

140.2.3 - Filing Bankruptcy Draws a Line in the Sand

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(Rev. 12, 10-18-02)

The petition date (i.e., the date the debtor files its petition in bankruptcy with the Bankruptcy Court) draws a line in the sand between prepetition and postpetition actions. Events that occur on or before the petition date are prepetition. Events that occur after the petition date are postpetition. The automatic stay governs many actions that contractors may take concerning a debtor postpetition. You must therefore consult the RO before you take action concerning the debtor postpetition.

Medicare's right to recover overpayments can depend on whether they are prepetition or postpetition. The RO will direct you how to treat payments for prepetition services (prepetition payments) and payments for postpetition services (postpetition payments) to maximize Medicare's recovery.

140.2.4 Bankruptcy Affects Nearly All Medicare Operations

(Rev. 12, 10-18-02)

Bankruptcy can affect every aspect of the interaction between the Medicare program and a debtor. Each contractor staff member who may come in contact with a debtor, is effectively a part of the Medicare "bankruptcy team" for that case. You, as contractor point of contact, must ensure that all potential bankruptcy team members alert you if they anticipate actions concerning the debtor, and that they then coordinate those actions with you and with the RO and Regional Counsel. In bankruptcy, both inaction and inappropriate action hurt Medicare's chances of recovery. Some commonly affected areas are:

1. Overpayment Recovery

Medicare's right to recover prepetition and postpetition overpayments also varies by federal jurisdiction. (See discussion on set-off and recoupment in section F below). If you have overpaid a debtor, you must consult the RO, then take appropriate action to maximize recovery of Medicare overpayments from debtors. Contractor overpayment staff should not send any letters to the debtor until the RO approves them for release.

2. Fraud and Abuse

Ensure that you consult with CMS Program Integrity staff and the RO before you suspend an entity for fraud and/or abuse, recover fraud overpayments, or continue suspensions. If you have evidence that the provider filed for bankruptcy because of fraud it committed, advise the RO handling the bankruptcy.

3. Reimbursement

Contractor reimbursement staff must notify the RO before suspending payments to a debtor for failure to file a cost report or a credit balance report. DO NOT issue tentative settlement payments in bankruptcy cases unless explicitly requested by the RO.

Unless otherwise directed, contractor reimbursement staff should continue to review and audit cost reports as usual. However, the contractor must submit notices of program reimbursement to the RO for review and obtain approval before issuing them.

CMS will advise the contractor reimbursement staff about stipulations and settlements that affect audit and/or reimbursement. In making global settlements decisions CMS will consider the cost and benefits of auditing cost reports in cases where recovery is unlikely and direct contractor staff accordingly.

4. Payment

Contractor payment staff must receive approval from the RO before taking any action that changes the amounts payable or owed by a debtor.

5. Appeals

Contractor staff will be asked about recent and current Administrative Law Judge, Provider Reimbursement Review Board and Department Appeal Board appeals involving a provider in bankruptcy.

6.Changes of Ownership

A debtor may attempt to transfer provider agreements so that both parties may avoid overpayment recovery. DMSO staff will notify other regional office staff when a debtor provider files for a CHOW, and immediately notify the Regional Counsel who is handling the bankruptcy. The CHOW will not be processed until the regional office obtains the concurrence of the Regional Counsel who is handling the bankruptcy.

140.2.5 - Recoupment and Set-off (see also §140.6.4) -

(Rev. 12, 10-18-02)

Recoupment and set-off are two of Medicare's strongest tools for recovering overpayments to debtor providers. Jurisdictions vary in their decisions about how Medicare can use these tools. Some jurisdictions consider the Medicare part A provider agreement one contract /transaction and allow it to be the basis for broad powers of recoupment. Other jurisdictions consider each cost report year as a distinct contract and restrict recoupment to periods within a particular cost report year. Your RO/Regional Counsel can advise you whether current law in a given jurisdiction permits recoupment.

1.Recoupment

Recoupment permits a party to reduce current payments to account for prior overpayments made under the same contract or transaction. Recoupment permits adjustment across the petition date and does not require approval of the bankruptcy court. Therefore, Medicare should recoup in any jurisdiction where it is permitted. Do not begin, continue or discontinue recoupment without approval of the RO.

2. Set-off

If recoupment is not permitted, set-off will be considered. Medicare must take quick action to recover overpayments using set-off. Set-off should not take place without specific instructions by the RO.

Set-off permits making similar adjustments in situations involving one or more contracts or transactions. For example, suppose B owes A $40.00 under one contract and A owes B $50.00 under another contract. If set-off is allowed then A can take her $40 from the $50 she is holding for B (A would only pay B $10.00). Generally, parties can request court permission to set-off. If allowed, parties can set-off prepetition claims against prepetition

payments or postpetition claims against postpetition payments. They cannot set-off prepetition claims against postpetition claims.

3. Administrative Freeze
Once it is discovered that a provider is in bankruptcy, Medicare can enact a temporary administrative freeze. An administrative freeze (sometimes called a Strumpf freeze, named after a Supreme Court case) will allow time for Medicare to determine if there are any overpayments and to ask the bankruptcy court to allow set-off. Speed is essential because courts do not permit set-off across the petition date. A pre-petition overpayment can only be set-off against a pre-petition claim.

140.2.6 - Time is of the Essence -
(Rev. 12, 10-18-02)

Do not wait for formal notice of a bankruptcy and do not assume that someone else has notified the appropriate party. Medicare does not always receive timely and proper notice. By waiting, we may lose the opportunity to recover Medicare overpayments. Notify the RO/Regional Counsel immediately when you get credible information that a bankruptcy is about to occur. Good sources to obtain early information about bankruptcies include the Internet; newspapers, trade journals, and business magazines are good sources. Each individual item listed below should be relayed to the RO as soon as you receive it:

Name and address(s) of the individual or entity,

Type and timing of Medicare reimbursement the provider receives,

Amounts and types of outstanding overpayments,

Date of pending or planned reopening,

Status of any unsettled cost report years (expected settlement date and expected results); remember, DO NOT make tentative settlement payments to an individual or entity in bankruptcy, and make final settlement payments only after obtaining the RO's concurrence.

Dates and amounts of next Medicare payments if possible,

The name of the court and jurisdiction, case number, phone number of the debtor's attorney in the matter, and

Any current changes of ownership or quality of care issues).

140.2.7 - Definitions -
(Rev. 12, 10-18-02)

You may encounter the terms listed below. The definitions are provided to give a general understanding. Specific terms may apply differently based upon the circumstances of a particular bankruptcy case.

Adversary Proceeding is litigation in bankruptcy court to recover money or property; determine the validity, priority or ranking of an interest in property; get approval for selling an estate's property interest; revoke a

discharge or an order of confirmation; and obtain declaratory judgments related to matters of the bankruptcy estate. Litigation against CMS to turn over recouped monies is an example of an adversary proceeding.

Affirmative Recovery Actions is debtor's assumption of its executory contract (its provider agreement).

Automatic Stay is an injunction that automatically springs into effect concurrent with the filing of the bankruptcy petition. The automatic stay protects the assets of the estate from lawsuits, foreclosures, garnishments, and any other collection activities that are not specifically exempt from the stay by statute or specifically approved by the bankruptcy court. The automatic stay applies to Medicare overpayment letters that demand repayment, assess interest or otherwise attempt to gain possession of property of the bankruptcy estate.

Bankruptcy Trustee is a private individual or corporation appointed to represent the interests of the bankruptcy estate and the debtor's creditors.

Bar Date is the deadline for filing a proof of claim. In general the bar date for government agencies such as CMS is 180 days after the date of the order for relief (usually, the date the provider files for bankruptcy). In some bankruptcies, however, the court may set a different date.

Claim is the creditor's right to payment or equitable relief creating a right to payment from a debtor or the debtor's property whether or not that right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured or unsecured. The date a claim arises determines whether it is prepetition or postpetition. In Medicare, the date of service is the date of the claim.

Confirmation is bankruptcy court approval of a plan of reorganization.

Contingent Claim is a claim that may be owed by the debtor under certain circumstances, for example, where the debtor is a co-signer on another person's loan and that person has not yet defaulted, but may fail to pay.

Creditor is a person or a business to which the debtor owes money or which claims to be owed money by the debtor.

Debtor is a person or business who has filed a bankruptcy petition.

Discharge is a release of a debtor from liability for certain dischargeable debts. It prevents the creditors that are owed those debts from taking any action to collect those debts from the debtor or the debtor's property. Prohibited actions include making telephone calls, sending letters, and having contact that is intended to induce the debtor to pay the debt.

Dischargeable Debt is a debt for which the Bankruptcy Code allows the debtor's personal liability to be eliminated. Dismiss does not release a debtor from liability on any debts. It does not prevent creditors that are owed those debts from taking appropriate action to collect those debts from the debtor or the debtor's property. When a case is dismissed it is as if the debtor never filed. Therefore, you may proceed with actions that include making telephone calls, sending demand letters, and having contact that is intended to induce the debtor to pay the debt.

Estate is the name for the Debtor's property interests overseen by the bankruptcy court. Filing a petition in bankruptcy creates an estate consisting of all legal and equitable interests the Debtor has. In general, a legal interest is a direct ownership of property. In contrast, an equitable interest typically is indirect and may require court involvement to obtain control or exercise the property rights.

Executory Contract is a contract under which the parties to an agreement have duties remaining to be performed. A Medicare Part A provider agreement is treated as an executory contract.

Exemption is property that the Bankruptcy Code or applicable state law permits a debtor to keep from creditors.

Fraudulent Transfer is a knowing and fraudulent transfer or concealment of property by the debtor with intent to defeat the provisions of the Bankruptcy Code.

Lien is a recorded claim upon specific property in order to secure payment of a specific debt or performance of an obligation. Medicare does not have a lien on overpayments.
Liquidation is the conversion of the debtor's property into cash with the proceeds to be used for the benefit of creditors.

Liquidated Claim is a creditor's claim for a fixed amount of money.

Motion to Lift the Automatic Stay is a request by a creditor to allow the creditor to take an action against a debtor or the debtor's property that would otherwise be prohibited by the automatic stay.

Non-Dischargeable Debt is a debt that cannot be eliminated in bankruptcy. Overpayments resulting from fraud are non-dischargeable. A complaint to determine dischargeability must be filed in the bankruptcy court. See Adversarial Proceeding, above.

Plan of Reorganization is a debtor's detailed description of how the debtor proposes to pay creditors' claims over a fixed period of time.
Priority is the Bankruptcy Code's statutory ranking of unsecured claims. It determines the order in which unsecured claims will be paid if there is not enough money to pay all unsecured claims in full.

Priority Claim is an unsecured claim that is entitled to be paid ahead of other unsecured claims that are not entitled to priority status. Administrative expenses for preserving the estate (e.g., certain accounting fees or postpetition Medicare overpayments) are considered priority claims.

Secured Debt is a debt backed by a mortgage, pledged collateral, or other lien. The creditor that has a secured debt has the right to pursue specific pledged property upon default. See lien above.

Schedule is a list submitted by the debtor along with the petition (or shortly thereafter) showing the debtor's assets, liabilities, and other financial information. (There are official forms a debtor must use.)

Settlement Agreement is an agreement settling a dispute between two or more parties.

Stipulation is an agreement between parties respecting the conduct of legal proceedings approved by the Bankruptcy Court. With appropriate approval, Medicare may enter a stipulation agreement to facilitate a change of ownership or to resolve an overpayment earlier than could be expected by litigation.

United States Trustee is an officer of the Department of Justice responsible for supervising the administration of bankruptcy cases, estates, and trustees, monitoring plans and disclosure statements, monitoring creditors' committees, monitoring fee applications, and performing other statutory duties.

Unsecured debt is one that is not backed by property or collateral. Medicare's claims are generally unsecured.

140.3 - Contractor's Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy

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(Rev. 12, 10-18-02)

140.3.1 - Contractor Staff Must Establish Relationships to Ensure That the RO and Regional Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action

(Rev. 12, 10-18-02)

The contractor may receive notice of a bankruptcy from many sources including the provider, other fiscal intermediaries or carriers, the State, the Regional Office Certification staff, or Regional Counsel. It is imperative that contractor staff act quickly when a provider files for bankruptcy in order to meet filing deadlines in the bankruptcy court. Therefore, contractor staff must establish relationships to ensure that they receive information promptly about provider bankruptcies.

140.3.2 - Contractors Must Recognize and Advise RO Staff About Potential Provider Bankruptcies

(Rev. 12, 10-18-02)

Contractor staff must be alert to news or notices of bankruptcy and notify RO staff immediately. Contractor staff should alert the RO to all potential bankruptcies via a telephone call, an e-mail, or a fax.

Bankruptcy warning signs for contractors (indications that a provider is experiencing financial difficulty, and may file for bankruptcy):

1. Frequent unfiled or late-filed cost reports.
2. Failure to make timely payments on an extended repayment plan schedule.
3. Frequent changes of ownership.
4. Litigation
5. Voluntary or involuntary termination from the Medicare Program.
6. Provider has difficulty meeting payroll.
7. History of significant overpayment determinations.
8. Significant decline in Medicare and/or total patient census.

140.3.3 - Contractor Staff Will Establish a Relationship With the RO That has Jurisdiction Over the Bankruptcy

(Rev. 12, 10-18-02)

Contractors will proactively establish and maintain ongoing communications with the RO that has jurisdiction over a particular bankruptcy case. This is important because bankruptcy law may differ significantly from one jurisdiction to another, due to the structure of the federal court system.

In the federal system, a party may appeal lower level court decisions to a higher court, which has the power to affirm or reverse the lower court. In order of increasing rank and authority, the federal system is comprised of Bankruptcy Courts, District Courts, Courts of Appeals, and the Supreme Court. Each court in this list generally hears appeals from the court immediately preceding it. Although the Supreme Court has the final word, it hears a highly limited number of cases each year. This permits conflicts between lower court decisions to continue for many years until they are resolved by the Supreme Court.

As a result, absent a Supreme Court decision, the most authoritative precedents that may exist (and which may conflict with one another) are issued by the Courts of Appeals. There are 11 Courts of Appeals (known as Circuits) covering various States, plus a District of Columbia Circuit. The decision of each Court of Appeals is controlling within the States covered by that Circuit.

As discussed in greater detail below, CMS may want to take different actions in a bankruptcy case for different providers, including suspending payments, or recouping overpayments. In addition, CMS may have taken such actions before the provider filed for bankruptcy. Whether CMS can legally take or leave in place such actions may well depend on where the provider filed for bankruptcy, and the existing legal precedents within that Circuit.

For example, at the time of this writing there is conflict in the Circuits about whether CMS may recoup prepetition overpayments from postpetition payments without first obtaining relief from the automatic stay. The Third Circuit (covering Pennsylvania, New Jersey, Delaware and the Virgin Islands) forbids recoupment over different fiscal years without such relief. By contrast, the Ninth Circuit (Alaska, Arizona, California, Guam, Hawaii, Idaho, Nevada, Oregon and Washington) and the District of Columbia Circuit permit such recoupment. No other Court of Appeals has decided the issue. There are various District Court decisions going both ways.

There are also conflicting decisions by District Courts on whether CMS may continue to suspend payments due to suspected fraud when the provider files for bankruptcy.
For these reasons, the contractors should neither initiate nor discontinue significant action affecting payment without first contacting Regional Counsel.

140.3.4 - RO Jurisdiction Generally Parallels the Bankruptcy Court Where Case is Filed -

(Rev. 12, 10-18-02)

In most cases, the RO which has jurisdiction over a bankruptcy case is the one which has jurisdiction over the State in which the debtor files for bankruptcy (bankruptcy is filed in federal court). This RO will usually be the lead RO. The RO will contact the contractor.

The ROs will review each bankruptcy, even when no current overpayments exist, since the possibility of overpayment determinations remains until the FI settles all cost reports. Medicare is an unsecured creditor in bankruptcy, and is among the last creditors to receive a distribution of funds, unless it takes proactive steps to protect Medicare's interests.

140.3.5 - Contractor and Regional Office Bankruptcy Point of Contact Staff Member-

(Rev. 12, 10-18-02)

The contractors should contact their home RO to determine which RO will have responsibility for the bankruptcy case. The RO point of contact may be at the RO level or the Consortium level in keeping with Consortium agreements. The RO point of contact will consolidate information and manage, report, and coordinate ongoing communication and activities among the appropriate involved parties (e.g., contractors, other ROs, Chief Counsels, and Central Office) regarding bankruptcies. The RO will communicate the name, phone number, fax and e-mail address of the point of contact in writing or via e-mail to the Accounting Management Group, Regional Counsel, and the affected Associate Regional Administrators for Financial Management and respective contractors.

140.4 - Actions to Take When a Provider Files for Bankruptcy

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(Rev. 12, 10-18-02)

140.4.1 - Establish Effective Lines of Communications With

(Rev. 12, 10-18-02)

As soon as the contractor learns that a provider has filed for bankruptcy, it must immediately notify the following partners:

RO, Division of Financial Management Staff
Program Integrity Staff.

Obtain the name of individual(s) whom you should contact to obtain information quickly and to communicate information about the bankrupt Medicare provider.

140.4.2 - Respond to RO Requests for Information

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(Rev. 12, 10-18-02)

1. For Part A bankruptcies, provide overpayment information using the Part A Referral Checklist (see Attachment A).

Contractor staff must divide the overpayment information into prepetition and postpetition amounts.

The contractor will report the following overpayment information to the RO using the Referral Checklist as a reference when the contractor is seeking technical advice:

a. Provider Information:

1. Provider Number

2. Provider Name

3. Provider Address

4. Tax Identification Number (TIN)

b. Information about each overpayment:

1. Cost year end

2. Determination date

3. Original overpayment

4. Whether overpayment is based on a tentative or final settlement

5. Notice of Program Reimbursement containing overpayment determination

6. Amounts Recouped

7. CMS 750/751 Line 7 reports a total ending balance for region. The intermediary would need to provide specific information on specific bankrupt providers, which are reflected on Line 7.

8. The date of the CMS 750/751 report on which the receivable was reported

9. Overpayment type

c. Information to Estimate Potential Future Overpayments:

1. Cost Reports in-house pending settlement with expected completion date

2. Cost Reports pending submission with expected dates

3. Cost Reports, which are overdue, and total amount of payments made for those cost years

4. Interim Rate Information by Cost Year for Previous three years

5. Overpayment History by Cost Year for Previous three years

6. Medical Review Overpayments or Fraud and Abuse Overpayments or Investigations. You should also include these in the totals above.

NOTE: If the bankruptcy involves a provider with an audit and claims intermediary, (e.g., hospital with a provider-based home health agency or hospice), the RO will establish guidelines for obtaining information through the audit intermediary or establish direct communication with both intermediaries.

2. For Part B Bankruptcies, Carriers and/or DMERCs will provide overpayment information using the Referral Checklist (see Attachment A) as a reference when the contractor is seeking technical advice from the RO: Provider Information:

1. Provider Number

2. Provider Name

3. Provider Address

4. Tax Identification Number (TIN)

a. Overpayment Information:

1. Claim numbers related to the overpayment

2. Dates of service for related claims (check with Regional Counsel on the need for this)

3. Dates of payment for related claims (check with Regional Counsel on the need for this)

4. Determination date of original overpayment

5. Correspondence notifying provider of overpayment

6. Original overpayment

7. Amounts recouped

8. CMS 750/751 Line 7 reflects outstanding receivable balance totals for entire region (both principal and interest)-You must request specific outstanding balances from FI carried for specific providers

9. The date of the CMS 750/751 report on which the receivable was reported

10. Overpayment Type

11. Medical Review overpayments

12. Fraud and Abuse overpayments or investigations

3. Inform the RO of any underpayments owed to providers. Ascertain whether any prepetition or postpetition underpayments have been determined. Do not release such funds until you have received RO approval.

140.4.3 - Immediate Contractor Directives From the RO

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(Rev. 12, 10-18-02)

The RO will give the contractors the following guidance as soon as a provider files for bankruptcy.

1. The RO will notify the Contractor of Provider Bankruptcy/Litigation.

a. Bankruptcy Filed

RO will inform the contractor that the RO has opened a bankruptcy case. RO will inform the contractor that it should clear any future actions concerning the bankrupt provider(s) through the RO.

b. Bankruptcy Filing Date.

The RO will notify the contractor of the bankruptcy filing date, since it impacts on actions that the contractor can take and the evaluation of whether payments are prepetition or postpetition.

c. Immediate response to requests.

Since bankruptcy has court imposed deadlines, the contractor must take immediate action whenever the RO or Regional Counsel makes a request.

d. Obtain approval of all correspondence to provider.

The contractor must submit all correspondence addressed to the provider to the RO for approval prior to release. The RO will inform Part B Carriers/DMERCs that they should write a notification letter to replace the system generated demand letter.

e. Lead RO

If another RO has the lead on the bankruptcy, the RO will provide the contractor with a contact name and telephone number. The Regional Office that supervises the contractor may need to continue to assist the contractor in an advisory role.

2. The RO Will Notify Contractor of Immediate Actions It Must Take.

a. Interim Rate Adjustment.

After consultation with Regional Counsel, RO will direct the intermediary to immediately perform an interim rate adjustment to ensure that payments are accurate and that no future overpayments occur. (Medicare Intermediary Manual §2760.1(C.). 42 CFR §413.64(i).

b. Recoupment.

RO will inform the contractor (after discussion with Regional Counsel) whether it should continue or cease any current recovery action.

c. Administrative Freeze.

RO will inform the contractor (after discussion with Regional Counsel) whether or not it should place payments in administrative freeze.

3. Actions The Contractor Must Take on an Ongoing Basis.

a. Expedite Cost Report Settlement

RO will tell the FI to expedite the settlement of any open cost reports. RO will caution the FI not to perform any tentative settlements unless explicitly requested by the RO (in consultation with Regional Counsel) and not to issue any final settlements to the provider without first obtaining permission from the RO (in consultation with Regional Counsel).

b. Contractors should suspend payments if provider does not timely file cost report.

If the bankrupt provider fails to submit a timely, acceptable cost report, immediately notify the RO and Regional Counsel prior to placing the provider in 100% withhold and immediately notify the RO and Regional Counsel that you have done so. When the provider submits an acceptable cost report consult with the RO and the Regional Counsel prior to release of the withheld funds.

c. Part B - Tracking Overpayments and Refunds

The carrier or DMERC may need to track overpayments and voluntary refunds for a bankrupt provider. The RO will work with Regional Counsel to determine what information Regional Counsel needs. The contractor should be aware of the impact on beneficiary deductibles and coinsurance in a Part B bankruptcy.

d. Contractors should check with RO before making other payments to provider.

It is important that intermediaries, carriers, and DMERCs establish a process to ensure they do not make payments (e.g., underpayments, lump sum payments, or payments resulting from appeals) to bankrupt providers who have outstanding overpayments unless the RO (in consultation with Regional Counsel) so directs. This is especially critical for intermediaries who must continue to settle open cost reports.

4. Contractors Will Track and Report Information to RO.

a. Cost Report Settlements and Claims Processed

Contractor staff should notify the RO promptly of any and all proposed cost report settlements, changes in the amount of determined overpayments or underpayments, and claims processed.

b. Appeals

If a bankrupt provider files an appeal on an overpayment, contractor staff must keep RO staff informed on the outcome of the appeal. Appeals may take place at the contractor location, with an Administrative Law Judge, or at any Office of Hearings and Appeals, at the Provider Reimbursement Review Board, or at Federal District Court. If the appeal is favorable to the provider, it may require CMS to amend its proof of claim because the provider would have a smaller overpayment. Alternatively, in some cases, the RO may direct the contractor to freeze any outgoing funds. The contractor will keep the RO and Regional Counsel updated on the status of appeals.

5. Record-Keeping.

a. Interest

The RO will advise the contractor whether or not it should continue to calculate interest for overpayments. Medicare's ability to assess interest varies based on the circumstances of the case. RO will consult with the Regional Counsel before determining whether the contractor should make an adjustment. If the bankruptcy is in a district where interest should stop accruing on the petition filing date, the contractor must make an adjustment to remove the interest.

The contractor should post these adjustments to the contractors' internal systems, the Provider Overpayment Reporting System (PORS) and the Physician Supplier Overpayment Report (PSOR) within ten (10) days of notice of transaction. The PORS reflects interest assessed and the PSOR reflects interest collected. It should also post the adjustments to the CMS 750/751 reports.

b. PORS/PSOR Update

RO will instruct the contractor to update the PORS/PSOR with appropriate bankruptcy status codes.

c. Bankruptcy Case At Contractor's Location.

RO will inform the contractor that they may not refer bankruptcy cases to the Debt Collection Center for collection under the Debt Collection Improvement Act. If the contractor has already referred a case to DCC and no recovery action has begun, the RO will take steps to retrieve the case. The overpayment case will remain at the contractor location for financial reporting purposes until the case is ready for termination write-off, or until the RO advises the contractor otherwise.

140.4.4 - Tracking Debts/CO Communications

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(Rev. 12, 10-18-02)

Financial Reporting. While the lead RO is responsible for managing the bankruptcy case, all bankruptcy debt will remain at the contractor location for financial reporting purposes on the CMS 750/751 report. RO staff must work with contractor staff to ensure proper reporting on CMS 751 reports throughout the bankruptcy.

140.5 - Chain Bankruptcies

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(Rev. 12, 10-18-02)

140.5.1 - Chain Providers

(Rev. 12, 10-18-02)

A chain provider is one that is owned by the same entity that owns another provider or providers. Chain affiliates may include facilities that are public, private, charitable, or proprietary. They may also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based clinics, are not chain affiliates (MFMM § 2760.1).

As set forth in §140.3.4, the lead RO for a bankruptcy is generally the office with jurisdiction over the state in which the provider files for bankruptcy. Nevertheless, Central Office staff may assign a chain bankruptcy to a specific region, or the Regional Counsel may request that a specific RO take the lead in a specific chain bankruptcy.

When a chain files bankruptcy, there may be multiple contractors involved in processing payments for the chain. If the bankruptcy involves other ROs and their contractors, the lead RO will work directly with the contractors, after informing their home RO(s) that they will be communicating directly with their contractor on the bankruptcy case. The lead RO and Regional Counsel are responsible for making all decisions. However, the lead RO should keep the contractor's home RO informed about its contractor's workload in connection with the bankruptcy.

140.5.2 - Single Providers Serviced by a National Contractor

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(Rev. 12, 10-18-02)

When a single provider who is serviced by a national contractor files for bankruptcy, the same principle for processing a bankruptcy of a chain provider will apply. The location where the bankruptcy is filed will determine

the lead RO. The lead RO will work directly with the national contractor staff on the bankruptcy case. The lead RO will keep the home RO of the national contractor informed in all issues related to the case (e.g., a provider within the jurisdiction of the San Francisco RO files for bankruptcy and their contractor is Mutual of Omaha). The San Francisco RO will assume lead responsibilities and will keep the Kansas City RO informed of all issues related to this case.

140.6 - Affirmative Recovery Actions

(Rev. 12, 10-18-02)

140.6.1 - Working With the RO and Regional Counsel's Office

(Rev. 12, 10-18-02)

The contractor will notify the RO/Regional Counsel's office immediately after it receives information that a provider has filed for bankruptcy. It is essential that you obtain information on all Part A, Part B, or DME entities involved in the bankruptcy, including Medicare identifying information, such as provider and supplier numbers. If the contractor has difficulty obtaining this information, it will consult with the RO/Regional Counsel. After gathering the information described in §140.4.2 , it will send it to the RO.

The contractor will discuss with RO/Regional Counsel whether it should put payments in administrative freeze (a holding account) until Medicare has time to assess its position in the bankruptcy. Also, during initial discussions with Regional Counsel, the RO will determine when the proof of claim is due and whether the Regional Counsel or the RO will need additional information to prepare the proof of claim. The contractor shall share all new information regarding the provider's overpayments and underpayments, cost report settlements, etc. with RO/Regional Counsel. The contractor will not take any further steps without obtaining the advice of RO/Regional Counsel. For example, the contractor should not send any overpayment letters to the debtor without RO/Regional Counsel approval. In addition, the contractor should not initiate new withholding or discontinue withholding without RO/Regional Counsel approval.

As the bankruptcy progresses, the Regional Counsel may ask the contractor to expedite settlement of cost reports, update the Regional Counsel on provider overpayments or underpayments, and provide Counsel with assistance on all aspects of the bankruptcy. As bankruptcy cases often have short deadlines for filing pleadings and other documents, requests from RO/Regional Counsel must have the highest priority in the workload, in order to protect Trust Fund assets.

140.6.2 - Assumption of the Medicare Provider Agreement

(Rev. 12, 10-18-02)

The Medicare Part A Provider Agreement is considered an executory contract for purposes of bankruptcy. Bankruptcy law permits a debtor to affirm ("assume") or reject each of its executory contracts. The debtor must first get the formal approval of the bankruptcy court.
If the debtor formally assumes the Medicare provider agreement, and the Bankruptcy Court approves that assumption, the relationship between the provider and Medicare will generally return to the ordinary course of business. The RO will inform the contractor if the provider assumes the Provider Agreement.

If the debtor rejects the Provider Agreement, the rejection is a voluntary termination of the Provider Agreement. The RO will inform the contractor if the provider terminates its provider agreement in this way. The contractor should not reimburse the provider for services it performs after the date it rejects/terminates the Provider Agreement.
If the bankrupt provider sells a facility to another entity and that entity assumes the debtor's provider agreement, any outstanding Medicare underpayments or overpayments regarding that facility should be transferred to the new owner (the purchaser) when the new owner assumes the provider agreement. Although the debtor and the new owner may have a private agreement regarding who is responsible for refunding Medicare overpayments and who should receive any Medicare underpayments, CMS is not bound by such agreements.

The contractor shall calculate net amounts that may be due to or owing from the debtor.

140.6.3 - Settlement Agreements or Stipulations

(Rev. 12, 10-18-02)

During the course of a bankruptcy, the RO and the Regional Counsel, working with DOJ, may negotiate a settlement agreement or stipulation with the debtor's attorney. Once a settlement agreement or stipulation goes into effect, the RO will advise all affected contractors, ROs, and the Office of Financial Management, CO. The contractors will consult with the lead RO to ensure that they conform to the conditions established in the settlement agreement or stipulation.

140.6.4 - Recoupment

(Rev. 12, 10-18-02)

Generally, bankruptcy law prohibits recovery of prepetition debt (debt arising prior to the filing of the bankruptcy petition) from postpetition payments. However, Medicare Part A payments require adjustments of ongoing payments to a provider to account for overpayments previously made to that provider. 42 U.S.C. §1395g(a); §1395x(v)(1)(A). Most courts recognize this method of adjusting payments as recoupment, which is permitted in bankruptcy, and is not subject to the automatic stay. Alternatively, they recognize that bankruptcy law does not alter the adjustment of payments that the Medicare statute requires. Thus, in most jurisdictions recoupment is appropriate. Nevertheless, the contractor should always consult RO/Regional Counsel's office about the adjustment (or recoupment) of any payments to a bankrupt provider before you take, omit, continue or discontinue any action. (See also, discussion of Recoupment in §140.2.5).

Some courts do not agree that Medicare can recoup overpayments (without first obtaining relief from the automatic stay), unless the provider incurred the overpayments in the current fiscal year. For instance, in bankruptcy cases filed in Pennsylvania, New Jersey, Delaware and the Virgin Islands, Medicare cannot recoup overpayments across fiscal years unless the debtor assumes the Medicare provider agreement or Regional Counsel obtains permission from the court. RO/Regional Counsel will advise the contractor whether it can recoup overpayments in these jurisdictions. Again, the contractor must consult RO/Regional Counsel before adjusting or recouping payments to a bankrupt provider.

140.6.5 - Administrative Freeze/Set-off - (Rev. 12, 10-18-02)

Medicare can ask the court's permission to set-off prepetition debts against prepetition payments (payments for prepetition services, even if made postpetition) and postpetition debts against postpetition payments (payments for postpetition services). Regional Counsel, through DOJ will file a motion requesting permission to set-off.

Bankruptcy law allows a creditor like Medicare to freeze payments if it thinks it has the right to set-off those payments. Generally, in the Part A context, the first 2-3 weeks of Medicare payments after a debtor files for bankruptcy result from prepetition services. Therefore, the RO and Regional Counsel might decide to freeze all payments for prepetition services and then request bankruptcy court permission to set-off those payments against prepetition overpayments. Because there is such a short period during which there might be prepetition payments available to set-off available to freeze for set-off, it is critical to find out about the bankruptcy and the provider's overpayments quickly.

Other prepetition payments, such as underpayments or payments delayed because of medical review may be available to set-off against prepetition overpayments. It is important to notify the RO and Regional Counsel of any such underpayments or delayed payments.

Finally, because the U.S. Government is considered one creditor in bankruptcy, a contractor may be asked to freeze prepetition payments to recover the debts owed by the provider to other government agencies. However, we must use prepetition payments to recover Medicare overpayments before applying them to debts owed to other agencies.

140.7 - Preparing and Filing Proof of Claim

(Rev. 12, 10-18-02)

We provide a working definition of the term "claim" in §140.2.7. The proof of claim form alerts the court to the existence of Medicare's claim. While exceptions exist, the general rule of thumb is that in order to share in the bankruptcy estate Medicare must file a proof of claim. Regional Counsel will file the proof of claim. It is critical that contractors produce accurate and detailed overpayment data to the RO and Regional Counsel when requested so that Regional Counsel can file a timely proof of claim.

In Chapter 7 and Chapter 13 bankruptcies, the deadline ("bar date") for the Government to file a proof of claim is 180 days after the bankruptcy court's order granting relief from creditors (usually the date the provider files for bankruptcy). The bankruptcy court establishes the bar date by court order in Chapter 9 and Chapter 11 bankruptcies. In order to meet the bar date the Government must:

1. Get notice of the bankruptcy;
2. Direct that notice to the appropriate agency and appropriate personnel;
3. Determine exactly how many payment agreements the entity in bankruptcy has with Medicare (i.e., do they owe Medicare and if so how much);
4. Determine the status of each payment agreement
5. Prepare the proof of claim form;
6. Get Regional Counsel approval;
7. Sign it; and

8. File it in the bankruptcy court.

Because the time to finalize a proof of claim can be short, contractors should update overpayment information on an ongoing basis.

140.8 - Closure of Bankruptcy Cases and Treatment Of Overpayment Reporting Systems at End of Bankruptcy

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(Rev. 12, 10-18-02)

140.8.1 - Closing the Bankruptcy Case

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(Rev. 12, 10-18-02)

After a bankruptcy case is fully administered and the bankruptcy court has discharged the trustee (if there was one), the bankruptcy court closes the case. RO/Regional Counsel will provide guidance to the contractor regarding any required further actions.

Once the debtor has emerged from bankruptcy it resumes business as usual. A Chapter 11 bankruptcy ordinarily ends with the debtor emerging from Chapter 11 with a confirmed plan of reorganization. The ordinary course of business typically begins on the "effective date" of the plan of reorganization. In the case of a Chapter 7, the bankruptcy typically ends when the Trustee has dissolved the corporation, shut down operations, and distributed assets to pay creditors. RO/Regional Counsel will provide specific guidance to the contractor.

When a bankruptcy case closes, whether a Chapter 7, a Chapter 11, or a proceeding under some other chapter of the bankruptcy code, the contractor must modify its financial records to reflect the outcome of the bankruptcy. In general, amounts that bankruptcy law does not require the provider to repay are considered "discharged," and Medicare must release the provider from liability for the debt.

All of the contractor's debt information, including the POR, PSOR, CMS-750, CMS-751, and Schedule 9 of contractor's financial statement, must incorporate the bankruptcy outcome by writing off or adjusting the amounts owed in accordance with applicable bankruptcy orders. This frequently will require you to remove line items and include new line items on affected reports. You must maintain detailed support for all revisions, as well as for any extended repayment arrangements. Detailed documentation related to principal, interest charges and immediate payments and extended repayment plans without interest are especially important in global settlement adjustments which are common in chain bankruptcy situations. These amounts may need to be modified based on the global settlement. In global settlements which may cut across providers in a chain, existing amounts may be removed from the provider listing and the new amount(s) substituted in accordance with the bankruptcy documents. This will require close coordination among the Regional Counsel, the RO, CO and affected contractor staff. Coordination and immediate action is especially important if you discover that a bankruptcy discharge for a provider has occurred in a previously unknown bankruptcy proceeding.

Occasionally, the court dismisses a bankruptcy because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of Regional Counsel, the RO and contractor can usually treat the case as if the bankruptcy had never occurred and continue the normal recovery process, which might include an "intent to refer" letter and subsequent transfer to the Debt Collection Center. Contractors and ROs must

ensure that their internal processing systems and financial reports no longer reflect the case as one under bankruptcy, and interest should be reassessed.

Always contact the RO/Regional Counsel for guidance on the closure of a bankruptcy. There is no formula for closing a bankruptcy, as it all depends upon the nature of the proceedings and the court orders in the case. The closure could be preceded by a successful reorganization under Chapter 11, a conversion to Chapter 7, or the result of a settlement agreement or stipulation. In all cases, obtain approval from the RO/Regional Counsel before closing the bankruptcy.

140.8.2 - Debt Located at the Debt Collection Center or Department of the Treasury

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(Rev. 12, 10-18-02)

If a debt is at the Debt Collection Center (DCC) and the provider files for bankruptcy, the certifier of the debt (contractor or RO) must immediately notify the Central Office Division of Financial Reporting and Debt Referral (DFRDR). The certifier must request that Central Office recall this debt from DCC as debts in bankruptcy status are ineligible for crossservicing and offset.

NOTE: Debts for unfiled cost reports are not reported on the H751 and/or R751, therefore, if these debts become "bankrupt," you will record no transaction on these forms.

If the debt is active (less than two years old), the DFRDR, Central Office will recall the debt, update the POR/PSOR to reflect a bankruptcy status, and change the location back to the contractor location. DCB will send an email or fax of the location change to the RO.

If the DCC or Department of Treasury receives the initial notification of a bankruptcy filing while servicing a debt, they will notify CMS Central Office, who, in turn, will notify the RO of the bankruptcy.

140.8.3 - Managing Bankruptcy Debt at the Contractor Location

(Rev. 12, 10-18-02)

All bankruptcy debts will remain at the contractor location throughout the life of the debt. The lead RO will assume full ownership and the responsibility for managing the debt at the respective contractor site. The contractor, will help the RO establish communication procedures and will ensure that contractor staff follow them.

When chain providers are involved, the lead RO will contact the appropriate contractor and RO staff and establish dialogue procedures that will provide timely and accurate transfer of required information.

The lead RO is responsible for management of the debt from the initial filing of the Proof of Claim until the closure of the Bankruptcy. The Associate Regional Administrator for the Division of Financial Management will have the authority to terminate collection activity for cases that meet the criteria for being written off at the Associate Regional Administrator level.

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view PDF files, you must have the Adobe Acrobat Reader (minimum version 4, version 5 suggested). You can check here to see if you have the Acrobat Reader installed on your computer. If you do not already have the Acrobat Reader installed, please go to Adobe's Acrobat download page now.

150- ACCELERATED PAYMENTS- FI ONLY

(Rev. 29, 01-02-04)

An accelerated payment may be issued where there is:

- A delay in payment by the FI for covered services rendered to beneficiaries and this delay has caused financial difficulties for the provider,

- In highly exceptional situations where a provider has incurred a temporary delay in its bill processing beyond the provider's normal billing cycle, or

- In highly exceptional situations where CMS deems an accelerated payment is appropriate.

A request for an accelerated payment shall not be approved unless the provider meets all eligibility requirements, including an assurance that recoupment of the payment will be made on a timely basis. The amount of the accelerated payment is computed as a percentage (sufficient to alleviate the impaired cash position but in no case to exceed 70 percent) of the amount of net reimbursement represented by unbilled discharges or unpaid bills applicable to covered services rendered to beneficiaries.

Accelerated payments shall be approved by the FI and the appropriate CMS Regional Office. The CMS regional office will review each request for an accelerated payment to assure that the accelerated payment provisions are being correctly and consistently applied and to provide the Administration with timely information concerning provider and FI bill processing.

150.1 - Eligibility for Accelerated Payment

(Rev. 29, 01-02-04)

Provider eligibility for accelerated payments is contingent on the provider meeting all of the following conditions;

- A shortage of cash exists whereby the provider cannot meet current financial obligations; and

- The impaired cash position described in "A" is due to abnormal delays in claims processing and/or payment by the FI. However, request for accelerated payments based on isolated temporary provider billing delays may also be approved where the delay is for a period of time beyond the provider's normal billing cycle. In this instance, the provider must assure and demonstrate that the causes of its billing delays are being corrected and are not chronic; and

- The provider's impaired cash position would not be alleviated by receipts anticipated within 30 days which would enable the provider to meet current financial obligations; and

- The basis for financial difficulty is due to a lag in Medicare billing and/or payments and not to other third-party payers or private patients; and

- The FI is assured that recovery of the payment can be accomplished according to the instructions in §150.4.

NOTE: Each FI is cautioned that neither the revision of the current financing regulations nor the recovery of current financing payments is a basis for justifying a provider's request for an accelerated payment.

150.2- Computation of the Accelerated Payment

(Rev. 29, 01-02-04)
To compute the accelerated payment on account:

1. Determine the amount of the interim reimbursement for unbilled and unpaid claims;

2. Subtract the deductibles and coinsurance amounts, and

3. Multiply by 70% to determine the net reimbursable amount which can be paid to the provider.

150.3- The Accelerated Payment and the Provider Overpayment Reporting (POR) System

(Rev. 29, 01-02-04)
The FI has ten calendar days from the date the accelerated payment is issued to enter a record in the POR System. The POR System shall contain the following information:

Overpayment type of "D"
Status code of "CA"
Date of determination should be the date of payment

At the time of the payment, a payment withhold should be entered into the FI's internal processing system for the amount of the accelerated payment.

If the accelerated payment is not paid in full within the 90-day period and demand letters are sent, the FI shall update the status code to reflect the action that is occurring on the debt.[intent to refer letter, referral to Treasury]

150.4- Recoupment of the Accelerated Payment

(Rev. 29, 01-02-04)

The FI must attempt to recover any accelerated payment within 90 days after it is issued. To the extent that a delay in the provider's billing process is the basis for the accelerated payment, recoupment is made by a 100 percent withhold against the provider's bills processed by the FI or other monies due the provider after the date of issuance of the accelerated payment. Any remainder is recovered by direct payment by the provider not later than 90 days after issuance of the accelerated payment.

If the payment is necessitated by abnormal delays in claims processing and/or payment by the FI, recovery by recoupment will be reasonably scheduled to coincide with improvement in the FI's bill processing situation and

such recoupment will not impair the provider's cash position. In this situation, recoupment shall be completed within 90 days of the FI processing the provider's claims.

If recovery is not complete 90 days after the accelerated payment is issued or 90 days after the FI begins processing claims, the accelerated payment is considered delinquent. The FI shall immediately send out a demand letter stating that 100 percent recoupment by withhold of all payments is in effect and that the recoupment will remain so until the debt is paid in full or acceptable payment arrangements are made. FIs shall include the "Intent to Refer" language required to refer the debt to the Treasury Department. (See CR 1683 or Chapter 4, §70) Interest shall begin to accrue on the 31st day after the date of the demand letter at the prevailing rate set by the Treasury Department. If the FI does not hear from the provider within 15 days from the date of the demand letter, the FI shall attempt to contact the provider by telephone. If the demand letter is returned undeliverable the FI shall attempt to locate the provider using some of the guidelines set forth in Chapter 4, §10. If the FI does not hear from the provider within 60 days of the date of the demand letter, the FI shall input the debt into the Debt Collection System for referral to the Treasury Department for additional collection activity.

EXHIBIT 1

SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCLERATED PAYMENT

1. Provider:_____ Provider Number:_____

Address:_____
_____

2. FI: _____

3. Check (a) or (b) if applicable:

Cash balance is seriously impaired due to:

(a) Abnormal delay in Title XVIII claims processing and/or payment by the health insurance FI.

(b) Delay in provider billing process of an isolated temporary nature beyond the provider's normal billing cycle and not attributable to other third party payers or private patients.

Note: If 3b is checked the provider should also include a narrative explaining the nature of the problem, how it will be fixed, and the expected duration of the delay.

4. a. General fund cash position for provider as of _____ $_____

b. Anticipated receipts from all sources (exclusive of accelerated payments) in the next 30 days $_____

c. Anticipated expenditures in next 30 days $_____

d. Indicated cash position in next 30 days (a + b – c) $ ____

160- Termination of Collection Action

(Rev. 29, 01-02-04)

The FI or Carrier cannot terminate collection action and write off closed any debt. In addition, an FI or Carrier internal system or claims processing system cannot automatically abandon or write off debt. The decision to terminate collection action and write off closed any debt must be approved by CMS RO or CO.

Note: The under tolerance instructions detailed in CR 2292 are an exception to the termination of collection action instructions above.

160.1- Termination of Collection Action – Provider Overpayments

(Rev. 29, 01-02-04)

Under normal circumstances if the FI or Carrier is unable to collect an overpayment, the overpayment will be referred to the Department of Treasury for additional collection efforts. However, if the principal balance of the overpayment is less than $25.00 the overpayment is not eligible for referral to the Department of Treasury.

Therefore, once an overpayment with a principal balance less than $25.00 becomes 180 days old (from the date of the first demand letter), the overpayment should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a quarterly basis. These requests should be sent by hard copy no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- Provider/Physician number
- Current principal amount of overpayment
- Current interest amount of overpayment
- Original amount of overpayment
- Other outstanding overpayments
- Cost Report Year (Part A) or Claim Paid Date (Part B)
- Determination Date
- Overpayment Type

The above list is the minimum amount of information that must be sent to the servicing regional office. The servicing regional office may request additional information. Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed by the first day of the last month of each quarter (i.e., December 1, March 1, June 1, and September 1). Once approval is received appropriate steps should be taken to close the overpayment on the POR/PSOR System, the internal accounting system, and report it correctly on all necessary financial reports.

160.2- Termination of Collection Action – Beneficiary Overpayments

(Rev. 29, 01-02-04)

A demand letter is not sent for beneficiary overpayments less than $50. Therefore, no recovery action should take place on these overpayments. Beneficiary overpayments less than $50 should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a monthly basis. The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- Beneficiary HIC number
- Current principal amount of overpayment
- Other outstanding overpayments
- Claim Paid Date (Part B)
- Determination Date

Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed. Once approval is received appropriate steps should be taken to close the overpayment on the internal accounting system and report it correctly on all necessary financial reports.

Note: Carriers utilizing the VMS System automatically abandon beneficiary overpayments less than $50. This instruction does not apply to these carriers until such time that standard system changes can be made to stop the abandonment.

170 – General Overpayment Provisions

(Rev. 29, 01-02-04)

The general overpayment provisions mentioned in this section are important to the overpayment collection process but could not be categorized into another section. Some of these provisions require input from other manual instructions and are only briefly mentioned in this manual. When necessary, another manual reference has been cited for additional information.

170.1 - Offset of Overpayments Against Other Benefits Due – FI

(Rev. 29, 01-02-04)

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.)

170.2 - When the Carrier Does Not Attempt Recovery Action

(Rev. 29, 01-02-04)

The Carrier shall not attempt recovery action on individual overpayments if:
A - Total Overpayment Less Than $10

The cost of recovering such a small amount ordinarily exceeds the amount recovered. However, the Carrier shall accept unsolicited overpayment refunds regardless of the amount. See §160.1 for termination of collection action procedures.

B - The 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 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 for Medically Unnecessary Services or Custodial Care Where Waiver of Liability Applies

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

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

(Rev. 29, 01-02-04)

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 or carrier. However, the FI or carrier shall not ask the SSO to collect, or indirectly aid in, the collection of an overpayment.

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

(Rev. 29, 01-02-04)

Where a physician or other individual practitioner who is liable for an overpayment dies, the overpayment should be withheld from other Medicare payments due their estate. If recovery is not possible by recoupment, 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 for possible litigation. 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.

170.5 -Provider Offers to Settle on Compromise Basis

(Rev. 29, 01-02-04)

An overpaid provider may offer to compromise an overpayment. The FI/Carrier shall forward compromise offers to the RO only when further collection efforts would be unproductive and would not benefit the Medicare Program.

170.6 - Unsolicited Overpayment Refunds

(Rev. 29, 01-02-04)

When a provider believes that an overpayment has been received and makes an unsolicited refund, the FI/Carrier accepts it regardless of the amount. All documentation submitted with the unsolicited refund should be forwarded to the correct department. (See Program Integrity Manual, Ch. 3, § 8.4 for unsolicited refunds related to an outstanding fraud investigation.)

170.7 - Timely Deposit of Overpayment Refund Checks

(Rev. 29, 01-02-04)

Promptly deposit all refund checks into the Medicare "Federal Health Insurance Benefits Account". The FI/Carrier shall credit all such deposits on the day following the date of receipt in its mailroom or initial point of entry. (It shall credit within 2 days if the bank is not located in the same city as the contractor.). (See Ch.5, §100.3)

170.8 – Informal Referral to RO

(Rev. 29, 01-02-04)

For Medicare overpayment purposes a referral is a request to the Regional Office for assistance in an overpayment. This may be for a waiver determination, a termination request, a request for technical assistance, a referral to the Department of Justice, or any other aspect of the debt collection process. The referral may be in the form of an email, phone, fax, or written correspondence. Any referral to the RO should occur before the debt is eligible to be referred to the Department of Treasury. If changes occur to the debt during the referral process, the FI/Carrier should immediately notify the RO.
Attachment A, located after the bankruptcy section, includes a referral checklist that FI/Carrier's should utilize if necessary.

180 - Exhibits

(Rev. 22, 10-03-03)

180.1 - Exhibit 1 - Provider Overpayment Reporting System

(Rev. 22, 10-03-03)

The reporting of outstanding provider overpayments is required to determine providers receiving overpayments, the amounts, and the length of time they are outstanding. To report these overpayments, use the electronic on-line Provider Overpayment Reporting System (POR). This system serves as a uniform method for reporting overpayment data and as a base for CMS to use in compiling management information on overpayments.

Create and maintain, on an ongoing basis, your own internal accounting system with appropriate controls to enable you to implement effectively and timely the overpayment collection procedures. The POR is not designed for, nor is it intended to be a substitute for the internal accounting and control system.

The POR is an on-line data entry/data capture mechanism. On entry, data is edited thoroughly. After editing, the POR master file is updated.

Where a provider changes its intermediary, the outgoing intermediary is responsible for reporting in the POR all overpayments incurred by that provider while it serviced the provider. The outgoing intermediary is also responsible for the updating of the POR of all recovery activity on any overpayment incurred while it serviced the provider, even if the incoming intermediary processed the recoupment unless the debt is transferred and accepted by the incoming intermediary. The responsibilities of the outgoing and incoming intermediaries are in the Financial Management Manual (FMM) Chapter 3, §80.

Note: Once a record has been established on the POR System the following fields cannot be corrected: Provider Number, Cost Report Date, Determination Date, and Overpayment Type. If any of these fields are incorrect, the user must delete the entire record and re-enter the overpayment with the correct information.

Note: Once an overpayment record is closed the detailed master screen is no longer available once the quarter ends. Since reopenings and questions often occur, CMS recommends to contractors that a copy of the POR screens be printed and placed in the case file when making any changes or recoupments to an overpayment record.

180.1.1 - Provider Overpayment Report System--Data Entry

(Rev. 22, 10-03-03)

Overpayments and data pertaining to them must be entered into the POR, no later than 10 calendar days after the date the overpayment was determined or information affecting it was received. The only exception to this is unfiled cost reports and as filed cost report overpayments, which must be entered into the POR no later than 17 calendar days after the date the cost report was due. For an as filed cost report that is submitted untimely, the overpayment must be entered into the POR no later than 10 calendar days after the determination date.

This includes initial entries onto the POR, payments, adjustments, interest entries, status code changes, termination and closures.

Detailed instructions for entering data into the POR are in the USER MANUAL (180.1.3).

180.1.2 - Provider Overpayment Report Printout

(Rev. 22, 10-03-03)

The RO will furnish you one copy of the POR printout, when it is prepared at the end of the specific reporting period. Medicare contractors will only receive information for their providers. This copy of the printout is for INFORMATION PURPOSES ONLY. The printout gives you the status of all overpayments that had been entered into the POR as of the date of the printout.

180.1.3 - POR System User Manual

(Rev. 47, 06-25-04)

SIGNING ONTO THE POR SYSTEM

This User Manual begins upon entry into the CMS Data Center. The following instructions for access onto the system are very brief. Any questions concerning access should be directed to your servicing regional office for assistance.

1. Upon entering the CMS Data Center press enter. You will then be taken to an Application Menu.
2. At the Application Menu enter #3 for the CICS41 System.
3. You will then be prompted to enter your Userid and Password. If you do not have a UserId or Password contact your servicing regional office to obtain instructions for access.
4. After entering your userid and password you will be required to choose the system you wish to enter.
5. Choose #1 for Provider Overpayment Recovery; Then hit Enter.
6. You should now be at the Request Screen.
7. **A new Business Segment Identifier (BSI) field has been added to the POR Master Screen.**

THE REQUEST SCREEN

Below is an example of what the request screen will look like upon entering into the POR System. Following the example, detailed instructions are given as to what to input in each field.

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - REQUEST SCREEN

REGION # xx INTERMEDIARY # xxxxx *BSI xxxx*

PROVIDER # xxxxxx PROV TYPE xx

COST REPORT DATE MMDDYYYY DETERMINATION DATE MMDDYYYY O/P TYPE x

FUNCTION: I = ADD NEW OVERPAYMENT RECORD

U = UPDATE AN EXISTING OVERPAYMENT RECORD

B = BROWSE OVERPAYMENT TRANSACTIONS

PRESS F3 TO END SESSION...
PRESS ENTER KEY TO CONTINUE

A. Positioning of the Cursor

Where the cursor is initially positioned when this screen is displayed depends upon the level of security found in the system security table for the User-identification code entered.

1. CMS Central Office Personnel - Security Level One (1)

The cursor is positioned at the Region Number field. There will be a default Region Number, Region Name, Intermediary Number and Intermediary Name placed in the appropriate fields by the security program. CMS Central Office personnel can key in all characters of the record key, starting with the default region number field if they wish.

2. Regional Office Personnel - Security Level Two (2)

For this level of security, the cursor is positioned at the Intermediary Number field. There will be a default Intermediary Number and Name displayed. The Region Number and Name fields, however, will be filled in with the appropriate values and are locked to the User. The Regional Office personnel may key in any valid intermediary WITHIN their region and then continue with the rest of the key fields.

3. Intermediary Personnel - Security Level Three (3)

For this level of security, the cursor is positioned at the Provider Number field. The Region Number, Region Name, Intermediary Number and Intermediary Name fields are filled in with the appropriate data and are locked to the User. The Intermediary personnel may key in any valid provider number WITHIN their area of responsibility and then continue with the rest of the key fields.

B. The following are field by field instructions for the Request Screen.

1. REGION NUMBER

Again, only CMS CO personnel can key in this field. If it is keyed, the value MUST BE 01 through 10. The Region Name is supplied to the screen by the System Tables File.

2. INTERMEDIARY NUMBER

Only CO and RO personnel may key in the five position numeric field. If it is keyed, it must be numeric, it must be a valid Intermediary Number and it must be valid for the Region Number associated with it on this screen. The Intermediary Name is supplied from the System Tables File.

Intermediaries are required to input the new Business Segment Identifer (BSI) effective October 1, 2004, for all new provider overpayments that are entered on the POR system. This BSI will e a four alpha field. Once the BSI has been input, then it will appear automatically on the POR Master Screen. (See CR 3023 for a complete list of the intermediaries' BSI.)

3. PROVIDER NUMBER

The Provider Number field must be keyed by all Users, must be numeric and must be contained on a Provider Extract File which was created especially for the PORS system. Additionally, when the Provider Extract File is checked for validity, the "servicing intermediary number" contained in that record is compared to the intermediary number on the screen. If they do not match, a security violation has occurred and the User is notified of that fact on the screen.

Note: The current six-digit provider number provides useful information to CMS. The first two digits identify the state in which the provider is located. The last four digits identify the type of facility. For a detailed listing see §2779 in the State Operations Manual.

4. PROVIDER TYPE

This two position numeric field is a key field. It must be entered, must be numeric and must be one of the following:

10 = Primary Hospital Number
20 = Psychiatric Unit S
30 = Hospital Rehabilitation Unit T
40 = Swing Bed U
50 = Alcohol/Drug Unit V
60 = Organ Procurement
70 = HIST Laboratory

If the third digit of the Provider Number is not = to zero (i.e., the provider is not a general hospital), the Provider Type field MUST BE A l0.

If the provider is a general hospital (i.e., the third digit of the provider number is equal to zero) the provider may have an overpayment determined for the primary facility (Provider Type = l0) or any of the six sub units described above (Provider Type = 20, 30, 40, 50, 60 or 70).

For the sub units above, the third position of the provider number has been replaced with the letters S, T, U, or V. These are shown above next to their corresponding Provider Types.

For purposes of the PORS system, an overpayment determined for one of the general hospital sub units described above, will be entered into the system using the provider's primary provider number (i.e., zero in the third position) and the applicable Provider Type (20, 30, 40, or 50). If the overpayment is for the primary facility, a Provider Type of l0 will be used.

Examples

a. If an overpayment has been determined for a hospital rehabilitation unit with a provider number of 05T0l2. This would be entered as:

0500l2 = Provider Number
30 = Provider Type

b. An overpayment has been determined for a general hospital with a provider number of 0500l2. This would be entered as:

0500l2 = Provider Number
l0 = Provider Type

5. COST REPORT DATE

This eight position numeric date is part of the overpayment record key and must be entered in the format of MMDDYYYY.
The Cost Report Date can never be later than the Recoupment Initiated Date, Recoupment Completed Date or Closed Date.

EXCEPT
If the overpayment type is equal to "D" or "J." In this case, the Cost Report Date may be later than any or all of the above dates.

6. DETERMINATION DATE

This eight position numeric date is also part of the record key and must be entered in the MMDDYYYY format. As explained in 5. above, the Determination Date may be equal to or later than the Cost Report Date but it never can be later than the Recoupment Initiated, Recoupment Completed or Closed Dates.

7. OVERPAYMENT TYPE (O/P TYPE)

The Overpayment Type is a one (1) position alphabetic field which must be entered since it is part of the record key. The values for this field, which are maintained in the System's Table File, are:
A = Audited Cost Report
B = Desk Review (Tentative Settlement)
C = Current Financing
D = Accelerated Payment
E = Cost Report Overpayment
F = Cost Report Reopening
G =Desk Review (Final Settlement)
H = Technically Recoverable Amounts - Unfiled Cost Reports
I = Others - Not Included Above
J = Interim Rate Adjustment
K = Hospice
L = Currently Not in Use
M = Unfiled Cost Report- Balance Recouped
X = Interest

8. FUNCTION CODE

This is a one position alphabetic code field which allows the User to select which system function is to be performed. It must be present and must be I, U or B.

I = Add a new overpayment record
U = Update an existing overpayment record or INQUIRE only
B = Browse the Online Transactions File

C. General information about the PORS Request Screen.

1. Explanation of the inter-relationship between the Function Code field and the Record Key fields

If the Function Code is "I" or "U", the entire 28 position key must be present and correct.

If the Function Code is "B" any number of key fields may be requested (after the Region Number). This is referred to as a 'generic key' and is usually executed to display related groups of data.

There are two points to remember about the "generic keys". One, you will still have your security defaults in the fields and two, the requested key (from major field to minor) must be contiguous - No Blanks.

2. If the Function Code of "I" or "U" was keyed in, the Provider Overpayment Reporting System Master Screen will be displayed - after the enter key is TAPPED.

3. If the Function Code of "B" was keyed in, the Provider Overpayment Reporting System Transaction History Screen will be displayed - after the enter key is TAPPED.

4. Fields 10 through 14 will contain all underlines initially but will contain the actual dollar values after that information has been supplied to the system.

ADD/UPDATE MASTER SCREEN

Below is an example of what the Add/Update Screen looks like in the Provider Overpayment Reporting System. Following this example are detailed instructions for entering the appropriate data into each section.

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - MASTER SCREEN UPDATE

REGION # xx INTERMEDIARY # xxxxx *BSI # xxxx*

PROVIDER # xxxxxx PROV TYPE xx PROV NAME xxxxxxxxxxxxxxxxxxxxxxxxxx

COST RPT DTE xxxxxxxx DETERM DTE xxxxxxxx O/P TYPE x O/P $ xxxxxxxx

RECOUPED T/D	OPEN BAL	RECOUPED T/Q	ADJUST T/Q	END BAL
$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx
01 CAUSES x $ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx

(F7=ROLL)

INTERMED CHANGE(Y/N) x OWNER CHANGE OWNER TYPE x ORG CHAIN(Y/N) x
TERMINATED(Y/N) x PIP(Y/N) x HHA/PPS x PPS DATE xxxxxxxx NUMBER BEDS xxxx

INIT RECOUP DATE xxxxxxxx COMP RECOUP DATE xxxxxxxx METH xx TOT REIM xxxxxxxxx

STATUS CODE xx LOCATION xxx STATUTE DATE xxxxxxxx CLOSED DATE xxxxxxxx
CNC DATE xxxxxxxx STATUS CHG DATE .....
TRANSACTIONS .. $ .... $ .... $ .... $ .....
PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN
PRESS F1 KEY FOR HELP; PRESS F4 KEY FOR TRANSACTIONS BROWSE

A. General Information Concerning the Screen - For both the ADD and UPDATE Functions.

1. Field numbers 1 through 7 are the key fields which were keyed into the Request Screen and carried forward to this screen automatically. *In addition to field number 2 (intermediary number), you will have to key the Business Segment Identifer (BSI) field UU into the Request Screen.*

2. Field 37 (top right hand corner) will display the word 'ADD' if an 'I' was the Function Code selected on the Request Screen or the word 'UPDATE' will appear if the 'U' Function Code was selected.

3. Field 8, fields 18 through 23 and field 26 are filled in initially by accessing the Provider Extract File created for the PORS system.

B. The following are field by field instructions for the ADD/UPDATE Master Screen.

1. Fields 1 through 7, again are key fields passed from the Request Screen. These fields are not keyable on the screen.

Immediately after this screen is displayed to the operator, for an ADD or UPDATE, review the key fields very carefully.

If the key is incorrect: TAP the F3 key to return to the Request Screen

2. Field 8 - PROVIDER NAME

This field will be displayed from the Provider Extract File.
IT IS NOT KEYABLE.

3. Field 9 - OVERPAYMENT AMOUNT (O/P $)

This field will contain the total overpayment amount.
For an ADD - This field will initially contain the underlines
For an UPDATE - This field will display the total overpayment amount.
IT IS NOT KEYABLE.

4. Field 10 - TOTAL RECOUPED TO DATE AMOUNT (RECOUPED T/D)

For the life of the overpayment, the field will reflect the current total of all recouped monies.
IT IS NOT KEYABLE.

For an ADD - This field will initially contain the underlines.

For an UPDATE - This field will display the total from the PORS Master File. If a regular recoupment transaction is entered on the Transaction Line (see fields 35 and 36), this field and the RECOUPED T/Q (Recouped T/D = Recouped-to-quarter) field (field 12) are changed instantly.

5. Field 11 - OPENING BALANCE (for the current quarter) (OPEN BAL)

This field was added to the screen and to the master file to assist in quarter to quarter comparisons. This field is calculated by a batch quarter end program and is not changed for the duration of the quarter.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field contains the underlines.

For an UPDATE - This field is not affected. The value that is displayed is the last quarter end calculated amount.

6. Field 12 - RECOUPED THIS QUARTER AMOUNT (RECOUPED T/Q)

This field will contain the total of all regular recoupment monies entered this quarter (i.e., transaction code RO). At the end of each quarter a batch program moves zeros to this field to begin the next quarter.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially displays underlines.

For an UPDATE - This field will initially display the amount from the master file. If the appropriate transaction code is entered with an amount, this field and the RECOUPED *T/D field (field 10) are updated instantly to reflect the change.*

7. Field 13 - RECOUPMENT ADJUSTMENT AMOUNT ENTERED THIS QUARTER (ADJUST T/Q)

This field will contain the total of all recoupment adjustment transactions entered within the current quarter. This field is also initialized to zeros at the end of each quarter by a batch program.

The current recoupment adjustment transactions are 'RA', 'RB', 'RC', 'RD', 'RI' and *'RZ'*.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

For an UPDATE - This field will initially contain the data value from the Master File. If a recoupment adjustment transaction is entered, this field and the RECOUPED T/D field (field 10) are updated instantly to reflect the change.

8. Field 14 - ENDING BALANCE (END BAL)

This field reflects the current balance of the overpayment case. It is recalculated after every financial transaction is added to the case.

The calculation required to arrive at this figure is the ORIGINAL-OVERPAYMENT-AMOUNT (Field 9) minus RECOUPMENT-TO-DATE (Field 10) minus ADJUSTMENT-TO-DATE (this field is on the master file but was not requested for the screen display.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

For an UPDATE - This field is recalculated and redisplayed after each financial transaction has been entered into the system and the enter key TAPPED.

9. Field 15 - TOTAL NUMBER OF CAUSES (CAUSES)

This field will display the current number of causes that have been added to the Master File for this overpayment. Its primary purpose is to alert the User to what the total is, especially if that figure is more than five (5). If there are more than five causes, the User can use the 'F7=Roll' feature to display the Cause Code and Cause Amount of each of the causes.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field contains the underlines.

For an UPDATE - This field will contain the number of causes that have been added to the master file.

ROLLING THE CAUSE LINE

During the ADD and UPDATE functions, when the Master Screen is initially displayed, you will be viewing the last five (5) cause codes and amounts that were entered.

Each time you TAP the F7 key, five more sets of codes and amounts will be displayed -until you reach the first cause entered.

If you wish to view all of the sets again, you must first TAP the Enter Key. (This will reset the screen display back to the last five causes entered.) Then you may TAP the F7 key as many times as necessary to 'Roll' the causes.

10. Field 16 - CAUSE CODE (There are 5 occurrences of this field)

Each of these five fields will contain a valid cause code which has been added to the file. There may be up to 26 cause codes used for one overpayment master record. The screen will show the User five of these at a time, and by using the 'F7=Roll' feature, may review all 26 if necessary.
THIS FIELD IS NOT KEYABLE.

For an ADD - These fields contain the underlines.

For an UPDATE - As many of these fields that are required will contain a one position valid cause code. As with all other transactions, the causes were entered on the transaction line as a two position 'TRANSACTION CODE', of which the rightmost position of the transaction code is the actual Cause Code. This rightmost position is moved to the five (5) field 16's.

A. Initial Retroactive Adjustment
B. Non Allowable Excessive Provider Expense
C. Chain Home Office Expense
D. Cost to Related Organization
E. Cost Finding
F. Return on Equity Capital
G. Reimbursement Statistics
H. Excessive Interim Rate
I. Excessive Cost Estimates
J. Excessive Census Days/Visits and/or Charges
K. Excess Cost Limit
L. Excessive Estimates of DRG Discharge
M. Erroneous DRG Designations
N.
O.
P.
Q.
R.
S.
T.
U.
V. Accelerated Payment (Type D)
W. Interim Rate Adjustment (Type J)

X. Unfiled Cost Report (Type H)
Y. Interest (Type X)
Z. Other
NOTE: Cause Codes N through U are reserved for future use.

NOTE: Cause Code CN shall be used with the M overpayment type M. When CN is used a closed date is required.

11. Field 17 - CAUSE AMOUNTS (There are 5 occurrences of this field.)

These five amount fields correspond directly to the five cause code fields explained in 9 above. Again, there may be up to 26 cause codes and amounts of which the User can see five (5) at a time.
THESE FIELDS ARE NOT KEYABLE.

For an ADD - These fields contain the underlines.

For an UPDATE - Each of these fields may contain an amount that corresponds to a specific cause code (up to 26 of them).

If the Master Record exists, the codes and amounts are displayed from the Master File initially on an update. New cause codes and amounts may be added or existing ones modified by using the Transaction Line (see fields 35 and 36). The User currently may key in a cause code with no amount on the Transaction Line and initialize to zeros, the corresponding amount field on the screen and in the Master Record but will maintain the Cause Code in both places.

12. Field 18 - INTERMEDIARY CHANGE (Y/N)

This field indicates whether there was a change in intermediaries by the provider during the cost report year in which the overpayment occurred.

This field, on and ADD and UPDATE, will display a "Y" or "N". This data value came from the Provider Extract File.

THIS FIELD, HOWEVER, MAY BE CHANGED.
If the User wishes to change the value of this field, the cursor should be positioned properly, the new data value entered (Y=Yes, N=No) and the enter key TAPPED.

13. Field 19 - OWNER CHANGE

The data values for this field are 'A through F' and blank, and indicate the number of times during the cost report year of the overpayment, the provider changed ownership. If there was no change, the field should be left blank; if there was one (1) change the value should be an "A" and so on.

This field, on an ADD and UPDATE , will display a blank or 'A' through 'F' which came from the Provider Extract File.
THIS FIELD MAY BE KEYED.
The User may update this field with a valid ownership change code. The update will be edited, as defined above.
14. Field 20 - OWNER TYPE

This field most closely describes the provider's ownership situation.

For an ADD and UPDATE, this field will be displayed with a valid Owner type which came from the Provider Extract File.
THIS FIELD MAY BE KEYED.

The User may update this field with a valid TYPE OF OWNER CODE. The valid list is as follows:
Hospitals and SNFs

1 = Church
2 = Other Non-Profit
3 = Proprietary
4 = State
5 = County
6 = City
7 = City - County
8 = Hospital District
9 = Other (SNFs Only)

HHAs

1 = Non-Profit other than Church
2 = Non-Profit Church
3 = State Health Department
4 = State Welfare Department
5 = Other State Departments
6 = City or County Health Department
7 = City or County Welfare Department
8 = Other City or County Departments
9 = Combination Government or Voluntary

15. Field 21 - ORGANIZATION CHAIN (Y/N)

This field indicates whether the provider, during the cost report year for which the overpayment is being reported, was part of a chain organization.

The valid data values are 'Y' and 'N'.

This field, for an ADD and UPDATE, is displayed with data received from the Provider Extract File.
THIS FIELD MAY BE KEYED.

This field can also be updated by the User by keying directly over the existing data.

16. Field 22 - TERMINATED (Y/N)

This field indicates whether the provider, for which the overpayment is being reported, has left the Medicare program.

The valid data values are 'Y' and 'N'.

This field for an Add and UPDATE, is displayed with data received from the Provider Extract File.

FI'S SHALL UPDATE THIS FIELD WITHIN 10 CALENDAR DAYS OF LEARNING OF THE TERMINATION FROM THE MEDICARE PROGRAM. (Notification should come from CMS RO/CO. If the FI learns of a termination from the Medicare Program from another source, the FI should contact the appropriate RO to determine further collection efforts.)

This field shall be updated by the User by keying directly over the existing data.

17. Field 23 - PIP (Y/N)

This field indicates whether the provider was participating in the PIP program during the cost report year for which the overpayment is being reported.

For an ADD function, this field is Mandatory.

For an UPDATE function, the User may change the value by keying directly over the existing data.
The valid data values are 'Y' and 'N'.

18. Field 24 - HHA/PPS

This one position, alphabetic code has a double purpose in the PORS system.

For an ADD function, this field is mandatory.

For an UPDATE function, the User may change the value by keying directly over the existing data.

For an ADD or UPDATE, the data values must be 'C,' 'D,' or 'X' where:

C = HHA which has Medicare utilization of no less than 85 percent
D = Indicates a PPS Provider
X = If neither of the above codes applies

Additionally, if the data value entered is equal to 'D,' the following edit checks are also performed.

The PPS DATE (field 25) MUST BE entered and MUST BE equal to or later than l0/0l/83.
If the data value entered is equal to 'C,' the following comparison is also made.

The third digit of the PROVIDER NUMBER (field 3) MUST BE equal to a '7'.

For an UPDATE function, this field is optional.

19. Field 25 - PPS DATE

This field is a six position date in the format of MMDDYY. The data value entered corresponds to the date the provider began PPS (Prospective Payment System). This date cannot be earlier than 10/01/83.

For an ADD this field is optional, but if entered, it must be a valid date.

For an UPDATE, the User will key the modification directly over the existing data. Again, the system will check this for validity.

20. Field 26 - NUMBER BEDS

This field displays the number of beds maintained by the provider during the Cost Report Year for which the overpayment is being reported. The data displayed on the screen has been received from the Provider Extract File. THIS FIELD IS OPTIONAL.

If entered, or modified in either an ADD or UPDATE function, the data values entered must be numeric or the program will issue an appropriate error message. When making these updates, the User keys directly over the existing data.

21. Field 27 - INIT RECOUP DATE

This field is an eight position date in the format of MMDDYYYY. This represents the date the intermediary first took positive action to recover the overpayment.

For an ADD, this field is optional until there is a recoupment transaction entered.

When there is recoupment to the overpayment, this field becomes MANDATORY.

For an UPDATE, the User may change the date by keying directly over the existing date.

The following edits are performed on this date.

Must be a valid date
Cannot be earlier than the Determination Date.
Cannot be later than the Recoupment Completed or Closed Dates.
Cannot be earlier than the Cost Report Data EXCEPT if the overpayment type is equal to a 'D' or 'J'.

22. Field 28 - COMP RECOUP DATE

This field is also an eight position date in the format of MMDDYYYY. This represents the date the intermediary EXPECTS the overpayment to be completely recovered.

For an ADD, this field is OPTIONAL.

For an UPDATE, the User may key the modifications directly over the existing data.

For both functions, the following edits are in effect.

The Completed Recoupment Date cannot be earlier than the Determination or Recoupment Initiated Dates.

It also may not be earlier than the Cost Report Data EXCEPT if the overpayment type is equal to 'D' or 'J'.

23. Field 29 - METHOD

The two position numeric field represents which best explains the actual method by which the overpayment will be recovered.

For an ADD, this field is MANDATORY.

For an UPDATE, the User may key directly over the existing data.

For either function, the data which is entered will be verified against the following table which has been included in the System Tables File.

01 Lump Sum Payment
02 Current Interim Payments
03 Combination of 01 and 02
04 Periodic Lump Sum Installments
05 Combination of 01 and 04
06 Combination of 02 and 04
07 Combination of 01, 02 and 04
08 Offset
09 Combination of 01 and 08
10 Combination of 02 and 08
11 Combination of 01, 02 and 08
12 Combination of 04 and 08
13 Combination of 01, 04 and 08
14 Combination of 02, 04 and 08
15 Combination of 01, 02, 04 and 08

24. Field 30 - TOTAL REIMBURSEMENT

This field represents the total reimbursement amount (benefits paid) to a given provider for the Cost Report Year for which the overpayment is being reported.

For an ADD and the Overpayment Type (field 7) is equal to 'D', 'J' or 'X', this field is OPTIONAL.

If supplied, however, the amount field must be numeric and must be greater than the Overpayment Amount (field 9).

For an ADD and the Overpayment Type is not equal to 'D', 'J' or 'X', this field is MANDATORY AND the amount must be greater than the Overpayment Amount (field 9). The only exception is an unfiled cost report. The amount of the overpayment and the total reimbursement will normally be equal for an unfiled cost report.

For an UPDATE, this field may be changed by the User by keying directly over the existing data.

25. Field 31 - STATUS CODE

This field represents the current status of the overpayment. The status shall change as the overpayment record proceeds through the recovery process.

This field is mandatory for an ADD function and shall be updated when a status change occurs.

The data values are two position alphabetic codes or spaces. These codes are supplied for your review in §180.1.4.

26. Field 32 - LOCATION

This field identifies the current work station of the overpayment case.

For an ADD, this field is mandatory and must be equal to the value 'INT'.

For an UPDATE, the User may change the location field by keying directly over the field. The valid location codes that shall be used are as follows:

INT = Intermediary
IDC = Intermediary- Referred to Treasury
INT# = Intermediary- Bankruptcy; the number represents the number of the lead regional office (example IN1 would mean that Region 1 is the lead regional office on the bankruptcy case)
ROA = Regional Office
COA = Central Office
DCC = Central Office- Referred to Treasury
DC# = Regional Office- Referred to Treasury (example DC1, DC2…DC0)
GAA = General Accounting Office
DJA = Department of Justice

For an ADD function, the online program will automatically move 'INT' into the location field.

27. Field 33 - STATUTE DATE

This field is an eight-position date in the format of MMDDYYYY. It is used to identify the date on which the 'statute of limitations' expires on this overpayment case. It is generally six years from the Determination Date.

For an ADD, this field is MANDATORY but the computer program will calculate a date of six years from the Determination Date and move that result to the screen and to the Master File.

For an UPDATE, the User may modify this field by keying directly over the existing data. Any update value must be a valid, six position date in the format MMDDYY.

28. Field 34 - CLOSED DATE

This field is an eight-position date in the format of MMDDYYYY. It is used to identify the date on which the overpayment was completely recovered.

This field is fully Keyable and for an ADD or UPDATE function, the date must be a valid six position date in MMDDYY format and must also pass the following inter-relationship edits.

1. If the outstanding balance (field 14) is equal to zero, you must supply a closed date.
2. If the outstanding balance is not equal to zero AND the location (field 32) is equal to 'INT' you cannot enter a closed date.
3. If the outstanding balance is not equal to zero you may enter a valid closed date ONLY if any of the following combinations of the location (field 32) and status (field 31) are true.

Location = ROA AND Status = DT
Location = COA AND Status = GK
Location = GAA AND Status = LF or LG
Location = DJA AND Status = PI or PJ
Location = ICC AND Status = UJ

29. Fields 35 and 36 - TRANSACTION CODES AND TRANSACTION AMOUNTS

These eight fields, four transaction code fields and four transaction amount fields, are the heart of the ADD/UPDATE MASTER SCREEN and will be discussed together. They are contained on the Transaction Line.

The primary Users have developed a group of two position transaction codes,, which they feel, will accommodate all possible FINANCIAL information to be entered into the system.

These forty codes, of which 26 are for CAUSE information, are located in and maintained by the System Table File.

A. When considering the functionality of the overall process, there are some general comments and/or instructions which should be conveyed first.

1. All four sets of fields can be used for any transaction, in any order. There is no expressed rule about starting in the left most set. Some users prefer to right align all transaction amounts to prevent the possibility of the system/user creating an error by adding additional zeros to the end of the transaction amount.

2. Except for the Overpayment Full Delete transactions, these sets of fields must be used in pairs, transaction code and transaction amount.

3. The 'OO' transaction (the original overpayment) must always be the first transaction entered on an ADD.

4. The total of all cause amounts must equal the overpayment amount at all times. If either total changes, the other must change accordingly.

5. When entering multiple transactions, you may enter one and TAP the enter key or you may use all four sets of fields and amounts before you TAP the enter key.

6. The error message line is the last line on the screen. Currently, only one error message at a time is displayed (in bright characters) and the cursor is positioned at the field in error. If you have more than one error, the second and subsequent ones will be displayed as their predecessors are being corrected.

7. If you have displayed the ADD/UPDATE Master Screen for either function, and you do not wish to continue - For Any Reason - simply TAP the F3 key and the program will return you to the PORS REQUEST SCREEN.

NOTE: IN DOING THIS YOU WILL LOSE CHANGES YOU HAVE MADE TO THE ADD/UPDATE SCREEN. IF YOU WERE IN AN ADD FUNCTION, THAT OVERPAYMENT CASE MUST BE ADDED ONCE AGAIN STARTING WITH THE REQUEST SCREEN.

8. If you are keying in a transaction code and you need assistance with what code should be used, or what codes are available, simply TAP the F1 key for HELP. This action will display the HELP SCREEN which shows all transaction codes available for use with their twenty two character descriptions.
After you have found the necessary information on the HELP screen, simply TAP the F3 key and the program will return you to the ADD/UPDATE Screen.

9. If you are working with the ADD/UPDATE screen and, for any reason, you wish to view the detail transactions for this overpayment case, simply TAP the F4 key. The program will then display the TRANSACTION HISTORY BROWSE SCREEN. This screen will show you every financial transaction that was entered for the case since it was added to the file.

When you are finished reviewing the transaction History Screen, you can TAP the F3 key to return to the ADD/UPDATE Screen.

ENTERING TRANSACTIONS

All financial transactions entered into the PORS System by the terminal USERS can be divided into three major categories; OVERPAYMENTS, CAUSES and RECOUPMENTS. The following are specific instructions for entering each kind of transaction into the PORS System using the Transaction Line.

A. OVERPAYMENT TRANSACTIONS

This category includes three types of overpayment transactions: ORIGINAL OVERPAYMENT, OVERPAYMENT ADJUSTMENT and OVERPAYMENT FULL DELETES.

1. ORIGINAL OVERPAYMENT

a. Valid transaction code is 'OO' only.
b. Must be the first financial transaction entered when adding a new overpayment.
c. The amount field must be numeric.
d. The amount field must be less than the TOTAL REIMBURSEMENT FIELD unless the overpayment type is an unfiled cost report (field 30).
e. This code, 'OO' is the only valid Overpayment transaction code for use in the ADD function.
f. The amount will be moved to field nine (9) on the ADD/UPDATE Screen and into the appropriate master record field when the ADD function is complete.
g. Only one (1) 'OO' transaction may be entered for an ADD.
h. An original overpayment transaction (OO) is invalid for an update.
i. When the ADD function is complete, the transaction code and amount are written to the Open Transaction History File.

2. OVERPAYMENT ADJUSTMENTS

a. Valid transaction codes are 'OA' through 'OD', 'OI' and 'OZ".
b. The functionality of all of the above codes is exactly the same. There are multiple codes for recording and reporting purposes.
c. The function of these transactions is to adjust the original overpayment amount.

d. The adjustment is accomplished by overlaying (replacing) the original overpayment amount in the master file with the amount on the overpayment adjustment transaction.
e. Although the adjustment amount is 'moved' to the Master File, the following must take place for the Transaction

File update:
1. The original amount (OO transaction) is still on the transaction file and can't be deleted.
2. To maintain fiscal integrity, the program will subtract the original overpayment amount in the master file from the overpayment adjustment amount.
3. This amount, positive or negative will be written to the transaction file along with the transaction code.
f. All overpayment adjustment amounts must be numeric.
g. Overpayment adjustments are invalid during the ADD process.
h. If the overpayment adjustment transaction code is equal to 'OI' the overpayment type must be a 'J'.

REMINDER:

When an overpayment adjustment is used to 'adjust' the original overpayment amount this action will probably establish an out of balance condition between the original overpayment amount and the SUM of the Causes. This condition must be resolved before the update will be accepted. You will have to update the Cause information that currently exists for this overpayment.

3. OVERPAYMENT FULL DELETES

These transaction codes are extremely powerful tools within the PORS System which must be handled with care. There are four codes which, functionally are identical, that will logically zero balance an overpayment case and allow that case to be closed.

a. Valid codes are 'OE', 'OF', 'OG', 'OH', and 'OI'.
b. The functionality of the codes above is exactly the same. There are multiple codes for recording and reporting purposes.
c. The major function of these transactions is to Logically zero balance the case. In doing so, a Closed Date will be Mandatory and the case will be officially closed.
d. All 'FULL DELETED' cases will be bypassed by all quarter and batch reporting programs, therefore the dollar amounts on all fully deleted cases will not be reflected in any report.
e. An OVERPAYMENT FULL DELETE is processed as follows:

1. A valid overpayment full delete transaction code is entered in any one of four transaction code fields on the transaction line.
2. NO AMOUNT IS REQUIRED IN THE TRANSACTION AMOUNT FIELD FOR A FULL DELETE TO PROCESS.
3. The User TAPS the enter key.
4. The PORS program then perform the following:

(a) The program issues an applicable warning message asking the User if they are absolutely sure they want to process a full delete.
(b) If the User wants the full delete to take place, an overpayment full delete transaction code must be re-entered and the enter key TAPPED.
(c) Calculates the current balance of the overpayment case.

(d) Writes a record to the transaction file using the overpayment full delete transaction code and an amount field equal to zeros.
(e) Generates and writes a Recoupment Adjustment record to the transaction file. This record will contain an amount equal to the ending balance calculated in (3) above. The transaction code will have an 'R' in the leftmost position and the rightmost position will correspond to the rightmost position of the overpayment full delete transaction code.
(f) At this time, the outstanding balance is zero and the program is looking for a valid close date by issuing another warning message and positioning the CURSOR at the CLOSED DATE FIELD.
(g) NOTE:
The User can still back out of the entire full delete procedure by TAPPING the F3 key. This action will abort all updates that have just been discussed and return control to the REQUEST SCREEN.
(h) The User should key in the proper closed date and TAP the enter key.
(i) If the above Close Date is valid, another warning message is issued to the User, stating the case is about to be closed.
(j) If the User is absolutely sure the full delete is correct, the enter key should be TAPPED.
(k) At this point, the full delete transaction has been processed and the case is closed.

B. CAUSE CODE TRANSACTIONS

1. For each determined overpayment case, the CAUSES(s) for that overpayment will be identified and entered into the system using the transaction line on the ADD/UPDATE SCREEN.
2. There are twenty six (26) CAUSE TRANSACTION CODES defined in the PORS System of which 18 are currently active. These codes, ranging from CA through CZ were explained earlier in the instructions for FIELD 16 (five of them).
3. Cause transactions are entered on the transaction line (fields 35 and 36), and after verification, are moved to fields 16 and 17.
4. As an enhancement, we have designed the Master File so we may retain all 26 Cause Codes and Cause Amounts for a given overpayment case.
5. Another enhancement we feel will help maintain the system's integrity, is to balance the sum of all entered Cause Amounts with the Overpayment Amount (field 9). This balancing MUST TAKE PLACE before a case is ADDED to the Master File. We understand that some overpayment cases will be very difficult to 'BALANCE' because of missing information. To allow this kind of overpayment into the system for tracking and recoupment efforts, we have added a Suspense Cause Transaction Code of 'CZ' to the list of valid cause codes.
This suspense cause code is intended for specialized, limited use, and it use will be monitored. The total amount that may be entered using this Cause Code is $10,000.

Note: If the original overpayment amount is adjusted, the appropriate cause codes should also be adjusted so that the original overpayment amount and the cause code amounts are the same.

6. Out of the possible 26 codes, only four Causes have special edit criteria.

a. CAUSE CODE V (Accelerated Payment) must only be used with TYPE D overpayments.
b. CAUSE CODE W (Interim Rate Adjustment) is only valid with TYPE J overpayments.
c. CAUSE CODE X (Unfiled Cost Report) must only be used with TYPE H overpayments.
d. CAUSE CODE Y (Interest) is only valid with TYPE X overpayments.

7. The two position Cause Code and Amount are keyed into the transaction line. Again, you may use any one of the four sets or all four at the same time.

8. When the enter key is TAPPED, the program moves the rightmost character of the Cause Transaction Code (which is the actual cause code) and the Cause Amount to an available set of fields on the 'Cause Line' (fields 16 and 17). It also moves the number of causes entered into the Cause Count Field (field 15). It then adds up all Cause Amounts and compares that SUM to the Overpayment Amount.
9. If the case is in balance, and no more input is required, the case is added to the Master File.
10. If the case is out of balance, the User will see an appropriate message in the message area. The User must balance the case either by keying in an Overpayment Adjustment or by modifying the just entered Cause Transactions.

C. RECOUPMENT TRANSACTIONS

This category includes three types of recoupment transactions; REGULAR RECOUPMENT, RECOUPMENT ADJUSTMENTS AND RECOUPMENT -FULL DELETES.

1. Regular Recoupment
a. Valid transaction code is 'RO' only.
b. Must be the first 'recoupment' transaction entered for an overpayment case.
c. The amount must be numeric and positive.
d. The transaction code of 'RO' and the amount may be keyed into any one of the 'sets' on the transaction line.
e. When the enter key is TAPPED, the transaction, after being thoroughly edited, is added to the RECOUPED-TO-DATE (field 10) and the RECOUPED-TO-QUARTER (field 12) fields on the screen and also to the appropriate Master File fields.
f. A record including the transaction code and amount is also written to the transaction file.

2. Recoupment Adjustments

a. Valid transaction codes are 'RA' through 'RD', 'RI' and 'RZ'.
b. All of the above codes have the exact same functionality. There are multiple codes for reporting purposes.
c. The function of these transactions is to adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars will stay on the Master and Transaction Files, but we will use the appropriate 'Recoupment Adjustment Transaction' to affect the required monetary change.
d. To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, the operator must key in the 'dash/hyphen' after the amount. For a positive value, there is no additional effort involved.
e. The User, after keying in the appropriate Recoupment Adjustment Transaction Code and amount, should TAP the enter key.
f. The amount, after thorough editing, is added to the 'ADJUST-T/Q' field (field 13) on the screen and to the same field in the Master File. It is also to the 'ADJUSTMENT TO DATE' field in the Master File.
g. After the Master File is updated, a record is written to the transaction file with the recoupment adjustment transaction code and amount fields included.

3. Recoupment - Full Deletes
a. Valid codes are 'RE', 'RF' 'RG' and 'RH' and 'RI'.
b. These four transaction codes are 'GENERATED ONLY' by their corresponding 'OVERPAYMENT FULL DELETE' transaction - 'OE', 'OF', 'OG', 'OH' and 'OI'.
c. The Recoupment - Full Delete transactions ARE NOT KEYABLE BY THE USER.

d. They are generated with appropriate amount fields and written to the transaction file to maintain fiscal integrity.
e. The amounts are also added to the Master File recoupment fields but, as explained earlier, these Master Records are bypassed for all PORS reporting.

30. Field 37 - CNC Date

This field is an 8-position date in MMDDYYY format. Enter the Currently Not Collectible date within 10 days of receiving written approval for CNC Classification from the Regional Office.

31. Field 38 – CNC Code

This field is a 2- position code. Enter the appropriate CNC Status Code from the Status Code Listing in 180.1.4 within 10 days of receiving written approval for CNC Classification from the Regional Office.

TRANSACTION HISTORY BROWSE SCREEN

A. General information concerning this Screen.
1. This Screen will be used for inquiry purposes only.
2. This Screen may be displayed only from the PORS REQUEST and PORS ADD/UPDATE Screens.
3. The displaying of information on this screen is governed by the same security hierarchy explained for the Request Screen.
4. There are two primary objectives of this Screen.

a. To provide an audit trail of all financial transactions that were entered for the life of an active, open case. This audit trail will provide the various levels of responsible Users with instant information about a specific case or groups of cases. It will identify which User entered the data, when it was entered and how that action affected the balance of that case.

b. The second objective is to have the physical protection of the Transaction File in case something should ever happen to the Master File. We could use the Transaction File to 'rebuild' the financial portion of our online PORS Master File.

5. The screen is divided into two distinct parts; the screen header line and the screen body.

a. The header line is represented by the line of dashes on the second line from the top of the screen. This line will contain the entire record key that was requested for the screen to be displayed.

1. If this screen display was 'requested' from the ADD/UPDATE processing, this header line 'record key' will be a specific 28 position key.
2. If, however. this screen was requested from the PORS REQUEST SCREEN using the 'B' function, the header line 'record key' may have from 2 to 28 positions filled in. This is the generic key search that was described earlier in these instructions.

EXAMPLES:
1. A regional office User may key in just the region number and 'B' function on the PORS REQUEST SCREEN and TAP the enter key. This action will display the Transaction History Browse Screen showing the User ALL open overpayment cases for that region.

2. A contractor User may do the same function, but, because of the security table, they must also key in their own intermediary number on the PORS REQUEST SCREEN.

b. The screen body consists of sixteen (16) detail lines showing the 13 individual fields on each line.

If there are more than 16 lines of detail to be displayed, the User may TAP the F8 key to page forward or F7 to page backward.

B. Specific information concerning the fields displayed on the screen.

1. Field 1 through 7

These fields constitute the overpayment record key. They will be printed according to the instructions contained in A.5 above.

2. Field 8 - SEQUENCE NUMBER

This field was added to ensure uniqueness when writing records to the transaction file.

3. Field 9 - OPERATOR ID

This is primary security code used throughout the system. It is shown on the Browse Screen for obvious reasons.

4. Field 10 - TRANSACTION ENTRY DATE
This is the date, in MMDDYYYY format; the User entered this particular transaction.

5. Field 11 - TRANSACTION CODE (TR CD)
This is one of the forty (40) valid codes used to enter financial information into the system.

6. Field 12 - TRANSACTION AMOUNT
This field displays the edited dollar amount which was keyed by the User on the ADD/UPDATE MASTER SCREEN.

7. Field 13 - BALANCE
This is a 'Running Balance' for the overpayment case. It is re-calculated after each successful financial update to the PORS Master File. It will provide the User with a display of the current balance of the case.

HELP SCREEN

A. General information concerning the Screen.

1. The screen contains all of the current, valid transaction codes in the system along with their descriptions.

2. The design function for this screen is to provide the terminal User with online assistance at the time of data entry. This will happen during transaction code selection and entry on the ADD/UPDATE MASTER SCREEN.

3. If the User forgets the transaction code to use or does not remember which ones are even available merely:

TAP the F3 key for HELP

This will display the HELP SCREEN. When the User finishes reviewing the HELP SCREEN, simply:

TAP the F3 key to return to the same position on the ADD/UPDATE SCREEN.

B. Specific information concerning the HELP SCREEN.

1. There are three columns displaying eighteen transaction codes each.

2. If there should be more than 54 transaction codes in the future, the User may TAP the ENTER KEY to view the remaining codes.

180.1.4 List of Status Codes

(Rev. 22, 10-03-03)

POR SYSTEM STATUS CODES- INTERMEDIARY LEVEL

Category	Status Codes	Description/When to Use
Accelerated Payments	CA	Accelerated Payment (Less than 90 days old)
	CB	Accelerated Payment (Over 90 days old)
Advanced Payments	AP	Advanced Payment
	CP	Advance Payment (Claims processing problem has not been corrected)
Demand Letters	AL	First Demand Letter
	BL	Second Demand Letter
	CL	Third Demand Letter
Recoupment	AC	Interim Payments Suspended
	BV	Congressional Intervention- repayment delayed
ERS	AE	Negotiating Repayment Schedule
	AF	Established Repayment Schedule (up to 12 months)
	AG	Defaulted Repayment Schedule
	BG	Established Repayment Schedule (over 12 months)
	BJ	Court Established Repayment Schedule
Appeals/ Hearing	AB	Intermediary Appeal Pending
	BP	PRRB Hearing
Fraud	BA	Active Fraud and Abuse Investigation- on Suspension by contractor Fraud department, RO, CO, or OIG
Bankruptcy	BH	Provider Filed Bankruptcy Petition
Litigation/ DOJ Involved	BN	RO Approved delay in Recovering Overpayments
	AW	Collections stopped by Court Decision- Litigation
	BE	DJA Case Returned to Intermediary for further Collection action
	BQ	Returned to INT for preparation of CCLR and Referral to DJ
Debt Referral	AQ	Pending Referral to Cross Servicing/TOP
	CM	Debt returned from DCC (waiting further action by INT)
CNC	01	Reclass to CNC
	03	CNC- DCIA Letter Sent
	04	Reactivate CNC- Bankruptcy
	05	Reactivate CNC- Payment Received

	06	Reactivate CNC- Appeal/Litigation/Fraud
	07	Reactivate CNC- Compromise
	08	Reactivate CNC- Extended Repayment Plan Approved
	09	CNC Debt Written Off Closed
	00	Reactivate CNC- Other (Deceased, etc)

Effective 10/01/03 the CNC Status Codes should be used in the CNC Code field not in the Status Code Field. When inputting a CNC Status Code a CNC Date should also be entered. The existing status code shall remain and shall be accurate as to the status of the debt. (For example bankruptcy, debt referral, appeal, fraud) The CNC Status Code field and the CNC Date field should only be used after written approval for CNC Classification is received from the Regional Office. Refer to the Financial Management Manual, Chapter 5, §400.20 for additional information concerning CNC Classification.

Write-off	BY	Pending Write-Off Authority
	CC	Closed- compromise negotiation by OGC/DOJ, Balance written off
	CD	Closed with a balance- CMS CFO approved compromise
	CE	Closed with a balance due to bankruptcy (Authority to close must be received from lead RO)
	CF	Closed with a balance- ARA DFM approved
Liability	AH	New Owner Assumed Liability
	AI	Assumption of Liability in Question
	AU	New Owner did not Assume Liability
Referred to RO	AK	Referred to Regional Office
Medicaid	AS	Title XIX Suspension in Effect
Cost Reports	AA	Cost Report Filed but Subsequently found to be Unacceptable
	AD	Final Settlement pending current or subsequent cost reports
	AM	Cost Report Filed- Overpayment Recouped
	AY	Cost Report Filed- Pending Acceptance
	BX	Cost Report not Filed- Provider Paid back all interim payments
Other	AN	Medicare Adjustment Bills
	AV	Waiver agreement obtained for Statute of Limitations
	AX	Terminated Provider re-entered Medicare program with New provider number
	BF	Financial Record of Provider in Hands of State- Exact Amount of OP Undetermined or Unknown
	BI	Incoming Intermediary recovering overpayment for Outgoing intermediary

BW	Waiver State of Demonstration Project
BZ	Outpatient Non-Physician Services

When determining the most accurate status code intermediaries must remember that certain status codes/categories take precedence over others:

Bankruptcy supercedes all other status codes
Appeal supercedes all other status codes except for bankruptcy and litigation
Litigation supercedes all other status codes except for bankruptcy
ERP supercedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation
Debt Referral supercedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation.

If you are not sure of the appropriate status code the servicing regional office should be contacted.

180.1.5 - Posting Interest Entries

(Rev. 22, 10-03-03)

Interest should be posted to the POR System on a monthly basis. Each overpayment should only have one interest record. When inputting the interest entry into the POR System the determination date used should be the date interest first accrues. In most cases this should be 30 days after the determination date of the overpayment. To allow for the continual posting and recouping of interest, an additional dollar should be added to the interest amount. This should occur when an initial interest assessment entry is made to the POR System. This dollar will remain in the interest record until the principal amount of the overpayment is paid in full. Once the principal amount of the overpayment is paid in full, the dollar should be adjusted downward. This will allow interest records to correlate with the principal records. The transaction code OD should be utilized to increase the interest amount to accrue additional interest. The cause code will change automatically.

Example 1

If on June 5, a $200 partial payment is made on an existing debt of $2500 with accrued interest of $151 (includes additional $1). Also, assume that on June 8th an additional interest charge of $25 will accrue. You should apply $150 of the partial payment to interest and leave a balance of $1 for the X type interest entry. You would also apply $50 of the partial payment to principal. The following transaction code would be used to update the POR for the X type interest entry:

Date	Transaction Code	Original	Recoup	Rec. to Date	Balance
xxx	OO	$151			$151
June 5, xxxx	RO		$150	$150	$1
June 8, xxxx	OD	$176		$150	$26

Example 2

Assume that on July 8 an additional interest charge of $24 will accrue. The following transaction code would be used to update the POR for the X type interest entry. The total original accrued interest balance of $176 plus additional accrued interest of $24 equals $200.

Date	Transaction Code	Original	Recoup	Rec. to Date	Balance
July 8, xxxx	OD	$200		$150	$50

At the time the overpayment is fully recovered, the total accrued interest will be posted to one record and the additional $1 remaining in the interest account can be adjusted out. This will result in one open interest record per principal overpayment case.

180.1.6 – Requesting Provider Overpayment Debts from the Provider Overpayment Reporting System (PORS)

(Rev. 47, 06-25-04)

Intermediaries are required to indicate the appropriate Business Segment Identifier (BSI) on all written requests, to open closed debts on the POR system. The request should include: regional office code, intermediary number, BSI code, provider number, provider type, cost report date, determination date, overpayment type, original amount, desired reopening amount and explanation for the reopening. (See CR 3023 for complete BSI codes.)

EXAMPLE of the Business Segment Identifier (BSI)

00380ARR – Intermediary Number (00380), State Code (AR) and Regional Home Health Agency (R).

00382NCA – Intermediary Number (00382), State Code (NC) and Intermediary (A)

180.1.7 – Requesting Report from the AD Hoc Reports Management System (ARMS)

(Rev. 47, 06-25-04)

When intermediaries are retrieving reports from the AD Hoc Report Management System (ARMS), they should use field code UU, which identifies the Business Segment Identifiers (BSI.) This is a new field that has been added to the POR system and it is associated with the intermediary numbers.

EXAMPLE:

FIELDS: 01,02, UU (New BSI field), 03,04,05,06,07,27,31,32,35,QQ

PARAMETER: 02 (Intermediary Number) # E (Equal) # 00380

180.2- Exhibit 2 - Physician/Supplier Overpayment Reporting System (PSOR)

(Rev. 22, 10-03-03)

The reporting of outstanding physician and supplier overpayments of $600 or more is required to provide data that:

- Identifies the entity overpaid;
- States the amount of the overpayment;
- States the amounts collected;
- Identifies the types of providers overpaid;
- Gives the status of repayment; and
- Specifies the length of time the overpayments are outstanding.

For overpayments under $600, report only the number, total amount of dollars recouped, and total interest received.

To report this information, use the online Physician and Supplier Overpayment Reporting System (PSOR). This system provides a uniform method for reporting overpayment data and a base for CMS to use in compiling management information on overpayments.

Create and maintain, on an ongoing basis, your own internal accounting and control system with appropriate controls to enable you to carry out effectively and timely the overpayment collection procedures. The PSOR system is neither designed nor intended to be, a substitute for your internal accounting and control system.

180.2.1- Data Entry

(Rev. 22, 10-03-03)

CMS's mainframe computers record the date that all overpayment transactions are entered into the PSOR system. To be considered timely, enter overpayments into the system within 10 calendar days of the date of determination. Also, to assure that the PSOR system is current, enter updates to the overpayments within 10 calendar days of the change.

180.2.2- PSOR User Manual

(Rev. 22, 10-03-03)

A. System Description.--There is a history file and a master file in the PSOR system. All verifiably accurate data from the above files have been taken to create the following:

1. PSOR Online Master File.--This is the center of the new system. It contains one contiguous record for each overpayment consisting of all source, cause, financial and demographic information. It is accessible, online, to add, update and inquire into, for any open overpayment. When an overpayment is closed, it is removed from the PSOR Online Master File, after the end of each quarter, and placed on a history file. This is done for two reasons; one to reclaim valuable storage resources and two, to limit the file to a manageable size which helps to improve the transaction through-put and overall online response time.
2. PSOR History Master File.--This contains the same data elements as the online master file except that only closed overpayment cases appear.

3. PSOR Online Transaction File.--This functions as a financial journal file to the PSOR Online Master. During the Add and Update process, every financial transaction that affects the master file is written to this file along with security identifying information. The operator's user identification code and date the transaction was generated are logged. It also assists us in reconstructing the PSOR Online Master with all pertinent financial information in case there is a problem with the Online Master.

Additionally, the PSOR Online Transaction File is read by the online browse program to display all financial transactions for an overpayment along with a 'running balance' after each transaction. The visual display is governed by the three (3) levels of system security. The browse function may be used directly from the main request screen or from the Add/Update screen if assistance is needed in reviewing the details of an overpayment.

4. PSOR History Transaction File.--This has the same format and file content as the online transaction file but is for closed overpayments. It is updated with newly closed overpayment transactions at the end of each quarter.

B. System Security.--The system contains a three-level system which safeguards the individual user's data. The complete functionality of the security system follows:

- There is a security file built into the system and maintained by the CO Project Officer. It contains the User Identification Code, RO number, carrier number and security level code of every PSOR user. If a new user is added, or any changes made to this file, only the project officer may make changes.

- There are five record identification key fields. The three highest level fields are region number, carrier number and physician/supplier number. In addition, the claim number and the date the claim was paid make each overpayment unique.

- All access into the PSOR system is controlled by User Identification and security level codes. This is for Master File Add, Update and inquiry as well as for the online Transaction File browse.

- The three levels of User security, from major to minor, are:

1. CO Personnel - Security Level 1.--CMS CO overpayment analysts have the authority to access all records in the online files. They may add/update/browse any physician/supplier's overpayment record.

2. RO Personnel - Security Level 2.--CMS RO overpayment analysts have the authority to access overpayment records for any physician/supplier within their region. They may not access an overpayment record for another region.

3. Carrier Personnel - Security Level 3.--Contractor personnel have the authority to access overpayment records for any physician/supplier within their responsible area. They may not access a physician/supplier overpayment record for another carrier.

SYSTEM OPERATING PROCEDURES

This contains the instructions to accomplish various system operating procedures.

A. Establish Connection with the CMS Mainframe Computer and Gain Entry into the PSOR System

- The HCFA Data Center “HDC”screen, shown in FIGURE 1, will be displayed.

- Press ENTER and the “Application Menu”, shown in FIGURE 2, will be displayed.

- Select application menu number 3 “CICS 41”, press the enter key and the “USERID” and “PASSWORD” screen, shown in FIGURE 3, will be displayed.

- KEY in-your “USERID” and “PASSWORD”, then press the ENTER key, and the overpayment “PRODUCTION CICS ENVIRONMENT” screen, shown in FIGURE 4, will be displayed.

- Select “OPTION” number 2, and the “PSOR SYSTEMS BROADCAST SCREEN”, shown in FIGURE 5, will be displayed.

- Press ENTER and the “CMS-PART B-ADVANCE/OVERPAYMENT INITIAL SCREEN”, shown in FIGURE 6, will be displayed.

- Type your "USERID" and select "PORB", press the ENTER key, and the "PSOR REQUEST SCREEN", shown in FIGURE 7, will be displayed. All entry into the PSOR System is through this screen

- Type in the PHYS/SUP #, CLAIM #, CLAIM PAID DATE, and the applicable function letter, press the ENTER key, and the CMS "MASTER SCREEN", as shown in FIGURE 8, will be displayed.

- Press "F4" to display the "TRANSACTION HISTORY" screen as shown in FIGURE 9, will be displayed.

B. General Instructions for Entering Data into the Physician/Supplier Overpayment Reporting System

REQUEST SCREEN

Positioning of the Cursor.--Where the cursor is initially positioned when this screen is displayed depends upon the level of security found in the system security table for the User-identification code entered (see FIGURE 7).

1.CMS CO Personnel - Security Level One (1).--The cursor is positioned at the Region Number field. There will be a default Region Number, Region Name, Carrier Number and Carrier Name in the appropriate fields. CMS can key in all characters of the record key, starting with the default region number field.

2.RO Personnel - Security Level Two (2).--The cursor is positioned at the Carrier Number field. There will be a default Carrier Number and Name displayed. The Region Number and Name fields, however, will be filled in with the appropriate values and are locked to the User. RO personnel may key in any valid carrier WITHIN their region and continue with the rest of the key fields.

3.Carrier Personnel - Security Level Three (3).--The cursor is positioned at the Physician-Supplier Number field. The Region Number, Region Name, Carrier Number and Carrier Name fields are filled in with the appropriate data and are locked to the user. However, carriers who have multiple-state carrier numbers will have access to the carrier number field. Carriers may key in any valid physician/supplier number WITHIN your area of responsibility and continue with the rest of the key fields.

Field by Field Instructions:

1. REGION NUMBER

Only CMS can key in this field. If it is keyed, the value MUST BE 01 through 11.

The Region Name is supplied to the screen by the System Tables File.

2. CARRIER NUMBER

Only CO and RO personnel may key in the five position numeric field. If it is keyed, it is numeric, must be a valid Carrier Number and must be valid for the Region Number associated with it on this screen.

The Carrier Name is supplied from the System Tables File.

3. PHYSICIAN-SUPPLIER NUMBER

This field is a 9 position alphanumeric field.
The Physician-Supplier Number field is keyed by all Users.

4. CLAIM NUMBER/CARRIER INTERNAL CONTROL NUMBER

The claim number is a 15-position numeric field that is keyed by all Users. All positions must be filled in with either a number or a zero. The carrier may enter the internal control number generated by its accounting system instead of the claim number. However, the carrier must be able to trace the control number back to the specific claim(s) number if needed. Otherwise, the carrier should enter the claim number. If there are multiple claims, the carrier must enter the oldest claim number related to the overpayment.

5. CLAIM PAID DATE

This 8-position numeric date is part of the overpayment record key. It is entered in the format of MMDDYYYY.

The Claim Paid Date can never be later than the Current or Closed Date. If the overpayment is a combination of more than one claim, the claim paid date used shall be the date the oldest claim was paid.

6. FUNCTION CODE

This is a 1-position alphabetic code field which allows the user to select which system function is to be performed.

It must be present and must be I, U or B.

I = Add a new overpayment record
U = Update an existing overpayment record or INQUIRE only
B = Browse the Online Transactions File

- General Information

1. Explanation of the inter-relationship between the Function Code field and the Record Key fields (fields 1 through 5 on FIGURE 8).

If the Function Code is "I" or "U", the entire 39-position key must be present and correct.

If the Function Code is "B" any number of key fields may be requested (after the Region Number). This is a 'generic key' and is usually executed to display related groups of data; i.e., Regional, Carrier, Physician/Supplier, etc.
There are two points to remember about the 'generic keys.' One, you still have your security defaults in the fields and two, the requested key (from major field to minor) must be contiguous - No Blanks. You cannot complete fields, 1, 2 and 3, skip 4 and complete 5. In this instance, 4 must be completed.

2. If the Function Code of "I" or "U" is keyed, the MASTER SCREEN shown as FIGURE 8 will be displayed - after the Enter key is TAPPED, assuming the information on the request screen passed the edits.

3. If the Function Code of "B" is keyed in, the TRANSACTIONS HISTORY SCREEN shown as FIGURE 9 will be displayed - after the Enter key is TAPPED.

- Information Concerning the Screen.--For both the ADD and UPDATE Functions.

1. Field numbers 1 through 5 are the key fields which were keyed into the Request Screen and carried forward automatically.

2. Field 25 (top right-hand corner) will display the word 'ADD' if an 'I' was the Function Code selected on the Request Screen. The word 'UPDATE' will appear if the 'U' Function Code was selected.

3. In most cases, when looking at FIGURE 8 the fields with 'underlines' are those that have had data moved to them from various files. These fields are not keyable by the operator initially, but some may be overridden manually by later actions. Fields on FIGURE 8 that are exhibited with dots (periods) are directly keyable.

4. Fields 6 through 10 are filled in initially by accessing the computer if the physician-supplier information is already on file.

5. All other fields will be blank for new overpayments to be added.

- Field-by-field instructions for the MASTER SCREEN.

1. Fields 1 through 5 are key fields passed from the Request Screen. These fields are not keyable on this screen.

Immediately after this screen is displayed, for an ADD or UPDATE, review the key fields carefully. If the key is

incorrect:

TAP the F3 key to return to the Request Screen

2. Field 6 - REGION NAME

This field will automatically be displayed.

IT IS NOT KEYABLE.

3. Field 7 - CARRIER NAME

This field will be displayed automatically.

IT IS NOT KEYABLE.

4. Field 8 - PHYSICIAN-SUPPLIER NAME

This field will contain name unknown for a new physician-supplier being added to the system, otherwise, it will automatically be filled in.
This field may be keyed for an ADD only.

5. Field 9 - SPECIALTY CODE (SPCLTY CODE)

This field will contain the specialty code shown in the following table if the physician-supplier is on file, otherwise, it will be blank.

The field is keyable for an ADD only.

SPECIALTY CODES

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Unassigned
16	Obstetrics/Gynecology
17	Unassigned
18	Ophthalmology
19	Oral Surgery (dentists only)

20	Orthopedic Surgery
21	Unassigned
22	Pathology
23	Unassigned
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Unassigned
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Unassigned
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

Code	Type of Supplier/Provider

32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical supply company with orthotic personnel certified by an accrediting organization
52	Medical supply company with prosthetic personnel certified by an accrediting organization
53	Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization
54	Medical supply company not included in 5l, 52, or 53
55	Individual orthotic personnel certified by an accrediting organization
56	Individual prosthetic personnel certified by an accrediting organization
57	Individual prosthetic/orthotic personnel certified by an accrediting organization
58	Medical Supply Company with registered pharmacist
59	Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Supplier/Provider
89	Clinical Nurse Specialist
95	Unassigned
96	Optician
97	Physician Assistant
A0	Hospital
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility

A3 Nursing Facility, Other
A4 Home Health Agency
A5 Pharmacy
A6 Medical Supply Company with Respiratory Therapist
A7 Department Store
A8 Grocery Store

6. Field 10 - STATE

This field will contain the State in which the physician-supplier is located, if the physician-supplier is on file, otherwise, it will be blank.

This field is keyable for an ADD only.

7. Field 11 - OVERPAYMENT DETERMINATION DATE (O/P DETERMINE DATE)

For an ADD, this field will be blank. For an UPDATE, it will contain the date that was previously entered in MMDDYYYY format.

This field is keyable for an ADD only.

8. Field 12 - OVERPAYMENT SOURCE CODE (O/P SOURCE)

For an ADD - the Field initially is blank and requires one of the source codes from the source table.

For an UPDATE - This field contains the code that was entered initially when the overpayment was put into the system.

SOURCE CODES

B -- Medical Review

C -- Utilization Review

D -- End of Line Review

E -- Special Review

F -- MSP Review

G -- CMS Review

H -- Central Office Review

I -- Inspector General (IG) Review

J -- GAO Review

K -- Beneficiary

L -- Physician/Supplier

M --

N --

O -- Other

P –

Q –

R –

S –

T –

U –
V –

W—

X – Advance Payments

Y—

Z--

9. Field 13 - OVERPAYMENT CAUSE (O/P CAUSE)

For an ADD - This field is blank and requires one of the codes from the cause table.

For an UPDATE - This field contains the cause code that was initially entered into the system.

CAUSE CODES

A -- Duplicate Payment/Duplicate Claim - Carrier Error

B -- Wrong Payee - Carrier

C -- Service Not Rendered

D -- Service Not Necessary

E -- Payment Exceeded Allowable Limit

F -- Payment Exceeded Psy/PT Limit

G -- Service Not Covered

H -- Duplicate Pmt/Clm - Physician/Supplier

I -- Medicare Secondary Payer

J -- Coding/Billing - Errors

K -- Wrong Payee - Physician/Supplier Error

L --

M --

N -- Unallowable Concurrent Service

O -- Other

P –

Q—

R—

S –

T –

U—

V –

W –

X— Advance Payments

Y—

Z –

0 -- Reactivate – Other (Includes Deceased Debtor)

10. Field 14 - ORIGINAL OVERPAYMENT AMOUNT (ORIGINAL)

This field will contain the total overpayment amount.

For an ADD - This field will initially contain the underlines.

For an UPDATE - This field will display the total overpayment amount.

IT IS NOT KEYABLE.

11. Field 15 - INTEREST RECOUPED TO DATE (INT REC)

For the life of the overpayment, the field reflects the total of all interest collected.

IT IS NOT KEYABLE.

For an ADD - This field will initially contain the underlines.

For an UPDATE - This field will display the total from the PSOR Master File. If interest collected transaction is entered on the Transaction Line (see fields 20 and 21), this field is changed instantly.

12. Field 16 - OPENING BALANCE (for the current quarter) (OPEN BAL)

This field assists in quarter to quarter comparisons. It is calculated by a batch quarter end program and is not changed until the end of the quarter.

IT IS NOT KEYABLE.

For an ADD - This field contains the underlines.

For an UPDATE - This field is not affected. The value that is displayed is the last quarter end calculated amount.

13. Field 17 - TOTAL RECOUPED TO DATE AMOUNT (RECOUPED)

For the life of the overpayment, the field reflects the current total of all recouped monies.

IT IS NOT KEYABLE.

For an ADD - This field will initially contain the underlines.

For an UPDATE - This field will display the total from the PSOR Master File. If a recoupment transaction is entered on the Transaction Line (see fields 20 and 21), this field is changed instantly.

14. Field 18 - RECOUPMENT ADJUSTMENT AMOUNT ENTERED TO DATE (REC. ADJ.)

This field will contain the total of all recoupment adjustment transactions entered for the overpayment.

IT IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

For an UPDATE - This field will initially contain the data value from the Master File. If a recoupment adjustment transaction is entered, this field and the CUR/BAL field (field 19) are updated instantly to reflect the change.

15. Field 19 - ENDING BALANCE (CUR BAL)

This field reflects the current balance of the overpayment. It is recalculated after every financial transaction is entered.

IT IS NOT KEYABLE.

The calculation required to arrive at this figure is the ORIGINAL-OVERPAYMENT-AMOUNT (Field 14) minus RECOUPMENT-TO-DATE (Field 17) minus RECOUPMENT-ADJUSTMENT-TO-DATE (Field 18).

16. Fields 20 and 21 - TRANSACTION CODES AND TRANSACTION AMOUNTS

These fields, four transaction code fields and four transaction amount fields, are the heart of the MASTER SCREEN. They are contained on the Transaction Line, which will accommodate all possible FINANCIAL information to be entered.

The 11 transaction codes are located and maintained in the System Table File.

TRANSACTION CODES

AA -- Add Overpayment Amount
AO -- Adjust Overpayment Amount or Record
BB -- Add Recouped Amount
BR -- Change Recouped Amount
CC -- Interest Collected
CI -- Change Interest Collected
CN -- Closed - No Collection
CP -- Closed - Partial Collection
DE -- Delete - Error
DH -- Delete - Hearing Decision
RO -- Reopen Closed Case

17. Field 22 - STATUS CODE (STATUS)

This field represents the status of the overpayment case as it proceeds through the recovery process. See following codes.

STATUS CODES

Category	Status Code	Description/When to Use
Demand Letter	I	Initial Entry (first demand letter)
	V	Follow-up Letter Sent (second demand letter)
	Q	DCIA Intent Letter Sent/Pending Referral to DCC
Recoupment	U	Offset Initiated
	Z	Partial Payment and/or Interest Received (overpayment not yet paid in full) (temporary- status code should be changed after use)
ERS	R	Repayment Being Negotiated
	S	Repayment Schedule Approved
Appeal	A	Case is pending Appeal (Review, Hear, ALJ Hearing)
	H	Hearing Reversal (Overpayment negated)
		Delete
Bankruptcy	B	Physician/Supplier has filed for Bankruptcy
Fraud	K	Active Fraud and Abuse Investigation- on suspension by Contractor Fraud Dept, RO, CO, or OIG
Compromise	C	Case Compromised and/or pending compromise (by OGC, ARA for DFM, or CFO in CO)
Error	E	O/P in Error (Only used with DE) (Deletes overpayment from master file)
Close	F	Fully Recovered, Close

	N	Write off closed with a balance (Only used with CN) (Must receive approval from ARA for DFM, OGC, or CFO in CO)
	P	Close with a balance due to bankruptcy (Only used with CP) (Authority to close must be received from Lead RO)
	Y	Closed w/Balance - DCC Fee
Litigation	L	In Litigation (any litigation circumstance)
Debt Referral	G	Debt returned from DCC (waiting further action by Carrier so debt can be referred again)
	X	Referred to PSC Cross Servicing (DCIA letter sent)
CNC	1	Currently Not Collectible (CNC)
	3	CNC - DCIA letter sent
	4	Reactivate - Bankruptcy
	5	Reactivate - Payment received
	6	Reactivate - Appeal/Litigation/Fraud & Abuse Invest.
	7	Reactivate - Compromise
	8	Reactivate - Extended Repayment Agreement
	9	CNC Debt - Written-off/Closed (w/valid closed date)
	0	Reactivate - Other (includes Debtor Deceased)

Effective 10/01/03 the CNC Status Codes should be used in the CNC Code field not in the Status Code Field. When inputting a CNC Status Code a CNC Date should also be entered. The existing status code shall remain and shall be accurate as to the status of the debt. (For example bankruptcy, debt referral, appeal, fraud) The CNC Status Code field and the CNC Date field should not be used until written approval for CNC Classification is received from the Regional Office.

Referred	W	Case Referred (To RO, To CO)
Other	M	Amend/Change Record- Only for Summary Entries
	D	Debtor Deceased - In Probate

When determining the most accurate status code carriers must remember that certain status codes/categories take precedence over others:

Bankruptcy supersedes all other status codes
Appeal supersedes all other status codes except for bankruptcy and litigation

Litigation supersedes all other status codes except for bankruptcy
ERP supersedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation
Debt Referral supersedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation

18. Field 23 - LOCATION

This field identifies the current location of the overpayment case.

For an ADD, this field is mandatory and must be equal to the value 'CAR'.

For an UPDATE, the user may change the location field by keying directly over the field. There are fourteen valid location codes which can be used. They are:

LOCATION CODES

CAR -- Carrier

ROA -- Regional Office

COA -- Central Office Claims Collection Officer

OIG -- Office of the Inspector General

GAO -- General Accounting Office

GCR -- Office of the General Counsel - RO

GCC -- Office of the General Counsel - CO

DJD -- Department of Justice - DC

DJR -- Department of Justice - RO

DJB -- Department of Justice Bankruptcy

COL -- Collection Agency

DCM -- Central Office – Debts at DCC

CDC -- Carrier - Debts at DCC

DC# -- (DC1, DC2, DC3, DC4, DC5, DC6, DC7, DC8, DC9, DC0)
Regional Office – Debts at DCC

19. Field 24 - CLOSED DATE

This field is a 8-position date in MMDDYYYY format. It identifies the date on which the overpayment was recovered or the case closed as unrecoverable.

This field is fully Keyable for an ADD or UPDATE function. The date must be a valid 8-position date in MMDDYYYY format and must pass the following interrelationship edits.

If the outstanding balance (field 19) is zero, a closed date must be entered.

If the outstanding balance is not zero, the status code must be E, H, N, or P.

20. Field 25 - SCREEN FUNCTION

This field displays the word 'ADD' if an 'I' was the Function Code that was selected on the Request Screen. It will be 'UPDATE' if the 'U' Function Code was selected.

IT IS NOT KEYABLE.

21. Field 26 – STATUTE DATE

The system will automatically compute the statute date 6 years from the determination date.

22. Field 27 – Bankruptcy Y/N?

If a bankruptcy was filed enter "Y" for yes, if not, enter "N".

23. Field 28 – BANKRUPTCY TYPE

Enter the type of provider bankruptcy: Chapter 7, 9, 11, and 13.

Chapter 7

Debtors file Chapter 7 bankruptcies to obtain discharge of their debts. Companies that file under Chapter 7 generally close.

Chapter 9

Chapter 9 bankruptcies involve municipalities such as a hospital district. Chapter provides for reorganization, much like Chapter 11.

Chapter 11

Debtor file Chapter 11 to reorganize the debtor individual or business. To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan").

Chapter 13

Chapter 13 bankruptcies adjust the debts of individuals (including sole proprietorships) with a regular income. Generally, debtors must file a debt adjustment plan within 15 days after filing.

24. Field 29 – BANKRUPTCY DATE

This field is an 8-position date in MMDDYYYY format. Enter the date of the bankruptcy filing.

25. Field 30 – CNC DATE

This field is an 8-position date in MMDDYYYY format. Enter the Currently Not Collectible date within 10 days of receiving written approval for CNC Classification from the Regional Office.

26. Field 31 – CNC CODE

This field is a 2-position code. Enter the appropriate CNC Status Code from the Status Code Listing under number 17 (Field 22) within 10 days of receiving written approval for CNC Classification from the Regional Office.

Transactions Processing

- When considering the overall process, there are some general comments and/or instructions.

All four sets of fields can be used for any transaction, in any order. There is no rule about starting in the left most set.

Except for the Overpayment Full Delete and Closed Case transactions, these sets must be used in pairs, transaction code and transaction amount.

The AA transaction (the original overpayment) must be the first transaction entered on an ADD.

When entering multiple transactions, enter one and TAP the ENTER key or use all four sets of fields and amounts before you TAP the ENTER key.

The error message line is the last line on the screen. Only one error message at a time is displayed (in bright characters) and the cursor is positioned at the field in error. If you have more than one error, the second and subsequent ones will be displayed as their predecessors are corrected.

If you have displayed the MASTER SCREEN for either an ADD or UPDATE function and you do not wish to continue - For Any Reason - TAP the F3 key and the program will return you to the REQUEST SCREEN.

NOTE: In doing this you will lose changes you have made to the add/update screen. If you were in an Add function, add the overpayment case again starting with the request screen.

If you are keying in a transaction code and you need assistance with what code to use, or what codes are available, TAP the F1 key for HELP. This action will display the HELP SCREEN (see FIGURE 10) which allows the user to select the codes available with their descriptions.

After you have found the necessary information on the HELP screen, TAP the F3 key and the program will return you to the ADD/UPDATE Screen.

If you are working with the ADD/UPDATE screen and you wish to view the detail transactions for this overpayment case, TAP the F4 key. The program will display the TRANSACTIONS HISTORY SCREEN (see FIGURE 9). This screen shows you every financial transaction that was entered for the case.

When you have finished reviewing the TRANSACTIONS HISTORY SCREEN, TAP the F3 key to return to the MASTER SCREEN.

All financial transactions entered into the PSOR System can be divided into three major categories: OVERPAYMENTS, INTEREST and RECOUPMENTS. Following are specific instructions for entering each transaction into the PSOR System using the Transaction Line.

NOTE: See “ENTERING SUMMARY DATA ON OVERPAYMENTS OF LESS THAN $600” for instructions on entering summary information for overpayments of less that $600.

- OVERPAYMENT TRANSACTIONS

This includes three types of overpayment transactions; ORIGINAL OVERPAYMENT, OVERPAYMENT ADJUSTMENT AND OVERPAYMENT FULL DELETES.

ORIGINAL OVERPAYMENT

The only valid transaction code for use in the ADD function is 'AA'.

Must be the first financial transaction entered when adding an overpayment.

The amount field must be numeric.

The amount will be moved to field fourteen (14) on the MASTER SCREEN and into the appropriate master record field when the ADD function is complete.

Enter only one (1) 'AA' transaction for an ADD.

An original overpayment transaction (AA) is invalid for an update.

When the ADD function is complete, the transaction code and amount are written to the Open Transaction File and Open Master File.

OVERPAYMENT ADJUSTMENTS

The only valid transaction code is 'A0'.

It adjusts the original overpayment amount.

The adjustment adds to, or subtracts from, the original overpayment amount in the master file the amount on the overpayment adjustment transaction.

The original amount (AA transaction) is still on the transaction file and cannot be deleted.

This amount, positive or negative will be written to the transaction file along with the transaction code.

All overpayment adjustment amounts must be numeric.

Overpayment adjustments are invalid during the ADD process.

OVERPAYMENT FULL DELETES

These are powerful tools which must be handled with care. There are two codes which functionally are identical, that will logically zero balance an overpayment case and allow that case to be closed.

Valid Codes are 'DE and DH'.

These codes are exactly the same.

A Closed Date is Mandatory and the case will officially be closed.

All "FULL DELETED" cases will be bypassed by all quarter and batch reporting programs; therefore, the dollar amounts on all fully deleted cases will not be reflected in any report.

Process an OVERPAYMENT FULL DELETE as follows:

Enter a valid overpayment full delete transaction code in any of four transaction code fields on the transaction line.

NO AMOUNT IS REQUIRED IN THE TRANSACTION AMOUNT FIELD FOR A FULL DELETE TO PROCESS.

TAP the ENTER key.

The PSOR program performs the following:

(1) The program issues an applicable warning message asking the User if he is absolutely sure he wants to process a full delete.

(2) If you want the full delete to take place, re-enter an overpayment full delete transaction code, and TAP the ENTER key.

(3) Writes a record to the transaction file using the overpayment full delete transaction code and an amount field equal to zeros.

(4) The full delete transaction is processed and the case is closed.

- INTEREST TRANSACTIONS

This includes two types of interest transactions: interest collected and change interest collected.

Interest Collected

Valid transaction code is 'CC'.

The amount must be numeric and positive.

The transaction code 'CC' and the amount may be keyed into one of the "sets" on the transaction line.

When the ENTER key is TAPPED, the transaction, after being thoroughly edited, is added to the Interest Recouped to Date field (field 15) on the screen and to the appropriate Master File fields.

A record including the transaction code is written to the transaction file.

Change Interest Collected

Valid transaction code is 'CI'.

These transactions adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars stay on the Master and Transaction Files. CMS uses the appropriate 'Recoupment Adjustment Transaction' to effect the required monetary change.

To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, key in the 'dash/hyphen' after the amount.

After keying in the appropriate Recoupment Adjustment Transaction Code and amount, TAP the ENTER key.

The amount, after thorough editing, is added to the 'INT REC' field (field 15) on the screen and to the same field in the Master File.

After the Master File is updated, a record is written to the transaction file with the transaction code.

- RECOUPMENT TRANSACTIONS

This includes two types of recoupment transactions: REGULAR RECOUPMENT and RECOUPMENT ADJUSTMENTS.

Regular Recoupment

Valid transaction code is 'BB' only.

Must be the first 'recoupment' transaction entered for an overpayment case.

The amount must be numeric and positive.

The transaction code of 'BB' and the amount may be keyed into one of the 'sets' on the transaction line.

When the ENTER key is TAPPED, the transaction, after being thoroughly edited, is added to the RECOUPED-TO-DATE (field 17) field on the screen and to the appropriate Master File fields.
A record including the transaction code and amount is written to the transaction file.

Recoupment Adjustments

Valid transaction code is 'BR'.

These transactions adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars stay on the Master and Transaction Files. CMS uses the appropriate 'Recoupment Adjustment Transaction' to effect the required monetary change.

To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, key in the 'dash/hyphen' after the amount.

After keying in the appropriate Recoupment Adjustment Transaction Code and amount, TAP the ENTER key.

The amount, after thorough editing, is added to the 'REC.ADJ.' field (field 18) on the screen and to the same field in the Master File.

After the Master File is updated, a record is written to the transaction file with the recoupment adjustment transaction code.

Closed Cases

There are 2 transaction codes used for closing cases: CN, and CP.

When any of these codes are entered, the overpayment is closed on the day the code is entered, unless a closed date is also entered.

When an overpayment is closed and there has not been any collection against it, enter code 'CN'.

When an overpayment is closed while there is still an outstanding balance and collections have been made, enter code 'CP'.

Reopening Closed Cases (Central Office Only)

Use the transaction code 'RO' to open a case that had been closed in the current quarter.

ENTERING SUMMARY DATA ON OVERPAYMENTS OF LESS THAN $600

The following instructions apply only for entering summary information on cases of less than $600:

Enter the new and updated summary records each month using the 25th day of the current month as the claim paid date and the determination date. Enter the information no later than the last working day of the current month:

- Physician overpayments from $10 to $599, along with any recoupments, adjustments, and/or interest collected.

1. PHYS/SUP #: Enter 099999999

2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, the 25th day, and the year for which data is being summarized.
4. FUNCTION: Enter an I, then TAP ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, 25th day, and the year for which the data is being summarized.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records.

9. OPEN CLAIMS: Enter the number of claims being summarized, preceded by zeros. Update this field by overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $10 or more than $599, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record The summary record will remain open on the PSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $25 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago

b. The cases had no collection activity within the 180 days.

c. The original amount of each case is under $25.

The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8. TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

- Supplier overpayments from $10 to $599, along with any recoupments adjustments, and/or interest collected.

1. PHYS/SUP #: Enter 088888888
2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, the 25th day, and the year for which data is being summarized.

4. FUNCTION: Enter an I, then TAP ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, the 25th day, and the year of the month.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter a CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records.

9. OPEN CLAIMS: enter the number of claims being summarized, preceded by zeros. Update this field by overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $10 or more than $599, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record: The summary record will remain open on thePSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $25 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago.

b. The cases had no collection activity within the 180 days.

c. The original amount of each case is under $25.

The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8. TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

- Physician and Supplier overpayments of less than $10, along with any recoupments.

1. PHYS/SUP #: Enter 077777777

2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, 25th day, and the year for which data is being summarized.

4. FUNCTION: Enter an I, then tap ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, 25th day, and the year for which the data is being summarized.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records

9. OPEN CLAIMS: Enter the number of claims being summarized, preceded by zeros. Update this field by OPEN overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $1 or more than $9, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record: The summary record will remain open on thePSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $10 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago.

b. The cases had no collection activity within the 180 days.

c. The original amount of each case is under $10.
The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8. TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

INSTRUCTIONS FOR PROCESSING THE CMS PHYSICIAN/SUPPLIER OVERPAYMENT REPORTING SYSTEM

TRANSACTIONS HISTORY SCREEN

General Information Concerning This Screen (FIGURE 9).

Use this screen for inquiry purposes only.

This screen may be displayed only from the REQUEST and MASTER Screens.

The information on this screen is governed by the same security hierarchy as for the Request Screen.

There are two primary objectives:

a. To provide an audit trail of all financial transactions that were entered for the list of an active, open case. The audit trail provides the users with instant information about a specific case or groups of cases. It identifies which User entered the data, when it was entered and how that action affected the balance.

b. The second objective is to have the physical protection of the Transaction File in case something should happen to the Master File. CMS could use the Transaction File to 'rebuild' the financial portion of the online Master File.

The screen is divided into the screen header line and the screen body.

The header line is represented by the line of dashes on the second line from the top of the screen.

It contains the entire record key that was requested for the screen to display.

If this screen display was 'requested' from the ADD/UPDATE processing, this header line 'record key' will be a specific 37 position key.

If this screen was requested from the REQUEST SCREEN using the 'B' function, the header line 'record key' may have from 2 to 39 positions filled in. This is the generic key search.

NOTE: An RO User may key in just the region number and 'B' function on the REQUEST SCREEN and TAP the ENTER key. This will display the Transaction History Browse Screen showing ALL open overpayment cases for that region. Carriers may do the same function, but, because of the security table, carriers must also key in their carrier number on the REQUEST SCREEN.

The screen body consists of sixteen (16) detail lines showing the 11 individual fields on each line.

If there are more than 16 lines of detail you may TAP the F8 key to page forward or F7 to page backward.

Specific Information Concerning the Fields Displayed.

Fields 1 through 5 (Region No. through Claim Paid Date).
These constitute the overpayment record key. They will be printed.

Field 6 - OPERATOR ID (OP/ID)-This is a primary security code.

Field 7 - TRANSACTION ENTRY DATE (Entry Date)

Field 8 - TRANSACTION CODE (TR CD)

Field 9 - STATUS CODE (ST)-This shows the associated status code.

Field 10 - TRANSACTION AMOUNT ($ Amount of Trans)- This field displays the edited dollar amount which was keyed by the User on the MASTER SCREEN.

Field 11 - BALANCE (Balance Remaining)- This is a 'Running Balance' for the overpayment. It is recalculated after each successful financial update to the PSOR Master File. It provides a display of the current balance.

INSTRUCTIONS FOR PROCESSING THE CMS
PHYSICIAN/SUPPLIER OVERPAYMENT REPORTING SYSTEM

HELP SCREEN

General Information Concerning the Screen (FIGURE 10).

The screen contains all current, valid codes in the system along with their descriptions. The HELP screen is only available from the ADD/UPDATE Master Screen.

It provides the terminal User with online assistance at data entry. This happens during code selection and entry on the MASTER SCREEN.

If you forget the code to use or do not remember which ones are available:

TAP the F1 key for HELP

This will display the HELP SCREEN shown in FIGURE 10. When you finish reviewing the HELP SCREEN:

TAP the F3 key to return to the same position on the MASTER SCREEN.

180.2.3 ADVANCE PAYMENTS USER MANUAL

(Rev. 22, 10-03-03)

INSTRUCTIONS FOR PROCESSING THE CMS
ADVANCE PAYMENTS REPORTING SYSTEM

The accompanying pages provide a screen-by-screen instructions for entering part B advance payment data into the Advance Payments Reporting (APR) System. This system is designed for use by the Medicare carriers for adding, updating, and closing advance payments made to physicians/suppliers. The APR System is a modified version of the PSOR System. An advance payment should be entered into the APR System within 10 days of the advance payment being issued. It should stay in the APR System until the advance payment is demanded. Any adjustments, recoupments or updates to the advance payment should be made within 10 days of their occurrence in the APR System. Once the advance payment is demanded, the advance payment should be posted onto the PSOR System.

The pages that follow illustrate each screen on your PC as you reach the next step in the data entry process. Each page contains thePC screen and an instruction that provides the steps needed to complete the entries required on the current screen. As each screen field entries are completed, the next screen will appear on the PC.

HCFA - PART B - ADVANCE/OVER PAYMENTS - INITIAL SCREEN

YOUR OP-ID: ....
SELECT EITHER OVERPAYMENT OR ADVANCED PAYMENT

ENTER "PORB" FOR OVERPAYMENT
ENTER "ADVB" FOR ADVANCE PAYMENT

SELECTION: ....

(MAKE SELECTION AND PRESS <<ENTER>>)

INSTRUCTIONS

- Key in your USER-ID in the “Your OP-ID:” field
- Type “ADVB” in the “Selection:” field and tap the enter key

Note: The user has the option of entering the PSOR system by typing “PORB”in the “Selection:” field and tapping the enter key.

HCFA - PART B - ADVANCE PAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 REGION CARRIER # 00000

PHYS/SUP # .....

CLAIM # ..... ADVANCE PAYMENT DATE MMDDCCYY

FUNCTION . I = ADD A NEW ADVANCE PAY RECORD TO THE MASTER FILE,

U = UPDATE AN EXISTING ADVANCE PAY MASTER FILE RECORD,

PRESS F3 TO END SESSION...
PRESS ENTER KEY TO CONTINUE

Instructions

- Type in the Physician/Suppler number in the “PHY/SUP #” field and the claim number in the “CLAIM #” field.
- Type in the “ADVANCE PAYMENT DATE” field, the date of the advance payment check.
- Type “I” in the “FUNCTION” field, tap the ENTER key, to add the new advance payment to the master file.

HCFA - PART B - ADVANCE PAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 _____ CARRIER # 00000 _____

PHYS/SUP # 000000000

CLAIM # 000000000000000 ADVANCE PAYMENT DATE 00000000

THIS PROVIDER HAS OUTSTANDING OVERPAYMENTS!

IS ADVANCE PAYMENT JUSTIFIABLE? (Y OR N) .

PRESS F3 TO END SESSION...
PRESS ENTER KEY TO CONTINUE

INSTRUCTIONS

- If the physician/supplier has an overpayment balance, the above screen will appear.

- Type “Y” and tap the enter key to continue to the Master Screen.
- Type “N” and tap the enter key to enter another case or log off the system.

Note: It is your option whether to continue to enter an advance payment on the system if the physician/supplier has an outstanding overpayment that is delinquent.

```
HCFA - ADVANCE PAYMENT SYSTEM MASTER SCREEN

REGION # 00                  REGION CARRIER # 00000

PHYS/SUP # 000000000  PHYS/SUP NAME           SPCLTY CODE 00  STATE

 CLAIM  # 000000000000000       ADVANCE PAYMENT DATE     00000000

A/P DETERMINE DATE .....  A/P SOURCE  X   A/P CAUSE  X  ORIGINAL $ _____
    STATUTE DATE _____

 BANKRUPT Y/N? .  BANKRUPTCY TYPE ..  BANKRUPTCY DATE .....

          OPEN BAL      RECOUPED      REC. ADJ.     CUR BAL
        $ _____   $ _____   $ _____   $ _____

TRANSACTIONS AA $ ..... .. $ ..... .. $ ..... .. $ .....

               STATUS   .   LOCATION  CAR    CLOSED DATE   .....

PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN
PRESS F1 KEY FOR HELP;     PRESS F4 KEY FOR TRANSACTIONS BROWSE
```

INSTRUCTIONS

- Type in the “A/P” DETERMINATION DATE” field, the date of the advance payment check.
- Type “X” in both the “Á/P SOURCE” and “A/P CAUSE” fields.
- Key in the remaining information and follow the instructions in Section 80.2, PSOR USER MANUAL, to update and close the case.

Note: This screen will appear if a physician/supplier advance payment is to be entered into the APR System.

```
DEPARTMENT OF HEALTH AND HUMAN SERVICES          Terminal
                HCFA DATA CENTER                 HDC91158

                        //
          HH     HH    DDDDDDD///      CCCCCCC
          HH     HH     DD   ///D     CC      CC
          HH     HH     DD  ///DD     CC      CC
          HHHHHHHHHH     DD /// DD     CC
          HHHHHHHHHH     DD -///DD     CC
          HH     HH     DD /// DD     CC      CC
          HH     HH     DD///  DD     CC      CC
          HH     HH    DD///DDDD       CCCCCCC
                  //
             THIS IS THE HCFA ESRV  LPAR

        PLEASE HIT 'ENTER' FOR APPLICATION SELECTION MENU
      (THE ACTION DESK PHONE IS: (410)-786-2580 or 1-800-562-1963)
           (THE HDC STATUS PHONE IS: (410)-786-2599)
!!!!! PLEASE HIT PF12 AT THE APPLICATION MENU FOR  LATEST HCFA NEWS !!!!!

****************** B R O A D C A S T   M E S S A G E S *********************
   ** PLEASE CHECK CMS NEWS FOR THE LATEST SYSTEM INFORMATION ***
   ************** HIT PF12 AT THE APPLICATIONS MENU *************
   ************************************************************
```

FIGURE 1

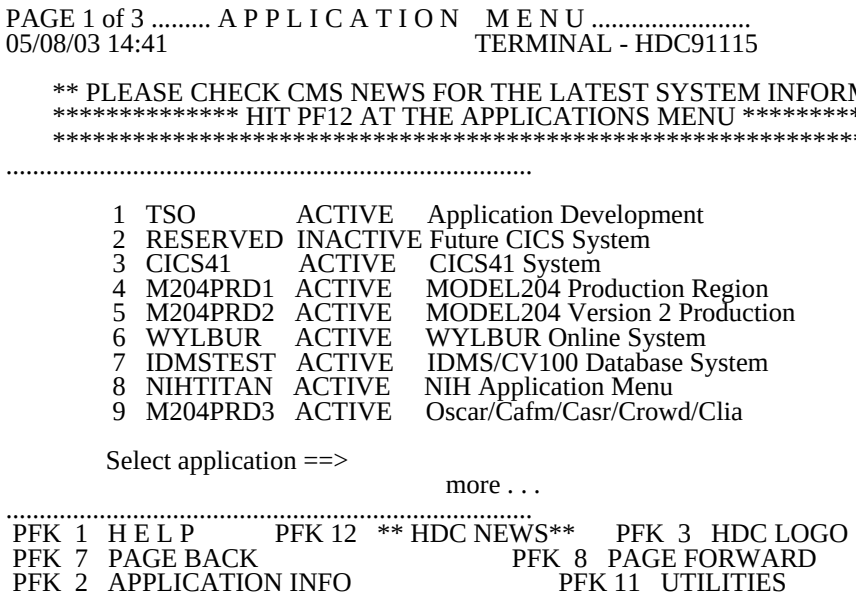

FIGURE 2

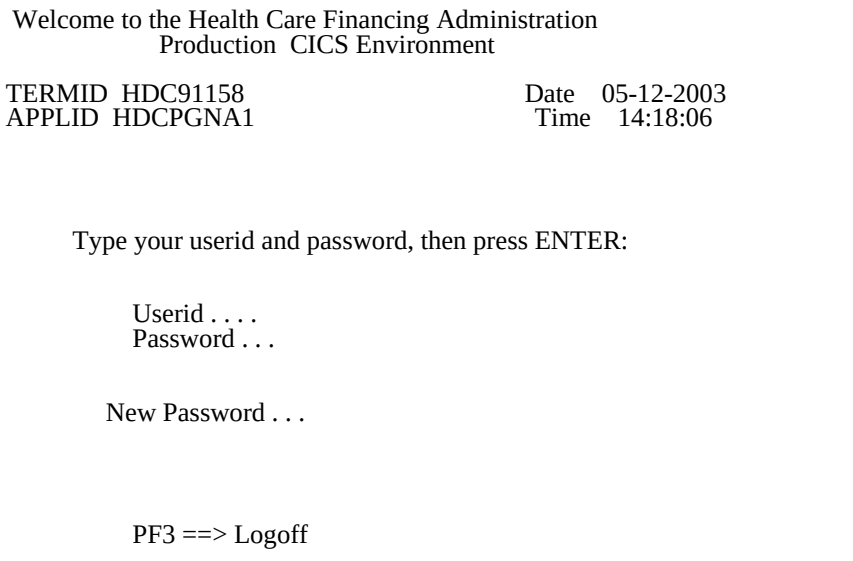

FIGURE 3

Welcome to the Health Care Financing Administration
Production CICS Environment

TERMID HDC91115 Date 05-08-2003
APPLID HDCPGNA1 Time 14:47:43

1 Provider Overpayment Recovery
2 Physicians Supplier Recovery
3 POR Provider File Maintenance
4 Exit CICS

Please enter an Option Number ===> Hit F1 for Help

FIGURE 4

PSOR SYSTEMS BROADCAST SCREEN
SYSTEMS UPDATE HISTORY
****

THE HELP SCREEN TEXT HAS BEEN REPOSITIONED

A CNC DATE FIELD HAS BEEN ADDED TO THE MASTER SCREEN

THE PHYSICIAN/SUPPLIER NAME NOW ALLOWS FOR FORTY CHARACTERS

(PRESS <<ENTER>> TO PROCEED)

FIGURE 5

HCFA - PART B - ADVANCE/OVER PAYMENTS - INITIAL SCREEN

YOUR OP-ID: ....
SELECT EITHER OVERPAYMENT OR ADVANCED PAYMENT

ENTER "PORB" FOR OVERPAYMENT
ENTER "ADVB" FOR ADVANCE PAYMENT

SELECTION: ....

(MAKE SELECTION AND PRESS <<ENTER>>)

FIGURE 6

HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 (Region Name) CARRIER # 00000 (Carrier Name)

PHYS/SUP # ..... (LEFT JUSTIFIED)

CLAIM # ..... CLM PAID DATE MMDDYYYY

FUNCTION . I = ADD A NEW OVERPAYMENT RECORD TO THE MASTER FILE,

U = UPDATE AN EXISTING OVERPAYMENT MASTER FILE RECORD,

B = BROWSE OVERPAYMENT TRANSACTIONS

PRESS F3 TO END SESSION...
PRESS ENTER KEY TO CONTINUE

FIGURE 7

```
       HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - MASTER SCREEN …25…

REGION #  ___1_____    (REGION NAME)    CARRIER #  ____2____(CARRIER NAME)

PHYS/SUP #     _____3______ PHYS/SUP NAME  ………..8……….   SPEC CODE ..9..  STATE ..10..

  CLAIM  #  ____________4_________________   CLM PAID DATE  _____5___

O/P DETERMINE DATE   …11…  O/P SOURCE   ..12..  O/P CAUSE  …13..    ORIGINAL$ ..14..
      STATUTE DATE  __26_

  BANKRUPT Y/N? ..27..  BANKRUPTCY TYPE  ..28..   BANKRUPTCY DATE  ..29..
  CNC DATE    ..30..
   INT REC       OPEN BAL        RECOUPED         REC. ADJ.      CUR BAL
$ ….15….       $ …..16…..       $ …..17……        $ ….18….       $ …19…..

TRANSACTIONS  ..20.. $ …..21…..   ..20... $ …..21…..  ..20..$ …..21…..   ..20.. $ …..21…..

OPEN CLAIMS  <N/A>    STATUS  …22…  LOCATION  …23…   CLOSED DATE  …24…

PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN
PRESS F1 KEY FOR HELP;     PRESS F4 KEY FOR TRANSACTIONS BROWSE
```

FIGURE 8

```
    HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - TRANSACTIONS HISTORY
00   00000    000000000  000000000000000 ______                    PAGE      1
RG CARR. PHY/SUPPL  CLAIMANT     PAYMENT OP/  ENTRY  TR   S   $ AMOUNT    BALANCE
 #     #           #              NUMBER        DATE       ID     DATE   CD   T    OF TRANS   REMAINING

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PRESS F7 TO PAGEBACK; F8 TO PAGE FORWARD; F3 TO RETURN TO PREVIOUS SCREEN
  TRANSACTION HISTORY ENDS ON THIS PAGE
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FIGURE 9

HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT ASSISTANCE MENU

SELECT THE CATEGORY WANTED

ENTER "03" FOR SPECIALTY CODES
ENTER "04" FOR LOCATION/TRANSACTION CODES
ENTER "05" FOR SOURCE CODES
ENTER "08" FOR STATUS CODES
ENTER "09" FOR CAUSE CODES

PLEASE ENTER SELECTION:

PRESS PF3 KEY TO RETURN TO MASTER SCREEN

FIGURE 10

ATTACHMENT A

PART A PROVIDER OVERPAYMENT

REFERRAL CHECKLIST

(CMS Pub. 100-6, §140)
REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Intermediary Name _____ Date Prepared:_____

Intermediary No. that OP is reported under on POR _____

Intermediary No. that OP is reported under on Accounts Receivable Report (751) _____

I. Provider & Overpayment Information
(All information that has corresponding field on Provider Overpayment Report (POR) must agree with POR. Discrepancies should be immediately resolved rather than the form delayed.)

A. Provider Name _____ B. Provider No._____

C. Cost Report Period_____

D. Responsible Individual(s) (Most Current)

Name: _____ Title: _____

Address: _____

City, State, Zip: _____ Telephone:_____

E. Overpayment Information (List information for each outstanding overpayment)

**Original Amount _____ **Interest Assessed _____/Rate

*Principal Recouped _____ *Interest Recouped _____

Principal Referred _____ Interest Referred

Through Date ____/____/_____

F. Overpayment Type _____ G. Determination Date _____

H. Intermediary Control #_____

NOTE: If unfiled cost report is the overpayment type, indicate the date unfiled cost report is (was) due to be filed, as well as the interim payments.

*Attach detailed information with case regarding recoupments, include dates applied.
**Include copies of the Master screen from the POR, for both principal and interest.

Part A Referral Checklist

II. Accounts Receivable Reporting
(All information reported in I.E. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line	Amount
A. HI Principal Reported on H751 Part A as transferred to RO		
Line Reported on		
HI Interest Reported on H751 Part A as transferred to RO		
Line Reported on		
SMI Principal Reported on H751 Part B as transferred to RO		
Line Reported on		
SMI Interest Reported on H751 Part B as transferred to RO		
Line Reported on		
Total		

B. Indicate quarter information was reported on the H751 ___/___/

III. Collection Efforts

(For items III A-C, unless there is a postpetition demand letter, this information would not be relevant to recovering in bankruptcy).

A. Include copies of the First, Second and Third demand letters (Ref. CMS Pub. 13-2, § 2222). If full series of letters was not sent, explain why.

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all; (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other legal entities

D. The contractor must establish whether or not a particular provider is participating in the Medicaid Program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 13-2, § 2226ff. PARTICIPATING: Yes ____ No ____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

E. Is the provider listed in the Fraud Investigation Data Base? (FID) Yes ____ No ____

Part A Referral Checklist

IV. Ownership

Check the appropriate ownership affiliation:

A. ___ INCORPORATED
Chain Organization Yes ___ No ___
If yes, who is the home office intermediary ? _____
Incorporation Date _____
EIN #_____

B. ____ PARTNERSHIP
EIN # _____

1) If partnership, list names and SS# s of all partners. 2) If Corporation, list names and addresses of officers. 3) If Chain organization, list other provider names, addresses, and provider numbers.

_____

_____

_____

_____

_____

C. Is "Responsible Individual(s)" information the most current? Yes _____ No _____
Provide alternate contact(s), Name, Title, Address and Telephone Number

_____

_____

_____

_____

_____

D. Are claims for services still being submitted? Yes _____ No _____
If yes, why is referral being made. _____

_____

E. Has there been a change of ownership? Yes _____ No _____
If yes, what is the date?_____
Has the new owner assumed the previous owner's provider agreement? Yes _____ No_____
(Provide copy of sales agreement.)

F. Has recoupment from new owner been attempted? Yes _____ No_____

Part A Referral Checklist

V. General

A. Is the provider still participating in the Medicare program? Yes _____ No_____

Note: If the provider is still participating in the program and claims recoupments are being made, do not transfer case to the RO.

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes _____ No_____
Copies of pertinent court documents should be submitted. Take the following program safeguard actions when a bankruptcy situation is identified:

- Adjust interim payment calculation to ensure that no overpayment is made
- Consult the CMS RO before applying any disposition regarding cost report underpayments
- Expedite cost report desk reviews and audit settlements
- Tentative settlements should not be made in bankruptcy cases
- Consult the CMS RO regarding any cost reports pending submission and the expected dates of submission

C. Did the provider request an extended repayment schedule (ERS)? Yes _____ No_____
If yes, was it approved? Yes _____ No_____ Length of ERS _____
Number of payments made _____
Attach any financial documentation submitted.

D. Did provider request an intermediary or PRRB hearing? Yes _____ No_____
If yes, do not transfer unless the decisions have been rendered. Submit all pertinent information.

Cases pending a Reopening, Bankruptcy, BCA Review, or PRRB Decision, should not be transferred to the CMS-RO until judgment has been rendered. Copies of all decisions must be included.

INSTRUCTIONS: If you do not provide any requested information, you must give a detailed explanation of why you cannot secure the information. We will return incomplete forms with the entire case.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: _____ PROVIDER NUMBER: _____

OVERPAYMENT AMOUNT: $_____ INITIAL DEMAND LETTER DATE: _____

INTEREST RATE: _____% COST REPORT PERIOD: _____

Payment Date	Period (30 Days)	Interest Charges	Recouped Amounts	Applied to Interest	Interest Balance	Applied to Principal	Principal Balance

PART B PHYSICIAN/SUPPLIER OVERPAYMENT
Referral CHECKLIST
(CMS Pub. 14-3, § 7142.2)

REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Carrier Name _____ Date Prepared: _____

Carrier No. that OP is reported under on PSOR _____ Carrier No. that OP is reported under on Accounts Receivable Report (751) _____

I. Physician/Supplier Overpayment Information
(All information that has corresponding field on Physician Supplier Overpayment Report (PSOR) must agree with PSOR)

A. Phy/Supp. Name _____ B. Phy/Supp No. _____

UPIN _____

C. Responsible Individual(s)

Name: _____ Title: _____

Address: _____

City, State, Zip: _____ Telephone: _____

D. Overpayment Information

**Original Amount _____ **Interest Assessed _____/Rate

*Principal Recouped _____ *Interest Recouped _____

Principal Referred _____ Interest Referred _____

Through date _____

Query if overpayment is based on fraud.

*Attach detailed information with case regarding recoupments, include dates applied.

**Include a copy of the Master screen from the PSOR.
Information requested in E though L is needed for all claims involved in overpayment.

E. Discovery Date _____ F. Determination Date _____

G. DCN _____ H. Cause of OP _____

I. Claim Number _____ J. Claim Paid Date _____

K. Beneficiary Name _____ L. HI Claim No._____

Part B Referral Checklist

II. Accounts Receivable Reporting
(All information reported in I.D. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line	Amount
A. SMI Principal Reported on H751 Part B as transferred to RO		_____
Line Reported on	_____	
SMI Interest Reported on H751 Part B as transferred to RO		_____
Line Reported on	_____	
B. Indicate quarter information was reported on the H751		_____
C. Is this Overpayment reported on the M751		Yes ___ No ____

III. Collection Efforts

A. Include copies of the First and Second demand letters (Ref. CMS Pub. 14-3, Sec. 7142). If full series of letters was not sent, explain why.

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all, (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other numbers).

D. The Carrier must establish whether or not a particular provider is participating in the Medicaid program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 14-3, § 7170.1.
PARTICIPATING: Yes _____ No _____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

Part B Referral Checklist

IV. Ownership

Check the appropriate ownership affiliation:

A. ___ INDIVIDUAL
Tax ID # _____
SS # _____

B. ____ INCORPORATED
Chain Organization Yes ___ No _____
Incorporation Date _____
TIN # _____

C. ___ PARTNERSHIP
TIN # _____

D. Is A Responsible Individual(s) information the most current? Yes _____ No _____
Provide alternate contact(s), Name, Title, Address and Telephone Number

_____

_____

_____

_____

_____

E. Is recovery due from the beneficiary or other 3rd party payor? Yes _____ No _____
If yes, why was recovery not made (enclose copies of letters and replies).

F. Are claims for services still being submitted? Yes _____ No _____
If yes, why is referral being made.

G. Are claims for services/supplies being submitted under another physician/supplier number?

Yes _____ No _____ If Yes, provide alternate number_____

Is the tax identification, or social security number the same as debtor's? If yes, recoupment should be attempted.

H. Has there been a change of ownership? Yes _____ No _____

If Yes, Has the new owner assumed any of the previous owner's liabilities? Yes _____ No _____

(Provide copy of sales agreement.)

Part B Referral Checklist

V. General

A. Is the physician/supplier still participating in the Medicare program? Yes _____ No _____

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes _____ No _____ Please provide copies of pertinent court documents.

C. Did the physician/supplier request an extended repayment schedule (ERS)?
Yes ____ No
If yes, was it approved? Yes ____ No ____ Length of ERS _____
Number of payments made_____
Attach any financial documentation submitted.

D. Did the physician/supplier request a Fair Hearing or ALJ Hearing?
Yes _____ No _____
If yes, do not transfer unless the both fair hearing and ALJ decisions have been rendered. Submit all pertinent documentation.

THIS FORM MUST BE COMPLETE. IF ANY REQUESTED INFORMATION IS NOT PROVIDED, A DETAILED EXPLANATION MUST BE GIVEN AS TO WHY THE INFORMATION CANNOT BE SECURED. INCOMPLETE FORMS WILL BE RETURNED WITH THE ENTIRE CASE.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: _____ PROVIDER NUMBER:

OVERPAYMENT AMOUNT: $_____ INITIAL DEMAND LETTER DATE:

INTEREST RATE: _____% CLAIM NUMBER:

Payment Date	Period (30 Days)	Interest Charges	Recouped Amounts	Applied to Interest	Interest Balance	Applied to Principal	Principal Balance

ATTACHMENT B

CONTRACTOR BANKRUPTCY CHECKLIST

- Send the following information to the RO upon learning that a provider has or may soon file for bankruptcy:
- Provider Name
- Provider Medicare Number
- Provider Address
- Provider Tax Identification Number
- Overpayment Determination Date
- Original Overpayment, Amounts Recouped, Current Balance Reported on the CMS 750/751 reports of principal and interest outstanding balances. Date the receivable was included on the CMS 750/751.
- Overpayment Type
- Fraud and Abuse Overpayments or Investigations
- For Part A Intermediaries, the Cost Report Year
- For Part A Intermediaries, the Cost Reports Settlements Pending Inhouse with Expected Completion Dates
- For Part A Intermediaries, the Cost Reports Pending Submission with Expected Dates
- For Part A Intermediaries, Interim Rate Information by Cost Year for Previous Three Years
- For Part A Intermediaries, Overpayment History by Cost Year for Previous Three Years
- For Part B Carriers or DMERCs, the Claim Numbers Relating to Overpayments
- For Part B Carriers or DMERCs, the Dates of Service for Related Claims
- For Part B Carriers or DMERCs, the Dates of Payment for Related Claims
- Medicare Review Overpayments or Reviews
- Anticipated Reopenings