Medicare Financial Management
Chapter 4 - Debt Collection

Table of Contents

(Rev. 53, 05-27-04)

NOTE: Revision 4 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.

10 - Requirements for Collecting Overpayments - Fiscal Intermediaries
(Rev. 29, 01-02-04)

The following collection activities are the minimum requirements of the Fiscal Intermediary for all overpayments, claim based or cost report based. However, see Chapter 3, §40 for additional instructions for claim accounts receivables.

- Once an overpayment is discovered and a final determination is made a first demand letter should be sent. This first demand letter shall meet the requirements set forth in §20.

- *Once a final determination is made, an accounts receivable shall be created and the overpayment shall be posted onto the POR System. (Cost report receivables only)*

- *If a full payment is not received 15 days after the date of the first demand letter the FI shall start recoupment on day 16. (See Chapter 4, §40) (Cost report receivables only)*

- *If no response is received from the provider 30 days after the date of the first demand letter, a second demand letter shall be sent on day 31. (See Chapter 4, §20.)*

- *If the overpayment is not paid in full by day 30 interest shall begin to accrue on day 31. (See Chapter 4, §30.)*

- *If by day 45 there has been no response or no contact with the provider the FI shall attempt to contact the provider by telephone. Attempted contact shall be completed at various times of the day until contact is made. The FI may cease attempting to contact the provider if the debt is referred to the Department of Treasury, if the provider files for bankruptcy, or under the guidance of CMS. At a minimum FIs shall attempt to call the delinquent provider weekly until contact is made (A voicemail message is not considered contact.). If contact is made, the FI shall determine how the provider plans to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed.*

- *If no response is received from the provider 30 days after the date of the second demand letter, a third demand letter shall be sent on day 61. If the debt is eligible for referral to the Department of Treasury, the third demand letter shall include language indicating an intent to refer the debt to the Department of Treasury if necessary. (See §20.)*

- *If the provider submits an application for an extended repayment plan the FI shall follow the instruction in §50. (An ERP application may be submitted at any time during the collection process.)*

- If the FI cannot reach the provider by telephone or the FI receives any demand letter back as undeliverable the FI shall attempt to locate the provider through other means. Overpayment departments shall refer to provider enrollment applications, Medical Review staff, and Fraud and Abuse staff for further ideas concerning the debtor's whereabouts. Overpayment departments shall attempt to find out if the provider is bankrupt and the names of the owner, partners, or the corporation officers. If the FI has access to an Internet search site, such as Lexis-Nexis® or a similar program, in the Overpayment department or another department this shall also be utilized. If the FI does not have access to a search program the servicing regional office shall be contacted to see if they could be of assistance. All attempts to find the provider shall be documented in the case file.

- If the FI believes the debt may be recovered in litigation, consult with the servicing regional office before referring the debt to the Department of Treasury.

- *After 60 days, if there is no response to the intent to refer letter, the FI shall input the debt into the Debt Collection System for referral to the Department of Treasury for cross servicing and offset. Until the Department of Treasury accepts the debt, the collection of the debt is still the responsibility of the FI. Therefore, collection activities shall not cease until the acceptance from the Department of the Treasury is received. This acceptance shall be noted on the contractor's internal system as well as in the case file. Recoupment by means of withhold will continue by the FI until the debt is collected in full.*

- Throughout all stages of the overpayment FIs shall keep records of all collection activity. These records can be in the overpayment case file or can be stored electronically or a combination of both. Regardless of which storage method is used all records must be retrievable. This includes all correspondence, all collection forms, all checks, and any other piece of the case file that was kept in hardcopy or electronically. This record is in addition to the internal accounting system and the Provider Overpayment Reporting (POR) System. This record shall be detailed and include all conversations and correspondence with the provider. An outside individual shall be able to see a complete audit trail. Hard copy files shall be available immediately upon request. Electronic files must be available within 48 hours of request. Files that have been converted to microfilm must be available within 48 hours of request. Files that have been stored offsite must be available within 72 hours of request. (See Ch. 5 §200 for additional information.)

FIs shall input all cost report overpayments on the POR System within 10 days of the determination date. Unfiled and as filed cost report overpayments shall be input within 17 days of the due date of the cost report. (This allows 7 days for mail time. The determination date for an unfiled cost report and an as filed cost report is the day after the due date of the cost report. This date should be utilized even if the as filed is received after the due date. Contractors will not be penalized for late entry into the POR System as long as the case file indicates when the cost report was received.) In addition, all changes, updates and recoupments shall be posted onto the POR System within 10 days. FIs shall attempt to use the most current status code. Once the status of the overpayment changes, the status code shall be updated within 10 days. FIs shall attempt to use the most current status code that accurately reflects the overpayment's current situation. FIs shall remember that certain codes such as bankruptcy, debt referral and Currently Not Collectible supercede all other codes. If the FI cannot determine the appropriate status code, the servicing regional office shall be contacted for assistance.

20 – Cost Report Overpayment Demand Letters
(Rev. 29, 01-02-04)
The purpose of an overpayment demand letter is to notify the provider of the existence and amount of an overpayment, and to request repayment. Every demand letter, regardless of the cause of the overpayment or the status of the provider shall meet certain requirements as to form and content. Each demand letter is:

- Sent to the provider. (For institutional providers, the FI will not address the letter to the facility only, but to the person(s) it identified as responsible for any debts incurred by the provider.
- Sent by certified mail, return receipt requested (FIRST REQUEST ONLY);
- Labeled either - FIRST REQUEST, SECOND REQUEST, or THIRD REQUEST;
- For a first request, mail *within 7 calendar days* of discovery or determination of the overpayment. In the case of the second or third request, mailed 30 days after the most recent demand letter;

- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined. *(Does not apply in situations involving overdue cost reports)*
- *The demand letter shall offer the provider the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be analyzed using the criteria set forth in Chapter 4, §50. Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter. (Does not apply in situations involving overdue cost reports.)*
- The demand letter constitutes a request to the provider to refund the overpaid amount. The FI provides a brief description of the methods of repayment (or, where applicable, it requests the provider to submit the overdue cost report).
  The demand letter informs providers that continue to participate and have filed the cost report, that the FI will adjust (reduce or withhold) interim payments if it does not receive repayment, or a *request for a repayment plan along with the first month's payment* within 15 days of the demand letter. I*n the situation of an unfiled cost report or an as filed cost report overpayment, the cost report reminder letter serves as sufficient notice that interim payments will be suspended if the overpayment is not received on or before its due date.*
- The FI shall not recoup interim payments before the 16th day after the date of notification. *Exception: If the provider has provided the FI with a written request or written authorization to begin recoupment before the 16th day, the FI shall comply with the provider's request.*
- The demand letter also points out that, where a cost report has not been filed timely and the provider continues to participate, interim payments were adjusted (reduced or suspended) on the *seventh (7th) calendar* day following the due date of the cost report.

NOTE: The cost report reminder letter *(see Chapter 3, §30)* serves as sufficient notice to the provider that interim payments will be suspended if the overpayment is not received on or before its due date.

- *Providers in bankruptcy proceedings. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.*

20.1 - Number of Demand Letters
(Rev. 29, 01-02-04)

In general the FI *shall* send **three** overpayment demand letters to a provider. These must be in the case file. The FI *shall keep* copies of all demand letters. *Where one or two demand letters have been sent and returned undeliverable the FI shall attempt to locate the provider. If the FI is unable to locate the provider and the overpayment is eligible for referral to the Department of Treasury, the FI shall immediately send the third demand letter which shall include the intent to refer language.*

Where a repayment plan has been established (either through refund or setoff against interim payments) after the first or second demand letters have been sent

and the provider defaults on the repayment plan, the FI counts the demand letters sent prior to the acceptance of the repayment plan toward the total of three letters normally sent to an overpaid provider.

20.2 - Content of Demand Letters - FI Serviced Providers (Rev. 29, 01-02-04)

Exhibit l contains a detailed list of the requirements (this Exhibit is not all inclusive) for each of the three basic demand letters for use in various overpayment situations. Certain items may be combined; for example, the Notice of Program Reimbursement may be attached to the first demand letter. Since some cases may become very complex, some sample letters have been included.

Exhibit 1: Contents of a Demand Letter
Exhibit 2: Sample Overpayment Demand Letter – Cost Report Filed -First Request
Exhibit 3: Sample Overpayment Demand Letter – Cost Report Filed - Second Request (30 days after the date of the first demand letter)
Exhibit 4: Sample Overpayment Demand Letter – Cost Report Filed - Third Request (30 days after the date of the second demand letter)
Exhibit 5: Sample Overpayment Demand Letter- Unfiled Cost Report- First Request
Exhibit 6: Sample Overpayment Demand Letter- Unfiled Cost Report- Second Request
Exhibit 7: Sample Overpayment Demand Letter- Unfiled Cost Report- Third Request

EXHIBIT 1: CONTENTS OF A DEMAND LETTER

Key: Overpayment Situations

A - an overpayment due to pattern of excessive or noncovered services
B - cost report overdue- (all payments are considered an overpayment) participating and terminated providers
C - cost report filed and an overpayment is due- participating and terminated providers

	First Demand				Second Demand				Third Demand		
	A	*B*	*C*		*A*	*B*	*C*		*A*	*B*	*C*
Send letter by certified mail	X		X								
Mail letter to provider with 7 days of the determination of the overpayment	X		X								
Mail letter to provider on the 7th day after the due date or extended due date of the cost report, if not received.		X									
Include explanation of the overpayment determination and the amount due or Notice of Program Reimbursement	X		X								
As applicable, request provider to submit cost report, make a refund, or arrange repayment	X	X	X		X	X	X		X	X	X

	1	2	3		4	5	6		7	8	9
An adjustment (reduction or suspension) of interim payments has been imposed (indicate percentage of withhold)		X			X	X	X		X	X	X
Notify provider it has 15 days to work out a repayment plan or to pay balance in full before adjustment (reduction or suspension) of interim payments is begun	X		X								
If payment in full is not received within 30 days, interest will be charged	X		X								
Notify provider it has 15 days to submit a statement of explanation before suspension of interim payments begins	X		X								
DCIA Intent Language for referral to the Treasury Department for cross servicing									X	X	X
Mail letter to provider 30 days after the date of the first demand letter					X	X	X				
Mail letter to provider 30 days after the date of the second demand letter									X	X	X

EXHIBIT 2- OVERPAYMENT DEMAND LETTER- COST REPORT FILED- FIRST REQUEST

(Rev. 41, 04-30-04)

FIRST REQUEST

Certified Mail #

Mr. Joe Smith, President
Provider Name
Anytown, State ZIP Code

                                                    Date

Dear Mr. Smith:

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

(NPR Issued)
On July 26, 20xx, we received your cost report for the fiscal year ending June 30, xxxx. We have fully reviewed this report, and the results of our review have been incorporated in the enclosed copy of your Notice of Amount of Program Reimbursement (dated August 21, 20xx. As explained in the Notice, we find that the Valley Convalescent Center has been overpaid $_____ for the past fiscal year.

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

(As Filed Cost Report)
On July 26, 20xx we received your cost report for the fiscal year ending June 30, xxxx, and on _____, the cost report was determined acceptable. The cost report, as filed, reflects an overpayment $_____ for this fiscal year. The Provider Reimbursement Manual

(PRM) Part 1, Chapter 24, Section 2409.A(2) states that when a cost report is filed indicating an overpayment, a full refund should accompany the cost report submission.

(Home Office Cost Report is Unfiled)
We have not received the home office cost report from _____. According to our records _____ serves as the home office for your facility. Since the home office cost report remains unfiled the amount stated on your filed cost report for the fiscal year ending _____ for home office costs has been disallowed. This disallowance will continue until the home office submits the home office cost report.

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

PLEASE MAIL TO:

If payment in full is not received by, (specify a date 15 days from the date of the notification), payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur on _____ you must notify <contractor> before ___. We will review your documentation, but will not delay recoupment. This is not an appeal of the overpayment determination. The appeal process is detailed in the NPR. In addition, in accordance with 42 CFR 447.30, if we do not receive payment in full or an extended repayment request from you within 15 days from the date of this letter we may initiate a request that your Federal share of Title XIX (Medicaid) be withheld, if applicable. If this withholding is initiated it will not be removed until payment in full is received or an acceptable extended repayment request is received and approved.

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

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

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

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

Should you have any questions please contact _____ at _____.

We expect to hear from you shortly.

Sincerely,

      (name and title)

Enclosure

EXHIBIT 3- OVERPAYMENT DEMAND LETTER- COST REPORT FILED - SECOND REQUEST

(Rev. 41, 04-30-04)

SECOND REQUEST

Date (30 days after the date of the first demand letter)

Mr. Joe Smith, President
Valley Convalescent Center
Anytown, State ZIP Code

RE: MEDICARE OVERPAYMENT FOR <contractor name>
     FISCAL YEAR ENDED _____
     PROVIDER NUMBER _____

Dear Mr. Smith:

On July 26, 20xx, we sent you a request for an overpayment that resulted from FY 20xx. We have not yet received payment or an application for an extended repayment plan. The outstanding amount due for this overpayment is $_____ which includes a principal amount of $_____ and interest assessed in the amount of $_____. This amount must immediately be refunded in full.

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received or an acceptable extended repayment plan is approved.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is repaid in installments or recouped by withholding your facility's interim payments, each payment will first be applied to accrued interest and then to principal. Interest will be assessed for each 30-day period that payment is delayed. The interest rate set by the Secretary of the Treasury for overpayment determinations made on or after _____ is _____percent.

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

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

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

Should you have any questions please contact _____ at _____. We expect to hear from you shortly.

EXHIBIT 4- OVERPAYMENT DEMAND LETTER- COST REPORT FILED -THIRD REQUEST

(Rev. 41, 04-30-04)

SECOND REQUEST

Date (30 days after the date of the first demand letter)

Mr. Joe Smith, President
Valley Convalescent Center
Anytown, State ZIP Code

RE: MEDICARE OVERPAYMENT FOR <contractor name>
     FISCAL YEAR ENDED _____
     PROVIDER NUMBER _____

Dear Mr. Smith:

On July 26, 20xx, we sent you a request for an overpayment that resulted from FY 20xx. We have not yet received payment or an application for an extended repayment plan. The outstanding amount due for this overpayment is $_____ which includes a principal amount of $_____ and interest assessed in the amount of $_____. This amount must immediately be refunded in full.

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received or an acceptable extended repayment plan is approved.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is repaid in installments or recouped by withholding your facility's interim payments, each payment will first be applied to accrued interest and then to principal. Interest will be assessed for each 30-day period that payment is delayed. The interest rate set by the Secretary of the Treasury for overpayment determinations made on or after _____ is _____percent.

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

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

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

Should you have any questions please contact _____ at _____. We expect to hear from you shortly.

EXHIBIT 5: OVERPAYMENT DEMAND LETTER – UNFILED COST REPORT- FIRST REQUEST (Rev. 41, 04-30-04)

(Mailed 7 calendar days after cost report was due)

Date:

FIRST DEMAND LETTER

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

<u>CERTIFIED MAIL – RETURN RECEIPT REQUESTED</u>

RE: **Late Medicare Cost Report**
Provider Name: {DBA Name}
Provider Number: {xxxxxxxx}
Fiscal Year End: {Month, Day, Year}
Taxpayer Identification Number: {xxxxxx}

Dear {Title} {Last Name}

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

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

If full payment is not received or arrangements made for an extended repayment plan, we will take all action(s) necessary to recover the full amount. (See enclosure for extended repayment plan details.)

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

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

1. Cost reports reflecting an amount due to the Medicare program must include the full amount owed (including interest) from the day following the date the cost report was due to the date that the cost report is filed.

 2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not included with the cost report, interest will continue to accrue on the overpayment until it is paid in full.

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

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report.
Under Title 42 CFR Section 405.378 (b) (2), interest charges are assessed *i*n thirty days periods. Thus, if payment is received 31 days from the date of final determination, *one* 30-day period of interest will be assessed *and for each full 30-day period until the debt is paid in full*.

Cost Report Submission:
Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with any amounts due (principal and interest), (2) A complete refund of all interim payments, the deemed overpayment (principal and interest), within thirty days of the date of this letter, or (3) A request for a repayment plan of all interim payments, the deemed

overpayment, within fifteen (15) days of the date of this letter. Checks are to be made payable to {Contractor}. They and/or your remittance advice should be annotated with your provider name, number, and cost report year end that applies to the amount due.

> {Prime Contractor}
> {Division or Group}
> {Routing, Room Number}
> {Mail To Address 1}
> {Mail To Address 2}
> {City, State, Zip}

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

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 and Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Medicaid Offset:
If this matter is not resolved within fifteen (15) days from the date of this letter, CMS may instruct the Medicaid State Agency to withhold the Federal share of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, Section 447.30(g). These recoveries will be in addition to any recoupments from other Medicare funds due you until the full amount owed to Medicare is recovered.

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the required cost report may result in the termination of your Medicare provider agreement.

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

Sincerely,

{Title} {Name}
{Position Title}

Exhibit 6- OVERPAYMENT DEMAND LETTER- UNFILED COST REPORT- SECOND REQUEST

Date:

SECOND DEMAND LETTER

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

RE: **Late Medicare Cost Report**
    Provider Name: {DAB Name}
    Provider Number: {xxxxxxxx}
    Fiscal Year End: {Month, Day, Year}
    Taxpayer Identification Number: {xxxxxx}

Dear {Title} {Last Name}

This is our second letter to you noting that we have not received the cost report for {DBA Name}, provider number {xxxxxxx} for the period ending {month/day/year}. Under Title 42 Code of Federal Regulations (CFR), Section 413.24, cost reports are due by the last day of the fifth month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS & R) reports from the contractor, whichever is later. Your report continues to be late as it was due {month/day/year}.

Deemed Overpayment:
As neither cost report or payment for the deemed overpayment has been received from your facility, all interim and lump sum payments made for the fiscal period noted above continue to be deemed an overpayment and are now delinquent. The amount owed is {$ xxxxx.xx}. This amount is overdue and must be remitted to us within thirty (30) days from the date of this letter. Interest will be assessed on any portion of this amount that is not paid timely. If full payment is not received, we will take all action(s) necessary to recover the full amount owed.

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

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

1. Cost reports reflecting an amount due the Medicare program must include the amount owed (including interest) from the day following the due date of the cost report to the date that the cost report is filed.

2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not included with the cost report, interest will continue to accrue on the overpayment until it is paid in full.

3. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settlement or NPR) interest will be assessed on the overpayment from the day following the date the cost report was due to the date the overpayment is paid. If the full amount is not paid, any partial payments will be applied first to accrued interest and then to principal. After each partial payment, interest will continue to accrue on the remaining principal balance.

Interest Computation:

The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report. Under Title 42 CFR Section 405.378, interest charges are assessed *i*n thirty days periods. Interest charges for a thirty (30) day period are calculated by multiplying the principal amount due by the interest rate and then dividing by twelve (12). *A* debt that is paid thirty-one (31) days late is assessed *one* (*1*) full thirty-day period.

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

> {Prime Contractor}
> {Division or Group}
> {Routing, Room Number}
> {Mail To Address 1}
> {Mail To Address 2}
> {City, State, Zip}

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

As we informed you previously, 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 and Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the required cost report may result in the termination of your Medicare provider agreement. However, termination of a provider agreement in no way abrogates the responsibility of the facility to file a cost report, repay an overpayment, or to comply with the Medicare law, regulations, and instructions applicable to the period when the facility was participating.

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions concerning this letter, please call _____ at _____.

Sincerely,

Name and title

Exhibit 7- Overpayment Demand Letter- Unfiled Cost Report- Third Request

(Rev. 41, 04-30-04)

If the overpayment is eligible for referral to the Department of Treasury the intent to refer language shall be placed in the third demand letter. See CR 1683 and Chapter 4, §70 for more information. If the overpayment is not eligible for referral to the Department of Treasury a third demand letter requesting the cost report shall be sent. A sample third demand letter for overpayments not eligible for referral to the Department of Treasury is below.

Date:

THIRD DEMAND

{Prime Contractor}
{Mail to Name}
{Mail to Address 1}
{Mail to Address 2}
{City} {State} {Zip}

RE: **Late Medicare Cost Report**

Provider Name: {DAB Name}
Provider Number: {xxxxxxxx}
Fiscal Year End: {Month, Day, Year}
Taxpayer Identification Number: {xxxxxx}

Dear {Title} {Last Name}

This is our third letter to you noting that we have not received the cost report for {DBA Name}, provider number {xxxxxxx} for the period ending {month/day/year}. Under Title 42 Code of Federal Regulations (CFR), Section 413.24, cost reports are due by the last day of the fifth month following the close of the provider's cost report year or 30 days after receipt of valid Provider Statistical and Reimbursement (PS & R) reports from the contractor, whichever is later. Your report continues to be late as it was due {month/day/year}.

Deemed Overpayment:
As neither cost report or payment for the deemed overpayment has been received from your facility, all interim and lump sum payments made for the fiscal period noted above continue to be deemed an overpayment and are now delinquent. The amount owed is {$ xxxxx.xx}. This amount is overdue and must be remitted to us within thirty (30) days from the date of this letter. Interest will be assessed on any portion of this amount that is not paid timely.   If full payment is not received, we will take all action(s) necessary to recover the full amount owed.

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

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

4. Cost reports reflecting an amount due the Medicare program must include the amount owed (including interest) from the day following the due date of the cost report to the date that the cost report is filed.

5. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not included with the cost report, interest will continue to accrue on the overpayment until it is paid in full.

6. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settlement or NPR) interest will be assessed on the overpayment from the day following the date the cost report was due to the date the overpayment is paid. If the full amount is not paid, any partial payments will be applied first to accrued interest and then to principal. After each partial payment, interest will continue to accrue on the remaining principal balance.

Interest Computation:
The interest rate in effect at the time your cost report was due is {xx.xxx%}. This rate is applicable to any overpayments related to the untimely filing of your cost report. Under Title 42 CFR Section 405.378, interest charges are assessed *i*n thirty days periods. Interest charges for a thirty (30) day period are calculated by multiplying the principal amount due by the interest rate and then dividing by twelve (12). *A* debt that is paid thirty-one (31) days late is assessed *one* (*1*) full thirty-day period.

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

> {Prime Contractor}
> {Division or Group}
> {Routing, Room Number}
> {Mail To Address 1}
> {Mail To Address 2}
> {City, State, Zip}

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

As we informed you previously, 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 and Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the required cost report may result in the termination of your Medicare provider agreement. However, termination of a provider agreement in no way abrogates the responsibility of the facility to file a cost report, repay an overpayment, or to comply with the Medicare law, regulations, and instructions applicable to the period when the facility was participating.

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions concerning this letter, please call _____ at _____.

Sincerely,

Name and title

30 - Interest Assessment/Payment on Overpayments and Underpayments
(Rev. 29, 01-02-04)

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

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

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

30.1 - Final Determination
(Rev. 29, 01-02-04)

For purposes of this chapter:

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

- An audited final settlement;

- Final settlement without audit; or

- Reopening for any reason.

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

- A written determination that an overpayment exists and a written determination for payment;

- A written determination of an underpayment;

- An Administrative Law Judge (ALJ) or hearing officer's decision that reduces the amount of an overpayment below the amount that CMS has already collected. *A final determination is deemed to have occurred only when the amount of the overpayment/underpayment has been calculated. This may be at the decision time and it may be at a later time if recalculations are necessary.*

- A written determination that an As Filed Cost Report has been received without payment;

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

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

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

30.2 - Rates of Interest - FIs and Carriers
(Rev. 30, 01-28-04)

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

The private consumer rate, historically higher than the current value of funds rate, is subject to quarterly revision. The Department of the Treasury certifies the revised rate to the Department of Health and Human Services on a quarterly basis. Medicare contractors

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

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

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

30.3 - Interest Accruals
(Rev. 41, 04-30-04)

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

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

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

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

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

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

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

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

Physician/Supplier Overpayment – Example of Interest Accrual Prior to 10/01/2004 –
The carrier discovers that an overpayment for $795.45 exists and sends a demand letter on 09/30/04. (The determination date of this overpayment is prior to the effective date of the revision to 42 CFR 405.378). The provider does not remit payment on the overpayment until 11/14/2004 (45 days after the date of the initial demand letter). Therefore, interest accrues on the $795.45 for two full 30-day periods.

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

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

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

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

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

Examples of Application when cost report not filed on time—

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

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

2. A provider with FYE 6/30/0*4* has a cost report that is due on 11/30/0*4*. The cost report became overdue on 12/01/0*4*. On 01/15/0*5* the cost report was submitted indicating an amount due the program; payment did not accompany the report. Due to the late submission of the cost report, interest is assessed for *one* 30-day period. The interest rate assessed is the rate in effect on the day the cost report became overdue, 12/01/0*4*. In addition interest, at the rate in effect on the day the cost report became overdue, will accrue on the declared overpayment from the date the cost report is filed to the date the amount due is paid.

On 03/12/0*5*, the intermediary completes a desk review and determines an additional overpayment, issuing a NPR and demand letter. Interest will be assessed on this additional amount at the rate in effect on 3/12/0*5*. In addition interest will be assessed for the period of delinquency at the rate in effect on the day the cost report became overdue, 12/01/0*4*.

C. Accrual of Interest; Rejected Cost Report
In terms of interest accrual, a rejected cost report is treated like an unfiled cost report. If a cost report is officially rejected by the contractor, (see Audit and Reimbursement section to determine when to reject a cost report) interest accrues on the determined overpayment amount from the date the cost report is due until the date the cost report is resubmitted with payment in full. The determined overpayment amount is the amount due the program on the accepted cost report. If a cost report is submitted with payment in full and is later rejected the accrual of interest depends on the determined overpayment amount on the accepted cost report. If the determined overpayment amount on the accepted cost report was paid in full by the original submission, no interest accrues. If the determined overpayment amount is different than the overpayment amount listed on the original rejected cost report, interest will accrue on the difference.
Example of Interest Accrual When the Cost Report is Rejected
1. A provider submits the cost report with payment in full before the due date. Upon review the contractor rejects the cost report.

The provider corrects the cost report and resubmits it. The contractor accepts the revised cost report. The amount due the program on the revised cost report is equal to the check that accompanied the original cost report. Since the check fulfilled the determined overpayment on/ before the due date, there is no interest accrual.

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

D - Underpayments

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

- An NPR (FI only) and a notice of final determination of an underpayment under §30.1.

- A notice of final determination of an underpayment under §30.1 when an NPR is not issued.

- An Administrative Law Judge (ALJ) or hearing officer's decision that reduces the amount of an overpayment below the amount that CMS has already collected. Interest begins to accrue once the underpayment amount has been determined. This may be at the decision time if the ALJ reverses the entire overpayment amount or the ALJ states a principal amount to be paid upon which interest may be calculated. However, if the ALJ does not specify the overpayment amount and recalculations are necessary (not including a full reversal of the overpayment amount) interest will begin to accrue at the time of the recalculations. If the FI/Carrier is unsure when interest should accrue for a particular case, the servicing regional office should be contacted.

- An Intermediary Hearing or a Provider Reimbursement Review Board (PRRB) decision that reduces the amount of an overpayment below the amount that CMS has already collected.

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

30.4 - Procedures for Applying Interest During Overpayment Recoupment
(Rev. 41, 04-30-04)

A - General

If a provider is unable to satisfy the overpayment within 30 days from the date of final determination and demand for repayment (§30.1), interest accrues on the unpaid principal balance and is due and payable for each *full* 30-day period that an overpayment

balance is outstanding. The contractor first applies any payments received to the accrued interest charges and then to the overpayment principal. If the provider has more than one overpayment outstanding and a payment is received, the contractor credits the payment to the oldest overpayment first, unless the provider designates otherwise.

B - Recoupment Through Installment Payments

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

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

Interest rates remain constant based upon the initial rate assessed unless the provider defaults, i.e., **misses 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. *(For FISS and APASS users only.)* Each payment is applied first to accrued interest and then to principal. After each payment interest will accrue on the remaining unpaid principal balance.

C - Proof of Receipt

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

30.5 - Notification to Providers Regarding Interest Assessment

(Rev. 41, 04-30-04)

A – Cost Report Reminder Letters

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

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

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

B - Notice of Program Reimbursement (NPR)

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

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

C - Overpayment Demand Letters

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

30.6 - Waiver and Adjustment of Interest Charges

(Rev. 41, 04-30-04)

A - Waiver of Interest Charges

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

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

For bankrupt providers and interest see Chapter 3, §140.
B - Adjustment of Interest Charges

1 – Reopenings-FI

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

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

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

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

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

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

Example of Application.--

    A. On 07/18/0*5*, the intermediary completes a final settlement and issues a NPR and a written demand showing an amount due the program of $16,000. On 09/15/0*5*, the provider pays the $16,000 overpayment plus *one* 30-day period of accrued interest.

As a result of a hearing on 12/l0/0*5*, the PRRB reverses the intermediary's findings and determines that the correct amount due the program was $4,000. The excess $12,000 in principal and the accrued interest on $12000 that was assessed and collected must be returned to the provider.

3 - Judicial Review

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

40 – Withholds and Suspensions
(Rev. 29, 01-02-04)
In accordance with regulations (42 CFR §405.370), recoupment and suspension are defined as:

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

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

40.1 – Recoupment by Withholding Payments
(Rev. 29, 01-02-04)
A. General--In accordance with regulations (42 CFR §§405.371-372), payments determined to be payable to providers can be withheld to protect the Medicare program against financial loss if the intermediary has determined that the provider to whom payments are to be made has been overpaid.

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

B. <u>Requirements for Withhold</u>--Comply with the following conditions to withhold interim payments:

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

C. <u>Cost Report Overpayments</u> <u>Percentage of Withhold</u>-- Some percentage of withhold shall begin 15 days after the date of the first demand letter (day 16) if the overpayment has not yet been liquidated or an extended repayment plan has not been requested. The matrix below shall be utilized to determine the percentage of withhold for an overpayment determined from a cost report that has been filed (as filed cost report, tentative settlement, or final settlement), a PIP review, or an interim rate review. See Chapter 3, §30.1 when a cost report remains unfiled.

Day 16	*No word from provider*	*100 % withhold*
Day 16	*Provider has submitted ERP application*	*No withhold as long as provider submitted a first payment along with ERP application. Payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If payment is not received with the application request, withhold shall be initiated at 30%.*
Day 16	*Provider has submitted ERP application but it is incomplete*	*No withhold as long as provider submitted a first payment along with ERP application. If payment is not received with the application request, withhold shall be initiated at 30%. Once a completed application is submitted payments must continue on a monthly basis until provider receives written approval or denial of the ERP request. If completed information is not received within an allotted amount of time (rarely more than 30 days) withhold shall be initiated at 100%.*
Day 16	*Provider has said that it is planning to*	*30% withhold- when ERP application is received, cease withhold if the first payment*

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

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

D. Physician/Supplier Overpayments- Withhold of Payments- Withhold of all payments shall begin 40 days (41st day) after sending the initial overpayment demand letter unless payment in full has been received or an ERP application has been received. If an ERP application has been received and is currently being reviewed by the Carrier or CMS RO or CO and the first payment was sent in by the provider with the application no withhold shall occur. If the first payment did not accompany the ERP application a 30% withhold shall be initiated.

NOTE: Additional Information for Both FIs and Carriers

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

The payment submitted with the ERP application shall be one month's payment based on the amortization schedule submitted with the ERP application. The amortization schedule shall not exceed 60 months, shall include principal and interest and the minimum monthly payment shall not be less than $1/60^{th}$ of the overpayment. If the provider requests an ERP in excess of 60 months the payment submitted shall be $1/60^{th}$ of the overpayment. If the payment submitted is not $1/60^{th}$ of the overpayment, the FI/Carrier shall contact the provider (in writing or a documented telephone call with the appropriate personnel at the provider's place of business) requesting additional funds. If the provider does not submit additional funds within 15 days of the date of the request, the FI/Carrier shall initiate a 30% withhold.

Until a final decision is made regarding the ERP the provider should submit monthly payments based on the amortization schedule. If the provider does not continue to submit monthly payments, the FI/Carrier shall contact the provider requesting the payment. If the provider does not submit the monthly payment within 15 days of the date of the request, the FI/Carrier shall initiated a 30% withhold.

E. Disposition of Withheld Funds- All funds withheld shall be applied towards the outstanding overpayment. The funds shall be applied to the outstanding interest first and then to the outstanding principal balance.

F. Duration of Withhold- The withhold shall remain in effect until:

- *The overpayment is liquidated;*

- *You enter into an agreement with the provider for liquidation of the overpayment; or*

- *On the basis of subsequently acquired evidence, or otherwise, you determine that there is no overpayment.*

40.2 – Suspension of Payment *(See Program Integrity Manual)*
(Rev. 29, 01-02-04)
Medicare authority to withhold payment in whole or in part for claims otherwise determined to be payable is found in federal regulations at 42 CFR 405.370-377, which provides for the suspension of payments.

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

- *Fraud or willful misrepresentation exists;*

- *An overpayment exists but the amount of the overpayment is not yet determined;*

- *The payments to be made may not be correct; or*

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

50 - Establishing Extended Repayment
(Rev. 29, 01-02-04)
Where the debtor does not comply with the first demand letter requesting that full refund of the overpayment be made, but acknowledges the existence of an overpayment, it may contact the FI or carrier to arrange for a repayment plan.

A debtor is expected to repay any overpayment as quickly as possible. If it cannot refund the total overpayment within 30 days after receiving the first demand letter, it should request an extended repayment plan immediately. However, an ERP request may be received and shall be reviewed at any time the overpayment is outstanding. The provider must explain and document its need for an extended (beyond 30 days) repayment plan.

A repayment plan may be established to recover all or part of an overpayment. *Following the withhold guidelines in Chapter 4, §40* the FI or carrier shall offset any money owed to the provider prior to establishing a repayment plan. Some examples of monies owed to the provider include underpayments money held by suspension or money withheld from the provider based on *Chapter 4, §40.* When a repayment plan is used to recover part of an overpayment, the FI/Carrier recovers the remainder of the overpayment by withholding interim payments *(See Chapter 4, §40),* setoff of monies due the debtor, or from a lump-sum payment by the provider. *Any approved ERP will run from the date of the initial demand letter.*

Note: Once an ERP is established, the offset of an underpayment against the ERP is not automatic. If a Medicare underpayment is determined subsequent to an established ERP, the FI shall notify the provider in writing of the underpayment. The FI will permit the provider 15 calendar days following the date of notification to submit a statement (including any pertinent evidence) as to why the underpayment should not be offset.

If the provider does not respond in the required time, the FI shall offset the underpayment against the ERP. If the provider responds timely, the FI shall not take action to offset until it has completed its review of the documentation. Based on its review, the FI will make a determination as to whether the facts justify offsetting the underpayment. If the FI determines that offset is appropriate, in whole or in part, written notice will be sent to the provider. Such notice shall contain specific findings on the conditions upon which the offset was based, and an explanation for the final decision.

50.1 – Documentation Required in an ERP Application--Physician is a Sole Proprietor – Carrier Only
(Rev. 29, 01-02-04)

The Carrier shall request the physician to complete and return a Form CMS-379, Financial Statement of Debtor and a copy of the physician's income tax filing for the most recent calendar year. *A request for an extended repayment of 12 months or more must also be accompanied with at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.*

50.2 - Documentation Supporting a Request for Extended Repayment – Provider is an Entity Other Than a Sole Proprietor

(Rev. 29, 01-02-04)

The FI/Carrier shall request the provider to furnish the following:

- **Amortization Schedule**- this schedule shall contain the proposed repayment schedule, including length of schedule, dates of payment, and payment amount broken down between principal and interest for the life of the schedule

- **Balance sheets** - the most current balance sheet and the one for the last complete Medicare cost reporting period or the most recent fiscal year (preferably prepared and certified by the provider's accountant).

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

- **Income statements** - related to the balance sheets (preferably prepared by the provider's accountant).

CMS suggests that both the balance sheets and income statements include the following statements:

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

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

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

                         Signed
                         Officer or Administrator of
                         Provider(s)

Title

Date

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

- **Statement of Sources and Application of Funds** - for the periods covered by the income statements (see Exhibit 2 for recommended format).

- **Cash flow statements** - for the periods covered by the balance sheets (see Exhibit 3 for recommended format). If the date of the request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than 3 months after that of the most recent balance sheet, a projected cash flow statement should be included for the 6 months following the date of the request.

- **Projected cash flow statement** - covering the remainder of the current fiscal year. If fewer than 6 months remain, a projected cash flow statement for the following year should be included. (See Exhibit 3 for recommended format.)

- **List of restricted cash funds** - by amount as of the date of request and the purpose for which each fund is to be used.

- **List of investments** - by type (stock, bond, etc.), amount, and current market value as of the date of the report.

- **List of notes and mortgages payable** - by amounts as of the date of the report, and their due dates.

- **Schedule showing amounts** - due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet--such as Accounts Receivable, Notes Receivable, etc

- **Schedule showing types** - and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

- **Loan Applications** - Requests for extended repayment of 12 months or more. Have the debtor include at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment. Also, include a copy of the loan application with the denial letter from the bank.

- **FIs Only - The percentage of occupancy** - by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods covered by the income statements; and

All financial records must be for the business participating in the program. They should not be for the owner if the business is a partnership or a corporation. If the financial aspects of the business are managed by an outside facility, the provider's individual financial records must still be submitted as well as the financial records of the outside facility.

If a debtor is unable to furnish some of the documentation, it should fully explain why it is unable to. Where the debtor's explanation is reasonable and the documentation is otherwise acceptable, the FI/Carrier shall forward the request for extended repayment to the RO with its recommendation. It shall comply with *Chapter 4, §40* regarding recoupment of the overpayments pending receipt of the documentation and a decision on the extended repayment request.

50.3- Approval Process

(Rev. 29, 01-02-04)

Below is a chart detailing the requirements of a Medicare contractor for an extended repayment plan. Once the FI/Carrier completes these requirements a decision regarding approval must be made. If the FI/Carrier determines that the provider does not meet the requirements for an extended repayment plan the provider shall be notified in writing. If the FI/Carrier determines that the provider does meet the requirements for an extended repayment plan the following criteria shall be followed:

- If the ERP request is for 12 months or less the FI/Carrier shall notify the provider immediately in writing of the approval.

- If the ERP request is greater than 12 months the FI/Carrier must send the entire ERP package including the documentation prepared by the FI/Carrier to the servicing RO for approval.

The FI/Carrier has the option of altering the length of time when approving an ERP request. For example, if a provider requests 24 months, but the FI/Carrier feels that 12 months is sufficient the FI/Carrier can deny the 24 month request and extend an offer of a 12 month repayment plan. If the FI/Carrier recommends approval of an ERP that is over 12 months in length, the recommendation must be forwarded to the RO for approval.

The FI/Carrier may request additional financial information from the provider as well as financial information from the owner if the owner is requesting to submit personal capital to help repay the Medicare debt.

The FI/Carrier shall attempt to review and approve or deny or recommend approval to CMS within 20 days of receipt of the completed ERP application.

Requirements to be Completed before approval or denial	ERP request 12 months or less	ERP request greater than 12 months	ERP request asking for an unconventional payment arrangement
ERP Protocol (See Exhibit 1)	X	X	X
Analysis of financial statements	X	X	X
Review of Last 12 months of claim history	X	X	X
Payments on the claim floor	X	X	X
Outstanding Advance/Accelerated Payments (Accelerated Payments are FI only)	X	X	X
FI - Outstanding settlements	X	X	X
Outstanding Fraud Investigations	X	X	X
Send to RO for additional approval		X	X

Exhibit 1 - Protocol for Reviewing Extended Repayment Plan (ERP) - Provider/Physician Medicare Overpayments

Protocol for Reviewing Extended Repayment Plan (ERP)

Provider_____

Provider Number _____

(FIs Only) Cost Report FYE _____

(Carriers Only) Date(s) Overpaid _____

Overpayment Amount $_____

Date of Demand Letter_____No. of Months Requested for ERP_____

Date ERP Approved/Not Approved (12 mos. or less) _____No. of Mos. Approved_____
Date Referred to RO for Consideration _____

Name of FI/Carrier

Reviewed By_____.....................................Date _____
    FI/Carrier Analyst

Supervisor Review_____   Date   _____
      FI/Carrier Official

1. Summarize the major reasons why the overpayment occurred.

2. FI/Carrier reviews the documentation sent by the debtor for completeness. (Refer to §70.2 for required documentation.)
    It analyzes the financial data submitted to determine the availability of cash, marketable securities, accounts receivable,
    restricted and unrestricted endowment funds, or special funds. It considers whether these funds could be used for partial
    or full payment of the overpayment.

3. FI/Carrier performs the following calculations by using the most current financial data submitted by the provider to
    determine if it qualifies for an ERP.

    a. Current Ratio

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

$$\underline{\text{CURRENT ASSETS}} = \underline{\hspace{6cm}}$$
CURRENT LIABILITIES

This ratio defines the number of dollars held in current assets per dollar of current liabilities (e.g., it relates current assets to current liabilities). Multiple coverage of liabilities is desirable. Generally, high values for the current ratio imply a good ability to pay short-term obligations and thus a low probability of technical insolvency.

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

b.   Quick Ratio

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

$$\underline{\text{CASH + MARKETABLE SECURITIES + ACCOUNTS RECEIVABLE}} = \underline{\hspace{2cm}}$$
CURRENT LIABILITIES

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

Normally, the FI/Carrier considers a quick ratio of 1.5 to 1 adequate to meet current liabilities. However, a debtor with a high quick ratio may have short-term payment problems if there are excessive amounts of slow-paying or doubtful accounts receivable which may not be turned into cash soon enough to meet maturing current liabilities. Conversely, a low quick ratio may not imply a future liquidity crisis if current liabilities include terms that will not require payment from existing current assets.

4.   The FI, for institutional debtors, determines if there are any settlements (interim rate adjustments or cost report) in process which could be used to offset the outstanding overpayment.

5.   Based upon the previous steps, the FI/Carrier summarizes whether or not a repayment plan should be approved or denied. If approval is recommended, it indicates the number of months, how it calculated the monthly payment and the reason(s) for the approval. If denial is recommended, it indicates the reason(s).

Exhibit 2 - Statement of Source and Application of Funds Period Covered

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Provided by:

Operations - Net income for the period	$XXXX	
Add: Charges not affecting working capital		
(depreciation, amortization, etc.)	XXXX	
	$XXXX	
Less: Operating revenues not affecting working capital	XXXX	
Total fund provided by Operation		$XXXX
Long term loans	XXXX	
Unrestricted cash donations		XXXX
Other (identify)		XXXX
Total Funds Provided		$XXXX

Exhibit 2 (Cont.)

STATEMENT OF SOURCE AND APPLICATION OF FUNDS
FOR THE PERIOD _____

Funds Applied to:

Retirement of long-term obligations (mortgages, notes, bonds, etc.)		$XXXX
Purchase of equipment		XXXX
Purchase of land	XXXX	
Dividends to stockholders		XXXX
Other (identify)		XXXX
Total Funds Applied		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	

Working Capital* (end of period) <u>(date)</u>		XXXX
Less: Working Capital* (beginning of period) (date)		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	

*Current Assets less Current Liabilities

Exhibit 3, Cash Flow Statement Period Covered

CASH FLOW STATEMENT
FOR THE PERIOD

Cash provided by:

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

Total Cash Provided $XXXX

Exhibit 3 (Cont.)

CASH FLOW STATEMENT
FOR THE PERIOD

Cash applied to:

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

Increase (Decrease) in Cash $XXXX

- -

Cash at end of period (date) $XXXX

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

Exhibit 4, Projected Cash Flow Statement Cash From Operations (Schedule A) Period Covered

PROJECTED CASH FLOW
CASH FROM OPERATIONS (SCHEDULE A)

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

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

50.4 – Sending the ERP Request to the Regional Office

(Rev. 29, 01-02-04)

After the FI/Carrier has reviewed the documentation submitted in support of the ERP request, it sends its recommendation to the RO for approval if the ERP request is over 12 months in length. It submits the following:

- All information submitted by the provider. (See § 50.l.);

- The date of the initial contact between the FI/Carrier and the provider concerning the overpayment;

- Copies of all correspondence (including demand letters) about the overpayment and the request for the ERP (including telephone conversations, if applicable);

- FI-The amount of the overpayment; cost report year in which it occurred; dates and amounts of any repayments; dates and amounts of payments (interim or retroactive) held in account.

- Carrier-The amount of the overpayment, claim paid date, dates and amounts of any repayment

- FI-The cost reports in which the overpayments appeared or were found. The FI furnishes any information it has on the financial status of related organizations, as determined through audits and other sources such as mercantile reports;

- The provider's proposed repayment plan and rationale;

- The FI/Carrier's recommendation and supporting rationale including a completed extended repayment plan protocol (See Exhibit 1) and the last twelve months claim history; and

- The FI/Carrier's opinion, based on experience, as to the reliability of the financial data.

50.5 - Monitoring An Approved Extended Repayment Plan

(Rev. 29, 01-02-04)

After an extended repayment plan has been approved, the FI/Carrier shall continue to monitor the case to ascertain whether recoupment is being effectuated as contemplated. If it becomes apparent that the repayment plan will not result in a liquidation of the indebtedness within the time period contemplated, it shall take further action, preferably the renegotiation of the amount of installment payments so that the overpayment will be recouped within the time period originally agreed upon. The FI/Carrier reports to the RO any significant changes in the provider's financial condition or any indication that the provider misstated or failed to disclose pertinent facts that may raise a question of its ability to refund the overpayment. The FI/Carrier shall notify the RO immediately by telephone and send a detailed written statement of the problem.

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

(Rev. 29, 01-02-04)

When approving/denying an ERP request the FI/Carrier is making a subjective decision concerning the provider/supplier's ability to repay. All complete ERP requests shall be reviewed. This includes ERP requests from terminated providers and requests received for debts where an Intent to Refer has already been sent. If the provider is still actively participating in the Medicare Program and claims are being submitted on a regular basis (no more than a 20% drop off during the last twelve month period) the FI/Carrier shall attempt to work with the provider to approve an ERP request. If denying an ERP request will result in the immediate referral of the active provider to the Department of Treasury the RO shall be contacted to determine if an alternative exists. If at all possible the referral of an active provider, who has requested a legitimate repayment plan, to the Department of Treasury should be avoided. (The requirements set forth in the Debt Collection Improvement Act of 1996 still apply.)

60 - Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments

(Rev. 29, 01-02-04)

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

60.1 - Withholding the Federal Share of Medicaid Payments to Recover Medicare Overpayments

(Rev. 29, 01-02-04)

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

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

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

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

Section 1914(a) of the Act permits, rather than requires, the Secretary to withhold the Federal share of Medicaid payments to recover Medicare overpayments. To allow flexibility in the administration of this provision, the ROs routinely determine whether it would be cost effective to withhold the Federal share. If they determine that it is not feasible, they notify the FI/Carrier, citing the reason for not processing the collection request.

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

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

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

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

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

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

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

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

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

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

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

- The amount of the Medicare payments to which the institution would otherwise be entitled;
- The total Medicaid overpayment.

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

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

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

70.7.3 - Intermediary Claims Accounts Receivable (A/R)
(Rev. 19, 07-25-03)

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). The adjustments may be the result of duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, or for any reason an intermediary adjusts a claim payment. These adjustments are usually recovered through recoupment and the recovered amounts are included in the remittance advices to the providers. If the overpayment has not been recouped, the balance remains outstanding and is reported on the intermediary's financial records.

The CMS has determined that these types of debt are eligible for referral for cross servicing/Treasury Offset Program (TOP). The following outlines procedures for referral/collection/termination of collection action and write-off closed of these debts. Intermediaries will use these procedures to:

- Address the current inventory of intermediary claims A/R.

- Demand and refer delinquent intermediary claims A/R as part of their on-going debt collection procedures.

To identify and address the current inventory of outstanding intermediary claims A/R and to identify, on an ongoing basis, claims A/R to be demanded or recommended for termination of collection action and write-off closed, intermediaries must be able to separately identify the following:

- Claims A/R, of any amount, regardless of age, that cannot be validated.

- Claims A/R, for an individual provider, totaling less than $25 for the aggregated principal balance, where no adjustment/recoupment has occurred in the past 60 days.

- Claims A/R for an individual provider, greater than 10 years old, regardless of amount.

- Claims A/R, for an individual provider, with an aggregate principal balance greater than or equal to $25, which is less than 10 years old, and no adjustment/recoupment has occurred in the past 60 days.

After these separations are made, the following procedures will be followed:

For Recommendation of Write-Off (Termination of Collection Action):

When recommending write-off (termination of collection action), intermediaries will follow instructions as outlined in the overpayment section of this manual, which begins at Section 100, *or contact their regional office (RO) for guidance*.

- Claims A/R for an individual provider, totaling less than $25 for the aggregated principal balance, where no recoupment has occurred in the past 60 days, should be recommended for termination of collection action and write-off closed. A listing should be forwarded to the RO which contains the following information:
    - Provider number;
    - Provider name;
    - Amount of claims A/R being requested for termination of collection action and write-off closed;
    - Date of claims A/R;
    - Date of last activity; and
    - Reason for requesting/recommending termination of collection action and write-off closed.

- Claims A/R, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and write-off closed. This could include claims A/R received as a result of a Medicare contractor transition where no remittance advices are available, and other claims A/R where no remittance advice is available to support the balances. The intermediary must make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R must be forwarded to the RO for approval. The list should contain the same information as above, with the reason for termination of collection action and write-off recommendation that provides reasonable evidence to substantiate that the claim is no longer available.

- Claims A/R for an individual provider greater than 10 years old, regardless of amount, will be recommended and submitted to the RO for termination of collection action and write-off closed.

Intermediaries will submit, at least quarterly, recommendations for write-off and termination of collection action of outstanding claims A/R meeting the above criteria. Requests will be submitted to the RO no later than 30 days after the end of each calendar quarter. ROs will have 30 days after receipt of the request to respond, except for cases exceeding the RO's delegated authority. For those cases exceeding the RO authority, the RO will forward the case to CO with the RO's recommendation, within 30 days of receipt of the contractor's request.

For issuing an initial demand letter:

This instruction supercedes any other instructions for issuing demand letters for claims A/R, including those found in FMM Section 130. These instructions, however, do not apply to medical review and fraud overpayments.

- Claims A/R for an individual provider with an aggregate principal balance greater than or equal to $25 and less than 10 years old, and where no recoupment has occurred in the past 60 days, must be validated and intermediaries will send an initial demand letter for the outstanding amount claim A/R balance. The demand letter will have a determination date equal to the date of the demand letter. In accordance with the intermediary's normal demand process, the provider will have 15 days to respond to the demand letter. In addition, the demand letter will contain the following:

    o The letter must explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest will begin to accrue if the debt is not paid in full within 30 days. The letter will provide the debtor with appeal rights and contain all provisions of a standard initial demand letter. The letter must also contain language that explains how the overpayment was determined and that the claims A/R has been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries will include the date(s) of the remittance advice and original amount(s) of the claims A/R.

    o If the initial demand letter is returned as undeliverable, the intermediary will attempt to locate a valid address. If a valid address is found, or it is determined that there was a change of ownership, the intermediary must send the demand letter to the valid address/owner.

    o If a current address cannot be located, send the Debt Collection Improvement Act (DCIA) intent letter, and follow regular debt referral procedures.

    o If the initial demand letter is not returned undeliverable, the intermediary will follow normal debt collection procedures, including sending the DCIA intent to refer letter if the overpayment is not recouped. The DCIA intent to refer letter must be sent no later than 120 days from the date of the initial demand letter.

- Each demanded claim A/R will be considered a separate identifiable debt and will not be aggregated with other demanded claim A/R.

Exception to above procedures for issuing the initial demand letter:

If the intermediary has knowledge that the letter to a debtor will be returned undeliverable, based on prior attempts to contact the debtor, and where the intermediary cannot obtain a current address, the initial demand letter may be expanded to include the DCIA intent to refer language. The intermediary will send the initial demand letter with the DCIA intent to refer language and follow normal debt referral procedures. The date of the initial demand letter will be the determination date for aging, interest accrual and DCIA referral purposes.

Claims A/R that are outstanding, but have not yet been demanded due to the fact that they have not met the timeframe for issuing an initial demand letter will be considered in cost report settlements. Intermediaries will review and include all outstanding undemanded claims A/R in the settlement process. Claims A/R that have been demanded, in accordance with these instructions, will not be included in the cost report settlement process, as these are now considered as separate receivables.

If the intermediary determines that the provider has filed bankruptcy, normal procedures regarding bankruptcy in Chapter 3, Section 140 will be followed, including administrative freezes on recoupment, exemption to DCIA, and issuance of letters regarding the overpayment. This instruction does not change any of the procedures to be followed for bankrupt providers.

70.7.4 - Physician/Supplier Overpayment reporting (PSOR) System Summary Entry Debts (Carriers Only)(Rev. 13, 02-03-03)

This instruction addresses the delinquent overpayments, with a principal balance greater than or equal to $25, which is listed in the PSOR in summary entries 0888888888 and 099999999.

If a debt does not meet the criteria set forth by the Code of Federal Regulations, 42 CFR 405.376 for termination of collection action and write-off closed, the debt should be processed for referral to the Debt Collection Center (DCC) for cross servicing/TOP. The "intent to refer" letter must be sent when the debt is no more than 90 days delinquent (120 days from determination date).

Carriers will not update the PSOR status code for summary entry debts to reflect that the "intent to refer" letter was sent, since all debts included in the summary entry will not have the "intent to refer" letter sent. Carriers will be responsible for identifying and tracking these debts for timely referral. Carriers will follow normal debt collection and referral procedures, including financial reporting on these debts.

Once an overpayment included on a summary entry is collected, the summary entry should be downwardly adjusted to reflect the correct outstanding balance.

70.12 - Debt Collection System

(Rev.53, Issued 08-27-04, Effective: 09-27-04, Implementation: 09-27-04)

The Debt Collection System (DCS) is a CMS developed system used for debt referral to Treasury or a designated Debt Collection Center (DCC) in order to comply with the provisions of the Debt Collection Improvement Act of 1996 (DCIA). This system is comprised of a Data Entry Screen which houses detailed information regarding the debt, a Comments screen for users to add comments regarding the particulars of a debt, and Collection screens for posting collections to a debt once it has been transmitted to Treasury for cross servicing/Treasury Offset Program (TOP).

Detailed user instructions are included in Exhibit 4.

CMS developed reports are produced from this system, however, the system does not have user adhoc reporting capabilities.

Non-MSP users other than CMS CO do not have update access to the debt once it has been transmitted. MSP users have same security access as CMS CO users and will be responsible for all updates to the debt in DCS.

This system has no delete capabilities. The status code of the debt, which appears on the Data Entry screen, indicates the current action being taken on the date. Specific codes are included in Exhibit 4.

70.15.2 - Financial Reporting for Intermediary Claims A/R (Rev.13, 02-03-03)

Intermediaries must be able to identify and separate the claims A/R that have been demanded from those claims A/R that have not been demanded. The date of the initial demand letter will become the new determination date for aging purposes and the financial reporting of the receivable in Line 2a. New Receivables on the H751, Status of Accounts Receivable, report. The date of the initial demand letter must be the determination date for interest accrual, delinquency determination and referral to DCC. The demanded claims A/R adjustment must be reported as delinquent in Section B, Delinquent Receivables, if payment is not received within 30 days after the date of the initial demand letter. The accrual of interest will begin on the 31st day, and will be charged from the date of the initial demand letter. Claims A/R that have been demanded, in accordance with this instruction, will be recorded on CMS Form H750 on the line "Claims Accounts Receivable."

ClaThe outstanding balance of the undemanded claims A/R will be included in ims A/R that have not been demanded will be included on the H750 under "Other." the "Adjustment" line on CMS Form H751. The claims A/R that have not been demanded will be reported as "current" for aging purposes.

Exhibit 4 – Debt Collection System User Guide

(Rev.53, Issued 08-27-04, Effective: 09-27-04, Implementation: 09-27-04)

SECTION ONE:

ACCESSING DCS

USER INSTRUCTIONS FOR DEBT COLLECTION SYSTEM (DCS)

TO ACCESS DCS

1. Follow the same procedures used to access Provider Overpayment Recovery System (POR), Physicians Supplier Overpayment Recovery System (PSOR) or M-Parts. For additional information, contact your system administrator.

2. *The CMS Data Center screen will appear. From this screen Hit Enter.*
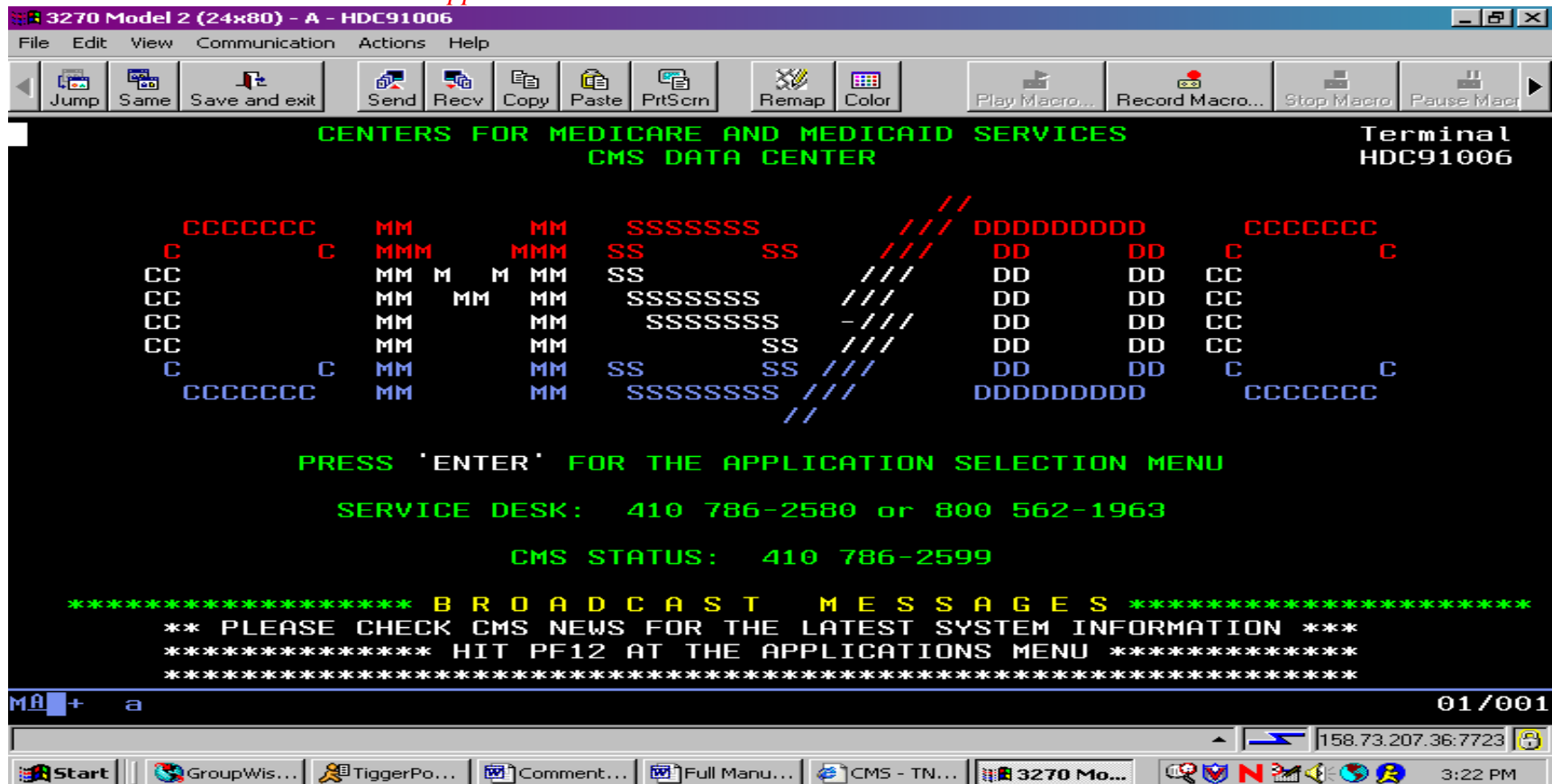
3. The next screen will be the application menu. From this screen Type "3" and Hit Enter.

Window title: 3270 Model 2 (24x80) - A - HDC91368

Menu: File   Edit   View   Communication   Actions   Help

Toolbar: Jump | Same | Exit | Send | Recv | Copy | Paste | PrtScrn | Remap | Color | Play Macro... | Record Macro... | Stop Macro | Pause Macro | Run Ap

```
PAGE 1 of 3 ........ A P P L I C A T I O N   M E N U ...............
08/29/02 11:38                                          TERMINAL - HDC91368

         ** PLEASE CHECK CMS NEWS FOR THE LATEST SYSTEM INFORMATION ***
         ************** HIT PF12 AT THE APPLICATIONS MENU *************
         ****************************************************************
 ...................................................................

            1    TSO         ACTIVE      Application Development
            2    RESERVED    INACTIVE    Future CICS System
            3    CICS41      ACTIVE      CICS41 System
            4    M204PRD1    ACTIVE      MODEL204 Production Region
            5    M204PRD2    ACTIVE      MODEL204 Version 2 Production
            6    WYLBUR      ACTIVE      WYLBUR Online System
            7    IDMSTEST    ACTIVE      IDMS/CV100 Database System
            8    NIHTITAN    ACTIVE      NIH Application Menu
            9    M204PRD3    ACTIVE      Oscar/Cafm/Casr/Crowd/Clia

            Select application ==>
                                                           more . . .
 ...................................................................
 PFK  1    H E L P            PFK 12   ** HDC NEWS**   PFK  3    HDC LOGO
 PFK  7    PAGE BACK                                  PFK  8    PAGE FORWARD
 PFK  2    APPLICATION INFO                           PFK 11    UTILITIES
MA +    a                                                          19/04(
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4. Next will be the HCFA Production CICS Environment screen. Type Your User ID and Password. This will be the same as what is used for POR/PSOR/M-Parts. For additional information, contact your system administrator.


```
Welcome to the Health Care Financing Administration
                Production  CICS Environment

TERMID  HDC91368                                    Date    08-29-2002
APPLID  HDCPGNA1                                    Time    11:43:24




        Type your userid and password, then press ENTER:


                    Userid . . . .  ■
                    Password . . .


            New Password . . .




                    PF3 ==> Logoff
```
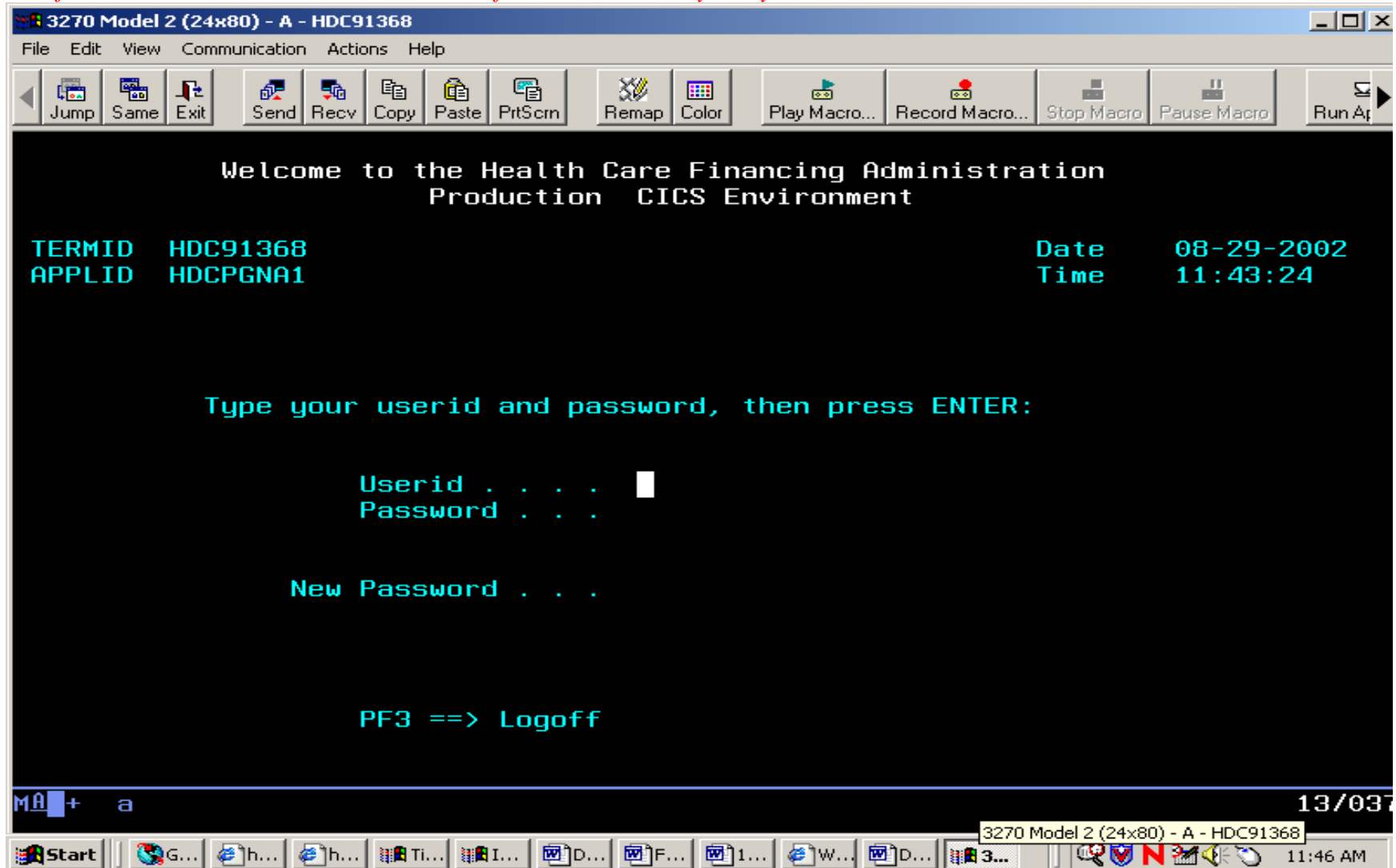
5. Next will be a menu option screen. Type in the corresponding number for DCS and Hit Enter.

Welcome to the Health Care Financing Administration
Production   CICS Environment

TERMID   HDC91368   Date   08-29-2002
APPLID   HDCPGNA1   Time   11:45:31

        1 Provider Overpayment Recovery
        2 Physicians Supplier Recovery
        3 Debt Collection
        4 POR Provider File Maintenance
        5 Exit CICS

Please enter an Option Number ===> ▮   Hit F1 for Help
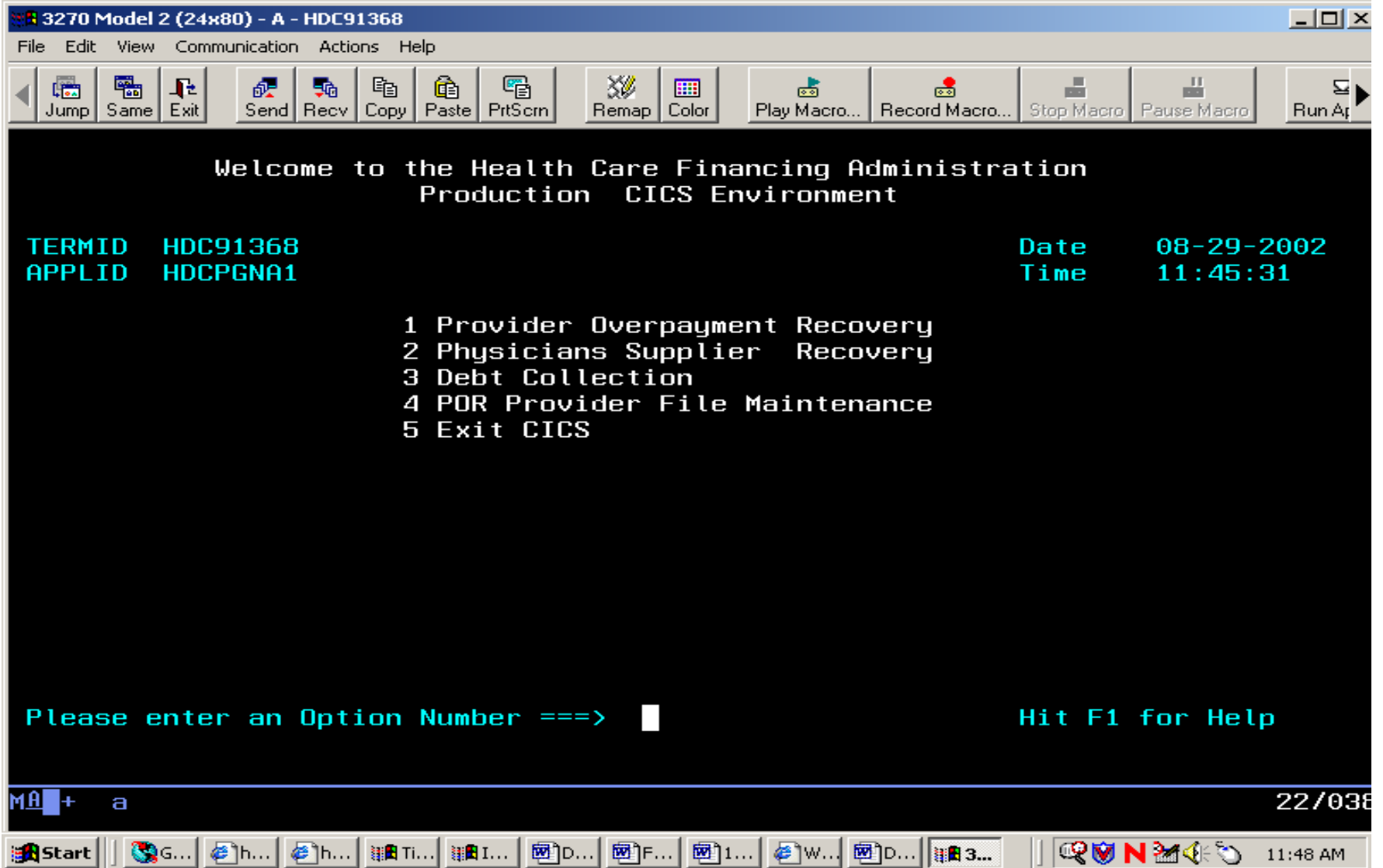
SECTION TWO:

ENTERING DEBTS INTO DCS

TO ENTER A DEBT INTO DCS

1. The next screen will be the Cross Servicing Production System Search Screen.
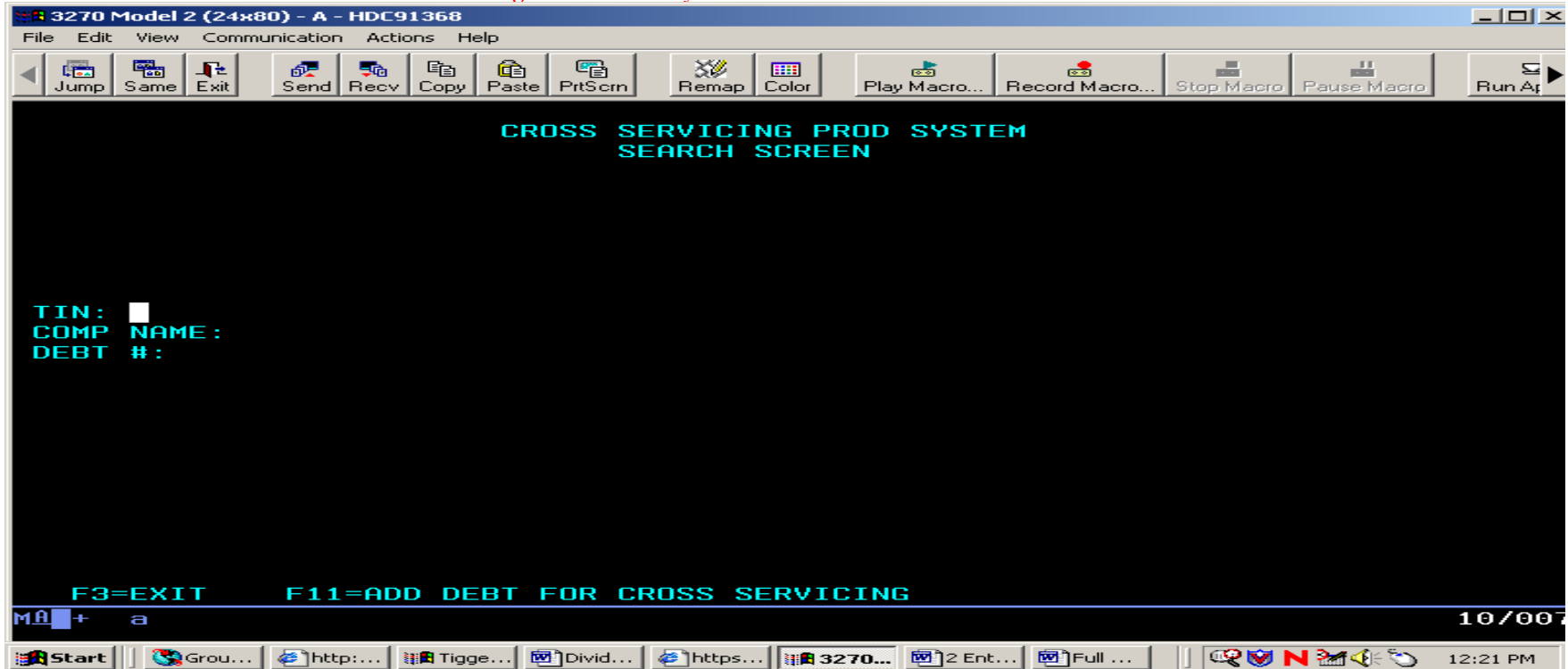
From this screen you may query a particular debt by entering data into any of the three fields listed. If you do not have the complete TIN, the system will allow you to enter a minimum of five characters. If you do not have the complete Company Name, the system will allow you to enter a minimum of six characters. If you do not have the complete Debt #, the system will allow you to enter a minimum of four characters. The system will then bring up all debts related to the information provided. You may then select the correct debt by using the F8 key to scroll forward through the debts.

IMPORTANT: This query should be used before entering a debt into the system so that you can check for a duplicate entry. Once you have determined that the debt is not currently in the system, Hit F11 to insert a new debt.

2. If you chose F11 to insert a new debt, the next screen to appear will be the Cross Servicing Production System Data Entry Screen. At this screen, you may begin data entry. Once all information has been entered Hit Enter to save.

FIELD SPECIFIC INSTRUCTIONS FOR DATA ENTRY SCREEN

Field #   **Description/Instruction**

1.   DEBT NUMBER - Enter the associated debtor number. For debt types PTB/TPB use the PSOR Physician / Supplier number. For debt types PTA/TPA use the POR Provider number. For debt type MSP use the report ID for a data match case or HIC number for a non-data match case. For all other debts, use a specific identifying debtor number. When entering this number, enter from left to right, DO NOT use spaces and DO NOT use dashes.

2.   **DEBT TYPE** - Enter the appropriate debt type. Debt types are as follows:
PTA (Part A, POR system, referred to a Private Collection Agency (PCA) and the Treasury Offset Program (TOP));
PTB (Part B, PSOR system, referred to PCA and TOP); **TPA** (Part A, POR system, referred to TOP only, will not be referred to a PCA); **TPB** (Part B. PSOR system, referred to TOP only, will not be referred to a PCA); **MSP** (Medicare Secondary Payer); **HMO**; **FOI** (Freedom of Information Act); **RRB** (Railroad Retirement Board); **OTH** (other); **PUB** (Public Invoices); **LTC** (Long Term Care); **OIG** (Office of the Inspector General); **CBC** (Centers for Beneficiary Choice) ; **CLA** (Intermediary Claims A/R); **PAO** (Part A Other, not on POR, , referred to PCA and TOP); **TAO** (Part A Other, not in POR, referred to TOP only); **PBO** (Part B Other, not on PSOR, , referred to PCA and TOP); **TBO** (Part B Other, not in PSOR, referred to TOP only)
Debt types PUB, LTC, OIG and CBC are used by Central Office only.

3.   **TIN (Taxpayer Identification Number)** - Enter the TIN (SSN or EIN).   Do not use dashes between numbers. This field is required for all Non MSP debts and must be entered on MSP debts if available. For MSP debts, use the beneficiary SSN as the TIN when the beneficiary is the debtor. Use the EIN for company debt. Do not enter a pseudo TIN.

4.   **SA CODE** - Enter **IND** for an individual debtor or **COR** for a corporate debtor or a partnership. This code is used for the Treasury Offset Program.

5.   **RG CD (Regional Code)** - Enter the Regional Office number (i.e. 01).

6.   **F NAME (First Name)** - Enter the first name of the debtor. This field should not be used for corporate debtors.

7.   **L NAME (Last Name)** - Enter the last name of the debtor. This field is required when the SA Code is IND. This field should not be used for corporate debtors.

8.   **COMP NAME (Company Name)** - *Enter the corporate name of the debtor. This field is required when the SA Code is COR.*

9.   **CORPORATE OFFICER** - *This is an optional field. Enter the corporate officer for the company.*

10. **STREET ADR (Street Address)** - *Enter the street address of the debtor.*

11. **CITY** - *Enter the city of the debtor.*

12. **ST (State)** - *Enter the state of the debtor.*

13. **ZIP** - *Enter the zip code of the debtor. This field must be at least five numeric digits. DO NOT MAKE THIS FIELD ALL ZEROS.*

14. **SUMM IND** – *This field is required for debt types PTB/TPB. Enter an S if the debt is included in a summary entry on PSOR. Enter an N if it is not part of a summary entry on PSOR.*

15. **PATIENT NAME** - *This field is ONLY for MSP debts. Enter the beneficiary's first and last name.*

16. **PRIN REFERRED AMT (Principal Referred Amount)** - *Enter the amount of the principal that is outstanding and is to be referred. This will be the principal amount due as stated in the intent letter minus any adjustments, reductions due to a valid documented defense, partial payments, etc which are made before the debt is referred. This figure must be entered in as dollars and cents (xxx.xx). For debt types PTA/PTB/TPA/TPB this amount must agree to the principal amount in POR / PSOR.*

17. **INT REFERRED AMT (Interest Referred Amount)** - *Enter the amount of interest due as of the date entered into field 19 (interest accrued thru date). This figure must be entered in as dollars and cents (xxx.xx). For debt types PTA/TPA, this amount must agree to the interest amount in POR. If there is no interest due at the time of referral enter .01 in this field.*

18. **INT RATE (Interest Rate)** - *Enter the interest rate for the debt. It must be entered as a whole number and be three decimal places (13 1/2% would be 13.500). This field is required if there is an interest referred amount.*

19. **ACCR THRU DT (Interest Accrued Thru Date)** - Enter the date the interest is accrued through. This must be entered as MM/DD/YYYY (slashes must be included). This is <u>not</u> the date of the last interest accrual. (ex. If your internal system accrues interest on 10/1 for the period of 10/1-10/30 the interest accrued thru date should be 10/30)

20. **CNC IND (CNC Indicator)** - Enter **Y** if the debt is an approved CNC debt or **N** if it is not an approved CNC debt.

21. **CNC DT (CNC Date)** - This field is required for both Non MSP and MSP debts if the CNC IND field is **Y**. This field is also required for MSP debts even when the CNC IND is N. For MSP, enter the date on which the debt is eligible to become a CNC debt. For Non MSP, enter the date the debt was approved as CNC. This must be entered as MM/DD/YYYY (slashes must be included).

22. **CONTR #(Contractor Number)**- Enter the Medicare contractor number. This field must be five numeric digits.

23. **PR TY (Provider Type) -** This field is required for debt types PTA/TPA/MSP/CLA/TAO/PAO. For debt types PTA/TPA enter the provider type from POR. For debt types CLA/TAO/PAO enter the appropriate provider type for the debt. For MSP debts this field will correlate to the type of MSP case being entered into the system. MSP case codes are as follows: **12** (Working Aged); **13** (ESRD – End Stage Renal Disease); **14** (Auto / No Fault); **15** (Workers' Compensation); **41** (Black Lung); **42** (VA – Veterans); **43** (Disability); **47** (Liability). This is a two digit numeric field (i.e. 10).

24. **POR OP (POR Overpayment) -** This field is required for debt types PTA/TPA. Enter the POR overpayment type. For Part A MSP debts this field will always be A. This is a one-character field (i.e H).

25. **CLAIM (Claim Number)** - This field is required for debt types PTB/TPB/TBO/PBO/CLA. For debt types PTB/TPB enter the fifteen-digit number used in the PSOR claim number field. For debt types TBO/PBO/CLA enter the fifteen-digit claim number or document control number. This is not required for MSP. This field is fifteen digits entered from left to right.

26. **A/R LOC (Accounts Receivable Location)** - Enter the appropriate location of the receivable. H - Central Office, **R** – Regional Office or **C** - Contractor. This field represents the reporting responsibility for financial statements (Form CMS-751).

27. **COST REPORT DT (Cost Report Date)** - *This field is required for Part A debts. For debt types PTA/TPA enter the date of the cost report from the POR. For debt types PAO/TAO/CLA enter the date of the cost report if applicable. For MSP debts enter the date of the intent letter. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.*

28. **DET DATE (Determination Date)** - *Enter the overpayment determination date for the debt. If it is an MSP debt, enter the date of the demand letter to the identified debtor. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.*

29. **CL PD DT (Claim Paid Date)** - *This field is required for debt types PTB/TPB/TBO/PBO. For debt types PTB/TPB enter the claim paid date from the PSOR system. For debt types TBO/PBO enter the claim paid date for the debt. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date. This is not required for MSP.*

30. **CERT BY (Certified By)** - *Enter the name of the contact person certifying the debt as valid and legally enforceable.*

31. **PHONE** - *Enter the phone number of the certifying/contact person. If possible, please use direct line numbers.*

32. **FAX NUMBER** - *Enter the fax number of the certifying/contact person.*

33. **RO/CONTR NAME (Regional Office/Contractor Name)** - *Enter the location of the certifying office of the debt prior to referral. This will be the Regional Office name (i.e. Dallas Regional Office) or the Contractor name (i.e. Trailblazers).*

34. **LTR (Letter)** - *Enter Y to indicate that the intent to refer letter containing the DCIA language has been sent to the debtor.*

35. **DT LTR (Date of Letter)** - *Enter the date the intent to refer letter was sent. This date is used to calculate the 60 days' notice the debtor is given prior to referral. This must be entered as MM/DD/YYYY (slashes must be included). This field cannot be greater than today's date.*

36. **LT GEN DT (Letter Generated Date)** - *This field is system generated and is for Central Office use only.*

37. **STAT CD (*Status Code*)** - *Enter **UU** to indicate initial input. If the intent to refer letter was returned undeliverable use the status code **UN** instead of UU. When the debt is sent to Treasury, the status code will be changed by Central Office to **UJ** to indicate that the debt was referred for cross servicing. If the debt is not transferred due to an error it will be placed in a TT (transmittal hold) status until the error is corrected.*

38. **STAT DT (*Status Date*)** - *This is a system-generated field. It will update each time the status code changes.*

39. **OPER-ID (*Operator ID*)** - *This field is system generated and shows the User ID.*

40. **LAST UPDATE DATE** - *This field is system generated and shows the date of the last change made to the data entry screen of the debt*

41. **TRANSMIT DATE -** *This field is system generated when the debt is transferred to Treasury.*

SECTION THREE:

UPDATING A DEBT

UPDATING A DEBT

NOTE: Once a debt has been transmitted, only Central Office and MSP Contractors will have access to update information with the exception of the CNC Ind & CNC Date fields.

Updates to a debt are made on the Data Entry Screen. Debts already added to DCS cannot be deleted. However, the system will allow users to update/edit information. Regional Offices and Contractors can edit information on the data entry screen until the debt has been transmitted. After transmittal, if a change needs to be made, Non MSP Regional Offices and Contractors must submit the appropriate forms to Central Office to have these updates processed.

The status code for Non MSP debts that require a status change prior to being transferred to Treasury begin with the number "1". The status code for Non MSP debts that require a status change after being transferred begin with the number "2". The status code for MSP debts that require a status change prior to being transferred to Treasury begin with the number "3". The status code for MSP debts that require a status change after being transferred begin with the number "4".

For MSP debts transmitted to Treasury, do not update principal and interest amounts on the data entry screen, Medicare Contractors should post all changes on the collection screen. Be advised that the amounts on the data entry screen will not change once these updates are made. These fields must stay in their original amounts so that Central Office can keep track of the dollar amount of debt referred to Treasury. To see the balance of the debt, press F5 to go to the collection screen.

To change information for a debt, you must first query the debt and be at the Data Entry Screen. If there is more than one debt for the queried information, use F8 to scroll to the correct debt. Once on the Data Entry Screen, Hit F9. At this point all information that can be updated will appear in red.


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3270 Model 2 (24x80) - A - HDC91368                                    _ |□| X

File   Edit   View   Communication   Actions   Help

 Jump  Same  Exit   Send  Recv  Copy  Paste  PrtScrn   Remap  Color   Play Macro...  Record Macro...  Stop Macro  Pause Macro   Run Ap

                      CROSS SERVICING PROD SYSTEM
                         DATA ENTRY SCREEN
DEBT #: 000008486     DEBT TYPE: PTB TIN: 431379789 SA CODE: IND RG CD: 06
F NAME: ROBERT                   L NAME: SCIORTINO
COMP NAME:
CORPORATE OFFICER:
STREET ADR: PO BOX 1209
CITY: MARYLAND HEIGHTS     ST: MO ZIP: 63043
PATIENT NAME:
PRIN REFERRED AMT:          633.07   INT REFERRED AMT:          58.56
INT RATE: 13.875 ACCR THRU DT: 04/13/2001 CNC IND: N CNC DT:
CONTR #: 00523 PR TY:     POR OP:     CLAIM: 908105001310200 A/R LOC: C
COST REPORT DT:            DET DATE: 09/15/2000 CL PD DT: 04/15/1998
CERT BY: BARBARA SCHMEDING                    PHONE: 314-212-1849
FAX NUMBER:   314-212-1975 RO/CONTR NAME: ABCBS/MO
LTR: Y DT LTR: 02/21/2001 LT GEN DT:            STAT CD: UJ STAT DT: 06/12/2001
OPER-ID: M145 LAST UPDATE DATE: 06/12/2001 TRANSMIT DATE: 06/12/2001

PAGE    ▮    9  OF     29




  F3=EXIT       F7=UP    F8=DOWN
  F9=UPDATE F11=ADD F5=COLLECTIONS F6=COMMENTS
MA +   a                                                          19/009

                                          ▲  _⌐_  158.73.207.36:7723  🔒
```

Note: Once a debt has been transmitted to Treasury, this screen can only be updated by CMS central office for Non MSP debts except for the CNC IND & CNC DT fields or by the MSP contractor for MSP Debt.

Tab to the field to be updated and insert the correct information. Once all corrections have been made, Hit Enter. A message will appear at the bottom of the screen stating that the record has been updated.

```
3270 Model 2 (24x80) - A - HDC91368                                    _ □ ×
File   Edit   View   Communication   Actions   Help

[Jump] [Same] [Exit]   [Send] [Recv] [Copy] [Paste] [PrtScrn]   [Remap] [Color]   [Play Macro...] [Record Macro...] [Stop Macro] [Pause Macro]   [Run Ap]

                    CROSS SERVICING PROD SYSTEM
                       DATA ENTRY SCREEN
DEBT #: 000008486    DEBT TYPE: PTB TIN: 431379789 SA CODE: IND RG CD: 06
F NAME: ROBERT                L NAME: SCIORTINO
COMP NAME:
CORPORATE OFFICER:
STREET ADR: PO BOX 1209
CITY: MARYLAND HEIGHTS    ST: MO ZIP: 63043
PATIENT NAME:
PRIN REFERRED AMT:           633.07   INT REFERRED AMT:         58.56
INT RATE: 13.875 ACCR THRU DT: 04/13/2001 CNC IND: N CNC DT:
CONTR #: 00523 PR TY:    POR OP:    CLAIM: 908105001310200 A/R LOC: C
COST REPORT DT:              DET DATE: 09/15/2000 CL PD DT: 04/15/1998
CERT BY: BARBARA SCHMEDING                      PHONE: 314-212-1849
FAX NUMBER:  314-212-1975 RO/CONTR NAME: ABCBS\MO
LTR: Y DT LTR: 02/21/2001 LT GEN DT:           STAT CD: UJ STAT DT: 06/12/2001
OPER-ID: M145 LAST UPDATE DATE: 08/29/2002 TRANSMIT DATE: 06/12/2001

PAGE        9  OF        29

   RECORD UPDATED

   F3=EXIT        F7=UP    F8=DOWN
   F9=UPDATE F11=ADD F5=COLLECTIONS F6=COMMENTS
MA  +   a                                                        03/01
                                            [158.73.207.36:7723]
```

NOTE: A change to one field may require changes to other fields, based on system edits. For example, changing the Debt Type from PTA to PTB will require changes to fields required for Part B debts. The User ID field, Transmit Date, and Letter Generated Date fields are system protected and cannot be updated.

SECTION FOUR:

COMMENTS SCREEN

COMMENTS SCREEN

(NOTE: Regional Offices and Contractors may still use the comments screen after a debt has been transmitted.)

When F6 is chosen for comments, this is the screen that will appear if there are no current comments for that debt. (Note: The system states that there is no history of comments.)
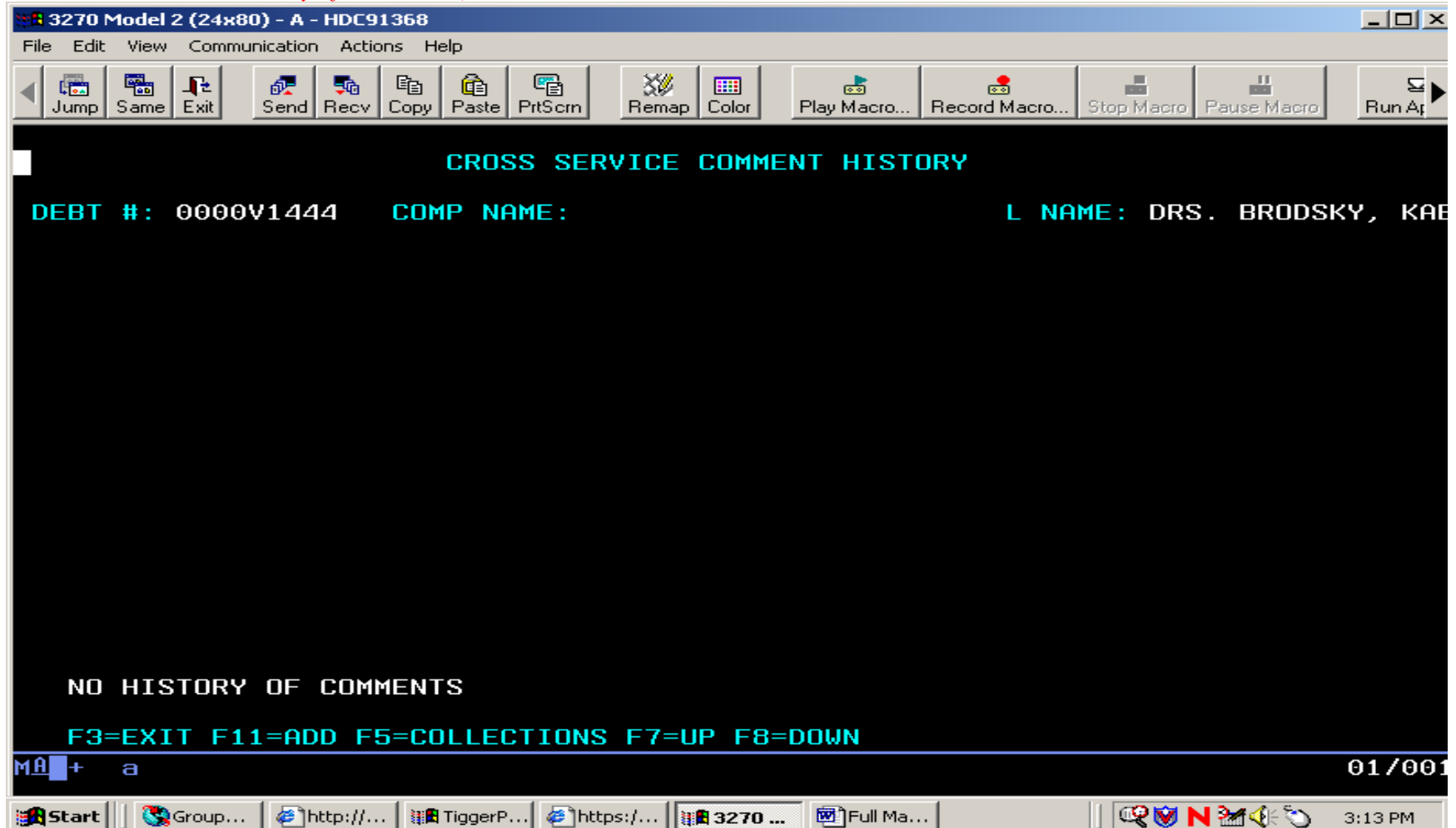
When F6 is chosen for comments, this is the screen that will appear if there are previous comments for that debt.

```
3270 Model 2 (24x80) - A - HDC91368

File   Edit   View   Communication   Actions   Help

Jump  Same  Exit  | Send  Recv | Copy  Paste  PrtScrn | Remap  Color | Play Macro...  Record Macro...  Stop Macro  Pause Macro | Run A
```

```
                    CROSS SERVICE COMMENT HISTORY

DEBT #: 000033443    COMP NAME: FAMILY PLUS MEDICAL CE L NAME: LAZO



DATE:    05/29/2002 PREV STAT CD:            UU
USERID: GDS6          PREV STAT DT:            05/23/2002




DATE:    05/23/2002 PREV COMP NAME:          FAMILY PLUS MEDICAL CETNE
USERID: GDS6







PAGE       ▊   1  OF        2




  F3=EXIT F11=ADD F5=COLLECTIONS F7=UP F8=DOWN

MA  +   a                                                        20/009
```

```
Start | Group... | http://... | TiggerP... | https:/... | 3270 ... | Full Ma...          3:15 PM
```

When F11 is depressed to add a new comment, the comment screen will appear as below. (NOTE: The new comment screen will only allow for four lines of text. Also, the text does not wrap from line to line. Once you near the end of the text line you must hit tab to proceed to the next line.)
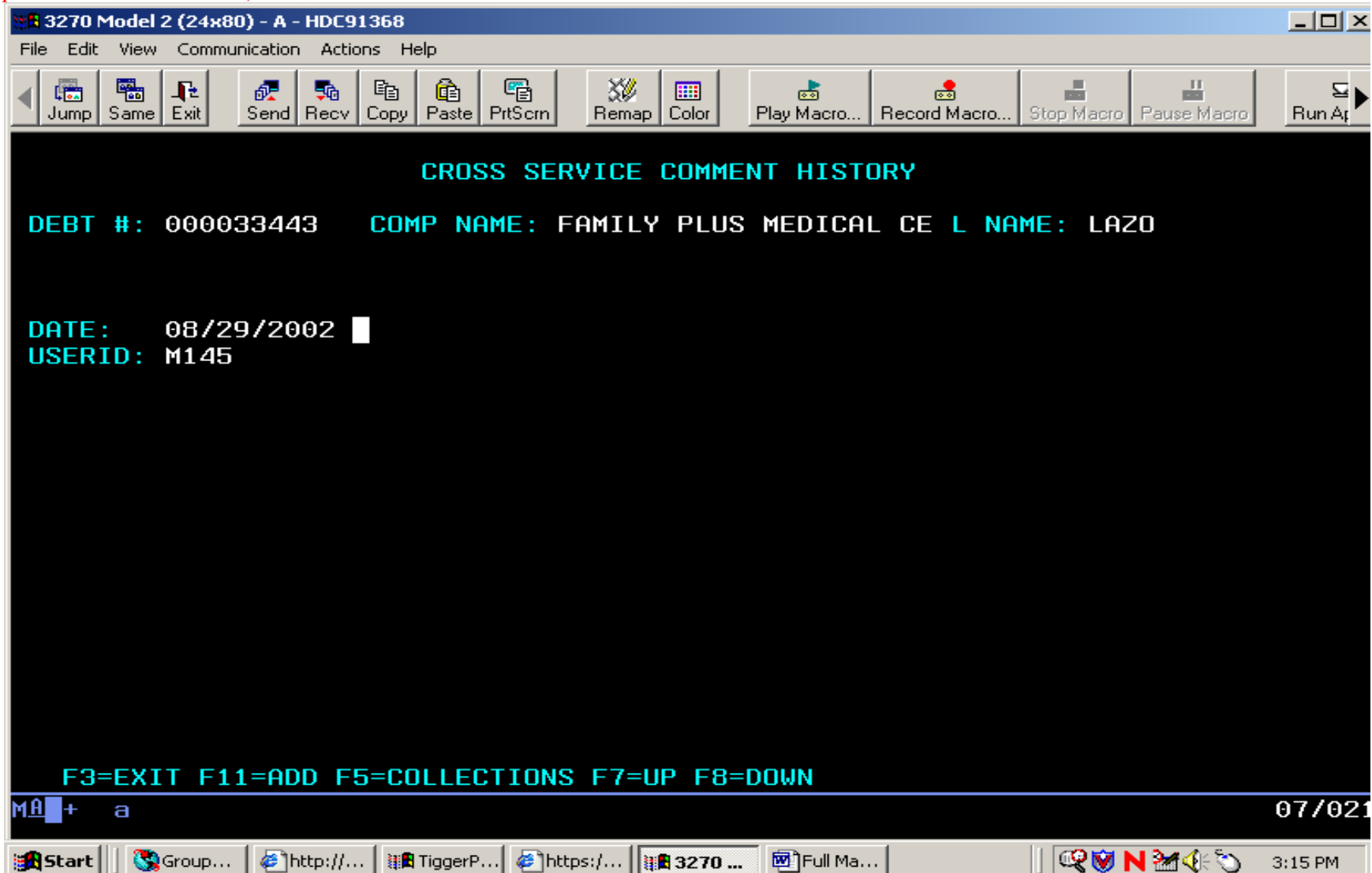
3270 Model 2 (24x80) - A - HDC91368

File   Edit   View   Communication   Actions   Help

Jump | Same | Exit | Send | Recv | Copy | Paste | PrtScrn | Remap | Color | Play Macro... | Record Macro... | Stop Macro | Pause Macro | Run Ap

```
                    CROSS SERVICE COMMENT HISTORY

   DEBT #: 000033443     COMP NAME: FAMILY PLUS MEDICAL CE L NAME: LAZO



   DATE:      08/29/2002
   USERID: M145

















     F3=EXIT F11=ADD F5=COLLECTIONS F7=UP F8=DOWN
```

MA + a   07/021

Start | Group... | http://... | TiggerP... | https:/... | 3270 ... | Full Ma...   3:15 PM

Once all new comment information has been entered, Press Enter. The system will provide a message to Hit F9 to add the comment.

CROSS SERVICE COMMENT HISTORY

DEBT #: 000033569   COMP NAME: HEALTH MEDICAL GROUP   L NAME: PEREZ

DATE: 08/29/2002 THIS IS A TEST
USERID: M145

HIT F9 TO ADD A COMMENT

F3=EXIT F11=ADD F5=COLLECTIONS F7=UP F8=DOWN

MA + a   07/021

Depress F9 and the message "Record Inserted" will appear.

The comments section may be used for two purposes.

First, the comments area is used as an update log. Each time the debt is updated a system generated entry is made in the comments screen. The entry will show the date of the change, user ID of the person making the change and the previous information that has now been updated. (NOTE: To have a history of all changes made to a debt, limit them to four at a time. This is because the system will only note the first four updates made on a record.)

Second, it can be used to enter important information that may clarify issues concerning the debt. Some examples of this type of information could include items not on the data entry screen, changes in company ownership or contractor transitions.

NOTE: All users must enter a comment whenever there is an update or additional information on a debt.

SECTION FIVE:

COLLECTIONS SCREEN

General Collections Information:

Only Central Office staff, MSP Regions and MSP Contractors will use the Collection Screen to enter all types of collections and offsets applied to a debt.

The status code of a debt may or may not change, based on a collection. If a debt is offset at the contractor location, but is not paid in full, and that debt is already at Treasury, the debt will remain there for further collection and the status code will remain UJ. If a debt is collected in full the status code should be changed to the appropriate code. However, Treasury must be notified of the reduction in amount to be collected. (See Section 10 for Recalls / Adjustments)

For Non MSP debts, Central Office will receive collections as a result of DCIA intent to refer letters or through Treasury collection efforts. Central Office will update the DCS as well as notify the Regional Office or Contractor as appropriate. If the Region or Contractor receives a collection or offset, Central Office must be notified immediately using the Collection Reconciliation Acknowledgement Form. It is the responsibility of Central Office to update DCS with all collection information as well as notify PSC/Treasury.

Central Office and MSP Regions and Contractors will use the Comments Screen in conjunction with the Collections Screen to add any particular information regarding the collection.

COLLECTIONS SCREEN
NOTE: Only Central Office and MSP Contractors will have access to enter collection information.

When F5 is chosen for Collections, this is the screen that will appear if there is no current payment history for that debt. (Note: The system states that there is no history of payments.)


```
3270 Model 2 (24x80) - A - HDC91008                                    _ ő X
File  Edit  View  Communication  Actions  Help

Jump Same Exit | Send Recv Copy Paste PrtScrn | Remap Color | Play Macro... Record Macro... Stop Macro Pause Macro | Run Ap

                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 000033443     COMP NAME: FAMILY PLUS MEDICAL CE L NAME: LAZO

TOTAL DEBT AMOUNT:        520,111.41  TOTAL NET CASH:                     .00
TOTAL AMT REFERRED:       520,111.41  TOT BALANCE OUTSTANDING:     520,111.41
AMT REFERRED(PRIN):       292,814.37  TOT BALANCE (PRIN):         292,814.37
AMT REFERRED(INT):        227,297.04  TOT BALANCE(INT):           227,297.04
ADDTL INT AMOUNT:                .00  AMT COLLECTED(PRIN):                .00
TOT FEE AMT:                     .00  AMT COLLECTED(INT):                 .00




    NO HISTORY OF PAYMENTS
    F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA + a                                                              01/001

                                            158.73.207.36:7723
```

When F5 is chosen for Collections, this is the screen that will appear if there are previous payments for that debt.

```
3270 Model 2 (24x80) - A - HDC91008                                    _ 8 X
File   Edit   View   Communication   Actions   Help

[Jump] [Same] [Exit]  [Send] [Recv] [Copy] [Paste] [PrtScrn]  [Remap] [Color]  [Play Macro...] [Record Macro...] [Stop Macro] [Pause Macro]  [Run Ap]

                      CROSS SERVICE COLLECTIONS HISTORY
 DEBT #: 0000V1841      COMP NAME: DIAGNOSTIC CARDIOLINE   L NAME: TURTURO

 TOTAL DEBT AMOUNT:       1,616,932.00  TOTAL NET CASH:               99,733.00
 TOTAL AMT REFERRED:      1,616,932.00  TOT BALANCE OUTSTANDING:   1,517,199.00
 AMT REFERRED(PRIN):      1,616,932.00  TOT BALANCE (PRIN):        1,517,199.00
 AMT REFERRED(INT):               .00  TOT BALANCE(INT):                   .00
 ADDTL INT AMOUNT:                .00  AMT COLLECTED(PRIN):          99,733.00
 TOT FEE AMT:                     .00  AMT COLLECTED(INT):                 .00

 DATE:        04/17/2001               AMT COLLECTED(PRIN):          99,733.00
 USERID:      AS41                     AMT COLLECTED(INT):                 .00
 COLL TYP:    AD                       FEE AMT:                            .00
 ACCT DATE:   04/17/2001               NET CASH RECEIVED:            99,733.00




 PAGE     ▮      1   OF         1


   F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA + a                                                                  21/009
                                                        158.73.207.36:7723
```

When F11 is chosen to add a payment entry, this is how the screen will appear. (See attached collection screen field specific instructions)

```
                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #  [1] 000V1841    COMP NAME [2] IAGNOSTIC CARDIOLINE   L NAME [3] JRTURO

TOTAL DEBT AMOUNT:    [4] 1,616,932.00   TOTAL NET CASH [5]              99,733.00
TOTAL AMT REFERRED [6]  1,616,932.00   TOT BALANCE OUTSTANDING: [7]  1,517,199.00
AMT REFERRED(PRIN):  [8] ,616,932.00   TOT BALANCE (PRIN):  [9]      1,517,199.00
AMT REFERRED(INT):         [10]  .00   TOT BALANCE(INT) [11]               .00
ADDTL INT AMOUNT [12]            .00   AMT COLLECTED(PRIN):  [13]      99,733.00
TOT FEE AMT [14]                 .00   AMT COLLECTED(INT) [15]             .00

DATE: [16]    08/29/2002              AMT COLLECTED(PRIN):   [17] |
USERID: [18] 1145                     AMT COLLECTED(INT) [19]
COLL TYP:  [20]                       FEE AMT [21]
ACCT DATE: [22]                       NET CASH RECEIVED: [23]




     ENTER AMOUNTS AS DOLLARS AND CENTS
     F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
MA  +   a                                                            11/064
```

After all collection information has been added, Hit Enter. The system will provide a message to Hit F9 to add the collection.

File   Edit   View   Communication   Actions   Help

| Jump | Same | Exit | | Send | Recv | Copy | Paste | PrtScrn | | Remap | Color | | Play Macro... | Record Macro... | Stop Macro | Pause Macro | | Run Ap |

```
                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 000000718      COMP NAME: GALITZ WEISS & ASSOC.   L NAME: GALITZ


TOTAL DEBT AMOUNT:            979.00   TOTAL NET CASH:                    .00
TOTAL AMT REFERRED:           979.00   TOT BALANCE OUTSTANDING:        979.00
AMT REFERRED(PRIN):           979.00   TOT BALANCE (PRIN):            979.00
AMT REFERRED(INT):               .00   TOT BALANCE(INT):                  .00
ADDTL INT AMOUNT:                .00   AMT COLLECTED(PRIN):               .00
TOT FEE AMT:                     .00   AMT COLLECTED(INT):                .00


DATE:        08/29/2002                AMT COLLECTED(PRIN):           103.35
USERID:      M145                      AMT COLLECTED(INT):             21.79
COLL TYP:    CO                        FEE AMT:                           .00
ACCT DATE:   05/21/2002                NET CASH RECEIVED:






    HIT F9 TO ADD A PAYMENT
    F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
```

MA +   a   11/064

Start | Full Manual.doc - Microsof... | Welcome to CMS - Micros... | 3270 Model 2 (24x80) ... | 4:58 PM

Depress F9 and the message "Record Inserted" will appear.


```
                    CROSS SERVICE COLLECTIONS HISTORY
DEBT #: 000000718   COMP NAME: GALITZ WEISS & ASSOC.   L NAME: GALITZ


TOTAL DEBT AMOUNT:          1,000.79   TOTAL NET CASH:              125.14
TOTAL AMT REFERRED:           979.00   TOT BALANCE OUTSTANDING:      875.65
AMT REFERRED(PRIN):           979.00   TOT BALANCE (PRIN):          875.65
AMT REFERRED(INT):               .00   TOT BALANCE(INT):               .00
ADDTL INT AMOUNT:              21.79   AMT COLLECTED(PRIN):         103.35
TOT FEE AMT:                     .00   AMT COLLECTED(INT):           21.79


DATE:        08/29/2002                AMT COLLECTED(PRIN):         103.35
USERID:      M145                      AMT COLLECTED(INT):           21.79
COLL TYP:    CO                        FEE AMT:                        .00
ACCT DATE:   05/21/2002                NET CASH RECEIVED:           125.14




PAGE     █    1  OF           1


   RECORD INSERTED
   F11=ADD F3=EXIT F6=COMMENTS F7=UP F8=DOWN
```

FIELD SPECIFIC INSTRUCTIONS FOR COLLECTION SCREEN

Field #   Description/Instruction

1. **DEBT # (Debt Number) -** *This field is carried over from the Data Entry Screen.*

2. **COMP NAME (Company Name) -** *This field is carried over from the Data Entry Screen*

3. **L NAME (Last Name) -** *This field is carried over from the Data Entry Screen. For MSP this field will be blank.*

4. **TOTAL DEBT AMOUNT -** *This is a system calculated field and is principal referred + interest referred + any additional interest.*

5. **TOTAL NET CASH -** *This is a system calculated field and is total principal collected + total interest collected - total fees collected.*

6. **TOTAL AMT REFERRED (Total Amount Referred) -** *This is a system calculated field and is principal referred + interest referred.*

7. **TOT BALANCE OUTSTANDING (Total Balance Outstanding) -** *This is a system calculated field and is principal balance + interest balance.*

8. **AMT REFERRED PRIN (Principal Amount Referred) -** *This field is carried over from the Data Entry Screen and is the principal amount referred to PSC/Treasury.*

9. **TOT BALANCE PRIN (Total Principal Balance) -** *This is a system calculated field and is the remaining unpaid principal after posted collections and adjustments. (Amount Referred Principal - Total Principal Collected)*

10. **AMT REFERRED INT (Interest Amount Referred) -** *This field is carried over from the Data Entry Screen and is the interest amount referred to PSC/Treasury.*

11. **TOT BALANCE INT (Total Interest Balance) -** *This is a system calculated field and is the remaining unpaid*

interest after posted collections and adjustments.

12.   ***ADDTL INT AMOUNT (Additional Interest Amount) -*** *This is a system calculated field and is for any additional interest collected over the initial referred interest amount.*

13.   ***AMT COLLECTED PRIN (Principal Amount Collected) -*** *This is a system calculated field and is the total principal amounts that have been collected to date.*

14.   ***TOT FEE AMT (Total Fee Amount) -*** *This is a system calculated field and is the total fee amounts that have been paid to PSC/Treasury to date.*

15.   ***AMT COLLECTED INT (Interest Amount Collected) -*** *This is a system calculated field and is the total interest amounts that have been collected to date.*

16.   ***DATE*** *- This field is system generated and shows the date of the entry.*

17.   ***AMT COLLECTED PRIN (Principal Amount Collected)*** *- This is a data entry field. Enter the amount of the collection received that is being applied to principal. This figure must be entered as dollars and cents (xxx.xx).*

18.   ***USER ID*** *- This field is system generated and shows the User ID of the user posting the collection.*

19.   ***AMT COLLECTED INT (Interest Amount Collected)*** *- This is a data entry field. Enter the amount of the collection received that is being applied to interest. This figure must be entered as dollars and cents (xxx.xx). If the collected interest amount is greater than the interest referred amount, the system will calculate the difference and apply it to the additional interest field.*

20.   ***COLL TYP (Collection Type)*** *- This is a data entry field. Enter the appropriate collection type code for the payment that was received. Collection type codes will be used for recording all collections. For MSP, the contractor could use any one of these codes but* ***CC***, ***AD***, *or* ***PC*** *will be used in most instances. (Refer to the end of this section for collection type codes.)*

21.   ***FEE AMT (Fee Amount)*** *- This is a data entry field. Enter the fee charged by PSC or Treasury to process the debt. This amount will be stated on the Intergovernmental Online Payment and Collection (IPAC) Report. For*

MSP, Central Office will supply this number.

22. **ACCT DATE (Accounting Date)** *- This is a data entry field. Enter the date the IPAC or collection was received. For MSP IPAC payments, use the date of receipt specified by Central Office. For MSP Contractor collections by check, use the date of the postmark on the envelope if available or the date of the check if the envelope is not available. (Contractors should routinely retain the envelop for all checks.)*

23. **NET CASH RECEIVED** *- This is a system generated field. This amount is principal collected plus interest collected minus any fees that apply.*

Rules for Edits:

If Collection Type = TO, TC, PC, JC, AO, SS, then the Fee Amount must be Greater than Zero.

If Collection Type = CO, CC, CU, RC, HC, MO, AD, XT, XP, XC, XR, XH, then the Fee Amount must be blank.

COLLECTION TYPE CODES

CO   *Contractor Offset*
CC   *Contractor Collection*
CU   *Contractor Underpayment (Underpayment Applied to Overpayment)*
RC   *Regional Office Collection*
HC   *Central Office Collection*
MO   *Medicaid Offset*
TO   *TOP Offset*
TC   *Treasury Collection*
PC   *PSC Collection (includes collections by any entity under contract to the PSC)*
JC   *Dept of Justice Collection*
AO   *HHS Administrative Offset*
SS   *SSA Offset*
AD   *Adjustments*
XT   *Treasury Compromise*
XP   *PSC Compromise*
XR   *Region Compromise*
XH   *Central Office Compromise*

MSP Collections

Certain fields on the Collection Screen are automatically system generated.   When the debt is entered into the Data Entry Screen and the Amount Referred Principal and Amount Referred Interest fields are completed, this will automatically fill in on the collection screen and the system will automatically total the amount of the debt being referred. Total Amount Referred, Total Debt Amount, Total Balance Outstanding, Total Principal Balance and Total Interest Balance fields are system generated.

When the contractor enters a collection the following fields on the Collection Screen must be entered:
-           the amount collected principal
-           the amount collected interest
-           the fee amount
-           the collection type status code
-           and the accounting date

If additional interest has accrued on a debt by the time a collection is received, add the additional accrued interest to the amount of the existing DCS interest amount. This additional interest will automatically post to the additional interest amount field. The total of the existing interest and additional accrued interest entered _cannot_ exceed the amount of the collection received. Interest shown in DCS is only updated to the extent that additional interest has also been collected. (Example: Where the existing interest = $50, new accrued interest = $20 and payment = $60, enter $60 in the interest collected field.)

When reviewing a debt for a current balance, always check the total balance principal, total balance interest and total balance outstanding fields on the collection screen. (NOTE: Interest balance will not reflect actual current accrued interest as reflected in the contractor's system.)

If an incorrect figure is entered on the Collection Screen, it can be backed out. This is accomplished by going back into the debt on the collection screen and entering the incorrect figure along with a negative (minus) sign. (ex: 100.00 -)

MSP Examples:

1) If a contractor receives a partial payment or a valid documented defense prior to entering the debt into DCS, the contractor must adjust the debt before entering it into the system. For a valid documented defense, the contractor must adjust both the principal amount and any associated interest. Where there is partial payment, the contractor must adjust the interest amount and the principal amount to reflect the amount of payment applied to interest and principal. In both instances, the remaining balance is the amount entered into DCS. The contractor must also annotate the Comments Screen in both situations. The annotation must show: how much the debt was prior to the valid documented defense and/or partial payment, the amount of any payment or the amount of reduction due to a valid documented defense and the basis of any valid documented defense. These figures must reflect the principal amount and interest amount separately.

2) If the debt has been referred to the PSC and the contractor receives a check (full or partial payment), this information must be entered onto the DCS Collection Screen. In addition, the contractor will note this on the DCS Comments Screen. If the collection is for a partial recovery the DCS status code on the data entry screen stays as a UJ. If the collection is for a full recovery the DCS status code on the data entry screen is changed to 4O. (Debt is in the DCS, with a UJ status code and a transmit date with a collection at the contractor site.)

3) If the contractor receives a valid documented defense, which will reduce the amount due Medicare and/or close the case after it has been referred to PSC, this information should be entered onto the DCS Collection Screen. If the valid defense closes the case, update the Collection screen with an AD status code and update the DCS data entry screen with a status code of 4F. If the valid defense reduces the amount due Medicare leaving a balance on the case, update the Collection Screen with a status code of AD but do not change the status code on the data entry screen.

4) If the contractor receives notification that the debtor is in bankruptcy, appeals, etc, and the debt has already been sent to PSC, enter the appropriate DCS status code on the data entry screen in order to pull back (recall) the debt from PSC.

5) If the contractor receives a collection on a debt in the DCS, which has a status code of UU (initial entry), update the data entry screen with the new principal referred amount and interest referred amount (old amount – collection = new amount that is entered into the DCS). In this situation, the collection would not need to be posted to the Collection Screen.

6) If the contractor receives a valid documented defense for part of the debt and a check for all or part of the remaining debt that has already been sent to the PSC, the information would be entered on the collection screen as follows:

> *1st the valid defense amount and appropriate collection code.*
> *2nd the collections/check received and/or fee amt if applicable with the appropriate collection code.*

If the debt is paid in full, update the data entry screen with a status code of 4Z. . If there is a remaining balance, the status code on the data entry screen would stay UJ so PSC can continue recovery of the debt.

7) If the contractor receives a collection on a debt in the DCS, with a status code of UJ and no transmission date listed on the data entry screen, notify Central Office of the situation and supply the new principal and interest amounts after collection. This will allow Central Office to catch the debt before it is transmitted to the PSC.

Collection Type Codes Defined:
The term "Collection Codes" is being used generically to cover both actual collections as well as adjustments and write off closed.

CC - Contractor Collection: *Contractor receives a check or cash from the debtor.*

PC - PSC Collection: *Program Support Center, HHS receives a collection from the debtor. The contractor would use this code when posting a collection that was recovered by PSC efforts.*

AD - Adjustment: *This code would be used for a valid documented defense that was received which would eliminate or lower the principal amount due Medicare. This also can be used for write off - closed or a provider adjustment. Adjustment is being used generically for this section to cover changes to the debt other than actual collections.*

SECTION SIX:

REPORTS

REPORTS

The Central Office will be responsible for generating reports and sending them to the Regional Offices. All Non MSP reports will be sent to both Regions and Contractors. MSP reports will be sent to the Regions and it will be their responsibility to forward these reports to the appropriate Contractors.

Last Debts Transmitted to PSC *- This report lists all debts that were sent to PSC during the last transmittal. Each Region and Contractor will receive reports for their area. There are a total of six transmittal reports: two are for Part A debts, two are for Part B debts, one is for Claims A/R debts and one is for MSP debts.*

MSP/DCS Snapshot – This is a MSP report only. It lists all referred MSP debts in DCS by Contractor. It is used by the MSP Contractors to reconcile their internal systems with DCS.

TT Report – This is a Non MSP report only. It lists all Non MSP debts in a transmittal hold status. These are eligible debts but are in a hold status due to some type of matching error between DCS and POR/PSOR.

SECTION SEVEN:

ERROR MESSAGES

ERROR MESSAGES

COLLECTION SCREEN

$ **Amount must be entered for payment** - *Amount collected (either principal or interest) cannot be left blank when entering a payment.*

$ **Acct Dt is an invalid date** - *The date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ **CO, CC, CU, RC, HC, MO, TO, TC, PC, JC, AO, SS, AD, XT, XP, XC, XR, XH are valid** - *The collection code can not be something other than the codes listed.*

$ **Date cannot be future date** - *The accounting date cannot be greater than today's date.*

$ **Fee amt must be greater than zero** - *If the Collection Type is TO, TC, PC, JC, AO or SS then the fee amount has to be greater than zero.*

$ **Fee amt must be equal to zero** - *If the Collection Type is CO, CC, CU, RC, HC, MO, AD, XT, XP, XC, XR or XH then the fee amount has to be zero.*

$ **Hit F9 to add a payment** - *Once payment information has been entered F9 must be hit to add it to the system.*

COMMENTS SCREEN

$ **Comment must be entered for history -** *When F11 is hit to add a new comment, it cannot be left blank. A comment has to be added.*

$ **Hit F9 to add a comment** - *Once comment information has been entered F9 must be hit to add it to the system.*

DATA ENTRY SCREEN

$ *CNC dt must be blank when CNC ind = n -* *If the debt type is PTA, TPA, PTB or TPB and the CNC indicator is N, the CNC date must be left blank.*

$ *MSP, HMO, FOI, PTA, RRB, CBC, LTC, OIG, PUB, PTB, TPA, TPB, OTH, CLA, PAO, TAO, PBO, TBO are valid values -* *The Debt Type cannot be something other than the codes listed.*

$ *Debt # must be 6 digits for Part A -* *If the debt is a Part A debt, the debt number cannot be less than six digits.*

$ *TIN must be 9 digit numeric -* *The TIN number has to be 9 characters and numeric.*

$ *COR or IND are valid -* *The SA Code cannot be something other than the codes listed.*

$ *RG CD must be 2 digit numeric -* *The Region Code has to be 2 characters and numeric.*

$ *F name must be alphabetic -* *The first name must be alphabetic.*

$ *L name must be alphabetic -* *The last name must be alphabetic.*

$ *Certified name must be alphabetic -* *The certified by name must be alphabetic.*

$ *City must be alphabetic -* *The city must be alphabetic.*

$ *State must be alphabetic -* *The state must be alphabetic.*

$ *Patient name must be alphabetic -* *The patient name must be alphabetic.*

$ *Corporate officer must be alphabetic -* *The corporate officer name must be alphabetic.*

$ *L name is required -* *If the SA Code is IND, last name cannot be left blank.*

$ *Comp name is required -* *If the SA Code is COR, company name cannot be left blank.*

$ ***Street address is required -*** *Street cannot be left blank.*

$ ***City is required -*** *City cannot be left blank.*

$ ***State is required -*** *State cannot be left blank.*

$ ***Zip is required -*** *Zip cannot be left blank.*

$ ***First 5 digits of zip must be numeric -*** *The first 5 characters of the zip code must be numeric.*

$ ***Patient name is required for MSP debt -*** *If the debt is an MSP Debt, a patient name must be entered.*

$ ***Interest amount required -*** *The interest amount is required for all MSP debts, all PTB / TPB debts and all PTA / TPA debts except H or J.*

$ ***Interest rate required –*** *The interest rate cannot be left blank.*

$ ***Enter % as xx.xxx -*** *The interest rate must be entered as two whole numbers and three decimal places.*

$ ***Accr thru dt must be entered -*** *Interest accrued thru date can not be left blank.*

$ ***Accr thru dt invalid mm/dd/yyyy -*** *The Interest accrued thru date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***Y or N or R are valid values -*** *The CNC indicator can not be something other than the codes listed.*

$ ***CNC dt required when CNC ind = Y or R -*** *If the CNC ind is Y or R then there must be a CNC date.*

$ ***Enter at least 4 digits -*** *The Debt Number must be at least 4 digits in length.*

$ ***CNC dt invalid mm/dd/yyyy*** *- The CNC date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***CNC dt required when debt typ = MSP*** *- If the debts is MSP then a CNC date is required.*

$ ***Contr# must be 5 digit numeric*** *- The Contractor number must be 5 characters and numeric.*

$ ***Pr ty must be numeric*** *- The Pr Ty must be two-digit numeric.*

$ ***Por op must be alphabetic*** *- The Por op has to be alphabetic.*

$ ***Claim must be 15 digit numeric*** *- The claim number must be 15 characters and numeric.*

$ ***Det date must be entered*** *- Determination date cannot be left blank.*

$ ***Det date invalid mm/dd/yyyy*** *- The determination date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***Cost report dt must be entered*** *- Cost report date is required on Part A debts.*

$ ***Cost report dt invalid mm/dd/yyyy -*** *The Cost report date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***CL pd dt must be entered*** *- Claim paid date is required on Part B debts.*

$ ***CL pd dt invalid mm/dd/yyyy -*** *The claim paid date is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***Claim must equal spaces*** *- Claim number must be left blank for this debt.*

$ ***CL pd dt must equal spaces*** *- Claim paid date must be left blank for this debt.*

$ ***12, 13, 14, 15, 41, 42, 43, 47 valid for MSP -*** *These are the only valid values for field PR TY for MSP debts.*

$ ***Pr ty must = spaces for debt typ = PTB*** *– This field must be left blank for this debt type.*

$ ***Pr ty must = spaces for debt typ = TBO*** *– This field must be left blank for this debt type.*

$ ***Pr ty must = spaces for debt typ = PBO*** *– This field must be left blank for this debt type.*

$ ***Pr ty must = spaces for debt typ = TPB*** *– This field must be left blank for this debt type.*

$ ***A/R loc must = H or R or C*** *– This field can only be H, R or C.*

$ ***Claim must = spaces for debt typ = PTA -*** *This field must be left blank for this debt type.*

$ ***Claim must = spaces for debt typ = TPA -*** *This field must be left blank for this debt type.*

$ ***Cl pd dt must = spaces for debt typ = PTA -*** *This field must be left blank for this debt type.*

$ ***Cl pd dt must = spaces for debt typ = TPA -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ PTB -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ TBO -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ PBO -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ TAO -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ PAO -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ CLA -*** *This field must be left blank for this debt type.*

$ ***Por op must = spaces for debt typ TPB -*** *This field must be left blank for this debt type.*

$ ***Cost report dt must = spaces for debtyp =PTB -*** *This field must be left blank for this debt type.*

$ ***Cost report dt must = spaces for debtyp =TBO -*** *This field must be left blank for this debt type.*

$ ***Cost report dt must = spaces for debtyp =PBO -*** *This field must be left blank for this debt type.*

$ ***Cost report dt must = spaces for debtyp =TPB -*** *This field must be left blank for this debt type.*

$ ***Principal + interest must not be less than 25.00 -*** *Principal and interest combined can not be less than $25.00 for MSP debts.*

$ ***Principal amt must not be less than 25.00 –*** *Principal cannot be less than $25.00 for Non MSP debts.*

$ ***Summary debt must be less than 600.00 –*** *Summary entry debts must have a principal amount no less than $25.00 and no more than $599.99.*

$ ***Summ ind required for PTB or TPB debt –*** *This is a required field for these debt types.*

$ ***Summ ind must = spaces for non B debt –*** *This field must be left blank for all Part A debt types.*

$ ***Summ ind must = S or N for PTB or TPB debt –*** *This field can only be S or N for these debt types.*

$ ***Pr ty must equal spaces*** *- Pr ty must be left blank for this debt.*

$ ***Por op must equal spaces*** *- POR op must be left blank for this debt.*

$ ***Cost report dt must equal spaces*** *- Cost report date must be left blank for this debt.*

$ ***Cert by is required*** *- Certified by can not be left blank.*

$ ***Phone must be in 999-999-9999 format*** *- The phone number must be entered with dashes.*

$ ***Fax number must be in 999-999-9999 format*** *- The fax number must be entered with dashes.*

$ ***Loc contact must be entered*** *- The regional office / contractor name cannot be left blank.*

$ ***Ltr must be Y or N*** *- Intent to refer letter cannot be something other than the codes listed.*

$ ***Dt ltr not valid for ltr=N*** *- Date of intent to refer letter must be left blank if Ltr is N.*

$ ***Dt ltr must be entered*** *- Date of intent to refer letter is required if Ltr is Y.*

$ ***Dt ltr invalid mm/dd/yyyy*** *- The date of intent to refer letter is not entered in mm/dd/yyyy format or the date is not a true date (i.e. 06/31/2000).*

$ ***Stat cd must be entered*** *-Status code cannot be left blank.*

$ ***Date can not be future date*** *- The date can not be greater than today's date for the following 6 fields: Interest Accrued Thru Date, Determination Date, Cost Report Date, Claim Paid Date or Date of letter.*

$ ***Duplicate debt exists on DCS*** *- There is another debt in DCS that matches. If it is a Part A debt then the Debt Number, Principal Amount, POR Overpayment Type and Cost Report Date are the same. If it is a Part B debt then the Debt Number, Principal Amount, Claim Paid Date and Claim # are the same. If it is a MSP debt then the Debt Number, Principal Amount, Determination Date and Cost Report Date are the same.*

SECTION EIGHT:

CODES/FUNCTION COMMANDS

DCS STATUS CODES - Non MSP

UN - *Undeliverable Letter*
UU *- Initial Entry*
UJ *- Sent to PSC for Cross Servicing*
UR *- Extended Repayment Plan*
XX *- Suspense / Needs Action/ Waiting for Documentation*
TT *- Transmittal Hold*

NOT TRANSFERRED TO DCC

1A	*Appeal*
1B	*Bankruptcy*
1C	*Compromise*
1D	*Deceased*
1E	*Error*
1F	*Cost Report Filed*
1G	*Fraud*
1L	*Litigation*
1O	*Contractor Offset*
1P	*Voluntary Payment*
1R	*Repayment Agreement*
1T	*Under $600*
1W	*Write Off*

RECALLED FROM DCC

2A	*Appeal*
2B	*Bankruptcy*
2C	*Compromise*
2D	*Deceased*
2E	*Error*
2F	*Cost Report Filed*
2G	*Fraud*
2L	*Litigation*
2O	*Contractor Offset/Paid in Full*
2P	*Voluntary Payment*
2Q	*Cross Servicing Collection/Paid in Full*
2R	*Reconciliation Issue*
2T	*Paid in Full/Treasury Offset*
2W	*Write Off*

DCS STATUS CODES - MSP

UN	*Undeliverable Letter*	**XV**	*Dispute/Valid Defense*
UU	*Initial Entry*	**XB**	*Dispute/Bankruptcy*
UJ	*Sent to PSC for Cross Servicing*	**XW**	*Dispute/Wrong debtor*
XA	*Dispute/Amount of Debt*	**XD**	*Dispute/Additional documentation requested*
XP	*Dispute/Paid in Full (excludes Treasury/PSC/PCA Collections)*	**XS**	*Dispute/Statue of Limitations*
XG	*Dispute/Part of Global Settlement*	**XO**	*Dispute/Other*

NOT TRANSFERRED TO DCC			***RECALLED FROM DCC***	
3A	*Appeal*	**4A**	*Appeal*
3B	*Bankruptcy*	**4B**	*Bankruptcy*
3C	*Compromise*	**4C**	*Compromise*
3D	*Deceased*	**4D**	*Deceased*
3E	*Error*	**4E**	*Error*
3F	*Full Valid Documented Defense*	**4F**	*Full Valid Documented Defense*
3L	*Litigation/Negotiation*	**4L**	*Litigation/Negotiation*
3O	*Contractor Offset/Paid in Full*	**4O**	*Contractor Offset/Paid in Full*
3P	*Voluntary Payment*	**4P**	*Voluntary Payment*
3R	*Repayment Agreement*	**4Q**	*Cross Servicing Collection/Paid in Full*
3W	*Write Off - Closed*	**4R**	*Repayment Agreement*
		4W	*Write Off-Closed*
		4Z	*Valid Defense & Check/Paid in Full*

FUNCTION KEY COMMANDS

F3 Exit - *If you are in one of the DCS screens, this will exit you out of the current screen and take you back to the previous screen. If you are at the search screen, it will exit you completely out of the system.*

F5 Collections - *This will take you to the Collections screen.*

F6 Comments - *This will take you to the comments screen.*

F7 Up - *This will allow you to scroll backwards through the screens when there is more than one page to a debt or more than one debt.*

F8 Down - *This will allow you to scroll forward through the screens when there is more than one page to a debt or more than one debt.*

F9 Update - *This will allow you to make changes to debt information on the data entry screen.*

F9 Add - *This confirms the addition of a comment or collection when in the comments or collection screens.*

F11 Add - *This will allow you to add a new blank entry screen to a debt.*

SECTION NINE:

NON MSP GENERAL HELP INFORMATION

NON MSP GENERAL HELP INFORMATION

Treasury Requests
All debts are transmitted through the Program Support Center (PSC) and are forwarded to the Department of Treasury for cross servicing. All debts are sent to the Treasury Offset Program.

Treasury forwards debts to Private Collection Agencies as part of their cross servicing procedures. As the private collection agencies work the debts and contact the debtors, questions arise or additional information may be needed.

Treasury sends a "Debt Management Services Action Form" to Central Office, which requests additional information and/or requires some type of action on the part of CMS. To maintain control over these requests, Central Office will update the debt in DCS with a status code of "XX". This status code will be used as a "Suspense" status meaning "Treasury Request – Needs Action". Central Office then forwards these forms to the individual who certified the debt. A report will be generated on debts with this status and used for follow up action. When Central Office receives the appropriate response, the status code will be changed back to UJ or to an appropriate status to reflect the final action taken on the debt.

Explanation of Debt Types

**PTA** – is used for intermediary Part A debts on the POR system where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.

If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

**PTB** – is used for carrier Part B debts on the PSOR system where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.

If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a physician/supplier who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

**TPA** – is used for intermediary Part A debts on the POR system where cross servicing will **not** include referral to a PCA though they will continue to be referred to TOP.

If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

**TPB** – is used for carrier Part B debts on the PSOR system where cross servicing will **not** include referral to a PCA though they will continue to be referred to TOP.

If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

**CLA** - is used for intermediary Claims A/R debts not on the POR system where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.

If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

PAO - is used for intermediary Part A debts not on the POR system where cross servicing will include referral to a Private Collection Agency (PCA) for further collection activity and the debt will continue to be referred to TOP.

If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a provider who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

PBO - is used for carrier Part B debts not on the PSOR system where cross servicing will include referral to a PCA for further collection activity and the debt will continue to be referred to TOP.

If a debtor is no longer participating in Medicare, the contractor should use this status code. This code should also be used for a physician/supplier who is still participating in Medicare, but the contractor does not believe that future internal offsets/withholding will be sufficient to collect the debt in full within three years of the date that the debt became delinquent.

TAO - is used for intermediary Part A debts not on the POR system where cross servicing will __not__ include referral to a PCA though they will continue to be referred to TOP.

If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

TBO - is used for carrier Part B debts not on the PSOR system where cross servicing will __not__ include referral to a PCA though they will continue to be referred to TOP.

If the debtor is currently participating in Medicare, is currently in offset/withhold status and the contractor believes the debt can be collected through internal offset within three years of the date that the debt became delinquent, the contractor should use this code.

SECTION TEN:

RECALLS / ADJUSTMENTS

RECALLS / ADJUSTMENTS

Recall/Adjustment Process for Non MSP debt
      1. The Region / Contractor must notify Central Office of the debt to be recalled/adjusted using the appropriate
      recall/adjustment/collection form. (See following pages for forms and instructions)
2. Central Office will update DCS to reflect all necessary changes.
3. Central Office will transmit a weekly report of all collections, recalls and adjustments to PSC.

Recall/Adjustment Process for MSP debt

1. The Contractor will update DCS with the appropriate recall codes & information.
2. Central Office will send a weekly report to PSC of all recalls, collections and adjustments.
3. PSC will then recall the debt.

RULES FOR RECALLS OR ADJUSTMENTS
Example 1: If a debt was incorrectly transmitted at $1000 but should have been $100, do an adjustment for this debt.
Example 2: If a debt was incorrectly transmitted at $100 but should have been $1000, do a recall for this debt. (This is because Treasury will not allow the upward adjustment of debts.)

Recall/Adjustment Form:
(Circle Appropriate Action)
Recall/Adjustment Initiated by: Contractor_____RO_____ CO_____

Section 1. Debt Information

Location of A/R: ____(Contractor, RO or CO where debt is reported for financial statements)

PART A

RO _____ Contr #_____
Debt # _____
Transmit Date: _____
DCS Prin Amt. Referred: _____
DCS Int Amt. Referred: _____
CNC? Yes _____No_____
Cost Report Date: _____
O/P Determination Date: ____
O/P Type:_____

PART B

RO _____Contr #_____
Debt #_____
Transmit Date:_____
DCS Prin Amt. Referred:_____
DCS Int Amt. Referred: _____
CNC? Yes _____No _____
Claim #_____-
Claim Pd Date: _____
O/P Determination Date: _____

Section 2. Reason for Recall/Adjustment:

A. _____New Status

Bankruptcy_____Appeal_____Litigation_____
Treasury Notification that Debt is Paid in Full _____(Any remaining Principal and Interest Balance will be Adjusted Off using Line 5(a) of CMS Form 751)
Treasury Notification that Debt has been Compromised _____(Any remaining Principal and Interest Balance will be Written Off Closed, per CMS, using Line 6 of CMS Form 751)_
Other (explain)_____
Amount to Recall: Principal $_____ Interest $_____
New Status of A/R Reported in Quarter Ending:_____
Comments: _____
_____

B. _____Other Adjustment
Type of Adjustment:_____
Principal Bal. After Adjustment $_____Interest Balance after Adjustment $_____
Adjustment to A/R Reported in Quarter Ending: _____
Comments: _____
_____
_____

If applicable, POR/PSOR Updated to: _____by:____

Section 3. CO Actions:

DCS Updated to:_____ Principal $_____Interest $_____
DCC Notified (Date):_____by _____Recall / Adjust
Comments:_____

Section 4. Notification/Acknowledgement/Acceptance

Recall/Adjustment Initiated by: Recall/Adjustment Accepted by:
_____   _____
_____   _____
Title/Location/Date   Title/Location/Date
                                             Phone _____

Fax #_____

*Phone #*_____*_____Fax #*__
*Phone #*_____   *Phone #*_____

Instructions for Completing Recall/Adjustment Form:

This form must be completed whenever there is a change to a Non MSP debt that has been input in DCS. Changes include data entry items, such as address of debtor, etc., adjustments to balance due to errors, etc., and changes in status code. (Collections will be reported on the Collection Reconciliation/Acknowledgement Form.)

Either CO, RO, or Medicare Contractors initiate the form.

Section 1. Debt Information, must be filled out for all debts.
Section 2. Reason for Recall/Adjustment,

A.   New Status is completed whenever a status change to a debt occurs.
B.   Other Adjustment is completed for all other debt adjustments/recalls.
Section 3., CO Actions will be completed by CO.
Section 4., Notification/Acknowledgement/Acceptance, is completed by the initiating location and the accepting location.
To complete the form: Circle either "Recall" or "Adjustment" on the form title.
Indicate the location of the initiator of the form. Either RO or CO or Contractor.

In Section 1. Debt Information, enter the Location of A/R: (where the debt is reported for 751 purposes)
Section 1 is divided into Part A and Part B. Complete the appropriate information.
RO – Indicate the RO number for the contractor servicing the debt
Contr # - Indicate the contractor number
Debt # - Enter the POR or PSOR number
Transmit Date: Enter the date the debt was transmitted to DCC.
DCS Principal Amt. Referred – Enter this amount from the DCS Data Entry Screen
DCS Interest Amt. Referred – Enter this amount from the DCS Data Entry Screen
CNC: Indicate if this debt was approved and reported as CNC
Enter specific information for either: POR overpayments: Cost Report Date, Overpayment Determination Date and, or PSOR overpayments: Claim Number, Claim Paid Date, O/P Determination Date.

Section 2, Reason for Recall/Adjustment, will be completed to document the reason for the Recall or Adjustment.

Subsection A, New Status, is for recalling debts due to a change in status. The debt is no longer eligible for cross servicing. Check the appropriate reason for the recall and enter the amount of principal and interest to be recalled. Enter the new status of the A/R and the quarter ending date that the new status will be identified for financial statement purposes. This section will be used when CMS receives Treasury notification that a debt has been paid in full or compromised.

Subsection B, Other Adjustment, is for reporting all other adjustments to the debt that will require either recall from DCC or notification to DCC of new amount/information. If the adjustment/recall changes the debt amount, indicate the amount to be recalled/adjusted.
POR/PSOR Updated to: If applicable, appropriate entries will be made to the POR/PSOR.
Section 3. CO Actions, will be completed by CO to show that the DCS has been updated to reflect the change. If the contractor or RO initiates this form, Section 3. Will be left blank and sent to CO. CO will complete Section 3, sign the form and return to the originating office. If the form is originated by CO, Section 3 will be completed prior to sending the form to the contractor or CMS RO.

Section 4. Notification/Acknowledgement/Acceptance. The form must be signed by both the initiating office and the accepting office. The contractor CFO or designee must sign the form.

Collection Reconciliation /Acknowledgement Form

Location of A/R: _____

(1) *Location of Collection:* _____

(2) *Region* _____*Contractor #*_____

(3) *Non MSP Accounts Receivable Information:*
Provider/Physician/Supplier Number _____
Provider/Physician/Supplier Number _____
*Tax Identification Number*_____
Overpayment Determination Date: _____
Claim Number: _____*Claim Paid Date:* _____
Overpayment Type: _____*Cost Report Year:* _____

MSP Accounts Receivable Information:
Debtor Name: _____
*HIC # / Report ID*_____
Determination Date: _____
Beneficiary Name: _____

(4) *Is debt in CNC status?* _____*(Yes/No)*

(5) *Date of Collection (Postmark or Government Collection Date)*_____

(6) *Type of Collection* _____*(check/cash/offset)*
Check # or Government Collection Number _____
Amount of Collection $_
*Amount Applied to Principal $*_____   *HI*_____*SMI*   _____
*Amount Applied to Interest $*_____
*Principal Balance After This Collection: $*_____
*Interest Balance After This Collection: $*_____

(7)   *Collection Reported in Quarter Ending:*_____
           A/R Adjusted in Quarter Ending: _____by:* ___

(8)   *For Contractor collections, is debt to Be Recalled from DCC?* _____*Yes/No If*
     *Yes, DCC Notified:*_____ *Note: If Non MSP, CO will notify DCC.*

(9) For DCIA debt only: Is collection part of an approved Extended Repayment Agreement?
_____ *Yes/No*

(10) POR/PSOR Updated by: _____

(11) If debt at DCC: DCS Updated by _____ *User ID:* _____
           Note: If Non MSP Debt at DCC – CO will update DCS

_____   _____
Signature of Official at Location Where   *Signature of Official at Location*
Collection is Reported   *Where Reduction of A/R is Recorded*
Location: _____   *Location:* _____
Date: _____   *Date:* _____
Phone: _____   *Phone:* _____
Fax: _____   *Fax:* _____

Instructions for Completing the Collection Reconciliation/Acknowledgement Form (CRAF)

*There are instances where one reporting entity has received and deposited cash/check/offset/electronic funds transfers (EFTs) for a receivable that is being reported by another entity. In this situation, **accounts receivable cases will not be transferred to the location where the deposit of the money is made**. To ensure proper matching and application of the collection of monies to the outstanding receivable, the "Collection Reconciliation/Acknowledgement" form (CRAF) must be completed. This form must be completed by the entity (Medicare contractor, CMS RO or CO) receiving a collection for an accounts receivable that is currently being reported on the financial reports (Forms CMS-751A/B) of another entity.*

Medicare Contractors are required to ensure that internal controls are in place over the cash/check receipts process to ensure adequate accounting, recording and custody of Medicare assets.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at Another Medicare Contractor Location (applies to Non-Medicare Secondary Payer (MSP) accounts receivables and MSP accounts receivables)

If a Medicare contractor collects a debt on behalf of another Medicare contractor, whether the receipt was solicited or unsolicited, then the collection must be forwarded to the Medicare contractor that has the accounts receivable. In these instances, the Medicare contractor receiving the collection would deposit the collection and re-issue that amount to the Medicare contractor that is reporting the accounts receivable. The Medicare contractor reissuing the check should ensure that proper segregation of duties exist over the check re-issuance (e.g., that the preparer is different from the check authorizer).

The re-issued check must be made payable to "Medicare." In addition, the check must be accompanied by a completed Collection Reconciliation/Acknowledgement Form (see MIM §1960.18 and MCM §4960.11), any correspondence received, and a copy of the original check including the postmark date. The CFO for Medicare Operations for the Medicare contractor reporting the accounts receivable should be contacted and informed of the pending check. A listing of CFO contacts has been issued to each Medicare contractor CFO. The deposit and re-issuance of the collection will only affect the CMS-H750A/B of the Medicare contractor that received the collection. The Collection Reconciliation/Acknowledgement Form will allow for tracking of the payment. Upon receipt of the check and Collection Reconciliation/Acknowledgement Form, the Medicare contractor reporting the receivable will apply its normal cash receipt procedures. However, a signed copy of the Collection Reconciliation/Acknowledgement Form must be returned to the Medicare contractor that sent the collection.

MSP additional information: *Medicare Contractors should follow the deposit and re-issue process whenever another Medicare contractor has the account receivable or another Medicare contractor is or should be the lead Medicare contractor. If there is no account receivable established but Medicare contractor X is the lead and Medicare contractor Y receives payment, Medicare contractor Y should follow the deposit/re-issue process. If there is no lead established and Medicare contractor Y receives payment, Medicare contractor Y should do an electronic referral via the Electronic Correspondence Referral System (ECRS) and follow the deposit/re-*

issue process if another Medicare contractor is assigned lead. This rule should be followed even if the non-lead Medicare contractor has an interest and/or has paid some of the claims at issue.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at a CMS Regional Office Location (applies to Non MSP accounts receivables and MSP accounts receivables.)

If a Medicare contractor collects a debt on behalf of a CMS RO location, whether the receipt was solicited or unsolicited, then the account receivable balance must be transferred to the Medicare contractor that received the collection. In these instances, the Medicare contractor receiving the collection would initiate the process by completing the Collection Reconciliation/Acknowledgement Form and sending it to the CMS RO who is reporting the receivable to notify them of the collection. The Medicare contractor that received the collection would deposit any cash or checks received into unapplied receipts, which would be reported as a liability until the transfer is complete.

In turn, the CMS RO reporting the receivable will complete the Transfer Request and Notification of Acceptance Form (TRNA) described in §1960.17 of the MIM and §4960.10 of the MCM. (The use of the TRNA is also discussed in question number 68.) Once both parties sign the TRNA, the transfer is considered complete and the collection would then be applied to the account receivable. The CMS RO transferring the receivable would record the account receivable on Line 5c, Transfer Out to other Medicare Contractors. The Medicare contractor receiving the account receivable would record it on Line 5d/5f, Transfers In from other CMS Locations POR/PSOR or Not on POR/PSOR and the applicable collection on either Line 4a, Cash/Check Collections or Line 4b, Offset Collections.

Only in the instance where a collection is made by offset for an account receivable at a CMS RO location can notification of the offset be e-mailed, as long as contents of the email ar in compliance with existing Privacy Act ad HIPAA regulations. Otherwise, the notification must be sent by FAX. The e-mail must be retained for audit trail purposes. The e-mail notification must be followed-up with the actual Collection Reconciliation/Acknowledgement Form and the Transfer Request and Notification of Acceptance form with all the appropriate signatures. Furthermore, since offsets may only be identified after being applied, the offset transaction must be moved manually on the Forms CMS-751A/B (i.e., the full amount of the accounts receivable prior to the offset must be shown as a transfer in and the amount of the offset must be captured on Line 4b, Offset Collection.) To assist in accounting for these offset transactions ONLY, Medicare Contractors can prepare the Collection Reconciliation/Acknowledgement Form(s) on a monthly basis.

Treatment of Collections Made by A Medicare Contractor for an Account Receivable at CO

Non MSP: *If Medicare Contractors receive collections on debt that is at the Debt Collection Center (DCC), and that debt is being reported by CO, the Medicare contractor must notify the CO by submitting the Collection Reconciliation/Acknowledgement form (refer to §1960.18 of the MIM and §4960.11 of the MCM). In addition, the receipt should be deposited into unapplied receipts until the actual account receivable is transferred back to the Medicare contractor.*

Once CO receives the Collection Reconciliation/Acknowledgement form, it will perform the necessary steps to update the collection information in the Debt Collection System (DCS) and the Provider Overpayment Reporting (POR) system or the Physician/Supplier Overpayment Reporting (PSOR) system. CO will change the accounts receivable location code in DCS from "H," which means CO is reporting the account receivable to "C," which means the Medicare contractor is reporting the account receivable. CO will also update the POR/PSOR with the appropriate location code of "IDC," which means the fiscal intermediary at debt collection or "CDC," which means the carrier at debt collection (i.e., the debt has been forwarded to debt collection but the debt is still on the books of the fiscal intermediary or carrier). If a balance is remaining after posting the collection, the debt will remain at DCC for cross servicing/TOP.

To allow the Medicare Contractors to properly apply the collection in their internal systems, CO will then transfer the receivable back to the Medicare contractor using the TRNA (refer to §1960.17 of the MIM and §4960.10 of the MCM). Upon CO receiving the signed TRNA from the Medicare contractor, CO will cease to report the receivable on its Form CMS-R751A/B. Once the TRNA has been signed and the receivable has been transferred, the Medicare contractor will record the transfer in of the receivable on Line 5d, Transfers In from other CMS Locations, POR/PSOR, or Line 5f, Transfers In from other CMS Locations, Not POR/PSOR. The receipt would then be applied to the account receivable and the collection would be recorded on Line 4a, Cash/Check Collections or Line 4b, Offset Collection on the appropriate Form CMS-H751A/B.

MSP: *If Medicare contractor X has an account receivable other than a debt which has been referred to the Department of Health and Human Services (DHHS) Program Support Center (PSC) under the DCIA and the CO/RO receives payment, the Medicare contractor should use Line 4c, Collections Deposited at Another Location and footnote in the comments section of the Form CMS-M751A/B that the CO/RO received the payment. An example of this type of receipt would be coordination of benefits contractor misrouted checks.*

Treatment of all Other Collections

In the instance where a Medicare contractor, RO or CO receives a collection (whether cash, checks, offset or EFT) the entity receiving the collection must complete lines 1 through 10 of the form and attach all documentation showing the collection and the re-issued check, if applicable. In the instance where a RO receives cash/checks and does not maintain a Medicare bank account to deposit the funds received, the RO must complete lines 1 through 10 of the form and attach the cash/check. This form should be forwarded to the reporting entity no later than (15) fifteen days before the end of the quarter. The entity receiving the form and the check must sign the form on line 11 and forward a copy of the form to the official who signed line 10, no later than (15) fifteen days after receipt of the form. This will acknowledge the receipt of the form and the check.

Instructions for Debts Referred to Cross Servicing/TOP in compliance with the Debt Collection Improvement Act of 1996 (DCIA):

Lines (1) through (5) are self-explanatory and must be completed.
Line (6)- enter appropriate collection information. For Treasury/DCC collections, the amount of the collection will equal the net cash and the fee amount. The CMS CO will credit the fee amount to interest or principal as appropriate, and indicate the amounts to be applied to Principal and Interest. (For Non MSP Part A collections only, the Medicare contractor will complete the appropriate HI and SMI fields to indicate the application of the Principal to Part A and Part B of A.)
The Medicare Contractor will complete the Principal Balance after this Collection and Interest Balance After this Collection fields.
Line (7) The location receiving the collection will complete the field for "Collection Reported in Quarter Ending" and the location adjusting the A/R will complete the "A/R Adjusted in quarter Ending" field with the appropriate quarter end date. These fields should reflect the same quarter ending date for financial statement reconciliation purposes.
Line (8) will be used for Contractor collections. Medicare Contractors will indicate if debt should be recalled from DCC as a result of this collection (i.e. paid in full.)
Line (9) will be checked by the CMS CO when subsequent collections are received on an approved extended repayment agreement when the debt is at Treasury/DCC for cross servicing/TOP. For Non MSP, debts in an extended repayment agreement will be removed from internal Medicare offset during the period of the extended repayment agreement.
Line (10) Non MSP debts on the POR/PSOR must also be updated for collections.
Line (11) The CMS CO will update the DCS for all Non MSP debts.

SECTION ELEVEN:

MSP GENERAL HELP INFORMATION

MSP General Information

When a debt is entered into the DCS, the user can update this debt or any other debt in the system prior to the debt being transmitted to Treasury. The debt will reflect a DCS status code of UU or UN when the debt is initially entered. If a debt has been transmitted to Treasury the status code will be UJ (Debt sent for cross servicing). The Contractor may make any necessary changes to the Data Entry Screen as long as the status code is UU or UN. If an error is discovered in one of these fields after the status code is UJ, the Contractor can adjust these fields (ie. Names, address, interest rate, dates, TIN, etc.) as long as they are NOT the principal or interest referred amount fields. If the principal or interest referred amounts need to be adjusted downward, make the necessary changes on the collection screen. If the principal or interest referred amounts need to be adjusted upward, these debts MUST be recalled and re-entered with the correct information.

If a change to a debt is a result of a partial or full payment, this must be documented by the contractor on the collection screen. Do not change the principal and interest amounts on the data entry screen. These must stay at their original amounts so that Central Office can track amounts referred to Treasury. If the change is because of a valid documented defense, bankruptcy, appeal, etc., the contractor must also make the appropriate changes to the DCS as part of the required activity to recall the debt.

Note: Contractors must be aware of the current status code of a debt on the DCS before entering collections, adjustments, etc. The status code is important in identifying exactly where a debt is at in the process of referral and/or collection. Knowing the location of a debt is critical in making a determination regarding what the next step will be.

Debts are transmitted weekly to PSC by Central Office. Debts received are set to a UJ status on the data entry screen on Monday morning of each week. These debts are then transmitted to the PSC on Friday morning of the same week. The reason for the delay is because Non MSP debts are updated by Central Office before transmission.

Contractors must use the appropriate interest rate as of the date of the original demand letter. This interest rate will not change for the life of the debt.

If the intent to refer letter was returned undeliverable and the contractor has been unsuccessful in identifying a more appropriate address, the contractor should immediately enter the debt into DCS with a status code of "UN".

MSP STATUS CODES

Upon initial DCS entry, Contractors will, with one exception use the status code **UU,** which means initial entry. If any subsequent activity occurs on the debt, the status code must be updated. Where the intent letter is returned undeliverable, the contractor will proceed with the normal MSP research to obtain a better address in order to resend the intent letter. If no additional information is found or the intent letter is returned a second time after being issued with a new mailing address, enter the debt into the DCS with a status code of **UN** (undeliverable). Both UU and UN allow the debt to be transmitted to Treasury.

Status Codes Defined:

There are two lists of DCS status codes: codes beginning with **3** are used for debts entered into DCC but not transmitted due to information received prior to Central Office transmission of the debt and codes beginning with **4** are for debts recalled from Treasury due to subsequent activity on information. In most cases Contractors will use the recall codes that begin with 4.

4E - Error: Duplicate, entered incorrectly or by mistake

4F - Full valid documented defense

4L - Litigation/Negotiation: Debt which was referred is in litigation/negotiations with CMS

4O - Contractor offset/Paid in full: This can mean two things: contractor offset has resulted in a payment in full or payment in full by check to the contractor from the debtor has occurred.

4Q - Cross Servicing Collection (PSC)/ Paid in Full: Contractors will use this code when PSC has received full recovery on a debt.

4P - Voluntary Payment: This is a voluntary payment from the debtor

4W - Write Off: CMS has decided to write off the debt as write off closed, no longer pursing debtor.

4Z - Valid Defense & Check/Paid in Full: The contractor receives both a valid documented defense and a check that covers full payment of the debt.

80 – Requirements for Collecting Overpayments-Carriers
(Rev. 29, 01-02-04)

When a Carrier determines an overpayment resulting from a Part B service the
Carrier, in most cases, shall attempt recovery from the physician, supplier or
beneficiary that was overpaid.

80.1 – Overpayment Recovery from the Beneficiary
(Rev. 29, 01-02-04)
See Chapter 3, §100 & 110ff

80.2 – Overpayment Recovery from the Physician/Supplier
(Rev. 29, 01-02-04)

The following collection activities are the minimum requirements of the Carrier for all
overpayments:

- *Once an overpayment is discovered and a final determination is made a first
  demand letter shall be sent. This first demand letter shall meet the
  requirements set forth in Chapter 4, §90.*

- *If the overpayment is not paid in full by day 30 interest shall begin to accrue
  on day 31(See Chapter 4, §30)*

- *If a full payment is not received 40 days after the date of the first demand
  letter the Carrier shall start recoupment on day 41. (See Chapter 4, §90)*

- *If no response is received from the physician/supplier 30 days after the date
  of the first demand letter, a second demand letter shall be sent between day
  31 and day 45 (See Chapter 4, §90)*

- *If by day 60 there has been no response or no contact with the
  physician/supplier the Carrier shall attempt to contact the physician/supplier
  by telephone. The carrier may cease attempting to contact the
  physician/supplier if the debt is referred to the Department of Treasury, if the
  physician/supplier files for bankruptcy, or under the guidance of CMS. At a
  minimum Carriers shall attempt to call the delinquent physician/supplier*

weekly until contact is made (A voicemail message is not considered contact.). If contact is made, the Carrier shall attempt to determine how the physician/supplier plans to repay the overpayment, if an appeal will be filed, or if an ERP application will be completed. Document each attempted contact, as well as any discussions with the physician/supplier. If the Carrier is unable to contact the provider by telephone because of a disconnected number or a number not in service the Carrier shall attempt to locate the provider through other means. (See Chapter 4, §90)

- *If the debt becomes 90 days delinquent and is eligible for referral to the Department of Treasury, a third demand letter shall be sent. (Normally 120 days from the determination date.) This letter shall include the DCIA Intent to Refer language. (See CR 1683 or Chapter 4, §70)*

- *If the physician/supplier submits an application for an extended repayment plan the Carrier shall follow the instruction in Chapter 4, §50. (An ERP application may be submitted at any time during the collection process.)*

- *If the Carrier cannot reach the physician/supplier by telephone or the Carrier receives any demand letter back as undeliverable the Carrier shall attempt to locate the physician/supplier through other means. Some examples of other sources include state and local medical societies, the American Medical Association, telephone directories, driver's license records, state insurance boards, Secretaries of State and the Carrier's own Medicare beneficiary records. Overpayment departments shall refer to physician/supplier enrollment applications, Medical Review staff, and Fraud and Abuse staff for further ideas concerning the debtor's whereabouts. Overpayment departments shall attempt to find out if the physician/supplier is bankrupt and the names of the owner, partners, or the corporation officers. If the Carrier has access to an Internet search site, such as Lexis-Nexis® or a similar program, in the Overpayment department or another department this shall also be utilized. If the Carrier does not have access to a search program the servicing regional office shall be contacted to see if they could be of assistance. All attempts to find the physician/supplier shall be documented in the case file.*

- *If you believe this debt may be recovered in litigation, consult with the servicing regional office before referring the debt to the Department of Treasury.*

- *If the debt is still delinquent 60 days after sending the third demand letter, the debt shall be input into the Debt Collection System for referral to the Department of Treasury for cross servicing and offset. Until the Department of Treasury accepts the debt, the collection of the debt is still the responsibility of the Carrier. Therefore, collection activities shall not cease until the acceptance from the Department of the Treasury is received. This acceptance shall be noted on the Carrier's internal system as well as in the case file. Recoupment by means of withhold will continue by the Carrier until the debt is collected in full or an acceptable extended repayment plan is approved. (See CR 1683 or Chapter 4, §70)*

- *Throughout all stages of the overpayment Carriers shall keep a record of all collection activity and attempted collection activity. This record can be in the*

overpayment case file or can be stored electronically or a combination of both. If electronic, the entire case file shall be retrievable. This record is in addition to the internal accounting system and the Physician/Supplier Overpayment Reporting (PSOR) System. This record shall be detailed and include all conversations and correspondence with the physician/supplier. An outside individual shall be able to make a complete audit trail with the case file. Hard copy files shall be available immediately upon request. Electronic files shall be available within 48 hours of request. Files that have been converted to microfilm shall be available within 48 hours of request. Files that have been store offsite shall be available within 72 hours of request. (See Ch. 5 §200 for additional information.)

- *Carriers shall input all overpayments (except summary entries) on the PSOR System within 10 days. In addition, all changes, updates and recoupments shall be posted onto the PSOR System within 10 days. Carriers shall attempt to use the most current status code. Once the status of the overpayment changes, the status code shall be updated within 10 days. Medicare Carriers shall attempt to use the most current status code that accurately reflects the overpayment's current situation. Carriers shall remember that certain codes such as bankruptcy, debt referral and Currently Not Collectible supercede all other codes. If the carrier cannot determine the appropriate status code, the servicing regional office shall be contacted for assistance.*

90 – Physician/Supplier Overpayment Demand Letters - Carrier
(Rev. 29, 01-02-04)
When a Carrier determines an overpayment for a Part B service the carrier issues a demand letter to the physician, supplier or beneficiary.

90.1 – Part B Overpayment Demand Letters to Beneficiaries
(Rev. 29, 01-02-04)
See Chapter 3 §100 &110ff

90.2- Part B Overpayment Demand Letters to Physicians/Suppliers
(Rev. 29, 01-02-04)

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

Overpayment Amount Is At Least $10

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

If the overpayment is less than $50.00, the carrier shall issue only one demand letter. When overpayments less than $10.00 are aggregated to $10.00 or more, but less than $50.00, it shall issue one demand letter.

Overpayment Demand Letter

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

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

Content of Demand Letters

- Sent to the physician/supplier.
- *For a first request, mail within seven (7) calendar days of determination of the overpayment.*
- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined.
- The demand letter shall offer the physician/supplier the opportunity to apply for an extended repayment plan if immediate repayment of the debt will cause financial hardship. An extended repayment plan must be approved using the criteria set forth in *Chapter 4, §50*. *Any approved repayment plan would run from the date of the FIRST REQUEST overpayment demand letter.*
- The demand letter constitutes a request to the physician/supplier to refund the overpaid amount.
- The demand letter informs physicians/suppliers that the carrier will recover the overpayment through the recoupment of current payments due or from future claims submitted unless the carrier receives repayment or the physician/supplier provides a statement within 15 days of the date of the letter of why this action should not take place. The demand letter shall also inform physicians/suppliers that this recoupment will begin on the 41st day from the date of the letter.
- The demand letter informs physicians/suppliers that interest will accrue on the overpayment if payment in full is not received by the 31st day from the date of the letter. The demand letter shall also inform physicians/suppliers of the applicable interest rate that will accrue if payment in full is not received by the 31st day from the date of the letter.
- The demand letter informs physicians/suppliers that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) A review is available for disputed overpayments of any amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least $100.
- *Bankrupt providers. All correspondence, including demand letters, addressed to a bankrupt provider must be submitted to the Regional Office who has the lead in the bankruptcy proceedings for approval prior to release.*

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

Recovery by Recoupment

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

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

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

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

Follow-up Request

If the initial demand letter for an overpayment of $50 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

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

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

Demand Letter to Physician Returned as Undeliverable

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

Direct Contact with Physician

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

Third Demand Letter

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

EXHIBIT 1- SAMPLE DEMAND LETTERS

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

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

EXHIBIT 1 - INITIAL DEMAND LETTER TO PHYSICIANS/SUPPLIERS

(Rev. 41, 04-30-04)

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

                                                              Date

Dear Dr. Smith:

Contractors should use the appropriate paragraph:

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

                                        or

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

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

How this overpayment was determined:

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

Why you are responsible:

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

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

What you should do:

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

Carrier Address

If you do not refund in 30 days:

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

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

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

If you wish to appeal this decision:

If this overpayment is less than $100, you may request a review. This request must be made within 120 days from the date of this letter. Please send your request for review to:

Address of Review Department

If this overpayment is $100 or more, you may request a fair hearing. This request must be made within 180 days from the date of this letter. Also, you may combine claims to meet the $100 minimum for a hearing. However, the dates of the determination letters must all be within six months of the hearing request in order for the amount in controversy to be included in the $100 minimum. If you would like to request such a hearing, please notify us in writing at:

Address of Hearings Department

If you have filed a bankruptcy petition:

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

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

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

Sincerely,

(name and title)

Enclosure

EXHIBIT 2 - FOLLOW UP DEMAND LETTER TO PHYSICIANS/SUPPLIERS

Dr. Joe Smith
Anywhere St
Anytown, State ZIP Code

Dear (Name of Physician/Supplier):

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

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

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

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

Sincerely,

(Name of individual)

Enclosure

EXHIBIT 3- INTENT TO REFER LETTER

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

EXHIBIT 4 - OPTIONAL OVERPAYMENT CUSTOMIZING PARAGRAPHS

A1 - *The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."*
Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because...(i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community).

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

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

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary. This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge. The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

B2 - The carrier shall include one of the appropriate paragraphs below in all overpayment letters that involve duplicate payments.
- The overpayment resulted from excess payments caused by multiple processing of the same charge.
- The overpayment resulted from Medicare payment on an assigned claim for which the beneficiary also received payment on an itemized bill and turned his payment over to you. Therefore, you are liable for $_____ which represents that portion of the total amount paid in excess of the fee schedule amount.
- You have mistakenly received duplicate primary payment from both Medicare and another entity (Specific payer). (Specific payer) is the appropriate payer. As such, you are liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer.
- This overpayment resulted from duplicate Medicare payments to you for services you provided to (**named beneficiary**).

NOTE: The above paragraphs are not all-inclusive.

EXHIBIT 5 - SAMPLE LETTER - CHECK INCLUDED FOR CORRECT AMOUNT

Dear (Name of Physician/Supplier):

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

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

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

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

Sincerely,

(Name of individual)

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

Dear (Name of Physician/Supplier):
We appreciate your recent inquiry regarding Medicare payment that you believe was paid in error. We thank you for bringing this overpayment to our attention.

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

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

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

Sincerely,

(Name of individual)

Enclosure

90.3 - Notification to the Beneficiary When Recovery Is Sought from the Provider or Physician
(Rev. 29, 01-02-04)

A notice to the beneficiary is required whenever recovery is sought from the provider. (See Chapter 3, §100 & 110*ff* when recovering from the beneficiary.)

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

Where overpayments to a provider have been determined by means of a sample study, the 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.

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

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

- A clear explanation of why the payment was incorrect.

- A statement that the provider has been requested to refund the overpayment and, if the provider is liable for medically unnecessary services or (FIs only) custodial care, the following additional information, as applicable:

- If the error is discovered subsequent to the third calendar year after the year the payment was approved, and the other conditions described in *Chapter 3, §80* apply, the FI or carrier shall advise the beneficiary that the provider is prohibited, by law, from requesting payment for the services; or

- If the beneficiary is determined to be without fault, the 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. (See Medicare Claims Processing, Chapter 30, Financial Liability Protections.)

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

- An explanation of the beneficiary's appeal rights. (See Medicare Claims Processing, Chapter 29 Appeals of Claims Decisions.) 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.

90.4 - Sample Letter to Beneficiary Where Recovery Is Sought From Provider
(Rev. 29, 01-02-04)

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, Financial Liability Protections.)

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

When this situation occurs, the law requires that the liability for these noncovered services be transferred to the physician.

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

- A copy of this notice;

- The bill you received for the services; and

- The payment receipt from (provider's name), your cancelled check, or any other evidence showing that you (the beneficiary) have (has) already paid (provider's name) for the services at issue.

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

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

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

C - All Other Cases

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

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