Medicare Financial Management Manual

Chapter 5 - Financial Reporting

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(Rev. 48, 07-09-04)

NOTE: Throughout this chapter, reference to **provider** includes institutional providers, physicians, and suppliers, i.e., all delivers of health care services that are reimbursed by either the intermediary or the carrier.

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

10 - Checks Paid Method - General - (Rev. 5, 08-30-02)

A1-1400, B1-4400

Certified Letter-of-Credit Defined:

A certified letter-of-credit is a legal reservation of funds on deposit in the Federal Reserve Bank that covers payments for which the contractor has contracted to pay by issuing checks and authorizing electronic funds transfer.

The objective of the letter-of-credit checks paid method of financing is to reduce the level of the Federal debt and the interest costs of short-term borrowing. This method provides cash availability to meet Medicare program requirements, while at the same time, controls the timing of cash withdrawals so that the impact of these withdrawals on the public debt level and related financing costs is minimized. Cash flow is controlled by:

- Postponing withdrawal of funds from the U.S. Treasury until Medicare checks are presented to the contractor's Medicare servicing bank for payment;
- Limiting the amount withdrawn at any time; and
- Reducing the amount of Federal funds required to offset bank service charges.

The Treasury Department requires all Government agencies that make advance payments to utilize the letter-of-credit checks paid method of financing. (See Circular No. 1075, revised February 27, 1973, and Chapter 1000 of the Treasury Fiscal Requirements Manual.)

20 - Summary of Procedures - (Rev. 5, 08-30-02)

A1-1401, B1-4401

A contractor shall use the following steps to implement the letter-of-credit checks paid method of financing:

- It shall notify the RO 165 days prior to the expiration of the current three-party bank agreement when a new bank will be secured under the checks paid method;

- It shall request the latest copy of the Invitation for Bid (IFB) from the Regional Office (RO);

- It shall use the IFB package as a guide to prepare its IFB. The language contained in the package cannot be materially altered except for "BID FORMS AND CONTRACTOR'S REQUIRED MEDICARE BANKING SERVICES." (See Attachment A, Section G, of the package.) The contractor shall obtain from its RO the implementation package that contains examples of material required for the bid process as follows:

    - Letter to Commerce Business Daily requesting IFB advertisement; and

    - Sample write-ups of contractor's specifications for bank services, computer requirements, check specifications, and electronic funds transfer capability;

- It shall send the completed IFB to its RO for approval prior to its release for bid. It shall send an additional copy to:

  Centers for Medicare & Medicaid Services
  Office of Financial Management
  7500 Security Boulevard
  Baltimore MD 21244-1850

- Obtain bids from two or more banks;

- Follow the Federal Acquisition Regulations (FAR), Part 14, when securing competitive bids;

- Evaluate the bank bids and, with the concurrence of the servicing RO, select the commercial bank that meets all of the mandatory requirements and submits the lowest required time account balance;

- Select a commercial bank and establish special bank accounts;

- Secure Signature Cards. Use Form SF-1194 to obtain the signatures of those individuals authorized **by the bank** to draw payment vouchers against the letter-of-credit and the signature of the bank official who has the authority to designate the authorized individuals;

NOTE: CMS executes the three-party bank agreement between the contractor, the bank, and the Government (the servicing RO). CMS also issues a letter-of-credit that sets forth the monthly limitation.

- Post (Bank) collateral with the Federal Reserve Bank;

- Establish (Bank) both the Benefits Account and the Time Account;

- Submit monthly letter-of-credit transmittals (form CMS-1521) via Contractor Administrative Financial Management (CAFM) to the Funds Control Branch, Central Office. Distribute Medicare funds withdrawn by bank via FNS-5401 payment voucher according to type of benefits; and

- Submit the monthly form CMS-1522, TAA-1b and TAA-1C, to CMS via the CAFM system.

30 - Establishment of Special Bank Accounts - (Rev. 5, 08-30-02)

A1-1403, B1-4403

Keep all Federal funds withdrawn under the letter-of-credit separate from all other funds. Designate the Medicare account for deposit in a special bank account established by you in a member bank of the Federal Reserve System. Designate the special demand deposit checking account as follows:

(Name of Contractor)
Federal Health Insurance Benefits Account

Designate the special non-interest bearing time account as follows:

(Name of Contractor)
Federal Health Insurance Time Account

Restrict withdrawals to transfer of funds to the Federal Health Insurance Benefits account.(FHIBA)

30.1 - Execution of Bank Agreement - (Rev. 5, 08-30-02)

A1-1403.1, B1-4403.1

The contractor shall execute the three-party bank agreement with the selected commercial bank. The bank agreement requires that the Federal Government retain a lien on all funds held in the special bank account. The bank abides by written instructions of the Government with regard to the deposit and withdrawal of funds. The Government also has the right to inspect or audit the bank's books and records that pertain to the special accounts. (Refer to Attachment C of the IFB package.)

The contractor shall use the following guidelines when it executes a bank agreement;

- It must strictly adhere to the wording and format of the bank agreement.

- It may alter only Covenant 7. The provisions of Covenant 7 may, by agreement of all parties, be written to require either a one or two-year period of performance following the initial two year period;

- The RO forwards an original and three copies of the completed three-party agreement to the bank via the contractor for execution. Each copy of the bank agreement must contain original signatures. Facsimile signatures are not acceptable; and

- After it is countersigned by CMS, individual copies of the agreement are distributed to:

    - The contractor;

    - The bank;

    - The servicing RO; and

    - Centers for Medicare & Medicaid Services
      Office of Financial Management
      7500 Security Boulevard
      Baltimore MD 21244-1850

30.2 - Collateral Requirement - (Rev. 5, 08-30-02)

A1-1403.2, B1-4403.2

Posted collateral is based on the balance to be maintained in the time account less FDIC coverage, if applicable. The RO advises the contractor, upon notification by the Federal Reserve Bank, when collateral is posted. (Collateral must be acceptable under the guidelines provided to the Federal Reserve by the Department of the Treasury).

The contractor shall place the collateral with the Federal Reserve Bank or Branch of the district where its servicing financial institution is located or with a custodian designated by the Federal

Reserve Bank or Branch. It shall include a letter with the collateral that states that the collateral is pledged as security for public money by CMS, agency account number 5555-4454-5 under the terms of 31 CFR, Part 202 (Treasury Circular 176).

30.3 - Changes in Collateral Pledged as Security for Federal Health Insurance Accounts - (Rev. 5, 08-30-02)

A1-1403.3, B1-4403.3

The CMS, Division of Contractor Financial Management (DCFM), monitors collateral requirements. DCFM continuously reviews the most recent balances maintained in the Federal Health Insurance Bank Accounts.

If an increase in pledged collateral appears necessary, DCFM requests the bank to post additional collateral with its Federal Reserve Bank.

If a decrease in pledged collateral appears warranted, DCFM advises the Federal Reserve Bank of the amount of excess collateral pledged.

The contractor shall direct any request for release of excess bank collateral to the local Federal Reserve Bank.

30.4 - Check Format Specifications - (Rev. 5, 08-30-02)

A1-1403.4, B1-4403.4, B2-5215

The following phrase must appear on all checks or drafts written for purposes of paying benefits and related administrative costs authorized under the Medicare program:
MEDICARE PAYMENT

For Health Insurance - Social Security Act

The contractor shall use the following check format specifications:

Check Front

The contractor shall center the words "Medicare Payment" at the top of the check or draft and print these words in at lease 1/4-inch type. Contractor name and address should appear on the face of the check. The check may also include the contractor's emblem or a picture of a building it occupies. The contractor may not include advertising on the face of the check. (Advertising should not appear on the envelope in which the check is mailed.) It is expected that the type sizes of the items placed on the check will not detract from the required "Medicare Payment" phrase.

Check Back

The contractor shall print on the back of all Medicare checks the following statement:

"This payment is made with Federal funds. Fraud in procuring, forging a signature or endorsement, or materially altering this check is punishable under the U. S. Criminal Code."

For carriers, assigned claims must also include the following statement:

"As provided by the terms of the law under which this check is issued, the undersigned payee, in accepting assignment, agreed that the charge determination by the Medicare carrier shall be the full charge for any service which the check is payable. The patient is responsible only for the applicable deductible and coinsurance, and for non-covered services."

It is not necessary to show the account name on the check. If one is shown, it should read "Federal Health Insurance Benefits Account." If both Part A and Part B are shown, it should read, "Federal Health Insurance Benefits Account - Part A" and "Federal Health Insurance Benefits Account - Part B."

The time limitation for cashing the check (if specified on the check) cannot be less than 6 months.

The contractor shall clear formats of checks with the servicing RO prior to printing or contracting for printing.

40 - Signature of Bank Individuals Authorized to Draw on The Letter-Of-Credit - (Rev. 5, 08-30-02)

A1-1405, B1-4405

Signatures of bank representatives authorized to sign payment vouchers must be on file along with the letter-of-credit at the servicing Federal Reserve Bank or branch in order to honor payment vouchers (FMS-5401). The contractor shall submit a signature card, Form SF-1194, for the person(s) authorized by the bank to sign payment vouchers.

NOTE: Executed signature card(s) must be received in DCFM no later than 20 calendar days prior to the effective date of a new letter-of-credit.

40.1 - Revision of Signature Cards - (Rev. 5, 08-30-02)

A1-1405.1, B1-4405.1

The contractor shall prepare new card(s) if more than two signatures are no longer valid. It shall prepare two original cards for every four individuals. If more than one card is needed, i.e., more than 4 individuals are authorized, it shall number the cards 1 of 2, 2 of 2 to ensure that all cards are received.

New signature cards must contain the signatures of all individuals who will sign payment vouchers and be certified by an official of the bank. The contractor need not resubmit a new signature card if change in position or title of an individual authorized to sign payment vouchers is involved.

The contractor shall mark new signature cards "Replaces and Supersedes all Previously Submitted Cards" on the top edge of the card.

40.2 - Request for Additional Cards - (Rev. 5, 08-30-02)

A1-1405.2, B1-4405.2

The contractor shall send requests for additional signature cards to:
Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Boulevard
Baltimore, MD 21244-1850

40.3 - Signatures of Contractor Personnel Authorized for Federal Health Insurance Time Account - (Rev. 5, 08-30-02)

A1-1405.3, B1-4405.3

Signatures of two or more individuals designated by the contractor to sign withdrawal requests to transfer funds from the Federal Health Insurance Time Account to the Federal Health Insurance Benefits Account must be on file with the designated commercial bank.

50 - Withdrawal of Federal Funds - (Rev. 5, 08-30-02)

A1-1406, B1-4406

The Federal Government assures that funds are always in the Federal Reserve Bank to honor properly drawn payment vouchers within the limits of the letter-of-credit. This arrangement is consistent with State banking laws since it eliminates any possibility of intent to defraud.

60 - Use of Payment Vouchers - (Rev. 5, 08-30-02)

A1-1408, B1-4408

To obtain Federal funds, the bank prepares a daily payment voucher, Treasury Form FMS-5401, and forwards it to the servicing Federal Reserve Bank or Branch holding the letter-of-credit.

When the bank receives the initial letter-of-credit, the bank sequentially numbers payment vouchers drawn beginning with the number one (1). Amendments to the letter-of-credit do not interrupt the sequential numbering of payment vouchers.

Payment vouchers are prepared only in an amount equal to the contractor's total checks, bank debit memos, and electronic funds transferred. These vouchers are presented for payment each day less any balance in the benefits account representing collected other deposits or transfers from the Federal Health Insurance Time Account.

If the bank is not located in a Federal Reserve Bank (FRB) city, CMS requests the Treasury Department to implement a telephonic method of receiving funds for the bank. The bank calls its FRB and requests a specific funding amount. The FRB prepares the payment voucher and a copy is sent to the bank.

The letter-of-credit provides a ceiling on the amount that may be drawn during the month and is purposely set high to meet peak cash needs. In no instance is a payment voucher to be drawn for less than $5,000 or more than $5,000,000 (unless the letter-of-credit has been annotated "Authorized to draw payment vouchers in excess of $5,000,000"). Only one payment voucher should be drawn per day. Regardless of the factors considered in determining when and in what amount to draw payment vouchers, banks are expected to abide by the intent of the letter-of-credit Checks Paid Method of financing system by assuring that the total of the daily voucher processed is the minimum required to finance current disbursements.

NOTE: The "Name and Address of Drawer" block on the Treasury Form FMS-5401 must include the name of the bank as it appears on the letter-of-credit sent by CMS and the annotation "agent for" (name of contractor). Due to space limitations, the contractor does not have to show the address in this block. A supply of payment vouchers is provided to each commercial bank. Additional supplies of payment vouchers may be ordered from:

Centers for Medicare & Medicaid Services
Office of Budget and Administration
Distribution Liason Officer
7500 Security Boulevard
Baltimore, MD 21244-1850.

70 - Form CMS-1521, Payment Voucher on Letter-Of-Credit Transmittal - (Rev. 5, 08-30-02)

A1-1410, B1-4410

The purpose of form CMS-1521, Payment Voucher on Letter-of-Credit Transmittal, is to record daily voucher data that the contractor's bank submits to the Federal Reserve Bank for payment of Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) benefit payments. Administrative costs paid through the Smartlink System are also reported on the form. Administrative costs are allocated to current or prior fiscal years and to special projects.

Transmit form CMS-1521 to CMS by the 15th of each month via the CAFM System. (See operating instructions for completion that are contained in the CAFM Users Guide.)

70.1 - Instructions for Completion of Form CMS-1521 - (Rev. 5, 08-30-02)

A1-1410.1, B1-4410.1

Data comes from Treasury Form FMS-5401 Payment Voucher.

Date drawn - Contractor enters the date funds were drawn. It shall use 2 digits.

Voucher Number - Contractor enters the payment voucher number in 3 digits beginning with voucher number 001 to 999. It shall inform the bank to start over when number 999 is reached.

Serial Number - Contractor enters the serial number of the payment voucher.

Hospital Insurance Benefits - Contractor enters the total amount drawn for HI and SMI. The total of HI and SMI benefits should equal the total funds drawn.

NOTE: Part B contractors enter amounts for SMI only.

PMS Smartlink Communication System for Administrative Costs -

On pages 1 and 2, the contractor shall continue to report administrative costs drawn via the PMS Smartlink Telecommunications System in the same designated "Administrative Cost" column 4. However, it shall show these amounts after it reports all benefit payment amounts.

Contractor shall indicate in the "date drawn" column the date the money was deposited into its commercial bank account and not the date it requested the money. This entry (entries) may occur on either page 1 or 2 depending on the number of entries.

Contractor shall not make entries in the columns for Voucher Number, Serial Number, and Voucher Totals.

Contractor shall reflect the current or prior year administrative costs drawn via Smartlink. It shall report on page 3 any special project(s) amount(s) drawn via Smartlink.

Public reporting burden for collecting this information is estimated to average 1 hour per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Contractor shall send comments regarding this estimated burden or any other suggestions for reducing the burden to:

Office of Management and Budget
Paperwork Reduction Project (0938-0361)
Washington, D.C. 20503;

and to:

Centers for Medicare & Medicaid Services
Office of Financial Operations
7500 Security Boulevard
Baltimore, Maryland 21244-1850.

80 - Form CMS-1522, Monthly Contractor Financial Report –

(Rev. 5, 08-30-02)
A1-1412, B1-4412

Form CMS-1522 is designed to provide a reconciliation of Medicare benefit dollars between CMS, the contractor, and the bank. The contractor shall transmit this report to CMS by the 15th of each month via the CAFM System.

80.1 - Instructions for Completion of Form CMS-1522 - (Rev. 5, 08-30-02) - (Rev. 5, 08-30-02)

A1-1412.1, B1-4412.1

- Screen 1 - Section A - Purpose for Which Funds are Drawn:
    - Contractor shall reflect the current or prior year administrative costs drawn via Smartlink. It shall report on page 3 any special project(s) amount(s) drawn via Smartlink.
    - Funds Drawn this Month - Contractor enters the total amount of Federal funds drawn via payment vouchers during the calendar month for use as HI benefits, line 1-B, or SMI benefits, line 2-B. Each entry must equal the sum of the amounts shown in this category on the Form CMS-1521 dated during the calendar month.
    - Total Funds Expended This Month - Contractor enters total funds expended for HI benefits, line 1-D, and SMI benefits, line 2-D during the calendar month. Totals should equal the sum of all checks drawn and electronic funds transfer payments against the special bank account during the calendar month. (It shall include all checks issued and electronic funds transferred, i.e. dated during the calendar month.) Any refunds received from beneficiaries or their assignees

during the calendar month because of prior overpayments deposited in the special bank account should serve to reduce total funds expended.

- Funds Drawn for Fiscal Year - This is a calculated field.

- Funds on Hand End of Month - This is a calculated field.

- Line 3, Drugs and Line 4, Regular Administrative Costs - Contractor shall not use at this time.

- Bills Paid - Lines 7 and 8 - Completed by Part A intermediaries. Part B carriers complete only line 8.

- Retro-Adjustment - Part A contractors enter credit adjustments on appropriate lines. Part B contractors do not use lines 9 or 10.

- Benefits Bank Account

  - From Bank Statement - The contractor shall take information for lines 15 through 19 from the statement of the special bank account issued by the bank at the end of the calendar month.

  - Line 15 - Balance Beginning of Month Per Bank - Contractor enters the balance in the special bank account as of the beginning of the calendar month as shown on the bank statement.

  - Line 16a - Payment Vouchers Drawn During Month - Contractor enters the total amount of funds drawn on payment vouchers (FMS-5401) during the calendar month and credited to the benefits account as shown on the bank statement. Since all checks drawn for deposit in the Time Account are cleared through the benefits account, a payment voucher is drawn for this transaction and is included in line

16a. The amount shown on this line must agree with the totals from the Form CMS-1521 corresponding to the calendar month and also with Section A, Line 5, column (b). The only exception is for vouchers in transit (line 20).

- Line 16b - Other Deposits - Contractor enters all other deposits credited during the month to the special bank account as shown on the bank statement. It shall reduce the next payment voucher by the amount of the deposited refunds in the account in order to minimize idle funds in the account. It shall Include any credits or adjustments made to the bank account during the calendar month in this line.

- Line 16c - Contractor shall include funds withdrawn from the Time Account and deposited in the Benefits Account.

- Line 16d - Miscellaneous Credit Memo - Contractor enters any miscellaneous adjustments to the benefits bank account during the calendar month.

- Line 17 - This is a calculated field.

- Line 18A - Contractor shall subtract: Checks and EFT Payments Honored by Bank During Month - It enters from the bank statement the total funds charged to the special bank account as a result of checks honored and electronic funds transferred by the bank during the month. This total must include all checks that were drawn for deposit in the time account and honored by the bank during the month.

- Lines 18B and C - Miscellaneous Bank Charges - Contractor enters any miscellaneous charges made to the special bank account that are part of the bank statement.

- Line 19 - This is a calculated field.

- Line 20 - Add: Deposits in Transit. - Enter payment vouchers drawn and other deposits made during the calendar month that the bank has not yet credited to the special bank account according to the statement.

- Line 21. - This is a calculated field.

- Line 22 - Subtract: Outstanding Checks. - Enter the total of all checks issued during the current month or any previous month that the bank has not yet paid as of the end of the calendar month. If during the calendar month payment is stopped on any check previously issued, or any previously issued check is otherwise voided, subtract the amount of funds represented by that check from this total before making an entry on this line.

- Line 23 - This is a calculated field.

- Line 24 - Highest Balance During Month Per Bank. Contractor enters the highest balance in the special bank account during the calendar month as reflected on the bank statement.

- Time Account

  - Line 15 - Balance Beginning of Month - Contractor enters the balance in the time account as of the beginning of the calendar month as shown on the bank statement.

  - Line 16a - Other Deposits - Contractor enters the amount of funds drawn from the benefits account for deposit in the time account.

  - Line 17 - Total. - This is a calculated field.

- Line 18a - Contractor enters only amount of funds withdrawn from the time account and deposited in the benefits account during the month.

- Line 18b - Contractor enters any miscellaneous items.

- Line 19 - Balance EOM Per Bank - This is a calculated field.

- Screen 4 - Completed by Part A Contractors Only

  - Periodic Interim Payments - Contractor enters amounts paid during the month by category.

  - Accelerated Payments - Contractor enters the amount of accelerated payments paid out and received during the month.

  - Suspended Payments - Contractor enters the amount of payments suspended and released during the month.

- Screen 5 - Bills Paid - Contractor enters the amount of money actually paid during the calendar month as follows:

  - Amount paid for disabled or disability (identified by Codes 1 and 3 as contained in S trailer of query reply).

  - Amount paid for chronic renal disease (identified by Code 2 as contained in S trailer of query reply).

  - Amount paid for premium paying enrollees (identified by Codes 8 and 9 as contained in S trailer of query reply).

- Amount paid for aged. Contractor shall complete entries for disabled, chronic renal disease, and premium paying enrollees prior to completing the entry. It shall then subtract the sum of these entries from the calculated Total and enter that amount.

- Total - (Bills paid for the month). This is a calculated field.

NOTE: For those Part A intermediaries that transmit bills to CMS from more than one point, each processing point should submit to the home office at the end of the calendar month all of the data requested in screen 1. (It shall consolidate data related to amounts paid in screen 1.)

- Only Part A Intermediaries complete retroactive adjustments.

- Only Part A Intermediaries complete adjustments between trust funds.

- Interest:

  - Interest Received From Providers On Overpayments - Separate Check for Interest Collected - When a check is received for interest on an overpayment, the contractor shall deposit the check immediately in the Medicare bank account. It shall report this check as an "Other Deposit" (line 16b). Also, it shall report the check as "Interest Received" on screen 5 and use as a reduction to expenditures on screen 1, funds expended column.

  - Check Includes Both Interest Collected and Overpayment Recoupment - Contractor shall deposit the check immediately into the Medicare bank account. It shall report the entire amount of the check as an "Other Deposit" (line 16b) on screen 2. It shall report the interest portion as "Interest Recovered" on screen 5. Both the interest recovered and the overpayment recoupment are used as a reduction to expenditures on screen 1, funds expended column.

- Interest Paid to Providers on Underpayments - Separate Check for Interest Paid - When a check is issued for interest due to a provider on an underpayment, the contractor shall report it as a "Check Honored" (line 18a) on screen 2. Also, it shall report this amount as "Interest Paid" on screen 5 and as an increase to expenditures on screen 1, funds expended column.

- Screen 6 - No entries are required at this time.

Public reporting burden for this collection of information is estimated to average 16 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Contractors may send comments regarding this estimated burden or any other suggestions for reducing the burden to:

Centers for Medicare & Medicaid Service
Office of Financial Management
Baltimore, Maryland, 21244-1850;

and to:

Office of Management and Budget
Paperwork Reduction Project (0938-0361)
Washington, D.C. 20503.

90 - Intermediary Benefit Payment Report (Form CMS-456) –

(Rev. 5, 08-30-02)
A1-1414

90.1 - Purpose and Scope - (Rev. 5, 08-30-02)

A1-1414.1

The Intermediary Benefit Payment Report (IBPR) is a report of current monthly information that covers the categories of benefits the contractor paid and selected statistical data that relates to those payments. CMS uses this data to:

Track benefit payments by type of provider to detect significant shifts in program expenditures; Monitor implementation of new programs, e.g., hospice benefits, and comprehensive outpatient rehabilitation benefits; and

Identify operation problem areas for resolution by the contractor or CMS.

90.2 - Due Dates and Transmittal - (Rev. 5, 08-30-02)

A1-1414.2

Contractor shall input the reports accompanying the reconciliation between IBPR and the Monthly Intermediary Financial Report (Form CMS-1522) into the CAFM system 20 work days following the report month.

90.3 - Verification of Data - (Rev. 5, 08-30-02)

A1-1414.3

The various subsidiary records that include the individual provider files must support the data entered on the report.

The contractor must have the capability to trace all data entered on the report to the individual provider files.

Where applicable, the Provider Statistical and Reimbursement Report and other provider reports containing benefits paid data must support the data on the report.

90.4 - Accuracy of Data Contained on Report and Reconciliation of Data Reflected on Monthly Intermediary Financial Report (Form CMS-1522) - (Rev. 5, 08-30-02)

A1-1414.4

The contractor must ensure that all data reflected on the report is accurate.

Line 36, column (g) of the report, should equal the amount shown on the CMS-1522, column (d), lines 1 and 2 in the aggregate. In the event that the amounts do not agree, the contractor shall complete a reconciliation report.

90.5 - General Reporting Instructions - (Rev. 5, 08-30-02)

A1-1414.5

Where money is withheld from payments due the provider (as an offset) for monies due the contractor, the contractor shall show the gross amount (less any deductibles, coinsurance, interest, or sequestration) as the payment on the appropriate line and column. It shall show the offset as a negative amount in its appropriate line and column.

For example, when the contractor reduces a PPS Periodic Interim Payment (PIP) for a settlement amount due from the provider, it shall record the gross PIP amount (less any deductibles, coinsurance, interest, or sequestration) on line lA in column 1 (a) or 1(b), as appropriate. It shall record the offset on line 6B in column 1(a) or 1(b), as appropriate. However, it shall record a claim adjustment (e.g., a PRO disallowance or subsequent reversal) as a reduction of claims payments on line 2A for a non-PIP/PPS hospital.

Where the contractor makes an accelerated payment and the provider repays a portion of the accelerated payment during the same reporting period, the contractor shall show the net amount on the appropriate line and column.

For example, when an accelerated payment of $100,000 is made to a provider during the period, and the provider repays $30,000 during the same period, the contractor shows $70,000 as the net accelerated payment.

In situations where an accelerated payment is made during the period, and the contractor recovers a portion of the accelerated payment through reduction of interim payments, it shall show the gross amount (less any deductibles, coinsurance, interest, or sequestration) of interim payments as payment on the appropriate line and column. It shall show the offset amount as a negative amount on the appropriate line and column.

For example, when an accelerated payment is made for $100,000 and later in the month $30,000 of the accelerated payment is recouped by offset against PPS/PIP amounts of $150,000 paid to the provider, the contractor shows the $150,000 gross PPS/ PIP amount on line 1A in column 1(a) or 1(b), as appropriate. It shows a net accelerated payment of $70,000 ($100,000-$30,000) on line 7 in column 1(a) or 1(b), as appropriate.

90.6 - Instructions for Completion of the IBPR - (Rev. 5, 08-30-02)

A1-1414.6

A – Heading

The contractor enters its name and assigned number. Multi-regional intermediaries use the number assigned to the home office for administrative budget and cost reporting purposes. The contractor shall furnish a consolidated report for all locations.

The contractor enters the calendar month and year as a four-digit entry, e.g., 1000, 1100, 1200, 0101.

B - Column Definitions - Page 1

Column (a) - Single Facility - refers to payments to PPS hospitals that do not have distinct part facilities, such as SNFs, HHAs, psychiatric units, or rehabilitation units.

- Column (b) - Facility With Distinct Parts - refers to payments to PPS hospitals that include distinct parts, such as SNFs, HHAs, psychiatric units, or rehabilitation units.

NOTE: The contractor enters non-PPS payments to the distinct part on the appropriate line and column of page 2.

- Column (c) - Non-PPS Payment - refers to payments to the following:

    - Hospitals excluded from PPS (e.g., psychiatric, children's, rehabilitation and long term);

    - Hospitals receiving payments via an alternative payment program (waiver States);

    - Hospitals yet to be phased into PPS; and

    - PPS hospitals for bills or underpayments applicable to pre-PPS fiscal years.

- Column (d) - Total - refers to the total of columns (a), (b), and (c).

C - Line Item Definitions - Page 1:

1. Hospital Inpatient (PIP) - refers to hospitals paid by the PIP method. The contractor shall show these figures less any deductibles, coinsurance, and interest for all items on the PIP bills and any sequestration applicable to this line with any offsets shown on line 6A or 6B.

    A. Inpatient Operating Payments - refers to the amount of the PIP that covers items that would otherwise be paid on a per claim basis plus those items paid on a per claim basis in addition to PIP payment. (Such as payments for outliers and hemophilia blood clotting factor add-on.)

The contractor enters the PIP amounts paid as follows:

PPS Provider Payments - Payments related to services furnished after conversion to PPS in columns 1(a) or 1(b), as applicable. This includes outlier payments, hemophilia blood clotting factor add-on payments, disproportionate share amounts, indirect medical education, ESRD payments, and phased-in capital-related costs during the transition period. Non-PPS Provider Payments - column (c) - Payments related to services furnished prior to conversion to PPS. Payments to all providers listed in the definitions for column (c).

B. Pass Through Costs - Contractor enters the PIP payments, including any withholdings, but less any sequestration amounts for items paid on a reasonable cost basis as follows:

- Capital;
- Direct medical education which includes nursing and paramedical health professional (allied health) programs and graduate medical education;
- Kidney and other organ acquisitions;
- Bad debts; and
- Nonphysician anesthetists.

NOTE: This includes that part of capital-related costs not included in line 1A.

C. Indirect Medical Education - Contractor enters the PIP payments for the indirect medical education adjustment, whether on a PIP or a claim-by-claim basis for PIP providers, less any sequestration (already included in line 1A).

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the amount of indirect medical education for PIP hospitals.

2. Hospital Inpatient (Non-PIP), refers to hospitals paid based upon bills reviewed and approved. Contractor shall show total payments less any reductions on line 6A or line 6B.

   A. DRG Bills Paid/Non-DRG Bills Paid - Contractor enters the calculated payment less any deductibles, coinsurance, and interest for all items on the bill and any sequestration applicable to this line. It shall include payments for outliers, disproportionate share, indirect medical education, high percentage of end-stage renal disease beneficiary discharges, and hemophilia blood clotting factor add-on payments on a claim-by-claim basis. Also, it shall include phased-in capital-related costs during the transition period.

      For DRG bills, it shall use columns (a) and (b). For non-DRG bills paid, it shall use column (c).

      It shall report all retroactive adjustments pertaining to hospitals on line 6A or 6B.

   B. Pass Through Costs - The contractor enters the interim payments, less any sequestration, for items paid on a reasonable cost basis as follows:

      - Capital;
      - Direct medical education which includes nursing and paramedical health professional (allied health) programs and graduate medical education;
      - Kidney and other organ acquisitions;

- Bad debts; and

- Nonphysician anesthetists. **NOTE:** This includes that part of the capital-related costs that are not included in line 2A.

C. Indirect Medical Education - Contractor enters the interim payments for the indirect medical education adjustment (already included in line 2A).

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the amount of indirect medical education for non-PIP hospitals. It shall not adjust these amounts for MSP or sequestration.

3. Outlier Payments - Contractor enters additional amounts paid for outlier cases.

NOTE: Contractor shall make entries on this line for memorandum purposes only to identify the total outlier payments that are found in the UB82 billing form in Locator 46-49 in Value Code 17. These amounts are already included in the amounts recorded on lines lA and 2A.

A. Days - The contractor enters additional payments made as a result of the length of stay exceeding the day outlier threshold criteria. It shall make entries on this line for memorandum purposes only. These are non-add items.

NOTE: After FY 1997, outlier days no longer exist.

B. Cost - The contractor enters additional payments made for claims where extraordinary costs were approved. It shall make entries on this line for memorandum purposes only. These are non-add items.

4. Subtotal - Contractor enters the total of the amounts on lines 1A, 1B, 2A, and 2B.

NOTE: The amounts included in lines 1C, 2C, 3A and 3B are memo entries only and have been included in lines 1A, 1B, 2A and 2B.

5. Outpatient Payments - Contractor enters the payment, less deductibles, coinsurance and sequestration for outpatient and Part B inpatient services. It shall report any offset against these amounts on line 6A or 6B. See line 19 for reporting SNF outpatient payments.

6. Retroactive Adjustments:

   - PPS Provider Payments - Contractor enters on lines 6A and 6B (as applicable), columns (a) or (b), the net amount of retroactive adjustments paid and received as a result of interim rate adjustments, pass through cost adjustments, and cost report settlements applicable to current or prior provider fiscal years.

     Contractor shall show interest on cost report overpayments and late-filed cost reports on these lines. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 of cash received from the provider as the first installment of the final settlement of $1,000,000 due the program from the prior year's cost report.

     Another example would be an entry of $500,000 offset against current PIP payments due of $1,000,000. (The $1,000,000 would be shown on line 1A.)

   - Non-PPS Provider Payments - Contractor enters on line 6A or 6B (as applicable) in column (c) the net amount of retroactive adjustments paid and received as a result of interim rate adjustments and cost report settlements applicable to current or prior p rovider fiscal years.

     It shall show interest on cost report overpayments and late-filed cost reports on these lines.

7. Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from hospitals and distinct part units. (See §160.5 for an explanation of the appropriate recording of offsets.)

8. Total - The contractor enters the total of lines 4 through 7.

D - Statistical Data-Hospitals-Page 1:

9. PIP:

    A. Contractor enters the total number of bills processed for hospitals paid by the PIP method.

    B. Contractor enters the dollar amount that would have been paid if the bills processed were not subject to PIP in accordance with the definition of line 2A.

10. Non-PIP - Contractor enters the total number of bills for hospitals paid on a submitted-bill basis.

11. Number of Hospitals - Contractor enters the total number of hospitals participating in the Medicare program.

12. Number of Admissions - Contractor enters the total number of admissions the Common Working File (CWF) has approved for payment.

13. Number of Discharges - Contractor enters the number of discharge bills processed during the reporting month.

14. Number of Readmissions - Contractor enters the total number of readmissions to a hospital within 7 calendar days of discharge from an acute care facility.

15. Number of Transfers - Contractor enters in column (a) and column (b) the total number of transfers to a PPS hospital. It enters in column (c) the total number of transfers to a non-PPS hospital.

16. Outlier Bills:

    A. Days - Contractor enters the total number of day outlier bills paid that relate to the dollar amounts shown in line 3A.

       NOTE: Outlier days have been obsolete since the end of FY 1997.

    B. Costs - Contractor enters the total number of cost outlier bills paid that relate to the dollar amounts shown in line 3B.

17. Outpatient - Contractor enters the total number of outpatient bills and Part B inpatient bills paid that relate to the dollar amounts shown in line 5.

E. Column Definitions - Page 2

- Column (e) - Single Facility - Refers to all providers that are not part of a hospital complex.

- Column (f) - Part of Hospital Complex - Refers to providers that are an integral part of a hospital and are operated with other departments of the hospital under common licensure and governance.

- Column (g) - Total - Refers to total of columns (e) and (f).

F. Line Item Definitions - Page 2

Skilled Nursing Facilities - Including swing bed payments for SNF care.

18. PIP - Contractor enters all PIP payments made to SNFs. It enters total payments (less any deductibles, coinsurance, interest or sequestration) with any withholding reductions being shown on line 20.

19. Bills Paid - Contractor enters total payments less any deductibles, coinsurance, interest, or sequestration with any withholdings shown on line 20. It enters the calculated payment, less any deductibles, coinsurance and interest for all items, and any sequestration applicable to SNFs on a submitted-bill basis. It shall include Part A and Part B services.

20. Retroactive Adjustments - Contractor enters the net amount of retroactive adjustments paid and received as a result of cost report settlements and lump sum interim rate adjustments made in prior or current provider fiscal years.

    It shall show interest on cost report overpayments and late-filed cost reports on this line. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 cash received from the provider as the first installment of the final settlement of $1,000,000 due the program from the prior year's cost report.

21. Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from SNFs. (See §160.5) for an explanation for reporting accelerated payments.)

22. Total SNF Payments - Contractor enters the total of lines 18 through 21.

Home Health Agencies:

23. PIP - Contractor enters all PIP payments made to HHAs including SNF-based.

    It shall show total payments less any deductibles, coinsurance, interest, or sequestration with any withholding reductions shown on line 25.

24. Bills Paid - Contractor shall show total payments (less any deductibles, coinsurance, interest, or sequestration) with any withholdings shown on line 25. It enters the calculated payment, less any deductibles, coinsurance, and interest, for all items, and any sequestration applicable to HHAs on a submitted-bill basis. It shall include Part A and Part B services and SNF-based HHAs payments.

25. Retroactive Adjustments - Contractor enters the net amount of retroactive adjustments paid and received as a result of cost report settlements and lump sum interim rate adjustments made in prior current provider fiscal years.

    It shall show interest on cost report overpayments and late-filed cost reports on this line. An example of a proper recording of a retroactive adjustment would be an entry of $500,000 cash received from the provider as the first installment of the final settlement of $1,000,000 due the program from the prior year's cost report.

26. Accelerated Payments - Contractor enters the net amount of accelerated payments made to and collected from HHAs. (See §160.5) for an explanation for reporting accelerated payments.)

27. Total HHA Payments - Contractor enters the total of lines 23 through 26.

Additional Providers:

28. ESRD - Contractor shall include in these columns payments to ESRD networks, as applicable:

    Column (e) - It enters net payments to independent facilities. Column (f) - It enters net payments to hospital-based facilities.

29. Hospice - Contractor enters net payments made to hospices.

30. RHC - Contractor enters net payments made to rural health clinics (RHCs).

31. OPA/HL - Contractor enters net payments made to organ procurement agencies and histocompatibility laboratories.

32. CORF - Contractor enters net payments made to comprehensive outpatient rehabilitation facilities (CORFs).

33. Distinct Part Units - Contractor enters net payments made to exempt distinct part rehabilitation and psychiatric units.

34. All Others - Contractor enters net payments made to other providers not listed in lines 28 -33.

NOTE: Contractor shall make adjustments, pertaining to providers, identified on lines 28 through 34 directly to the specific line. This includes checks received and offsets or withholdings.

35. Total - Contractor enters the total of lines 28 through 34.

36. Grand Total - Contractor enters the total of lines 8(d), 22(g), 27(g) and 35(g).

G. Statistical Data - Page 2:

37. SNF:

- Number of SNFs - Contractor enters the total number of participating SNFs.
- Number of Admissions - Contractor enters the total number of SNF admissions.

38. HHA:

- Number of HHAs - Contractor enters the total number of participating HHAs.
- Number of Bills - Contractor enters the total number of bills processed. (Audit intermediaries should not complete this line.)

39. Number of Transfers to Distinct Part Units - Contractor enters the total number of transfers to distinct part units for which payments are shown in line 33.

    It shall use edit checks to ensure completeness, arithmetical accuracy, and to discover inconsistencies. It shall have an authorized official sign and date the report.

90.7 - Form CMS-456 - Schedule R - (Rev. 5, 08-30-02)

A1-1414.7

(Page 3 of 3 of the Monthly Intermediary Benefit Payment Report) Reconciliation Between IBPR and CMS-1522.

A - Purpose and Scope

The contractor shall use the Schedule R to account for any variances between line 36(g), Total on the IBPR, and the HI and SMI Benefits reported on lines 1(d) and 2(d) of the CMS-1522 Report.

Schedule R is an integral part of the IBPR and must be completed each month whether or not a variance exists between the IBPR and the CMS-1522 Report. If there is no variance, the contractor shall complete line 36(g) of the IBPR and HI and SMI Benefits for lines 1(d) and 2(d) of the Form CMS-1522. If there is a variance, it shall reconcile the two reports by completing the appropriate lines.

It must have the capability to substantiate all amounts reflected on Schedule R.

Schedule R includes line items that will facilitate the contractor's reconciliation process.

It shall input the Schedule R, along with pages 1 and 2 of the IBPR, into the Contractor Administrative Budget and Financial Management System (CAFM) for each report month.

B - Instructions for Completion of Schedule R:

Heading - The contractor enters the report month and year. (See §160.6A) for intermediary name and number.) Also, it enters its current letter-of-credit number.

Line Item Definitions - Schedule R:

CMS-456 (IBPR) Column:

Line 36(g) Total - Contractor enters the amount obtained from page 2 of 3 on line 36(g) of the IBPR.

Medicare Secondary Payer (Non-Providers Cash Recoveries) - Contractor enters the cash receipts and offsets applied to claims payments or other refunds that are received from attorneys, beneficiaries, insurance companies or other non-providers. These amounts should be negative numbers since they represent cash receipts.

Other Recoveries Identify - Contractor enters recovered or offset amounts not included in any other line item (lines 1 through 36 or lines 1 and 3 of Schedule R). These amounts should be negative numbers since they represent cash receipts.

Other Items Identify (Lines 3A through 3E) - Contractor enters any other benefit payments or refunds not included elsewhere on the CMS-456 or on lines 1 and 2. The items shown here may be unique to its operation and should be identified accordingly. It shall itemize each major category on lines 3A. through 3E. These amounts could be positive or negative numbers.

Total - Contractor enters the sum of all line items in this column. It must take care to subtract negative amount(s) included on the above lines. The total amount must equal the amount in the total adjacent CMS-1522 column.

1. Remarks - Contractor enters an explanation to clarify any item or amount.

- Line Item Definitions - Schedule R:

CMS-1522

1. HI Benefits, Line 1 (d) - Contractor enters the HI benefits amount from form CMS-1522 in line 1(d).

2. SMI Benefits, Line 2(d) - Contractor enters the SMI benefits amount from form CMS-1522 in line 2(d).

3. Subtotal - Contractor enters the total HI and SMI benefit amounts.

4. Other Items Identify - Contractor enters any other benefit payments or refunds that may be unique to your operation that are not included on lines 1(d) or 2(d) of form CMS-1522. It shall itemize each major category and identify on line 1 through 6. These amounts could be positive or negative numbers.

5. Total - Contractor enters the sum of all line items in this column. It must take care to subtract negative amounts included in items 1 through 6. The total amount must equal the amount in the total adjacent CMS-456 column.

Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Boulevard
Baltimore MD 21244-1850

and to:

Office of Management and Budget
Paperwork Reduction Project (0938-0361)
Washington DC 20503

100 - Issuance of Letter-Of-Credit - (Rev. 5, 08-30-02)

A1-1416, B1-4414

The Letter-of-Credit, Standard Form-1193, authorizes a Federal Reserve Bank or Branch to advance funds to a designated commercial bank on behalf of CMS. Under the Checks Paid Method of financing, a letter-of-credit is issued to authorize the designated commercial bank to withdraw funds for deposit only to the contractor's Benefits Account when a bank presents a payment voucher (FMS-5401).

Upon receipt of the properly executed signature cards and notification from the Federal Reserve Bank that the required collateral has been posted, CMS prepares and certifies a letter-of-credit in favor of the designated commercial bank. The certified letter-of-credit, together with the executed signature cards, are sent to the Treasury Department for forwarding to the servicing Federal Reserve Bank or Branch. A copy of the certified letter-of-credit and signature cards are also sent to the contractor, the RO, and the designated commercial bank.

100.1 - Monthly Limitation - (Rev. 5, 08-30-02)

A1-1416.1, B1-4414.1

The letter-of-credit specifies a maximum amount of funds that the bank may draw during each month. The ceiling amount on the letter-of-credit is established at a sufficiently high level to provide for fluctuations in monthly disbursement patterns and is based upon benefit payments

estimated by CMS and the contractor. The unused portion of the letter-of-credit is revoked at the end of each month, and the full monthly ceiling amount is automatically renewed at the beginning of each month. There is no carryover of any unused ceiling amount. Each month stands by itself.

100.2 - Amending Letter-of-Credit - (Rev. 5, 08-30-02)

A1-1416.2, B1-4414.2

Any one of the following conditions require a revised letter-of-credit from CMS:

- A significant increase or decrease in Medicare workload or expenditures that is expected to continue for an extended period and affects the contractor's financial requirements;
- The bank's letter-of-credit monthly limitation is insufficient to cover all Medicare checks presented to the bank for payment during the current month;
- A change in contractor name;
- A change in the name of the contractor's servicing bank; or
- A change in the Federal Reserve Bank or Branch servicing the contractor's commercial bank.

The contractor shall make all routine requests for changes in the monthly letter-of-credit limitation to the RO no later than 20 calendar days before the end of the month. If the revision is urgent, it shall make the request for an increase by telephone to the RO. It shall follow-up all telephone requests, in writing, and include the reason for the revision to the letter-of-credit. An amendment to the letter-of-credit does not interrupt the progression of the numbers assigned to the payment vouchers.

100.3 - Establishment of Accounting Records - (Rev. 5, 08-30-02)

A1-1416.3, B1-4414.3

The contractor shall establish adequate accounting records to ensure that:

- The total monetary amount on the payment vouchers issued during the month does not exceed the monthly limitation established by the letter-of-credit;

- Funds drawn are properly allocated between HI and SMI benefits. The contractor shall establish memorandum accounts to separate the respective benefit payments;

- Refunds received from providers or beneficiaries resulting from prior overpayments or retroactive adjustments are immediately deposited into the FHIBA. The contractor shall credit all such deposits on the day following the date of receipt in its mail room or initial point of entry. (It shall credit within 2 days if the bank is not located in the same city as the contractor.); and

- Bank charges for services furnished are in accordance with the contractual agreement and that the volume by types of service (e.g., checks paid and deposits) are in agreement with the contractor's records.

110 - Initial Federal Health Insurance Time Account Deposit –

(Rev. 5, 08-30-02)

A1-1418, B1-4416

To preclude excessive use of Federal funds, the contractor shall delay the initial deposit in the Time Account until it has actually started processing checks that are cleared against the FHIBA. It shall effect the initial deposit of Federal funds into the Federal Health Insurance Time Account by drawing a check on the new FHIBA payable to the Time Account.

It shall establish the amount of the initial time deposit check by re-computing the Award Schedule (AS) (Page 2 of 2) that the selected bank submits to reflect the effective prime rate (i.e., prime minus one percent) in effect on the date the new accounts are implementation.

It shall make the check payable to the designated bank with the following directive clearly printed on the reverse:

For Deposit Only In (Name of Contractor)
Federal Health Insurance Time Account

The contractor shall delay use of the Federal Health Insurance Accounts until the Federal Reserve Bank has received authorization from the Treasury Department for the designated commercial bank to process payment vouchers under the letter-of-credit procedure.

110.1 - Subsequent Time Account Deposits and Adjustments –

(Rev. 5, 08-30-02)

A1-1418.1, B1-4416.1

The quarterly review of bank activity in the Benefits Account may disclose the need for an adjustment in the Time Account balance. When an adjustment is indicated, the contractor shall make the adjustment within 15 calendar days after the close of the quarter.

It shall follow the procedures outlined for the initial Time Account deposit as described in §110 to increase the Time Account balance.

To decrease the Time Account balance, it shall prepare a Time Account withdrawal slip that instructs the bank to transfer the amount of the required reduction from the Time Account to the FHIBA.

NOTE: The contractor shall report all initial deposits and subsequent adjustments in the Time Account balance on form CMS-1522

110.2 - Bank Account Analysis - (Rev. 5, 08-30-02)

A1-1418.2, B1-4416.2

To ensure a continuing evaluation of all bank services and associated charges, the contractor shall adhere to the following procedures:

- Arrange to receive from the bank its account analysis on a regular monthly basis no later than the 10th of the following month. Bank analysis must include:
    - Bank Processing Charges (Schedule TAA-lb); and
    - A list of daily closing bank balances (Schedule TAA-1c).
- The contractor shall verify the accuracy of the data presented for the average daily bank balance, units of service, and all other computations on the bank's account analysis.
- The contractor shall complete and forward, within 30 calendar days after the end of each month to CMS via CAFM, the following schedules:
    - Monthly account activity of bank processing charges (Schedule TAA-lb); and
    - Recap of Daily Available Balances (Schedule TAA-1c).
- The contractor shall complete and forward, within 30 calendar days after the end of each quarter to CMS via CAFM, the following schedules:
    - Summary of Bank Processing Charges for Quarter, Schedule TAA-la; and
    - Quarterly Adjustment of Federal Health Insurance Time Account, Schedule TAA.

120 - Reviewing Bank Agreements - (Rev. 5, 08-30-02)

A1-1420, B1-4418

The contractor shall determine if it wants to continue, renegotiate, or terminate the bank agreement by reviewing the bank's performance and processing charges for the present term. It shall review 165 days prior to the expiration of the three-party bank agreement.

If the bank's performance is acceptable, and the bank does not request a rate increase, the contractor shall recommend to the RO, in writing, that it wants to continue with the bank agreement and that it be continued for another year or two year period. It shall advise the RO as soon as a bank's request for a rate increase is received along with its evaluation of the bank's performance and recommendation, to continue or renegotiate the contract. The RO develops comparative analysis of three banks' charges with similar volumes to support the recommendation to continue the bank agreement at a higher processing charge. If the higher processing charge is not justified, the contractor will be advised to begin the termination process.

120.1 - Terminating Bank Agreements - (Rev. 5, 08-30-02)

A1-1420.1, B1-4418.1

The contractor, the Government, or the bank may terminate the bank agreement when the party wishing to terminate submits written notification to the other parties 150 days prior to the expiration of the current term. In the event of termination, the bank agrees to retain the contractor's Federal Health Insurance Account(s) for an additional 180-day period (phase-out) beyond the current term to allow for clearance of outstanding checks.

120.2 - Terminating Federal Health Insurance Accounts - (Rev. 5, 08-30-02)

A1-1420.2, B1-4418.2

- Initial Adjustment to the Federal Health Insurance Time Account - Pending receipt of the prior month's bank statement, the contractor shall reduce on the first day of the phase-out period the current balance in the Federal Health Insurance Time Account by seventy-five percent (75%). It shall prepare a Time Account withdrawal slip that instructs the bank to immediately transfer the computed amount to the FHIBA.

- Time Account Analysis - Within 7 days of the expiration of the current term, the contractor shall complete Schedule TAA in its entirety to determine whether the time account should remain open during the phase-out period. It shall include in line 4 the total projected service charges for the entire phase-out period. It shall modify the 25 percent figure on line 10 to reflect the actual length of the phase-out period, e.g., 6-month period would show 50 percent.

    - If line 13 of Schedule TAA (page 1 of 3) indicates a positive amount, the contractor shall maintain that amount of money in the time account during the phase-out period, and adjust the present time account balance accordingly in lines 14-16.

    - If line 9 of Schedule TAA (page 1 of 3) indicates a negative amount, the contractor shall immediately transfer the current time account balance to the benefits account, and the contractor should secure from the bank a check payable to the benefits account in an amount equal to the negative amount reflected on line 9.

- Closing Federal Health Insurance Time Accounts - At the expiration of the phase-out period, the contractor shall transfer all funds on deposit in the Time Account, if applicable, and FHIBA immediately to the new FHIBA.

120.3 - Phase-out Period for Federal Health Insurance Bank Accounts –

(Rev. 5, 08-30-02)

A1-1420.3, B1-4418.3

In the event of termination of the bank agreement, the bank agrees to retain the contractor's Federal Health Insurance Account(s) for up to an **additional** 180-day period, beyond the current term, to allow for clearance of outstanding checks. (See subsection C of the IFB.) The letter-of-credit issued to the bank remains in effect to allow the bank to draw payment vouchers to cover all outstanding checks as they are presented for payment.

During this phase out period, the current bank agreement continues in effect with the exception of the following:

- Letter-of-Credit - Covenant 5;
- The Term of the Bank Agreement - Covenant 7;
- Termination of Agreement - Covenants 8 and 9; and
- Renegotiation of Agreement - Covenant 10.

It is further understood that during the phase out period:

- The bank maintains collateral in an amount sufficient to cover the high balances in the account(s) less FDIC coverage on each account;
- All bank service charges and earnings credits are consistent with those amounts reflected in the current agreement;
- All terms and conditions of the original bid submitted by the bank, which are not inconsistent with this additional term, remain in effect; and
- The contractor continues to complete the CMS-1521, CMS-1522 and the TAA Schedules.

130 - Invitation For Bid (IFB) to Provide Banking Services Under The Checks Paid Method of Letter-Of-Credit Financing - (Rev. 5, 08-30-02)

A1-1422, B1-4420

The contractor shall request the most recent copy of the IFB package from the RO to prepare its procurement. The IFB is constantly being updated to meet CMS requirements in the changing banking environment.

140 - Bonding - (Rev. 5, 08-30-02)

A1-1424, B1-4422

The contractor is required to have a fidelity bond on, as a minimum, each certification and disbursement employee. Blanket bonds are an acceptable alternative.

Bonds must protect against at least the risks contained in the contractor's agreement (specified in the article entitled "Certification and Disbursement and Indemnification").

As a general rule, the amount of the bond should equal 1/10 of the monthly limitation of the letter of credit but not exceed $500,000.

CMS accepts a bond in excess of $500,000 and assumes an allocated share of its total cost if the contractor determines that a larger bond is desirable.

No deductibles are permitted with respect to coverage, risks, and amounts.

150 - Letter-Of-Credit Check List - (Rev. 5, 08-30-02)

A1-1426, B1-4424

FORM NAME	DUE DATE
Intermediary Benefit Payment Report, CMS-456	Monthly - within 20 working days after the end of the reporting month.
Payment voucher on Letter-of-Credit Transmittal - CMS-1521	Monthly - within 15 days after the end of the reporting month.

Monthly Intermediary Financial Report, CMS-1522	Same as above
Time Account Adjustment Schedules,	
TAA, pages 1 - 3	Quarterly - within 30 days after the end of the reporting quarter
TAA-1b and TAA-1c	Monthly - within 15 days after the end of the reporting month

160 - Electronic Funds Transfer (EFT) - (Rev. 5, 08-30-02)

A1-1430, B1-4430

The contractor shall pay claims from providers of services according to the following criteria.

A - Requirement

The contractor may transmit payments electronically to each provider who bills Medicare, elects to receive payments electronically, and who provides the necessary bank account and routing data to enable the contractor to pay electronically.

B - Notification Requirement

The contractor shall provide its Regional Office (RO) with quarterly data on the number of providers paid under EFT, the transmission protocol, such as the ANSI X12 835 used for its EFT transmissions, and the benefit payment amount of EFT transactions. It shall use Form CMS-588, Authorization Agreement for Electronic Funds Transfer, to maintain a record of those physicians and suppliers that authorize Medicare payment under EFT.

C - Claims Processing Timeliness (CPT) Requirement

When transmitting electronic payments to providers, the contractor shall pay claims in a timely manner consistent with the payment floor in effect at the time of payment. It shall transmit the EFT authorization to its originating bank upon the expiration of claims processing timeliness payment floor, as discussed in the Medicare Claims Processing Manual, Chapter 1, General Billing Requirements. For example, an EFT payment in March 2001 for an electronic claim may not be transmitted to the originating bank earlier than 14 days after the date of receipt. An EFT payment in March 2001 for a paper claim may not be transmitted to the originating bank earlier than 27 days after the date of receipt. Payment settlement, i.e., the date on which funds are posted to the provider's account, should not be earlier than 2 business days following transmission of the electronic payment data to the originating bank. The contractor shall accomplish this by designating an effective payment date on the electronic payment file of no earlier than 2 business days after the transmission date.

D - Electronic Transmission Standard

When making direct deposits to the accounts of providers under EFT, the contractor shall use a transmission format that is both economical and compatible with its servicing bank and the Automated Clearing House.

For Standard Systems Maintainers, the Medicare standard ANSI 835 health care payment/advice can be abbreviated and used to generate an ACH-FORMATTED EFT file that contains no beneficiary-specific data. In these cases, the bank translates the abbreviated ANSI 835 into an ACH-COMPATIBLE payment file. The entire ANSI 835 Remittance advice record will be sent directly to the provider. In the event these abbreviated ANSI data are not acceptable to certain banks for purposes of initiating electronic payments through the appropriate ACH, the standard system users should consult with their individual banks to determine which electronic payment data format is acceptable. The contractor should refer to Part 3, Chapter 24, EDI Support Requirements for more information on the abbreviated ANSI-835.

E - Alternatives to Electronic Payment

When EFT is not used, the contractor shall make payments to providers via hardcopy checks drawn on the commercial bank servicing its Medicare account. It shall send the hardcopy check by first class U.S. Postal Service only.

NOTE: The pickup, next-day delivery, express mail or the use of a courier service for hardcopy checks is prohibited except in emergency situations, as authorized by the contractor's RO.

F - Modification of Tri-partite Bank Agreement to Include EFT Method of Payment

The contractor shall work with its servicing bank and its RO to ensure that the Tri-partite bank agreement is modified to include wording that allows funding of the Letter of Credit to include electronic payments as well as hardcopy checks. The Tri-partite bank agreement needs to clearly state that all references to checks in the original bank agreement shall mean checks and/or electronic funds transfer (EFTs).

The contractor shall have its legal department and that of the originating bank review the Tri-partite bank agreement to ensure that it meets contractor needs and the requirements of the Medicare program. It shall forward any modifications to the Tri-partite bank agreement at least 1 month prior to its effective date to the RO and the Chief, Financial Management Unit, OCA, BPO in CO for review and approval. See §160.1, Exhibit 2 for a sample addendum to the Tri-partite bank agreement that includes general provisions for payment under the EFT method.

G - The Receiving Bank's Role in EFT/Electronic Remittance Advice (ERA)

While providers may wish to consider criteria such as experience with EFT and receipt of ANSI-formatted financial data when choosing a bank, these procedures should in no way be interpreted as requiring providers to do business with a particular financial institution (e.g., receiving bank only).

H - Electronic Funds Transfer Transaction Costs

Prior to transmitting payments electronically, the originating bank fills in the relevant EFT transaction costs on the Schedule AS (Schedule of Bank Processing Charges), and submits it to

the contractor. The contractor shall transmit this information to both the RO and CO. Once electronic payments are initiated, the originating bank shall include all payment information on the Monthly Schedule of Bank Processing Charges, (TAA 1-b), and transmit this form to the contractor, who enters the data into the Contractor Administrative Budget and Financial Management (CAFM) system where it is reviewed and approved first by the RO and then CO.

NOTE: The EFT costs reported on line 8 of the AS Schedule and the Monthly Schedule of Bank Processing Charges (TAA 1-b) shall include a breakdown of all costs associated with EFT, including the cost per EFT transaction, set-up costs, monthly charges, transmission costs, etc.

I - Contractor Responsibility for EFT/ERA Records Retention

The contractor shall retain records on EFT/ERA in accordance with established CMS and Department of Justice procedures for retention of documentation associated with electronic claims.

J - Provider Responsibility for the Accuracy of Claims Data

To minimize errors and disruptions to cash flow, providers are responsible for verifying the accuracy of claims payment information submitted to their Medicare contractor.

170 - Electronic Remittance Advice (ERA) - (Rev. 5, 08-30-02)

A1-1431, B1-4431

The contractor shall accommodate provider requests to receive hardcopy checks or electronic payments with ERAs. Providers have the option to receive remittance information on paper or electronically. Providers who elect EFT are not required to receive ERAs. The contractor shall furnish ERAs to providers using the following criteria:

A - Standard Format Requirement

In lieu of the traditional method of sending hardcopy remittance advices and checks to providers, effective October 1, 1992, the contractor shall transmit, over wire only, the ANSI X12.835, Health Care Claim Payment/Advice (ANSI-835) to a requesting provider or to a requesting provider's billing service. The ANSI-835 is the only electronic remittance option available as of this date. If the contractor has any technical questions on formats or electronic remittance transmission requirements, it should contact its RO.

B - Privacy Act Compliance

Unless otherwise directed by CO, the contractor shall ensure that remittance information is transmitted to providers or their authorized billing agents either directly, through a Value Added network, or as authorized by a provider, to a bank that is capable of receiving ERA data and agrees to safeguard the data.

C - Reconciliation Requirement

Prior to entering into an electronic payment arrangement with a provider, the contractor shall ensure that its providers are able to reconcile their accounting records using the ANSI-835 remittance advice. Once this determination is made, it shall provide telephone support during normal business hours and allow for an initial reconciliation period of up to 30 days during which it will produce both paper and electronic remittances. After this 30-day phase-in period, it shall eliminate paper remittances for these providers.

D - Standard Format Reference

See the Claims Processing Manual, Chapter 22 - Remittance Notice to Providers, for information and additional requirements concerning the standard remittance advice format.

180 - Exhibits - (Rev. 5, 08-30-02)

A1-1435

Exhibit 1 - Form CMS-1521 - - See CMS Forms page.

Exhibit 2 - Form CMS-1522 - - See CMS Forms page.

Exhibit 3 - Intermediary Benefit Payment Report - - See CMS Forms page.

Exhibit 4 -Authorization Agreement for Electronic Funds Transfer

PROVIDER/PHYSICIAN **PROVIDER/PHYSICIAN NAME_____**

ID NUMBER_____

I hereby authorize (**Insert Contractor Name**), hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my ( ) Checking ( ) Savings account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT NUMBER _____ ACCOUNT NUMBER _____

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

NAME _____ TITLE _____

(PLEASE PRINT)

SIGNED X _____ DATE _____

Exhibit 5 - Addendum to Medicare Bank Agreement

The parties have executed this Agreement for the Medicare A(B) Bank Accounts using the Checks Paid Method of Letter of Credit Financing and desire to add changes to the existing agreement currently in force. These changes are necessitated by the implementation by (**Insert Contractor Name**) of the Electronic Funds Transfer (EFT) method of paying providers effective (**Insert Date**). This change in payment method is under the direction of the Centers for Medicare and Medicaid Services (CMS) as an initiative to increase the uniformity and efficiency of the provider payment process.

Also, item number 10 below, although not related to EFT, is incorporated into the bank agreement to insure that no excessive earnings credits accumulate during the period of the bank agreement.

The parties hereby agree to the following terms and conditions that shall be considered an integral part of the bank Agreement:

1. The rates as reflected on the Schedule of Bank Processing Charges shall be in effect for the term of this Agreement.

2. This Agreement, with all its provisions and covenants, shall continue in force from year to year after the expiration of such term; provided, however, that notification to terminate or renegotiate has not been given by any party as specified in the Agreement executed on (Insert Date).

3. All references to checks in the original Agreement shall hereby mean checks and/or Electronic Funds Transfers (EFTs).

4. The Fiscal Intermediary (Carrier) is obligated to obtain, retain, and provide copies of provider authorizations, particularly with regard to the rights, liabilities, and responsibilities of Medicare contractors and financial institutions under Regulation E.

5. The nature, format and medium of entries, or entry information is to be furnished to the originating bank in writing by the Fiscal Intermediary (Carrier) prior to entering into an EFT arrangement.

6. The Fiscal Intermediary (Carrier) and the originating bank shall negotiate the level of security to be established for delivering the payment data from the Fiscal Intermediary (Carrier) to the originating bank, such as transmittals with authorized signatures, and the method used to verify authenticity of telecommunicated data, prior to entering into an EFT arrangement.

7. The Fiscal Intermediary (Carrier) shall specify the time when funds are to be provided to the originating bank prior to entering into an EFT arrangement.

8. The Fiscal Intermediary (Carrier) and the originating bank shall agree to the deadline for reversals, corrections, or changes by the Fiscal Intermediary (Carrier) of entries or entry information furnished to the originating bank prior to entering into an EFT arrangement.

9. In those cases where the Fiscal Intermediary's (Carrier's) Medicare bank is unable to originate EFT transactions, the Medicare bank may subcontract certain functions. The Medicare bank agrees that none of the functions to be performed under the Tri-partite agreement shall be subcontracted without prior written approval of the Fiscal Intermediary (Carrier) and the CMS. Any such approved subcontract shall contain the language of the Examination of Records Clause contained in the bank agreement (Covenant 3).

10. If Line 7 of Page 1 of the Quarterly Time Account Adjustment Schedule reflects any positive balance, the contractor shall immediately forward supporting documentation and a check made payable to CMS for that amount to:

Send a copy of the check and transmittal letter

to:

Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Boulevard
Baltimore MD 21244-1850

190 - General Information About Termination Costs - (Rev. 5, 08-30-02)

A1-1800

The contractor shall prepare a shut-down cost budget voucher based on its natural expense line items, and submit the budget to both CMS's Central Office (CO) and to the contractor's Regional Office (RO).

It shall include the following information on the voucher:

- All incurred shut-down expenses determined by the contractor's natural cost items;
- The amount, and a detailed explanation, for each item it claims; and
- An attestation signed by a company official that validates the costs the contractor is claiming are correct.

CMS pays shut-down costs based on the contractor's voucher's information. The contractor shall not draw administrative funds, via its letter-of-credit, after the official date of either contract close-out or termination.

It shall submit the voucher on official company letterhead. It shall make sure the voucher is signed by an authorized company official, and forward a copy to CMS's CO at the following address:

Centers for Medicare & Medicaid Services
Division of Contractor Financial Management, OFO
7500 Security Boulevard
Baltimore MD 21244-1850

200 - General - (Rev. 14, 02-03-03) A1-1900, B1-4900

The Contractor Financial Reports provide a method of reporting financial activities for benefit payments by Medicare contractors according to the Chief Financial Officers (CFOs) Act of 1990. The contractor is required to maintain accounting records according to government accounting principles and applicable government laws and regulations. This requirement complies with the Office of Management and Budget (OMB) Bulletins about Financial Statements. These policies and procedures are developed by the Federal Accounting Standards Advisory Board (FASAB).

The accounting principles and the auditing standards required are not substantially different from Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS) as formulated by the accounting profession. Government accounting principles which are developed by FASAB, however, require maintaining records not only for preparing financial statements, but also to enforce applicable laws and regulations. Accounts are maintained to provide control over operations as well as to provide financial information.

Medicare contractors are required to use double entry bookkeeping and accrual basis accounting. For example, if an accounts receivable is established, accounts receivable should be debited and, most likely, operating/program expense should be credited. If an accounts payable is established, accounts payable should be credited and, most likely, operating/program expense should be debited. In addition, the information reported must be supported by the contractor's books and records as of the end of the period requested and adequate audit trails must be maintained. To ensure accurate reporting, proper cutoff procedures must also be established in order to limit reporting to activities attributable to the reporting period. Where actual data is not available, reasonable estimates are acceptable. See Exhibits 12 through 15 for protocols for estimating relevant accounts. When end of period entries are made to accrue account balances, the contractor shall reverse the entries in the following quarter to allow normal processing of accounting transactions.

In order to maintain consistent and accurate financial reporting, Medicare contractors must have an internal control structure that integrates the accounting and claims processing systems. The internal control structure must provide for the following control procedures:

1. Independent review of proper valuation of recorded amounts and performance;

2. Segregation of duties (separate authorization, record-keeping, and custody);

3. Safeguards over access to assets and records;

4. Authorization of transactions and activities;

5. Documents and records that are adequate to ensure proper recording; and

6. Quarterly reconciliation of internal systems to the Provider Overpayment Report (POR) system for intermediaries and the Physician Supplier Overpayment Report (PSOR) system for carriers.

Supporting documentation must be maintained and available for review and audit. This must include lead schedules for all amounts used for report preparation and detailed documentation, such as demand letters for accounts receivable. A very good procedure that CMS recommends to ensure the accuracy of reported amounts, is trending and comparative analysis. This analysis involves comparing reported amounts to prior amounts to identify material errors.
Hardcopy books and records used to prepare the annual financial reports should be retained for 6 years unless microfilmed. Then, the hardcopy needs to be retained for 3 years and the microfilm retained for the balance of the 6-year period.
The Office of the Inspector General (OIG) will conduct audits of contractors according to government auditing standards. This requirement complies with OMB Bulletin No. 98-08, Audit Requirements for Federal Financial Statements. Applicable government laws and regulations also supplement the government auditing standards. These standards are similar to those contained in the **Comptroller General of the United States Standards for Audit of Governmental Organizations, Programs, Activities, and Functions** (The Yellow Book).

The OMB Bulletin No. 01-09, Form and Content of Agency Financial Statements requires the preparation of Federal Agency interim financial statements, in addition to accelerating the due date of the submission of year-end audited financial statements to OMB and Congress. Because

of OMB's new requirements, CMS and its Medicare contractors must be able to prepare financial statements at the end of any month at the request of CMS.

To meet this obligation, all shared systems must be able to produce any system reports required by Medicare contractors utilizing those systems to prepare all the Forms CMS-750 A/B and the Forms CMS-751 A/B on a month-end basis. These reports must be cumulative in order to provide Medicare contractors' financial position and status of accounts receivable activity from the beginning of the fiscal year through the month requested.

Medicare contractors must be able to support all summary amounts reported on any of these reports with transaction level detail, and must be able to produce this support upon request by CMS or internal/external auditors.

210 - Instructions For Completing The Form CMS-750A/B, Contractor Financial Reports - (Rev. 5, 08-30-02)

A1-1910, B1-4910

There are separate reports and data screens for Part A, Hospital Insurance (HI), and Part B, Supplementary Medical Insurance (SMI) in the Contractor Administrative-Budget and Financial Management (CAFM) system. The intermediary enters data in both HI and SMI data screens (see Exhibits 1 and 2). The carrier enters data in the SMI data screens (see Exhibit 2).

The data for the report is HI and SMI financial information as defined in the Medicare Account Definitions (see Exhibit 11). In order to facilitate reconciliation, balancing and error resolution, the contractor shall report all data in dollars and cents.

The data on the report may not equate on a one-to-one basis with data reported to CMS in other reports, such as Draws on Letter of Credit, reported on Form CMS-1521. The contractor must maintain records that will allow reconciliation of Form CMS-750A/B with those other reports.

220 - Due Date - (Rev. 5, 08-30-02)

A1-1911, B1-4911

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

230 - Certification - (Rev. 5, 08-30-02)

A1-1912, B1-4912

Medicare contractor certification by the Chief Financial Officer (CFO) is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of the Form CMS-750A/B:

I hereby CERTIFY that I have examined the Statement of Financial Position prepared by [name of contractor] for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

NAME _____ Date _____ Title _____

240 - Instructions for Completing Form CMS-751 A/B, Status of Accounts Receivable - (Rev. 5, 08-30-02)

A1-1920, A1-1940, B1-4920, B1-4960

Forms CMS-H751A/B and CMS-M751A/B are similar data entry screens used to report the following receivables.

- Form CMS-H751A to report debt under Part A (HI) by intermediaries
- Form CMS-H751B to report debt under Part B (SMI) by intermediaries and carriers
- Form CMS-M751A to report MSP debt under HI by intermediaries;

- Form CMS-M751B to report MSP debt under SMI by intermediaries and carriers;

MSP accounts receivable data reported on CMS-M751A/B is a subset of total accounts receivable data reported on Form CMS-H751A/B (e.g., 751A/B includes the data reported on the CMS M751A/B **and** non-MSP data.

The screen heading indicates whether the report is for the MSP subset.

Samples of the screens are shown in Exhibits 3 - 9. There are separate reports and data screens for Part A, HI, and for Part B, SMI in the CAFM system. The intermediary enters data in both HI and SMI data screens (Exhibits 3 and 4). The carrier enters data in only the SMI data screens (Exhibit 4).

The intermediary or carrier reports the accounts receivable activity for fiscal year-to-date (FYTD) for the period of the report. In order to facilitate reconciliation, balancing and error resolution, it reports the accounts receivable in dollars and cents.

The reports require information both for the amount and the number of accounts receivable. To provide standardization, CMS suggests that contractors use their collection process as a guide when reporting the number of accounts receivable. For example, a separate, stand alone accounts receivable collected would be reported as a quantity in the number column.

EXAMPLES:

1. (Intermediaries only). A cost report is one receivable. Even though several claims are associated with the cost report, the collection activity would be against the entire cost report rather than each claim.

2. A demand letter issued in a Medicare Secondary Payer (MSP) case to one debtor with several claims listed on the letter. If the collection is made and posted against an individual claim, each claim on the demand letter would be an individual receivable.

3. A demand letter issued to a physician based on adjustments projected from sampling claims equals one. Even though many claims are represented by projection of the sample.

Once the principal number is established, the contractor shall report the interest associated with the principal amount in the same manner. There can be a difference between the principal number and the interest number because some receivables are not subject to interest.

250 - Due Date - (Rev. 5, 08-30-02)

A1-1921, A1-1941, B1-4921, B1-4941

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

260 - Certification - (Rev. 5, 08-30-02)

A1-1922, A1-1942, B1-4922, B1-4942

Medicare contractor certification by the CFO is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of Form CMS-H751A/B:

> I hereby CERTIFY that I have examined the Status of Accounts Receivable prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

For (Status of MSP Accounts Receivable) (Form CMS-M751) the statement includes a reference to MSP and reads as follows:

> I hereby CERTIFY that I have examined the Status of MSP Accounts Receivable prepared by (name of contractor) for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete

statement prepared from the books and records of the contractor in accordance with applicable instructions.

The name, date and title of the person making the certification are on both certifications.

270 - Line Item Instructions Form CMS-H751A/B - (Rev. 5, 08-30-02)

A1-1923, A1-1943, B1-4923, B1-4943

Medicare contractors must develop and maintain transaction level detail (at a minimum, this would include the provider name, provider number, date of determination, outstanding balance, and any adjustments or recoupments) by debt to support the amounts reported for each line outlined below.

In addition, non-MSP amounts must be reconciled to the POR (intermediary) or PSOR (carrier) system as applicable.

Part I, Status of Receivables

For each line in Section A, below, the instruction applies to each the Form CMS-H751 and Form CMS-M751, and to the intermediary report and to the carrier report unless otherwise noted. The instructions are applicable only to MSP amounts for the Form CMS-M751 and are applicable to all amounts for the Form CMS-H751.

Section A - Outstanding Receivables

270.1 - Line 1, Beginning FY Balance (Principal & Interest) –

(Rev. 5, 08-30-02)

A1-1923.1, A1-1943.1, B1-4923.1, B1-4943.1

The contractor enters the number and amount for all accounts receivable outstanding as of the beginning of the FY. These amounts will be pre-filled with the ending balances reported on the

preceding (9/30/XX) FY Contractor Financial Reports. The contractor must make any corrections to the beginning principal and interest FY balance on Line 5a, Adjusted Amounts, Internal Adjustments. It shall apply the offsetting entry, on the related Form CMS-750A/B report (debit or credit) to Operating/Program Expense for transactions that affect principal, or interest revenue if the transaction affects interest.

270.2 - Line 2a, New Receivables (Principal) - (Rev. 5, 08-30-02)

A1-1923.2, A1-1943.2, B1-4923.2, B1-4943.2

The contractor enters the number and amount for all new receivables established at its location during the FY. New receivables for intermediaries include cost report settlements and credit balances. For both intermediaries and carriers, overpayments and claims accounts receivables for all claim types are included. For carriers only, beneficiary debt and under-tolerance accounts receivable are included.

For MSP new receivables includes group health plan data-match, non-data-match, liability (including worker's compensation, auto and no fault), etc.

The contractor does not include those receivables transferred from other Medicare contractors, other CMS locations, Currently Not Collectible (CNC), or other transferred locations in prior fiscal periods. It includes all of these items on Lines 5b, 5d, 5f, or 6b, Transferred In Amounts.

NOTE: MSP accounts receivable are not established until a settlement, judgment or award has been reached and a demand letter is sent.

270.3 - Line 2b, Accrued Receivables (Principal) - (Rev. 5, 08-30-02)

A1-1923.3, A1-1943.3, B1-4923.3, B1-4943.3

Line 2b is not applicable to carriers or to MSP.

The intermediary enters the number and amount of Periodic Interim Payment (PIP) accrued receivables, fiscal year-to-date on this line. The **only** receivables a FI will accrue are those that

result from comparing PIP payments to claims submitted. For each quarterly reporting period, a new accrual is established and the prior quarter's accrual must be reversed or zeroed out. Both the establishment and reversal of the PIP accrual must be reflected in this line, **except** for the reversal of the September's quarterly accrual, which would be reflected in Line 5a, Adjusted Amounts, Internal Adjustments (see Exhibit 13, Periodic Interim Payments (PIP) Protocol for Estimating Payables/Receivables for the Form CMS-750A/B, Statement of Financial Position).

270.4 - Line 3, Interest Earned (Interest) - (Rev. 5, 08-30-02)

A1-1923.4, A1-1943.4, B1-4923.4, B1-4943.4

The contractor enters the number and amount of interest earned on: (a) existing or new receivables established at its location during the FY; and (b) the interest earned on receivables transferred to it, following the date the receivables are established on its records. The contractor shall not include the amount of accrued interest earned at other locations. It shall report the accrued interest earned at other locations as transferred in on Line 5b, 5d, 5f or 6b, Transferred In Amounts.

270.5 - Line 4a, Cash/Check Collections on Receivables (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.5, A1-1943.5, B1-4923.5, B1-4943.5

The contractor enters the amount collected by cash or check on receivables during the fiscal period.

270.6 - Line 4b, Offset Collections on Receivables (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.6, A1-1943.6, B1-4923.6, B1-4943.6

The contractor enters the amount collected by offset on receivables during the fiscal period.

270.7 - Line 4c, Collections Deposited at Another Location (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.7, A1-1943.7, B1-4923.7, B1-4943.7

The contractor enters the amount collected or offset by CMS Central Office (CO) for collections on accounts receivable referred under the Debt Collection Improvement Act (DCIA). Do not transfer the case to CO where the deposit or offset of the money is made. Upon receipt of the Collection Reconciliation/Acknowledgement form, enter the amount collected or offset by cross servicing/TOP and received by CO in this line to reduce the outstanding amount of the receivable being reported on Form CMS-751A/B. CO will record the actual deposit of cash/check/offset on Line 10, Cash/Offsets Received for Receivables at Another Location of its' Form CMS-R751.

The Medicare contractor or CO that records the actual deposit of cash/check/offset will record this amount on Line 10, Cash/Offsets Received for Receivables at Another Location. (See §270.15 for instructions and Exhibit 18 Collection Reconciliation/ Acknowledgement Form).

270.8 - Line 5, Adjusted/Transferred/Waived Amounts (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.8, A1-1943.8, B1-4923.8, B1-4943.8

The contractor enters the amount of receivables it has adjusted, transferred in from or out to other locations, or waived. It is required to maintain supporting documentation and records for all these receivables transferred in and out. Amounts transferred in from or out to other CMS locations or Medicare contractors must be reconciled to the other entity's records for the same reporting period **prior** to submission of the quarterly reports to ensure that only **approved** transfers are being reported. Documentation of the reconciliation must be maintained and must indicate that a supervisory review of the reconciliation was performed. Refer to Exhibit 17 for instructions for the transfer of debt between other reporting entities.

The contractor reports in Lines:

5.

a. Adjusted Amounts (Principal & Interest). The contractor enters the amount for any adjustments to the beginning balance, or corrections/adjustments of receivables previously established during the fiscal period. These adjustments can be either positive or negative. It separately reports adjustments resulting from Auditor/Consultant recommendations, and those determined independently.

b. Transfers In from other Medicare Contractors (Principal & Interest). The contractor enters the amount transferred in from other Medicare contractors during the fiscal period.

c. Transfers Out to other Medicare Contractors (Principal & Interest). The contractor enters the amount transferred out to other Medicare contractors during the fiscal period.

d. Transfers In from other CMS Locations, POR/PSOR (Principal & Interest). (Carriers report PSOR, and intermediaries report POR). The contractor enters the amount transferred in from other CMS locations and reported on the POR/PSOR during the fiscal period. (Applies to non-MSP debt only)

e. Transfers Out to other CMS Locations, POR/PSOR (Principal & Interest). Carriers report PSOR, and intermediaries report POR). The contractor enters the amount transferred out to other CMS locations and reported on the POR/PSOR during the fiscal period.

f. (Applies to non-MSP debt only)

g. Transfers In from other CMS Locations, Not POR/PSOR (Principal & Interest). The contractor enters the amount transferred in from other CMS locations and not reported on the POR/PSOR during the fiscal period.

h. Transfers Out to other CMS Locations, Not POR/PSOR (Principal & Interest). The contractor enters the amount transferred out to other CMS locations and not reported on the POR/PSOR during the fiscal period.

i. Waivers (Principal & Interest). The contractor enters the amount of accounts receivable waived based on the application of §§ 1862(b) and 1870(c) of the Social Security Act.

270.9 - Line 6, Amounts Written-off Closed (Bad Debts)/Transferred CNC (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.9, A1-1943.9, B1-4923.9, B1-4943.9

The contractor enters the amount which it has written-off as a bad debt, or transferred to or from CNC.

The contractor reports in lines:

6.

a. Amounts Written-off Closed (Bad Debts)(Principal & Interest). The contractor enters the amount for which collection efforts have been abandoned. (This would include the remaining balance on accounts receivable after the bankruptcy court has ruled on bankruptcy, appeals, and other litigated cases).

b. Transfers In from CNC (Principal & Interest). The contractor enters the amount re-established as active debt that was previously classified as CNC during the fiscal period.

c. Transfers Out to CNC (Principal & Interest). The contractor enters the amount removed from the ending balance and reclassified as CNC during the fiscal period.

270.10 - Line 7, Ending Balance (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.10, A1-1943.10, B1-4923.10, B1-4943.10

The ending balance is a computed field reporting the number (manual entry) and amount for receivables outstanding as of the end of the reporting period. It equals:

	Principal		Interest
+	Beginning FY balance (Line 1)	+	Beginning FY balance (Line 1)
+	New Receivables (Line 2a)	+	Interest Earned (Line 3)
+/-	Accrued Receivables (Line 2b)		
-	Collections on Receivables (Line 4a-4c)	-	Collections on Interest (Line 4a-c)
+/-	Adjusted/Transferred Amounts (Line 5a-5g)	+/-	Adjusted/Transferred Amounts (Line 5a-5g)
-	Waivers (line 5h)	-	Waivers (line 5h)
+/-	Amounts Written-off/Transferred CNC(Lines 6 a - c)		Amounts Written-off/Transferred CNC (Lines 6 a - c)
=	Ending Balance (Line 7)	=	Ending Balance (Line 7)

NOTE: Although Line 7 is a calculated amount, the contractor must be able to provide a detailed listing of all outstanding receivable balances that support this line at any given period of time. The ending balance must be equal to the accounts receivable and interest receivable amounts reported on the form in Statement of Financial Position.

270.11 - Line 7a, Current Receivables (Principal and Interest) –

(Rev. 5, 08-30-02)

A1-1923.11, A1-1943.11, B1-4923.11, B1-4943.11

The contractor enters the amount of the receivables due within 12 months following the reporting period. The definition of current and non-current does not depend on the time a debt is outstanding but when the debt is due. A receivable for which the due date is 12 months or less from the report date is a current receivable. For example, a debt due September 30, 2003, within 12 months from the date of a report for September 30, 2002, is a current receivable. In addition, all delinquent receivables are to be reported as current. The contractor shall assign between current and non-current the appropriate amount of those receivables for which it has negotiated extended repayment schedules, based on the installment payment dates.

270.12 - Line 7b, Non-current Receivables (Principal) - (Rev. 5, 08-30-02)

A1-193.12, A1-1943.12, B1-4923.12, B1-4943.12

The contractor enters the amount of non-current receivables due more than 12 months after the reporting period. The definition of non-current receivables includes those receivables for which the due date is more than 12 months from the end of the reporting period. For example, those receivables for which the due date is October 1, 2003, 1 year from the date of a report for September 30, 2002, are non-current receivables.

270.13 - Line 8, Allowance for Uncollectible Accounts (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923. 13, A1-1943.13, B1-4923.13, B1-4943.13

The contractor enters the amount of the ending balance reported in Line 7 for accounts receivable it estimates will not be collectible. (See Exhibit 14, Allowance for Uncollectible Accounts).

270.14 - Line 9, Total Receivables Net of Allowance - (Rev. 5, 08-30-02)

A1-1923.14, A1-1943.14, B1-4923.14, B1-4943.14

Total Receivables Net of Allowance is a computed field (Line 7 less Line 8) reporting the contractor's estimate of the amount of accounts receivable it reasonably expects to collect.

270.15 - Line 10, Cash/Offsets Received for Receivables at Another Location (Principal & Interest). - (Rev. 5, 08-30-02)

A1-1923.15, A1-1943.15, B1-4923.15, B1-4943.15

This line shall be used only be used in the instances where CO receives collection from cross servicing/TOP for DCIA debt.

The Medicare contractor who reports the receivable on Form CMS-751A/B will reduce the outstanding balance of the receivable for the amount deposited by CO by recording the amount of the collection in Line 4c, Collection Deposited at Another Location. (See Exhibit 18, Collection Reconciliation/Acknowledgement Form).

Section B - Delinquent Receivables

270.16 - Line 1, Total Not Delinquent (Principal & Interest) –

(Rev. 5, 08-30-02)

A1-1923.16, A1-1943.16, B1-4923.16, B1-4943.16

The contractor enters the total number and amount of accounts receivable that are not delinquent.

270.17 - Line 2, Total Delinquencies (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.17, A1-1943.17, B1-4923.17, B1-4943.17

The contractor enters the total number and amount of delinquent receivables. It enters the amount of the past due payment unless the full amount is normally due and declared payable. The debt becomes delinquent the day following the date that the debt is due with all extensions recognized. Thus, for non-MSP if the debt is due 30 days after demand, the first day of delinquency starts on day 31. For MSP, if the debt is due 60 days after demand, the first day of delinquency starts on day 61. If any portion of a debt has been delinquent more than 180 days,

the entire amount is reported as delinquent. The contractor enters the amount of receivables that are delinquent for the respective periods (a through i) indicated.

270.18 - Line 3, Status of Delinquent Receivables, less than or equal to 180 Days (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.18, A1-1943.18, B1-4923.18, B1-4943.18

The contractor enters the total number and amount of delinquent receivables 180 days delinquent and less, which are in (a) Bankruptcy, (b) Appeal, (c) Department of Justice, (d) Referred for Cross Servicing and/or (e) Other Status.

270.19 - Line 4, Status of Delinquent Receivables, greater than 180 Days (Principal & Interest) - (Rev. 17, 05-02-03)

A1-1923.19, A1-1943.19, B1-4923.19, B1-4943.19

The contractor enters the total number and amount of delinquent receivables 181 days delinquent and greater, which are in *one of the following categories:*

(a) Referred to the Department of the Treasury for Cross Servicing. For MSP, this means debts entered into the DCS. For Non-MSP, this means debts that have been transmitted to DCC by CMS Central Office and the Medicare contractor has acknowledged and verified the validity and accuracy of the debts transmitted.

(b) Not Eligible for Referral, the number and dollar amount is equal to the sum of lines (1) through (11) of this section.

1) *Bankruptcy;*
2) *Appeal;*
3) *Department of Justice/Litigation;*
4) *Fraud and Abuse Investigation, if the contractor has received specific*

instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel, etc.) not to attempt collection;
5) Deceased Debtor, debts where the debtor is deceased and the estate is closed;
6) Debts less than $25;
7) Federal Entity Debts, MSP only, where the only entity which received the last demand letter is the employer and the employer is a Federal agency;
8) Beneficiary Debts, Non-MSP only;
9) Pending Request for Waiver or Compromise;
10) CMS Identified Exclusions, MSP only, debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral.
11) Other Exclusions, must footnote.

(c) Eligible for Referral, debts that are eligible for referral to the Department of the Treasury for cross servicing but not yet referred.

Section C - Other Collections

270.20 - Line 4c, Collections Deposited at Another Location (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.20, A1-1943.20, B1-4923.20, B1-4943.20

The contractor enters the distribution of collections on receivables, by location, for amounts offset or received and deposited at another location. The total amounts listed in this section must equal the amount reflected in Section A, Line 4c of this report.

270.21 - Line 10, Cash/Offsets Received for Receivables at Another Location (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.21, A1-1943.21, B1-4923.21, B1-4943.21

This will not apply to Medicare contractors.

270.22 - Collections on Delinquent Debt (Principal & Interest) –

(Rev. 5, 08-30-02)

A1-1923.22, A1-1943.22, B1-4923.22, B1-4943.22

The contractor enters the number and amount of collections on receivables that were delinquent upon collection. The total amount should be less than total collections for the FY.

Section D - Transferred Receivables

The contractor enters the distribution of debts transferred to Medicare contractors or other CMS locations.

For Form CMS-H751A/B, the data in this section is also reported in Section A, Status of Accounts Receivable Transfers Out to other Medicare contractors or other CMS locations, and will be used by the contractor and other CMS locations to reconcile its books and records.

For Form CMS-M751A/B, the data in this section is also reported in Section A Outstanding Receivables, Line 5c, Transfers Out to other Medicare Contractors; Line 5e, Transfers Out to other CMS locations on the POR/PSOR; and Line 5g, Transfers Out to other CMS Locations, Not POR/PSOR.

270.23 - Line 5c, Transfers Out to other Medicare Contractors (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.23, A1-1943.23, B1-4923.23, B1-4943.23

The contractor enters the distribution to Medicare contractor locations of the debts, entered in Line 5c, Transfers Out to other Medicare Contractors, reflected in Section A of this report.

270.24 - Line 5e, Transfers Out to other CMS Locations, POR/PSOR (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.24, A1-1943.24, B1-4923.24, B1-4943.24

The contractor enters the distribution to the various regional offices (ROs) or CO of the debts on the POR, entered in Line 5e, Transfers Out to other CMS Locations, POR/PSOR, reflected in Section A of this report.

270.25 - Line 5g, Transfers Out to other CMS Locations, Not POR (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1923.25, A1-1943.25, B1-4923.25, B1-4943.25

The contractor enters the distribution to the various ROs or CO of the debts not reported on the POR/PSOR, entered in Line 5g,Transfers Out to other CMS Locations, Not POR/PSOR, reflected in Section A of this report. POR is applicable to FIs. PSOR is applicable to carriers.

280 - Instructions for Completing the Form CMS-C751A/B, Status of Debt - Currently Not Collectible (CNC), and Form CMS-MC751A/B, Status of MSP Debt - Currently Not Collectible (CNC) - (Rev. 5, 08-30-02)

A1-1930, A1-1950, B1-4930, B1-4950

Form CMS-C751A/B and Form CMS-M751A/B are similar data entry screens used to report the following.

- Form CMS-C751A to report non-MSP debt under Part A (HI) by intermediaries;
- Form CMS-C751B to report non-MSP debt under Part B (SMI) by intermediaries and carriers;
- Form CMS-MC751A to report MSP debt under HI by intermediaries; and
- Form CMS-MC751B to report MSP debt under SMI by intermediaries and carriers;

Note that currently not-collectible debt reported by Forms CMS-C751 and CMS-MC751 is reported separately for non-MSP and MSP accounts receivables.

The screen heading indicates whether the CNC report is for the non-MSP or MSP subset.

Samples of the screens are shown in Exhibits 5 and 6. Note that intermediaries must prepare separate reports for each category by trust find.

There are separate reports and data screens for Part A, HI, and for Part B, SMI in the CAFM system. The intermediary enters data in both HI and SMI data screens (Exhibits 5 and 6). The carrier enters data in only the SMI data screens (Exhibit 6).

The data for each of these reports are essentially the same.

The contractor reports the CNC accounts receivable activity for FYTD for the period of the report. In order to facilitate reconciliation, balancing and error resolution, it reports the CNC accounts receivable in dollars and cents.

The reports require information both for the amount and the number of accounts receivable. To provide standardization, CMS suggests the contractor use its collection process as a guide when reporting the number of accounts receivable. For example, a separate, stand alone accounts receivable collected would be reported as a quantity in the number column.

Once the principal number is established, the contractor reports the interest associated with the principal amount in the same manner. There can be a difference between the principal number and the interest number because some receivables are not subject to interest.

290 - Due Date - (Rev. 5, 08-30-02)

A1-1931, A1-1951, B1-4931, B1-4951

This report is due on January 21, April 21, July 21, October 21 (21 days after the end of each quarter) via the CAFM system. If that date occurs on a holiday or a weekend, the report is due the following Federal workday.

300 - Certification - (Rev. 5, 08-30-02)

A1-1932, A1-1952, B1-4932, B1-4952

Medicare contractor certification by the CFO is required. The CFO must input their password on the CAFM system (see Exhibit 16). Failure to record the official's password is a serious error that will prevent acceptance of the report by the CAFM system. The following statement appears at the end of the Form CMS-C751A/B (as well as the Form CMS-MC751A/B):

I hereby CERTIFY that I have examined the Status of Non-MSP Debt - CNC prepared by name of contractor for the period beginning (first day of FY) and ending (last day of quarter), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the contractor in accordance with applicable instructions.

NAME _____ DATE _____ TITLE _____

NOTE: In the above statement, "MSP" replaces "Non-MSP" for the MSP report.

310 - Line Item Instructions Form CMS-C751A/B - Non-MSP and Form CMS-MC751A/B - MSP - (Rev. 5, 08-30-02)

A1-1933, A1-1953, B1-4933, B1-4953

The following instructions are to be used by Medicare contractors to report the status of Non-MSP or MSP, as applicable, CNC debt. Medicare contractors must develop and maintain transaction level detail (at a minimum, this would include the provider name, provider number, date of determination, outstanding balance, and any adjustments or recoupments) by debt to support the amounts reported for each line outlined below (see Exhibits 5 and 6). Medicare contractors must reclassify MSP or Non-MSP debt as CNC in accordance with CMS policy (see Exhibit 19 and Exhibit 20).

Within this subset of instructions, the designation "MSP" or "Non-MSP" is implied, depending on which report is being submitted, MSP or Non-MSP.

Section A - CNC Debt

310.1 - Line 1, Beginning FY Balance (Principal & Interest) – (Rev. 5, 08-30-02)

A1-1933.1, A1-1953.1, B1-4933.1, B1-4953.1

The contractor shall report the number and amount for all CNC debts outstanding as of the beginning of the FY. These amounts will be pre-filled with the ending balances from the prior FY on Form CMS-C751A/B, Status of Non-MSP Debt-CNC Financial Report or Form CMS-MC751A/B, Status of MSP Debt-CNC Financial Report. It shall make any corrections to the beginning principal and interest FY balance only on Line 4e, Reclassified CNC Debt - Other.

310.2 - Line 2, New CNC Debt (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1933.2, A1-1953.2, B1-4933.2, B1-4953.2

The contractor enters the number and amount of all debt approved by CMS RO and CO for CNC during the FY. This line should include the outstanding principal balance and all outstanding interest associated with the debt that was earned up to the date the debt was removed from Form CMS-751A/B or Form CMS-M751A/B reports, as appropriate, and included on the current Form CMS-C751A/B report or Form CMS-MC751A/B. This amount must equal the principal and interest amounts reported on Line 6c, Transfers Out to CNC.

310.3 - Line 3, Interest Earned Since CNC Approval (Interest) – (Rev. 5, 08-30-02)

A1-1933.3, A1-1953.3, B1-4933.3, B1-4953.3

The contractor enters the amount of interest earned in this fiscal year on CNC debt since the date the debt was reclassified and included in Line 1, Beginning FY Balance and interest earned on debts reclassified to CNC during the FY included in Line 2, New CNC Debt on the current report.

310.4 - Line 4(a) through (e), Reclassified CNC Debt (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1933.4, A1-1953.4, B1-4933.4, B1-4953.4

Reclassified CNC debt reported on Line 4a, Re-established as Active Accounts Receivable (A/R) Due to Collection of Cash; Line 4b, Re-established as Active A/R Due to Collection by Offset; and Line 4c, Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse, Litigation, or Appeal must agree with the total amount reported on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Medicare contractors must retain all documentation supporting any reclassified amounts.

4. The contractor reports in Lines:

    a. Re-established as Active Accounts Receivable (A/R) Due to Collection of Cash (Principal & Interest). The contractor enters the amount of CNC debt that is re-established as active debt because cash/checks have been collected on CNC debts during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval on Form CMS-C751A/B or Form CMS-MC751A/B, as appropriate,) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Simultaneously, the collection should be recorded on Line 4a, Cash/Check Collections on Form CMS-H751A/B. The effect of this transaction will reclassify the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. Additionally, if the outstanding balance of the CNC debt was greater than the amount collected, the remaining balance of the debt is now considered an active account receivable that will be reported on the Status of Accounts Receivable report (Form CMS-751A/B & Form CMS-M751A/B as appropriate). Any new interest assessed on the remaining balance after it becomes active again will be reported on Line 3, Interest Earned on Form CMS-H751A/B.

For non-MSP only, if after 12 months there is no collection activity on this debt, the contractor shall consider reclassifying it as CNC.

Any remaining MSP balance after reactivation is automatically eligible for reclassification to CNC and must again be submitted to the RO to request reclassification to NC.

b. Re-established as Active A/R Due to Collection by Offset (Principal and Interest.) The contractor enters the amount of CNC debt that is re-established as active debt because offsets have been made on CNC debt during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval of Form CMS-C751A/B or Form CMS-MC751A/B,as appropriate,) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. Simultaneously, the collection should be recorded on Line 4b, Offset Collections on Form CMS-H751A/B. The effect of this transaction will reclassify the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. Additionally, if the outstanding balance of the CNC debt was greater than the amount collected, the remaining balance of the debt is now considered an active account receivable that will be reported on Form CMS-H751A/B. Any new interest assessed on the remaining balance after it becomes active again will be reported on Line 3, Interest Earned on Form CMS-H751A/B.

For non-MSP only, if after 12 months there is no collection activity on this debt, the contractor shall consider reclassifying it as CNC.

Any remaining MSP balance after reactivation is automatically eligible for reclassification to CNC and must again be submitted to the RO to request reclassification to NC.

c. Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse, Litigation, or Appeal (Principal & Interest). The contractor enters the amount of the CNC debt that has been re-established to be active debt because the CNC debt is now determined to be in bankruptcy, fraud & abuse, litigation, or appeal during the FY. In addition, an upward adjustment for the full amount of the outstanding balance (principal and all interest associated with the debt included in Line 1, Beginning FY Balance; Line 2, New CNC Debt; and Line 3, Interest Earned Since CNC Approval of the Form CMS-C751A/B) for the CNC debt on which a collection should be applied, will be recorded on Line 6b, Transfers In from CNC on Form CMS-H751A/B. The effect of this transaction will reclassify CNC the debt from an inactive memorandum entry to an active receivable that will be reported for financial statement purposes. No new interest should be accrued on debts re-established as active due to bankruptcy, fraud and abuse, litigation or appeal.

   This item is not applicable for MSP. MSP receivables on which the status changes to bankrupt, fraud and abuse, litigation or appeal will not be re-established as active accounts receivable.

d. Written-off Closed (Principal & Interest). The contractor enters the number and amount of CNC debt that has been approved for written-off closed during the FY. The receivables will be "closed" in its internal systems. No further action will be taken on these debts. CNC debts that are written-off as closed will not be reported on the financial statements, and all collection activity (i.e., future offsets or interest accruals) and servicing of the debt will be terminated. The debts will be closed within the contractor's records, reports, and accounts receivable systems. These debts will be written-off and closed through Form CMS-C751A/B, or Form CMS-MC751A/B as applicable, on this line. These debts **should not be reactivated** on Form CMS-H751A/B or Form CMS-M751A/B.

   NOTE: Medicare contractors cannot write-off debt until formal approval has been received from the appropriate authorized official in accordance with the existing CMS delegations of authority

e. Other (Principal & Interest). The contractor uses this line only to make corrections to Form CMS-C751A/B or Form CMS-MC751A/B beginning principal and interest FY balance. Medicare contractors must retain all documentation justifying any adjustments made to the beginning balance

310.5 - Lines 5(a) through (f), Amounts Transferred (Principal & Interest - (Rev. 5, 08-30-02)

A1-1933.5, A1-1953.5, B1-4933.5, B1-4953.5

The contractor enters the amount of CNC debts that have been transferred in from or out to Medicare contractors or CMS RO or CO during the FY. It shall not enter an amount on these lines until it has received confirmation that the Medicare contractor, CMS RO or CO, has accepted the debt. (See Exhibit 17, Transfer of Debt Between Reporting Entities).

5. The contractor shall report in lines:

a. Transfers In from other Medicare Contractors (Principal & Interest). The amount of CNC debt transferred in from other Medicare contractors during the fiscal period.

b. Transfers Out to other Medicare Contractors (Principal & Interest). The amount of CNC debt transferred out to other Medicare contractors during the fiscal period.

c. Transfers In from CMS RO (Principal & Interest). The amount of CNC debt transferred in from RO during the fiscal period.

d. Transfers Out to CMS RO (Principal & Interest). The amount of CNC debt transferred out to RO during the fiscal period.

e. Transfers In from CMS CO (Principal & Interest). The amount of CNC transferred in from CO during the fiscal period.

Transfers Out to CMS CO (Principal & Interest). The amount of CNC transferred out to CO during the fiscal period.

Collection efforts do not cease when debt is reclassified to CNC. Medicare contractors must recognize that all debts including CNC debt will continue to be referred (if eligible) to the Program Support Center (PSC), Department of Health and Human Services (DHHS) or the Treasury Offset Program (TOP).

Medicare contractors are expected to follow existing procedures for the routine referral of delinquent debt to the Debt Collection Center (DCC) in accordance with the Debt Collection Improvement Act (DCIA) of 1996.

Amounts transferred in from or out to other CMS locations or Medicare contractors for the reporting period must be reconciled to the other entity's records for the same reporting period **prior** to submission of the quarterly Forms CMS-750/751A/B. Medicare contractors and other CMS locations must reconcile the transfers out lines to ensure that only **approved** transfers are being reported. Documentation of the reconciliation must be maintained and must indicate that a supervisory review of the reconciliation was performed. See Exhibit 17 for instructions for the transfer of debt between other reporting entities.

310.6 - Line 6, Ending Balance (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1933.6, A1-1953.6, B1-4933.6, B1-4953.6

The ending balance is a computed field, reporting the number (manual entry) and amount of CNC debt outstanding as of the end of the reporting period. It equals:

	Principal		Interest
+	Beginning FY balance (Line 1)	+	Beginning FY balance (Line 1)

	Principal		Interest
+	New CNC Debt (Line 2)	+	New CNC Debt (Line 2)
		+	Interest Earned (Line 3)
-	Re-established as Active A/R Due to Collection of Cash (Line 4a)	-	Re-established as Active A/R Due to Collection of Cash (Line 4a)
-	Re-established as Active A/R Due to Collection by Offset (Line 4b)	-	Re-established as Active A/R Due to Collection by Offset (Line 4b)
-	Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse Litigation or Appeal (Line 4c)	-	Re-established as Active A/R Due to Bankruptcy, Fraud & Abuse Litigation or Appeal (Line 4c)
-	Written-off Closed (Line 4d)	-	Written-off Closed (Line 4d)
+/-	Other (Line 4e)	+/-	Other (Line 4e)
+	Transfers In From Medicare Contractors/ RO/CO (Lines 5a, 5c, 5e)	+	Transfers In From Medicare Contractors/ RO/CO (Lines 5a, 5c, 5e)
-	Transfers Out to Medicare Contractors/ RO/CO (Lines 5b, 5d, 5f)	-	Transfers Out to Medicare Contractors/ RO/CO (Lines 5b, 5d, 5f)
=	Ending Balance (Line 6)	=	Ending Balance (Line 6)

NOTE: Although Line 6 is a calculated amount, the contractor must be able to provide a detailed listing of all Non-MSP (or MSP, as applicable) CNC receivable balances that support this line at any given period of time.

Section B - Aging of MSP or Non-MSP CNC Debt

310.7 - Line 1, Total Aged CNC Debt (Principal & Interest) –

(Rev. 5, 08-30-02)

A1-1933.7, A1-1953.7, B1-4933.7, B1-4953.7

The contractor enters the number and amount of MSP or Non-MSP CNC debt, as applicable. The total dollar amount equals the sum of lines (a) through (e), and should also equal Line 6, Ending Balance on Form CMS-C751A/B or Form CMS-MC751AB, as applicable.

The contractor reports on lines (a) through (e) the dollar amounts of receivables aged from the date of determination of the debt for the respective time periods listed. For Non-MSP, it provides an explanation in the remarks section regarding why debts in category (d) and (e) were not recommended for written-off closed.

Section C - Collection Information

310.8 - Collections on CNC Debt (Principal & Interest) - (Rev. 5, 08-30-02)

A1-1933.8, A1-1953.8, B1-4933.8, B1-4953.8

The contractor enters the number and amounts of cash/checks/offsets actually collected on Non-MSP or MSP CNC debt, as applicable, that is reported on Line 4a, Re-established as Active A/R Due to Collection of Cash, and Line 4b, Re-established as Active A/R Due to Collection by Offset.

Section D - Status CNC Debt over 181 Days

310.9 - Status of CNC Debt over 181 Days (Principal & Interest) - (Rev. 17, 05-02-03)

The contractor enters the total number and amount of delinquent receivables 181 days delinquent and greater, which are in *one of the following categories:*

(a) Referred to the Department of the Treasury for Cross Servicing. For MSP, this means debts entered into the DCS. For Non-MSP, this means debts that have been transmitted to DCC by CMS Central Office and the Medicare contractor has

acknowledged and verified the validity and accuracy of the debts transmitted.

(b) Not Eligible for Referral, the number and dollar amount is equal to the sum of lines (1) through (11) of this section.

1) Bankruptcy;

2) Appeal;

3) Department of Justice/Litigation;

4) Fraud and Abuse Investigation, if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel, etc.) not to attempt collection;

5) Deceased Debtor, debts where the debtor is deceased and the estate is closed.

6) Debts less than $25;

7) Federal Entity Debts, MSP only, where the only entity which received the last demand letter is the employer and the employer is a Federal agency;

8) Beneficiary Debts, Non-MSP only;

9) Pending Request for Waiver or Compromise;

10) CMS Identified Exclusions, MSP only, debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral.

11) Other Exclusions, must footnote.

(c) Eligible for Referral, debts that are eligible for referral to the Department of the Treasury for cross servicing but not yet referred.

400 - Exhibits - (Rev. 5, 08-30-02)

A1-1960, B1-4960

Exhibit 1

CMS-750A Contractor Financial Reports, Hospital Insurance (HI) Statement of Financial Position/Statement of Operations

Exhibit 2

CMS-750B Contractor Financial Reports, Supplementary Medical Insurance (SMI) Statement of Financial Position/Statement of Operations

Exhibit 3

CMS-751A Status of Accounts Receivable, Hospital Insurance (HI)

Exhibit 4

CMS-751B Status of Accounts Receivable, Supplementary Medical Insurance (SMI)

Exhibit 5

Form CMS-C751A Status of Non-MSP Currently Not Collectible (CNC) Accounts Receivable, Hospital Insurance (HI)

Exhibit 6

Form CMS-C751B Status of Non-MSP Currently Not Collectible (CNC) Accounts Receivable, Supplementary Medical Insurance (SMI)

Exhibit 7

Form CMS-M751A Status of Medicare Secondary Payer (MSP) Accounts Receivable, Hospital Insurance (HI)

Exhibit 8

Form CMS-M751B Status of Medicare Secondary Payer (MSP) Accounts Receivable, Supplementary Medical Insurance (SMI)

Exhibit 9

Form CMS-MC751A Status of MSP Currently Not Collectible (CNC) Accounts Receivable, Hospital Insurance (HI)

Exhibit 10

Form CMS-MC751B Status of MSP Currently Not Collectible (CNC) Accounts Receivable, Supplementary Medical Insurance (SMI)

Exhibit 11

Medicare Contractor Account Definitions, Data Element Definitions

Exhibit 12

Accounts Payable, Protocol for Estimating Claims

Exhibit 13

Periodic Interim (PIP) Payments Protocol for Estimating Payables/Receivables on the CMS-750A/B, Statement of Financial Position

Exhibit 14

Protocol for Estimating Allowance for Uncollectible Accounts

Exhibit 15

Protocol for Prorating Intermediary Time Account Balances Between the CMS 750A (HI) and the CMS 750B (SMI)

Exhibit 16

Electronic Certification

Exhibit 17

Transfer of Debt Between Reporting Entities

Exhibit 18

Collection Reconciliation/Acknowledgement Form

Exhibit 19
Procedures for Non-MSP Reclassification as Currently Not Collectible (CNC)

Exhibit 20
Procedures for MSP Reclassification as Currently Not Collectible (CNC)

Exhibit 21
CMS Policy for Recognizing Accounts Receivable

400.1 - Exhibit 1 - Statement of Financial Position and Statement of Operations - HI/SMI - (Rev. 5, 08-30-02)

A1-1960 Exhibit 1, B1-4960.1

The FI submits the HI report (Form CMS-H750A). Both FI and carrier submit the SMI report (Form CMS-H750B).

- The HI report, in applicable line item descriptions, refers to "provider" and the SMI report refers to "physicians, provider or supplier".

- For the SMI report (Form CMS-H750B), the FI completes the items dealing with cost reports, PIP, and credit balances; but the carrier omits them. Also, the intermediary inserts data relating to the Provider Overpayment Report (POR), while the carrier inserts data relating to the Physician Supplier Overpayment Report (PSOR).

View Exhibit of Statement of Financial Position and Statement of Operations.

400.2 - Exhibit 2 - Statement of Financial Position and Statement of Operations - SMI - (Rev. 5, 08-30-02)

This report is a duplicate of the above Exhibit 1, Statement of Financial Position and Statement of Operations - HI, except:

- The HI report, in the applicable line item descriptions, refers to "provider", and the SMI report refers to "provider, physician, and supplier".

- For the SMI report (CMS-750B), the FI completes the items dealing with cost reports, PIP, and credit balances; but the carrier omits them. Also, the intermediary inserts data relating to the Provider Overpayment Report (POR), while the carrier inserts data relating to the Physician Supplier Overpayment Report (PSOR).

400.3 - Exhibit 3 - Status of Accounts Receivable - HI - (Rev. 17, 05-02-03)

This exhibit is the same as Exhibit 4, Status of Accounts Receivable - SMI, with the following exceptions:

Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for the HI report and refer to the POR/PSOR for the SMI report. Only intermediaries enter POR data on both the HI report and the SMI report. Only carriers enter the PSOR data on the SMI report.

CMS-751A is the CMS Form Number for the HI (Part A) report.

CMS-751B is the CMS Form Number for the SMI (Part B) report.

View Exhibit of Administrative Budget and Cost Report, Activity Form.

400.4 - Exhibit 4 - Status of Accounts Receivable - SMI - (Rev. 5, 08-30-02)

This exhibit is the same as Exhibit 3, Status of Accounts Receivable - HI, with the following exceptions:

- Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for the HI report and refer to the POR/PSOR for the SMI report.

- Only intermediaries enter POR data on both the HI report and the SMI report.

- Only carriers enter the PSOR data on the SMI report.

- Form CMS-H751A is the CMS Form Number for the HI (Part A) report.

- Form CMS-H751B is the CMS Form Number for the SMI (Part B) report.

400.5 - Exhibit 5 - Status of Non-MSP Debt - CNC - HI - (Rev. 17, 05-02-03)

The screen formats in exhibits 5 and 6 are identical except 5 is for HI non-MSP and 6 is for SMI non-MSP.

MSP debt is reported in exhibits 9 and 10.

View exhibit of debt form.

400.6 - Exhibit 6 - Status of Non-MSP Debt - CNC - SMI - (Rev. 5, 08-30-02)

See §400.5, Exhibit 5 - Status of Non-MSP Debt - CNC - HI.
The formats in exhibits 5 and 6 are identical except 5 is for HI non-MSP and 6 is for SMI. non-MSP.

MSP debt is reported in exhibits 9 and 10.

400.7 - Exhibit 7 - Status of MSP Accounts Receivable - HI –

(Rev. 5, 08-30-02)

This is an exact duplicate of Exhibit 3 - Status of Accounts Receivable - HI, except that the data is limited to data involving Medicare as secondary payer.

This exhibit, and Exhibit 8, Status of MSP Accounts Receivable - SMI, are identical with the following exceptions:

- Section B, items 5d through 5g and Section D, items 5d and 5e refer to the POR for HI reports and refer to the POR/PSOR for the SMI report.

- Only carriers enter the PSOR data on the SMI report.

- The CMS Form Number for this report (HI) is CMS-M751A.

- The CMS Form Number for the SMI report is CMS-M751B.

400.8 - Exhibit 8 - Status of MSP Accounts Receivable - SMI – (Rev. 5, 08-30-02)

See Exhibit 3 - Status of MSP Accounts Receivable - HI above.

400.9 - Exhibit 9 - Status of MSP Debt - CNC - HI - (Rev. 5, 08-30-02)

See Exhibit 5 - Status of Non-MSP Debt - CNC - HI

400.10 - Exhibit 10 - Status of MSP Debt - CNC - SMI - (Rev. 5, 08-30-02)

See Exhibit 5 - Status of Non-MSP Debt - CNC - SMI.

400.11 - Exhibit 11 - Medicare Contractor Account Definitions - Data Element Definitions - (Rev. 5, 08-30-02)

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
1000	Assets
1100	Cash
1100.01	Part A and Part B
1100.01.01	Benefit Account
1100.01.02	Time Account
1110	Undeposited Collections
1110.01	Part A and Part B

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
1110.01.01	Undeposited Collections
1310	Accounts Receivable
1310.01	Part A and Part B
1310.01.01	Non-MSP Overpayments
1310.01.01.01	Provider
1310.01.01.01.01	Cost Report Settlements (FI)
1310.01.01.01.02	Claims Accounts Receivable (FI)
1310.01.01.01.03	PIP Accrual (FI)
1310.01.01.01.04	Credit Balance (FI)
1310.01.01.01.05	Other (FI)
1310.01.01.02	Beneficiaries
1310.01.01.03	Physicians/Suppliers
1310.01.04	Medicare Secondary Payer (MSP)
1310.01.04.01	Group Health Plan
1310.01.04.01.01	Data Match
1310.01.04.01.02	Non-Data Match
1310.01.04.02	Liability MSP
1310.01.04.02.01	MSP Beneficiary
1310.01.04.02.02	MSP Provider/Physician Supplier
1310.01.04.03	Other MSP
1310.01.99	Other

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
1311	Advances to Others
1311.01	Part A and Part B
1311.01.01	Advance Payments
1311.01.02	Accelerated Payments
1330	Interest Receivable
1330.01	Part A and Part B
1990	Other Assets
1990.01	Part A and Part B
2000	Liabilities
2110	Accounts Payable
2110.01	Part A and Part B
2110.01.01	Unprocessed Claims
2110.01.02	Benefits Payable
2110.01.02.01	Provider
2110.01.02.01.01	-PIP Provider Cost Report Settlements
2110.01.02.01.02	-PIP Provider Estimated Payable Accrual
2110.01.02.01.03	-Non-PIP Provider Underpayments Interim Rate
2110.01.02.01.04	-Non-PIP Provider Underpayments (Cost Report Settlement)
2110.01.02.01.05	Claims Withheld for Non-receipt of Cost Reports
2110.01.02.02	Beneficiaries

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
2110.01.02.03	Physicians/Suppliers
2110.01.02.04	Claims on the Payment Floor
2110.01.03	Suspended Payments
2110.01.03.01	Claims
2110.01.03.02	Common Working File (CWF)
2110.01.03.03	MR/UR Prepayment Review
2110.01.03.0	Medicare Secondary Payer (MSP)
2140	Accrued Interest Payable
2140.01	Part A and Part B
2990	Other Liabilities
2990.01	Part A and Part B
2990.01.01	Unapplied Receipts
2990.01.02	Excess Recoupments
2990.01.03	Due Medicaid
2990.01.04	Other
3010	Fund Account Balance
3310	Cumulative Results of Operations
3310.01	Part A and Part B
5000	Revenue

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
5303	Interest Revenue
5303.01	Part A and Part B
5303.01.01	Adjustments/Waivers (Contra Account)
5303.01.02	Write-off Closed/Transfers
5303.01.02.01	Bad Debt (Contra Account)
5303.01.02.02	Transfers Out to Other CMS Locations (Contra Account)
5303.01.02.02.01	Transfers In from Other CMS Locations
5303.01.02.03	Transfers Out to CNC (Contra Account)
5303.01.02.03.01	Transfers In from CNC
5303.01.02.04	Transfers Out to Other Medicare Contractors (Contra Account)
5303.01.02.04.01	Transfers In from Other Medicare Contractors
5700	Appropriated Capital Used
5700.01	Part A and Part B, Draws on Letter of Credit
5900	Other Revenue
5900.01	Part A and Part B
5900.01.01	Other
6000	Expense
6100	Operating/Program Expense

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
6100.01	Part A and Part B
6101	Waivers
6101.01	Part A and Part B
6101.01.02	Transfers Out to Other CMS Locations (Contra Account)
6101.01.02.01	Transfers In from Other CMS Locations
6101.01.03	Transfers Out to CNC (Contra Account)
6101.01.03.01	Transfers In from CNC
6101.01.04	Transfers Out to Other Medicare Contractors (Contra Account)
6101.01.04.01	Transfers In from Other Medicare Contractors
6106	Write Offs/Transfers
6106.01	Part A and Part B
6106.01.01	Bad Debts
6330	Interest Expense
6330.01	Part A and Part B
6330.01.01	CPT Interest
6330.01.02	Other Interest
6909	Other Expense
6909.01	Part A and Part B
7400	Prior Period Adjustments

Medicare Contractor Account Definitions
Data Element Definitions

Account Number	Title
7400.01	Part A and Part B

Medicare Contractor Account Definitions
Data Element Definitions

The account numbers used in this chart are for reference purposes only. They are not mandated for use by Medicare contractors.

Account Number	Title
1000	Assets The contractor reports amounts of physical items or rights to ownership
1100	Cash The contractor reports monetary resources on hand or on deposit with banks or other financial institutions. Balances are the end of quarter amounts per the contractor's books.
1100.01	Part A and Part B The contractor reports cash allocable for Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) activities. HI data must reconcile to Column E, Line 1, on Form CMS-1522, Monthly Contractor Financial Report. SMI data must reconcile to Column E, Line 2. Prorate the Time Account by the number of checks and electronic funds transfers (EFTs) issued for HI or SMI services. (See Exhibit 15 Protocol for Prorating Intermediary Time Account Balances between HI and SMI.)
1100.01.01	Benefits Account The contractor reports the Federal Health Insurance Benefits Account by

Account Number	Title
	HI and SMI
1100.01.02	Time Account The contractor reports the balance as of the end of the quarter in the Federal Health Insurance Time Account by HI and SMI.
1110	Undeposited Collections
1110.01	Part A and Part B The contractor reports undeposited collections for HI and SMI activities
1110.01.03	Undeposited Collections The contractor reports collections on hand not deposited within the accounting period. Undeposited collections include those items received by the last day of the quarter that will be deposited during the subsequent quarter. The contractor prorates undeposited collections on the basis of Column D, Funds Expended, on Form CMS-1522, Monthly Contractor Financial Report for Part A (HI) and Part B (SMI). Report deposits in transit as part of the book balance for either 1100.01.01, Benefits Account, or 1100.01.02, Time Account. It reports amounts due from others. A receivable is the identification of an overpayment for services rendered. CMS will only recognize receivables related to Fraud and Abuse once they are litigated by the Department of Justice (DOJ)
1310.01.01	Overpayments The contractor accounts receivable for overpayments. It includes amounts that exceed adjudicated claims processed, cost reports settled, or other authorized payments. This includes, but is not limited to, overpayments resulting from adjustment bills. It reclassifies any overpayment when Medicare is deemed as secondary payer to

Account Number	Title
	1310.01.04, MSP
1310.01.01.01	Provider The intermediary reports overpayments for institutional providers. This includes, but is not limited to, those items listed on the Provider Overpayment Report (POR) and the Credit Balance Summary Report. Include periodic interim payments (PIP) in excess of PIP bills. Include overpayments resulting from the receipt of cost reports, tentative settlements or cost settlements when the Notices of Provider Reimbursement (NPR) are prepared. It includes overpayments from PRRB settlements when the Notices of Correction (NOC) are prepared. This is not a carrier function.
1310.01.01.01.01	Cost Report Settlements The intermediary reports the accounts receivable as a result of cost report settlements, interim rate reviews and overpayments as a result of accelerated payments
1310.01.01.01.02	Claims Accounts Receivable The intermediary reports the accounts receivable as a result of claims accounts receivable. This is not a carrier function.
1310.01.01.01.03	PIP Accrual The intermediary reports the amount accrued for the (estimated) accounts receivable PIP. (See Exhibit 13 Protocol for Estimating Payables and Receivables for PIP). This is not a carrier function.
1310.01.01.01.04	Credit Balances The intermediary reports the accounts receivable as a result of credit

Account Number	Title
	balance reports This is not a carrier function.
1310.01.01.02	Beneficiaries The contractor reports overpayments for beneficiaries. This includes, but is not limited to, those items listed on the CMS-2174, Carrier Beneficiary Overpayment Activity Report.
1310.01.01.03	Physicians/Suppliers The carrier reports overpayments for physicians and suppliers. This includes, but is not limited to, those items listed on the Physician/Supplier Overpayment Report (PSOR) This is not an intermediary function.
1310.01.04	Medicare Secondary Payer The contractor reports accounts receivable for amounts due as a result of MSP activity, and based on documented debts due Medicare for all debtors. Debtors are employers, insurers, providers, beneficiaries or other persons to whom a demand letter has been issued
1310.01.04.01	Group Health Plan (GHP)
1310.01.04.01.01	Data Match (FI) The contractor includes the amounts identified (CMS supplied receivables via tapes with an identified report ID on MPaRTS) as a result of MSP activity for which a demand letter has been issued for IRS/SSA Data Match cases. Outstanding receivables are the amount of debt that has been demanded and payment has not yet been received
1310.01.04.01.02	Non-Data Match (FI)

Account Number	Title
	The contractor includes the amounts identified (debt specific to GHP debt, working aged, disability, End-Stage Renal Disease (ESRD) as a result of MSP activity for which a demand letter has been issued. Outstanding receivables are the amount of debt that has been demanded and payment has not yet been received
1310.01.04.02	Liability MSP The contractor includes the amounts (inclusive of all workman's compensation, automobile/no fault and liability debt, this includes CMS identified cases) due to MSP activity for which a settlement has been reached related to liability cases. Outstanding receivables are the amount of debts that have been demanded, subsequent to settlement and/or other action, and payment has not yet been received.
1310.01.04.02.01	MSP Beneficiaries
1310.01.04.02.02	MSP Providers/Physicians/Suppliers Outstanding receivables are the amount of MSP initiated debts that have been demanded and payment has not yet been received.
1310.01.04.03	Other MSP The contractor includes the amounts due as a result of other MSP activity for which a valid MSP debt has been recognized.
1310.01.99	Other The contractor reports actual or estimated other accounts receivable. It includes those receivables not otherwise classified in the categories presented above. It provides an identifying footnote on CAFM of the nature of this receivable

Account Number	Title
1311	Advances to Others The contractor reports payments made to providers, physicians, or suppliers in anticipation of claims being processed. Advances are not to be considered as accounts receivable. It does not include them on Form CMS-751A/B, Status of Account Receivable report
1311.01	Part A and Part B The contractor reports advance payments and accelerated payments attributable to HI and SMI activities
1311.01.01	Advance Payments The contractor the outstanding balance for payments authorized by CMS instructions for advanced payments based on actual provider claims data. If not recovered according to CMS instructions, it reclassifies and reports as overpayments
1311.01.02	Accelerated Payments (FI) The intermediary reports the outstanding balance for payments authorized by CMS instructions for accelerated payments based on actual provider claims data. If not recovered according to CMS instructions, it reclassifies and reports as overpayments This is not a carrier function.
1330	Interest Receivable The contractor reports interest receivable on accounts receivable. It accrues interest through the last day of the reporting period.
1330.01	Part A and Part B The contractor reports HI and SMI interest receivable on accounts receivable, including extended repayment plans

Account Number	Title
1990	Other Assets The contractor reports assets that are not otherwise classified. It provides an identifying footnote in the remarks section of Form CMS-750A/B report.
1990.01	Part A and Part B The contractor reports HI and SMI unclassified assets.
2000	Liabilities The contractor reports amounts owed after processing Medicare claims and related activities
2110	Accounts Payable Report amounts owed after processing Medicare claims or other authorized expenditures. This includes, but is not limited to, underpayments resulting from adjustment bills
2110.01	Part A and Part B The contractor reports accounts payable attributable to HI and SMI activities
2110.01.01	Unprocessed Claims The contractor reports the value of the accounts payable for unprocessed claims received in-house that have not yet started processing. The actual value may be developed after the reporting period but before the required date for reporting. It uses the 30 day rolling average for the number of claims received and not processed to determine the number of average unprocessed claims.

Account Number	Title
2110.01.02	Benefits Payable The contractor reports accounts payable for those claims that have completed processing checks, but have not yet been issued nor offsets applied. This includes, but is not limited to, underpayments resulting from adjustment bills. It includes claims approved by the Common Working File (CWF) and claims not approved by the CWF, but approved by the RO for payment outside the CWF.
2110.01.02.01	Provider The intermediary reports benefits payable to institutional providers of Medicare services. This includes, but is not limited to the following: accounts receivable accrual where the periodic interim payment (PIP) bills is in excess of periodic interim payments (PIP); underpayments from receipt of accepted cost reports, tentative settlements and final cost settlements, when Notices of Provider Reimbursement (NPR) are prepared; and underpayments for PRRB settlements, when Notices of Correction (NOC) are prepared, etc This is not a carrier function.
2110.01.02.01.01	PIP Providers - Cost Report Settlements The intermediary reports benefits payable to PIP providers as a result of Cost Report Settlements This is not a carrier function.
2110.01.02.01.02	PIP Providers - Estimated Payable Accrued The intermediary reports the amount accrued for the (estimated) accounts payable PIP. (See Exhibit 13 Protocol for Estimating Payables and Receivables for PIP). This is not a carrier function.
2110.01.02.01.03	Non-PIP Providers - Underpayments (Interim Rate) The intermediary reports benefits payable to Non-PIP providers as a result of Interim Rate Reviews This is not a carrier function

Account Number	Title
2110.01.02.01.04	Non-PIP Providers - Underpayments (Cost Report Settlement) The intermediary reports benefits payable to Non-PIP providers as a result of Cost Report Settlements This is not a carrier function.
2110.01.02.01.05	Claims Payments Withheld for Non-receipt of Cost Reports The intermediary reports benefits payable for claims withheld for payment for non-receipt of provider cost reports This is not a carrier function.
2110.01.02.02	Beneficiaries The contractor reports benefits payable to beneficiaries for reimbursement for Medicare services.
2110.01.02.03	Physicians/Suppliers The carrier reports benefits payable to physicians or suppliers of Medicare services. This includes, but is not limited to, underpayments of quarterly Health Professional Shortage Area (HPSA) bonus amounts for which a check has not been issued. Not an intermediary function.
2110.01.02.04	Claims on the Payment Floor Adjudicated claims not yet paid
2110.01.03	Suspended Payments The contractor reports actual or estimated benefits payable for claims that were suspended from payment to allow for additional processing.
2110.01.03.01	Claims The contractor reports estimated benefits payable for claims needing

Account Number	Title
	additional information or further development, including CWF rejects and adjustments
210.01.03.02	Common Working File (CWF) The contractor reports benefits payable for claims that are pending submission or were submitted to the CWF for approval.
2110.01.03.03	MR/UR Prepayment Review The contractor reports estimated benefits payable, based on a developed rate, suspended for MR/UR before payment. The payables after MR/UR are in 2110.01.02, Benefits Payable
2110.01.03.04	Medicare as Secondary Payer (MSP) The contractor reports benefits payable that are suspended for investigation of third party liability for MSP prior to payment
2140	Accrued Interest Payable The contractor reports actual or estimated interest payable on Medicare liabilities through the end of the reporting period including, but not limited to, pending claims, court settlements, claims payment timeliness (CPT), etc.
2140.01	Part A and Part B The contractor reports HI and SMI interest payable on Medicare liabilities
2990	Other Liabilities The contractor reports liabilities not otherwise classified. It provides an

Account Number	Title
	identifying footnote in the remarks section of Form CMS-750A/B report.
2990.01	Part A and Part B The contractor reports other liabilities attributable to HI and SMI activities.
2990.01.01	Unapplied Receipts The contractor reports amounts deposited and not yet applied to an accounts receivable.
2990.01.02	Excess Recoupments The contractor reports amounts recovered from overpayments or from other sources in excess of receivables established and which are eligible for refund. It includes those payables identified as due to third party liability payers, e.g., excess recoupment of MSP recoveries being returned to the third party.
2990.01.03	Due Medicaid The contractor reports Medicare claims reimbursements withheld based on RO instructions for payment to Medicaid.
2990.01.99	Other The contractor reports actual or estimated amounts payable not otherwise classified. These include, but are not limited to, claims payments withheld to satisfy Internal Revenue Service liens, court liens, unidentified receipts that have not been applied to an account receivable. It provides an identifying footnote in CAFM.
3010	Fund Balance Fund balance reflects the cumulative results of program

Account Number	Title
	operations and extraordinary items. It equals the difference between assets and liabilities.
3310	Cumulative Results of Operations These accounts track the net difference between income and expense activity as reported on the Statement of Operations. This account is updated with the current year-to-date net results of operations
3310.01	Part A and Part B The contractor reports HI and SMI interest revenue from accounts receivable. It includes current fiscal period earned interest, and any adjustments. It also includes accrued interest in account 1330, Interest Receivable
5000	Revenue and Other Financing Sources The contractor reports the amount of income from Medicare activities. Typical sources are draws on letter of credit, interest and recoveries of amounts expended in prior periods.
5303	Interest Revenue The contractor reports interest earned from accounts receivable.
5303.01	Part A and Part B The contractor reports HI and SMI interest revenue from accounts receivable. Include current fiscal period earned interest, and any adjustments. This will also include accrued interest in account 1330, Interest Receivable.
5303.01.01	Adjustments/Waivers (Interest)

Account Number	Title
	The contractor reports the reduction of the amounts of interest receivable based on Collections on Delinquent Debt in accordance with §§1862(b) and 1870(c) of the Social Security Act. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5h, Waivers (Interest).
5303.01.02	Write-offs Closed/Transfers (Interest) The contractor reports interest receivable for which collection efforts have been abandoned or that have been transferred to another Medicare contractor or other CMS location. These accounts must be reconciled with the receiving Medicare contractor or other CMS location.
5303.01.02.01	Amounts Written-Off Closed (Bad Debts) (Interest) The contractor reports interest receivables for which collection is no longer being pursued according to CMS regulations. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6a, Amounts Written-off Closed (Bad Debts).
5303.01.02.02	Transfers Out to other CMS Locations (POR/PSOR & Not POR/PSOR) (Interest). POR not applicable to carriers. The contractor reports interest receivable transferred to other CMS locations. Reconcile with Form CMS-751A/B, Status of Accounts Receivable, Line 5e, Transfers Out to Other CMS Locations, POR/PSOR, (interest) and Line 5g, Transfers Out to Other CMS Locations, Not POR/PSOR, (interest). POR not applicable to carriers.
5303.01.02.02.01	Transfers In from other CMS Locations (POR/PSOR & Not POR/PSOR) (Interest). POR not applicable to carriers. The contractor reports interest receivable that has been transferred to your location from other CMS locations in the current period. It

Account Number	Title
	reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5d, Transfers In from Other CMS Locations, POR, (interest), and Line 5f, Transfers In from Other CMS Locations, Not POR, (interest). POR not applicable to carriers.
5303.01.02.03	Transfers Out to CNC (Interest) The contractor reports interest receivable transferred to CNC in accordance with CMS regulations. It transfers the full amount of interest due on the debt. It reconciles this with Form CMS-C751, Status of Non-MSP Debt - CNC, Line 2, New CNC A/R (interest) and Line 6c, Transfers Out to CNC
5303.01.02.03.01	Transfers In from CNC (Interest) The contractor reports interest receivable that has been transferred in to its location from CNC.
5303.01.02.04	Transfers Out to other Medicare Contractors (Interest) The contractor reports interest receivable transferred to other Medicare contractors. Reconcile with Form CMS-751A/B, Status of Accounts Receivable, Line 5c, Transfers Out to Other Medicare Contractors.
5303.01.02.04.01	Transfers in from other Medicare Contractors (Interest) The contractor reports interest receivable transferred to your location from other Medicare contractors. It reconciles this with Form CMS-751A/B Status of Accounts Receivable, Line 5b, Transfers In from Other Medicare Contractors (Interest)
5700	Appropriated Capital Used The contractor reports the amount of Medicare funds drawn to be

Account Number	Title
	matched against current period expense. This amount must be consistent with amounts reported on Form CMS-1521, Contractor Draws on Letter of Credit, and on Form CMS-1522, Monthly Contractor Financial Report. The contractor does not include administrative draws through the Payment Management System (PMS), (Smartlink)
5700.01	Part A and Part B, Draws on Letter-of-Credit
5900	Other Revenue The contractor reports revenue not otherwise classified. It provides identifying footnote(s) in the remarks section of Form CMS-750 A/R report
5900.01	Part A and Part B The contractor reports HI and SMI other revenue
5900.01.01	Other The contractor reports revenue not otherwise classified
6000	Expense The contractor reports the outflow of assets or incurrence of liabilities during a period resulting from rendering Medicare services.
6100	Operating/Program Expense The contractor reports net benefits costs incurred throughout the FY. The expense is the adjusted benefits outlay in cash or its equivalent and accrued liabilities incurred in carrying out the Medicare program. This includes, but is not limited to, adjustments for MSP recoveries, reconsiderations, and pending litigation.

Account Number	Title
6100.01	Part A and Part B The contractor reports HI and SMI benefit program expense.
6101	Waivers (Principal) The contractor reports HI and SMI waiver expense.
6101.01	Part A and Part B The contractor reports the reduction of the amounts receivable based on application of §§1862(b) and 1870(c) of the Social Security Act. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5h, Waivers.
6101.01.02	Transfers Out to other CMS Locations (Principal) The contractor reports accounts receivable transferred to other CMS locations. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5e, Transfers Out to Other CMS Locations, POR/PSOR and Line 5g, Transfers to Other CMS Locations, Not POR/PSOR. POR not applicable to carriers.
6101.01.02.01	Transfers In from other CMS Locations (Principal) The contractor reports accounts receivable amounts that have been transferred to its location from other CMS locations in the current period. It reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5d, Transfers In from Other CMS Locations, POR/PSOR (principal), and Line 5f, Transfers In from Other CMS Locations, Not POR/PSOR (principal). POR not applicable to carriers.
6101.01.03	Transfers Out to CNC (Principal)

Account Number	Title
	The contractor reports accounts receivable amounts that have been transferred to CNC in accordance with CMS regulations. . It reconciles this with Form CMS-C751A/B, Status of Non- MSP Debt - CNC, Line 2, New CNC A/R, and Line 6c Transfers Out to CNC of Form CMS-751A/B, Status of Accounts Receivable report. It transfers the full amount of principal due.
6101.01.03.01	Transfers In from CNC (Principal) The contractor reports accounts receivable amounts that have been re-established as an active accounts receivable. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6b, Transfers In from CNC
6101.01.04	Transfers Out to other Medicare Contractors (Principal) The contractor reports HI and SMI accounts receivable transferred out to a Medicare contractor for collection. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 5c, Transfers to Other Medicare Contractors.
6101.01.04.01	Transfers In from other Medicare Contractors (Principal) The contractor reports HI and SMI accounts receivable transferred to your location from other Medicare contractors. It reconciles this with Form CMS-751 A/B, Status of Accounts Receivable, Line 5b, Transfers In from Other Medicare Contractors.
6106	Write-offs Closed/Transfers (Principal) The contractor reports accounts receivable for which collection efforts have been abandoned, or that have been transferred to another Medicare contractor or other CMS location. These accounts must be reconciled with the receiving Medicare contractor or other CMS location.

Account Number	Title
6106.01	Part A and Part B The contractor reports HI and SMI accounts receivable written off or transferred.
6106.01.01	Amounts Written-Off Closed (Bad Debts) (Principal) The contractor reports receivables for which collection is no longer being pursued according to CMS rules. It reconciles this with Form CMS-751A/B, Status of Accounts Receivable, Line 6a, Amounts Written-off Closed (Bad Debts).
6330	Interest Expense The contractor reports interest expense incurred for claims for Medicare benefits or accounts payable.
6330.01	Part A and Part B The contractor reports HI and SMI interest expense.
6330.01.01	Claims Payment Timeliness (CPT) Interest The contractor reports interest paid for claims that failed the claims payment timeliness (CPT) requirement. It reconciles this with Form CMS-1522, interest paid, claims timeliness.
6330.01.02	Other Interest The contractor reports interest for other late payments. It reconciles this with Form CMS-1522, interest paid, provider underpayments.
6909	Other Expense

Account Number	Title
	The contractor reports benefit expenses not reported in named categories or otherwise classified. It provides an identifying footnote in the remarks section of Form CMS-750A/B report.
6909.01	Part A and Part B The contractor reports HI and SMI unclassified benefit expenses.
7400	Prior Period Adjustments The contractor reports adjustments for prior period activity to restate assets, liabilities, etc. It provides an identifying footnote in the remarks section of Form CMS-750 report.
7400.01	Part A and Part B The contractor reports HI and SMI prior period adjustments.

400.12 - Exhibit 12 - Accounts Payable - Protocol for Estimating Claims - Form CMS-H750A/B, Statement of Financial Position - (Rev. 5, 08-30-02)

A1-1960.12, B1-4960.12

Accounts Payable Protocol for Estimating Claims
Form CMS-H750A/B, Statement of Financial Position

The amounts recorded in accounts payable (A/P) may be estimated based on actual volumes and historical rates; therefore, the FI or carrier calculates and accrues a new estimated liability each reporting period and reverses the accrual for the previous period in full. It charges the expense accounts, rather than the A/P, as actual payments are made.

INTERMEDIARY PROCEDURES

Methodology for Calculating Average Reimbursement Amount and Average Interest for Pricing Claim Liabilities

To assign an estimated value to claims for which the amount to be paid is unknown, the contractor counts claims and multiplies the total by the average reimbursement amount (net of interest) and an average interest amount (CPT), if applicable, determined as follows:

The intermediary calculates the average reimbursement amount by taking a representative sample of the most recent 12 months of paid claims history. It totals the reimbursement amount minus interest and divides by the total number of claims processed. It calculates the Claims Payment Timelines (CPT) by adding the interest from the same claims and divides by the total number of claims (not just those bearing interest).

The intermediary performs these calculations by bill types and will be segregated between Part A and Part B. (See Intermediary Manual, Part 3, §3894.3.)

GENERAL PROCEDURES

These methods may be used to assign an estimated value to claims in the following categories:

1. In-house, unprocessed claims; and

   MR/UR
   PRO

2. Claims suspended for prepayment review

   Claims
   MR/UR
   PRO

400.13 - Exhibit 13 - Periodic Interim Payments (PIP) Protocol for Estimating Payables/Receivables for the Forms CMS-H750/751A/B, Statement of Financial Position and Status of Accounts Receivable Report (Intermediaries Only) - (Rev. 5, 08-30-02)

A1-1960.13, B1-4960.13

Periodic Interim Payments (PIP)
Protocol for Estimating Payables/Receivables for the Form CMS-H750/H751A/B, Statement of Financial Position and Status of Accounts Receivable Reports

It is necessary to report on Form CMS-H750, a cumulative estimated accounts receivable or payable for all fiscal periods since the provider's last accepted cost report period. To estimate this amount, the intermediary performs the following steps:

1. It determines the total amount for PIP bills processed for the fiscal period less outlier amounts;

2. It compares the PIP bills amount to the actual PIP cash payment and lump sum payments (checks issued) made during the fiscal period. This does not include any outlier payments that may have been issued on the same check with the PIP;

3. It reports the amount that PIP bills exceed the PIP cash payment as an account payable; and

4. It reports the amount that PIP cash payment exceeds the PIP bills as an account receivable.

For example: If the provider's FY ends on December 31, then the cost report should be received and accepted before the June 30 reporting period. The following demonstrates how the PIP accumulations would be reported for this provider.

Period Ending	Reporting
December 31	Assuming all prior year cost reports have been accepted, the only entry on the books for this provider would be the estimated accounts receivable or accounts payable after comparing PIP payments to claims submitted since January 1st to current.
March 31	Given the same assumption regarding prior cost reports, the PIP estimate for this provider will include the entire prior FY for the provider (January 1 - December 31) unless the cost report has been filed and accepted, and the current FY for the provider (January 1- March 31).
June 30	Given the same assumption regarding prior cost reports, assuming the latest cost report has now been received and accepted and the appropriate accounts receivable or accounts payable are booked, the PIP estimated for this provider will now include only the current FY for the provider (January 1- June 30).
Sept 30	Given the same assumption regarding prior cost reports, assuming the latest cost report has now been received and accepted, the PIP estimate for this provider will now include only the current FY for the provider (January 1- September 30).

400.14 - Exhibit 14 - Protocol for Estimating Allowance for Uncollectible Accounts Forms CMS-*H/M*751A/B, Status of Accounts Receivable

(Rev. 28, 12-24-03)

A1-1960.14, B1-4960.8

The Federal Accounting Standards Advisory Board (FASAB) recommends through Statement of Federal Financial Accounting Standard Number 1 (Paragraphs 44&45) that losses on receivables should be recognized when it is more likely than not that the receivables will not be totally collected. The phrase "more likely than not" means more than a 50 percent chance of loss occurrence. An allowance for estimated uncollectible amounts should be recognized to reduce the gross amount of receivables to its net realizable value. The allowance for uncollectible amounts should be re-estimated on each annual financial reporting date (at a minimum) and when information indicates that the latest estimate is no longer correct. These losses should be measured through a systematic methodology. The systematic methodology should be based on analysis of both individual accounts and a group of accounts as a whole.

Accounts that represent significant amounts, i.e., greater that $1 million, should be individually analyzed to determine the loss allowance. Loss estimation for individual accounts should be based on (a) the debtor's ability to pay, (b) the debtor's payment record and willingness to pay, and (c) the probable recovery of amounts from secondary sources, including liens, garnishments, cross collections and other applicable collection tools.

The entire allowance for losses generally cannot be based solely on the results of individual account analysis. In many cases, information may not be available to make a reliable assessment of losses on an individual account basis or the nature of the receivables may not lend itself to individual account analysis. In these cases, potential losses should be assessed on a group basis.

CMS has implemented FASAB's recommendations and has developed this protocol for Medicare contractors to follow for estimating the allowance for uncollectible accounts. The following section outlines this methodology.

Protocol for Estimating Allowance for Uncollectible Accounts

Medicare contractors must recognize on Line 8, Allowance for Uncollectible Accounts, on Form*s* CMS-H/*M*751A/B, an estimated amount for uncollectible debt in order to reduce the gross amount of receivables to its net realizable value. Medicare contractors must re-estimate the allowance for uncollectible amounts on March 31 and September 30 of each FY and when information indicates that the latest estimate is no longer correct.

Medicare contractors must measure potential losses due to uncollectible amounts through a systematic method. This systematic method must be based on an analysis. *The analysis requires that r*eceivables be further stratified into sub-groups (i.e., Cost Report Settlement Activity, Claims Accounts Receivable, Credit Balances, Group Health Plan (GHP) MSP, Liability MSP and Other Accounts Receivables). The subgroups are somewhat different for Group 1 - *Fiscal* Intermediaries, as compared to Group 2 - Carriers.

Group 1 (Fiscal Intermediaries)

Sub-Group 1

1. Cost Report Settlements Activity (Non MSP)

2. Claim*s* Account*s* Receivable, Credit Balances & Other Accounts Receivables (Non-MSP)

Sub-Group 2

1. Group Health Plan (Data Match/Non Data Match) MSP

2. Liability MSP

For Group 1, Subgroup 1, *fiscal* intermediaries *must* perform *the following* steps to calculate and validate the allowance for uncollectible accounts.

1. *C*alculate the allowance based on the historical collection percentage (see detailed instructions below) for Non-MSP as a whole.

2. Individual Account Analyses: For cost report settlement activity only, fiscal intermediaries will identify and total those provider debts that meet certain risk characteristics (i.e., bankruptcy, terminations, poor collection history, no collection

activity for 6 months or more). These will be considered risk accounts, and the fiscal intermediary should total all risk accounts identified through this analysis.

3. *Compute* the total delinquencies exceeding 180 days (Section B of Form*s* CMS H/*M*751A/B "Delinquent Receivables").

4. *Compare the three estimated amounts calculated in Steps 1, 2 & 3 and identify the amount that ensures that the net receivable is reported at its realizable value.*

For Group 1, Subgroup 2, the *fiscal* intermediary *must* perform *the following* steps to calculate and validate the allowance for uncollectible accounts.

1. *C*alculate the allowance based on the historical collection percentage (see detailed instructions below) for MSP as a whole.

2. *Compute* the total delinquencies exceeding 180 days (Section B of Form*s* CMS-H/*M*751A/B "Delinquent Receivables").

3. *Compare the two estimated amounts calculated in Steps 1 & 2 and identify the amount that ensures that the net receivable is reported at its realizable value.*

Historical Collection Percentage Calculation

A - Determine Total Receivables Eligible for Collection. (Using Form*s* CMS *H/M*751A/B)

Required Formula:

Beginning Balance	(Line 1)
Plus: New *Receivables*	(Line 2a)

Plus/Less: Adjust*ed Amounts* (Line 5a)
(plus if positive number less if negative number)

Plus: Transfers In from other Medicare Contractors (Line 5b)

Plus: Transfers In from other CMS locations, POR & Not POR (Lines 5d & 5f)

Plus: Transfers In from CNC *(Lines 6b)*

Less: Transfers Out to other Medicare Contractors *(Line 5c)*

Less: Transfers Out to other CMS locations, POR & Not POR *(Lines 5e & 5g)*

Less: Waivers & Amounts Written Off (Bad Debts) *(Lines 5h & 6a)*

Less: Transfers Out to CNC *(Line 6c)*

Equals: Total Receivables Available to be Collected

B - Determine Rate of Collections

Line 4a, *Cash/Check* Collections plus Line 4b, Offsets *Collection plus Line 4c*, *Collections Deposited At Another Location* divided by *T*otal Receivables Available to be Collected (number calculated from Step *A*) multiplied times 100 determines the rate of collections percentage.

C - Determine the Allowance Rate

1.00 minus the percentage determined from Step B, equals the allowance rate

D - Average the Percentage Calculated in Step C with a 5-year Historical Allowance Rate (if available, if not available, maintain statistical data to develop historical rate, and proceed to *S*tep E).

E - Calculate the Allowance

Multiply the allowance rate from Step C or Step D *by the sum of Line 7, Ending Balance less Line 2b, Accrued Receivables.*

Group 2 (Carriers)

Sub-Group 1

1. Claim*s* Account*s* Receivable, Credit Balances & Other Accounts Receivables (Non-MSP)

Sub-Group 2

1. Group Health Plan (Data Match/Non Data Match) MSP

2. Liability MSP

For Group 2, Subgroup 1, the carrier *must* perform *the following* steps to calculate and validate the allowance for uncollectible accounts.

1. *C*alculate the allowance based on the historical collection percentage (see detailed instructions below) for Non-MSP as a whole.

2. *Compute* the total delinquencies exceeding 180 days (Section B of Form*s* CMS-H/*M*751B "Delinquent Receivables").

3. *Compare the two estimated amounts calculated in Steps 1 & 2 and identify the amount that ensures that the net receivable is reported at its realizable value.*

For Group 2, Subgroup 2, the carrier *must* perform *the following* steps to calculate and validate the allowance for uncollectible accounts.

1. *C*alculate the allowance based on the historical collection percentage (see detailed instructions below) for MSP as a whole.

2. *Compute* the total delinquencies exceeding 180 days (Section B of Form*s* CMS-H*/M*751B "Delinquent Receivables").

3. *Compare the two estimated amounts calculated in Steps 1 & 2 and identify the amount that ensures that the net receivable is reported at its realizable value.*

Historical Collection Percentage Calculation

A. Determine Total Receivables Eligible for Collection. (Using Form*s* CMS-*H/M*751B)

Required Formula:

Beginning Balance	(Line 1)
Plus: New *Receivables*	(Line 2a)
Plus/Less: Adjust*ed Amounts*	(Line 5a)
(plus if positive number less if negative number)	
Plus: Transfers In from other Medicare Contractors	(Line 5b)

Plus: Transfers In from other CMS locations, POR & Not POR	(Lines 5d & 5f)
Plus: Transfers In from CNC	(Line 6b)
Less: Transfers Out to other Medicare Contractors	*(Line 5c)*
Less: Transfers Out to other CMS locations, POR & Not POR	*(Line 5e & 5g)*
Less: Waivers *& Amounts Written Off (Bad Debts)*	(Line 5h *& 6a*)
Less: Transfers Out to CNC	(Line 6c)

Equals: Total Receivables Available to be Collected

B. Determine Rate of Collections

Line 4a, *Cash/Check* Collections plus Line 4b, Offsets *Collections plus Line 4c, Collections Deposited At Another Location* divided by Total Receivables Available to be Collected (number calculated from Step A) multiplied times 100 determines the rate of collections percentage.

C. Determine the Allowance Rate.

1.00 minus the percentage determined from Step B, equals the allowance rate

D. Average the percentage calculated in Step C with a 5-year historical allowance rate (if available, if not available, maintain statistical data to develop historical rate, and go proceed to *S*tep E).

E. Calculate the Allowance

Multiply the allowance rate from Step C or Step D *(Group 2, Carriers Section) by Line 7, Ending Balance.*

Medicare contractors are required to compare the results of the estimated allowance based on the protocol and report on Line 8, Allowance for Uncollectible Accounts, ***the amount that ensures that the net receivable is reported at its realizable value****. The Medicare contactors are required to maintain supporting documentation, that includes the assumptions used to calculate the allowance amount reported on Forms CMS H/M751A/B. The documentation must be available for review by CMS, OIG, GAO or other parties as required.*

Note: Medicare contractors are required to apply the same method of results of the principal comparison (Col. D, Example 400.14.3) to estimate the **interest** allowance amount (Col. E, Example 400.14.3) to be reported on Line 8, Allowance for Uncollectible Accounts, of the Forms CMS H/M 751A/B. For example, the method of results for the Non-MSP principal is delinquencies exceeding 180 days. The amount reported on the allowance matrix for interest (Sub-Group 1, Col. E) must equal the delinquencies exceeding 180 days from the interest column on Form CMS 751. The method of results for the MSP principal is the historical collection percentage. The amount reported on the allowance matrix for interest (Sub-Group 2, Col. E) must equal the **same percentage calculated** for MSP principal, multiplied by Line 7, ending balance from the interest column on Form CMS 751.

Each Medicare contractor must complete the Allowance for Uncollectible Accounts Matrix (Attachment I or Attachment II) for the periods ending March 31 and September 30 of each year. The accounts matrix is to be mailed to CMS CO. The March 31 Allowance for Uncollectible Accounts Matrix is due on April 21 and the September 30 Allowance for Uncollectible Accounts matrix is due on October 21. The Medicare contractor must submit a

separate Allowance for *Uncollectible Accounts Matrix for each Form CMS 751 (i.e. H751A, H751B of A, H751B and* H751B-DMERC).

Pleases submit your matrix(s) via email to ALLOWMATRIX@cms.hhs.gov as well as a hard copy to the following address:

Centers for Medicare & Medicaid Services

Division of Financial Oversight
Attention: Maria Montilla
Mail Stop: N3-11-17
7500 Security Boulevard
Baltimore, Maryland 21244

Example 400.14.1

Status of Accounts Receivable
Hospital Insurance (HI)
As of March 31, 2003

		H751	Non-MSP	M751
Section A: Outstanding Receivables		**Principal**	**Principal**	**Principal**
1.	Beginning FY Balance	329,345,200	188,945,200	140,400,000
2a.	New Receivables	80,050,600	57,500,600	22,550,000
2b.	Accrued Receivables	40,455,000	40,455,000	0
3.	Interest Earned	-	-	
4a.	Cash/Check Collections	(218,697,200)	(202,697,200)	(16,000,000)
4b.	Offset Collections	(424,000)	(424,000)	0
4c.	Collections Deposited at another Location	(50,000)	(50,000)	0
5a.	Adjusted Amounts		-	
	Internal Adjustments	(4,409,000)	(2,319,000)	(2,090,000)
	Auditor/Consultant Adjustments	(5,617,400)	(5,617,400)	0
5b.	Transfers In from other Medicare Contractors	10,242,000	10,242,000	0
5c.	Transfers Out to other Medicare Contractors	(160,000)	-	(160,000)
5d.	Transfers In from other CMS Locations, POR	304,000	304,000	0
5e.	Transfers Out to other CMS locations, POR	(247,600)	(247,600)	0
5f.	Transfers In from other CMS Locations, Not POR	126,000	126,000	0
5g.	Transfers Out to other CMS Locations, Not POR	(150,000)	(150,000)	0
5h.	Waivers	(292,000)	-	(292,000)
6a.	Amounts Written-off (Bad Debts)	(536,000)	-	(536,000)
6b.	Transfers In from CNC	-	-	0
6c.	Transfers Out to CNC	(106,420,000)	(2,089,600)	(104,330,400)
7.	**Ending Balance**	**123,519,600**	**83,978,000**	**39,541,600**
	a. Current	92,639,700	62,983,500	29,656,200
	b. Non-current	30,879,900	20,994,500	9,885,400
8.	**Allowance for Uncollectible Accounts**	**(49,745,910)**	**(29,327,200)**	**(20,418,710)**
9.	**Total Receivables Net of Allowance**	**73,773,690**	**54,650,800**	**19,122,890**
10.	Cash/Offsets Received for Receivables at Another Location	-		

		H751	Non-MSP	M751
Section B: Delinquent Receivables		**Principal**	**Principal**	**Principal**
1.	Total Not Delinquent	239,000	186,000	53,000
2.	Total Delinquent	123,280,600	83,792,000	39,488,600
	(a) 1-30 days	6,150,302	4,182,736	1,967,566
	(b) 31-60 days	20,341,299	13,825,680	6,515,619
	(c) 61-90 days	23,976,069	16,346,304	7,629,765
	(d) 91-180 days	29,511,844	20,110,080	9,401,764
	(e) 181-365 days	**12,316,710**	**8,371,915**	**3,944,795**
	(f) 1-2 years	**30,797,413**	**20,940,700**	**9,856,713**
	(g) 2-6 years	**86,850**	**7,285**	**79,565**
	(h) 6-10 years	**15,113**	**3,200**	**11,913**
	(I) over 10 years	**85,000**	**4,100**	**80,900**

Example 400.14.2

Allowance for Uncollectible Accounts

Historical Collection Percentage Calculation

		H751A	Non-MSP	M751A
A. Determine Total Receivable Eligible for Collection		**Principal**	**Principal**	**Principal**
1.	Beginning FY Balance	329,345,200	188,945,200	140,400,000
2a.	New Receivables	80,050,600	57,500,600	22,550,000
5a.	Adjusted Amounts			
	Internal Adjustments	(4,409,000)	(2,319,000)	(2,090,000)
	Auditor/Consultant Adjustments	(5,617,400)	(5,617,400)	-
5b.	Transfers In from other Medicare Contractors	10,242,000	10,242,000	-
5c.	Transfers Out to other Medicare Contractors	(160,000)	-	(160,000)
5d.	Transfers In from other HCFA Locations, POR	304,000	304,000	-
5e.	Transfers Out to other HCFA locations, POR	(247,600)	(247,600)	-
5f.	Transfers In from other HCFA Locations, Not POR	126,000	126,000	-
5g.	Transfers Out to other HCFA Locations, Not POR	(150,000)	(150,000)	-
5h.	Waivers	(292,000)	-	(292,000)
6a.	Amounts Written-off (Bad Debts)	(536,000)	-	(536,000)
6b.	Transfers In from CNC	-	-	-
6c.	Transfers Out to CNC	(106,420,000)	(2,089,600)	(104,330,400)
	Total Receivables Available to be Collected	**302,235,800**	**246,694,200**	**55,541,600**
B. Determine Rate of Collections				
4a.	Cash/Check Collections	218,697,200	202,697,200	16,000,000
4b.	Offset Collections	424,000	424,000	-
4c.	Collections Deposited at another Location	50,000	50,000	-
	Total Collections	219,171,200	203,171,200	16,000,000
	Rate of Collections (Total Collections divided by Adjusted Total Eligible for Collection) [203,171,200 / 246,694,200 = .82 or 82%]	**N/A**	**82%**	**29%**
C. Determine Allowance Rate				
	1.00 minus (-) the percentage determined for Step B [1.00 - Rate of Collections (1.00 - 0.82 = 0.18 or 18%)]	**N/A**	**18%**	**71%**
D. 5-year Average (if available)				
	(.50+.46+.48+.43+ Allowance Rate from Step C)/5 =	**N/A**	**41%**	**52%**
	FY 99 = 50% FY 00 = 46% FY 01 = 48% FY 02 = 43% FY 3/03 =			
E. Calculate the Allowance				
	Multiply the ending balance less PIP accrual (Line 7 - PIP accrual) by the allowance rate (Step C or Step D)			
7.	Ending Balance	123,519,600	83,978,000	39,541,600

Status of Accounts Receivable
Hospital Insurance (HI)
As of March 31, 2003

Systematic Analysis Comparison	**H751A**	**Non-MSP**	**MSP**
Historical Collection %	38,232,020	17,813,310	**20,418,710**
Individual Account Analysis	15,000,800	15,000,800	-
Delinquencies Exceeding 180 days	43,301,086	**29,327,200**	13,973,886

400.14 - Exhibit 14 - Protocol for Estimating Allowance for Uncollectible Accounts

Attachment I - Fiscal Intermediary

Allowance for Uncollectible Accounts Matrix

Group 1	**Col. A**	**Col. B**	**Col. C**	**Col. D**	**Col. E**	
	Historical Collection % Total	Individual Account Analysis Total	Delinquencies Exceeding 180 Days Total	Estimated Allowance for Uncollectible A/R	Estimated Allowance for Uncollectible A/R **(Interest Only)**	Justification for amount reported on Line 8
Sub-Group 1 (Non-MSP) Cost Report Settlements, Claims A/R, Credit Balance & Other Accounts Receivables	17,813,310	15,000,800	29,327,200	29,327,200	4,768,143	See Attached Workpapers
Sub-Group 2 (MSP) Group Health Plan (Data-Match & Non-Data Match), Liability	20,418,710		13,973,886	20,418,710	3,319,762	See Attached Workpapers **(Amount reported on M751A/B)**
Total	38,232,020	15,000,800	43,301,086	**49,745,910**	**8,087,905**	**Amount Reported on H751A**

Each Medicare contractor will be required to complete the allowance for uncollectible account matrix on **March 31** and **September 30** of each year. In addition, this matrix is to be mailed to CMS CO. Supporting documentation must include assumptions used to calculate the allowance for uncollectible accounts and should be available for review by CMS, OIG, GAO or other parties as required. The matrix must be submitted to the following address/email (provided above) on **April 21** and **October 21**. If these dates occur on a holiday or weekend, the matrix is due the following Federal workday.

400.14 - Exhibit 14 - Protocol for Estimating Allowance for Uncollectible Accounts Exhibit 14.1

Fiscal Intermediary

Allowance for Uncollectible Accounts Matrix

Group 1	**Col. A**	**Col. B**	**Col. C**	**Col. D**	**Col. E**	
	Historical Collection % Total	Individual Account Analysis Total	Delinquencies Exceeding 180 Days Total	Estimated Allowance for Uncollectible A/R	Estimated Allowance for Uncollectible A/R **(Interest Only)**	Justification for amount reported on Line 8
Sub-Group 1 (Non-MSP) Cost Report Settlements, Claims A/R, Credit Balance & Other Accounts Receivables						See Attached Workpapers
Sub-Group 2 (MSP) Group Health Plan (Data-Match & Non-Data Match), Liability						See Attached Workpapers **(Amount reported on M751A/B)**
Total						**Amount Reported on H751A/B**

Each Medicare contractor will be required to complete the allowance for uncollectible account matrix on **March 31** and **September 30** of each year. In addition, this matrix is to be mailed to CMS CO. Supporting documentation must include assumptions used to calculate the allowance for uncollectible accounts and should be available for review by CMS, OIG, GAO or other parties as required. The matrix must be submitted to the following address/email (provided above) on **April 21** and **October 21**. If these dates occur on a holiday or weekend, the matrix is due the following Federal workday.

400.14 - Exhibit 14 - Protocol for Estimating Allowance for Uncollectible Accounts Exhibit 14.2

Carrier

Allowance for Uncollectible Accounts Matrix

Group 2	**Col. A**	**Col. B**	**Col. C**	**Col. D**	**Col. E**	
	Historical Collection % Total	Individual Account Analysis Total	Delinquencies Exceeding 180 Days Total	Estimated Allowance for Uncollectible A/R	Estimated Allowance for Uncollectible A/R **(Interest Only)**	Justification for amount reported on Line 8
Sub-Group 1 (Non-MSP) Claims A/R, Credit Balance & Other Accounts Receivables						See Attached Workpapers
Sub-Group 2 (MSP) Group Health Plan (Data-Match & Non-Data Match), Liability						See Attached Workpapers **(Amount reported on M751B)**
Total						**Amount Reported on H751B**

Each Medicare contractor will be required to complete the allowance for uncollectible account matrix on **March 31** and **September 30** of each year. In addition, this matrix is to be mailed to CMS CO. Supporting documentation must include assumptions used to calculate the allowance for uncollectible accounts and should be available for review by CMS, OIG, GAO or other parties as required. The matrix must be submitted to the following address/email (provided above) on **April 21** and **October 21**. If these dates occur on a holiday or weekend, the matrix is due the following Federal workday.

400.15 - Exhibit 15 - Protocol for Prorating Intermediary Time Account Balances Between Form CMS-H750A (HI) and Form CMS-H750B (SMI) - (Rev. 5, 08-30-02)

A1-1960.15, B1-4960.15

Protocol for Prorating Intermediary Time
Account Balances Between Form CMS-H750A (HI) and Form CMS-H750B (SMI)

The contractor selects a representative sample of checks and EFT payments issued and determines the ratio of the number of HI checks/EFT payments to the number of SMI checks/EFT payments. Checks or EFT payments for both HI and SMI will be split 50-50. It uses this ratio to prorate the time account balance for the financial reports.

400.16 - Exhibit 16 - Electronic Certification - (Rev. 5, 08-30-02)

A1-1960.16, B1-4960.16

Electronic Certification

The Electronic Certification process requires that the Chief Financial Officer (CFO) enter their password in the certifying official's current password field on the remarks page of Form CMS-H750A/B and Form CMS-H751A/B. When the password is keyed in, the CFO's name and title will appear on the document, and allow the document to be submitted electronically through the CAFM. For security purposes, the new password field is present to allow the certifying official to change the password assigned by CMS to one only the CFO knows.

Two people are required to submit a certified report. The preparer may input the financial data, but cannot certify the reports. The CFO may not input data. The preparer must retrieve the report in order to allow certification.

1. From the CAFM Main Menu select option 2 - Data Entry

2. Select the type of report to certify

3. From the Data Entry Menu select option 5 - Update Remarks

4. Select the package (report) to certify

5. Enter the certifying official's current password

If there are no serious errors (use PF6 SHOW ERRS to show errors), the contractor may submit the report (use PF2 SUBMIT to submit the report) and it will be accepted.

If the contractor is working in a worksheet and decides to certify and submit the report, it may either use the function keys (PF7 PAGE- and PF8 PAGE+), enter FREM (find remarks) on the transporter line or use the jump key (PF9 JUMP) to go to the remarks page.

The contractor must re-enter its password if it reviews any portion of the report after certification and prior to submission even if no changes are made. CAFM will not store the contractor's password.

400.17 - Exhibit 17 - Instructions for the Transfer of Debt Between Reporting Entities - (Rev. 5, 08-30-02) A1-1960.17, B1-4960.10

Instructions for the Transfer of Debt Between Reporting Entities

CMS continues to receive criticism from the OIG and its financial statement auditors for being inconsistent in methods of transferring accounts receivable cases to and from Medicare contractors, and other CMS locations. This criticism is a direct result of the lack of a formalized process and specific instructions for transferring accounts receivable cases between reporting entities.

For financial reporting purposes, the term "referred" is used when a case is not physically sent to the receiving entity for collection purposes. In a "referral" situation, the receiving entity merely "advises and/or assists" the referring entity on what actions to take next with respect to the debt. The responsibility to collect and report the accounts receivable remains with the referring entity and must be reported as part of the ending accounts receivable balance on their Form CMS-H751A/B, Status of Accounts Receivable report.

A "transfer" results when a copy of the up-to-date overpayment case file is physically "transferred" to another reporting entity, i.e., the RO, CO or another Medicare contractor. Along with the case file, the transferring entity must attach a "**Transfer Request and Notification of Acceptance**" form (see Exhibit 17, Attachment I for intermediaries (parts A and B transfers and Attachment II for carriers). This form will serve as both: 1) the transferring entity's request to transfer the case(s), and 2) the receiving entity's notification of acceptance of the transfer.

The transferring entity must complete the form and sign Line 1. The form summarizes the case(s) requiring transfer approval. No entry will be made on Form CMS-751A/B at this time. Upon receipt of the form, the entity receiving the request will sign Line 2 of the form and forward a copy of the form back to the transferring entity. This will notify the transferring entity of the receipt of the request. The

receiving entity will process the request within 30 days of receipt of the transfer, and will return a copy of the Transfer Request and Notification of Acceptance form indicating the case(s) approved for transfer by signing Line 3 of the form.

Only upon receipt of the form signed by the receiving entity, will the transferring entity update its internal systems to reflect the transfer of the accounts receivable to the receiving entity. The transferring entity will reflect the dollar amount of the case(s) approved for transfer on the appropriate transfers out line of Form CMS-H751A/B (Line 5c, Transfers Out to Other Medicare Contractors; Line 5e, Transfers Out to Other CMS Locations, POR/PSOR; Line 5g, Transfers Out to Other CMS Locations, Not on POR/PSOR). Also upon receipt of the form, the transferring entity must sign Line 4 and forward a copy to the receiving entity to acknowledge receipt of the formal approval for transfer.

The receiving entity will update all internal systems, as well as the POR/PSOR to reflect the transfer. The location or Medicare contractor number must also be updated in the POR/PSOR system to reflect the transfer. In addition, the receiving entity will reflect the dollar amount of the case(s) approved for transfer on the appropriate transfers in line of Form CMS-H751A/B (Line 5b, Transfers In from Other Medicare Contractors; Line 5d, Transfers In From Other CMS Locations, POR/PSOR; Line 5f, Transfers In from Other CMS Locations, Not POR/PSOR).

Prior to submission of the quarterly Form CMS-H750/751A/B, reporting entities must reconcile the transfers in and transfers out lines to ensure **approved transfers** are only being reported. In addition to the requirement to maintain detailed transaction level documentation to support these lines, reporting entities must also retain copies of the signed Transfer Request and Notification of Acceptance forms.

View Exhibit of Transfer Request and Notification of Acceptance Form Intermediary Part A or Part B - Accounts Receivable

400.18 - Exhibit 18 - Collection Reconciliation/Acknowledgement Form - (Rev. 5, 08-30-02)

A1-1960.18, B1-4960.11

Collection Reconciliation/Acknowledgement Form

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 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-H751A/B-CMS-R751A/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. 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.

Usage of the Collection Reconciliation/Acknowledgement Form

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.

Collection Reconciliation/Acknowledgement Form

1. Location of A/R_____(i.e., Medicare contractor, RO, or CO)

2. Location of the Collection _____(i.e., Medicare contractor, RO, or CO. If RO Collection, indicate such even though actual deposit is made at Central Office)

3. Region_____ Medicare contractor Name and Number_____

4. **Non-MSP Accounts Receivable**

   Provider/Physician/Supplier) Number_____

Provider/Physician/Supplier Name_____
Provider/Physician/Supplier Name_____
Overpayment Determination Date_____
Claim Number_____
Cost Report Year _____
MSP Accounts Receivable
Debtor Name _____
HIC # / Report ID_____
Determination Date_____
Beneficiary Name _____

5. Was debt in CNC status prior to this collection:_____(Yes/No)

6. Date of Collection (Postmark or Government Collection date)_____

7. Type of Collection _____ (i.e., cash/check or offset)
   Check Number or Government Collection Number _____
   Amount of Collection $_____
   Amount Applied to Principal $_____
   Amount Applied to Interest $_____

8. Collection Reported in quarter ending_____

9. A/R Reported in quarter ending_____

_____ _____

10. Signature of Official at Location Where Collection is Reported

Phone #_____
Fax #_____

11. Signature of Official at Location Where Reduction of A/R is Recorded

Phone #_____
Fax #_____

400.20 - Exhibit 20 - *Procedures for Reporting Currently Not Collectible (CNC) Debt* (Rev. 18, 05-02-03)

A1-1960.19, A1-1960.20, B1-4960.12, B1-4960.13

As part of its effort to improve financial reporting, CMS has implemented the category of currently not collectible (CNC) for delinquent debt that is unlikely to be collected within a reasonable time frame. The *CMS'* CNC policy provides that CNC debt will not be recognized as *an active* accounts receivable (A/R) for financial statement reporting purposes because to do so would overstate the true economic value of the assets on the financial statements. While CNC debts are not A/R reported on the financial statements, Medicare contractors must continue appropriate recovery efforts for these debts until they are recommended and approved by CMS for "write-off - closed" *as such, these debts must remain in their internal system for interest accrual and offset.* The CNC process permits and requires the use of tools of the Debt Collection Improvement Act (DCIA) of 1996. *By using these tools delinquent debt will be worked until the end of its statutory collection life cycle.*

Criteria for Selection

All A/R, *whether it is classified as Medicare Secondary Payer (MSP) or Non-MSP,* that are 180 days delinquent must be recommended for CNC reclassification. The A/R must be 180 days delinquent *(i.e., 240 days old if the repayment time frame is 60 days or 210 days old if the repayment time frame is 30 days)* as of the last day of the quarter prior to the quarter in which the CNC recommendation is submitted for RO approval.

All MSP A/R means all *demanded debt,* without regard to whether the debt is Group Health Plan (GHP) based or liability/no-fault/workers' compensation based and without regard to the type of debtor (employer, insurer, beneficiary, provider/supplier, etc.). Where the MSP recovery demand letter stated that the debt was due and payable 30 days from the date of the demand, the debt is delinquent on day 31 if it has not been paid in full or there is no valid documented defense for the unpaid amount. Where the MSP recovery demand letter stated that the debt was due and payable 60 days from the date of the demand, the debt is delinquent on day 61 if it has not been paid in full or there is no valid documented defense for the unpaid amount.

All Non-MSP A/R means all demanded debt without regard to whether the debt is provider/physician/supplier or beneficiary-based. This includes debts that are not normally reported (separately or in summary entries) in the POR/PSOR systems, as long as they meet the CNC criteria. These debts should be listed separately, must be identified as not on the POR/PSOR, and the type of debt must be listed on the CNC request form in the comments section. Debts that are excluded from this definition are as follows:

- *Debts with a principal balance of less than $25. Although these debts may satisfy the CNC criteria, Medicare contractors should recommend the termination of collection activity and request approval by the Regional Office (RO) to write this debt off as "write-off closed" in accordance with Title 42 of the Code of Federal Regulations, Section 405.376(e)(3), since the cost of further collection action is likely to exceed any recovery.*

- *Debts with a collection within the last 180 days. Hence, the debt must be 180 days delinquent without any collection/recoupment activity within the last 180 day time period for CNC reclassification.*

Additionally, all accounts receivable *that meet the CNC criteria* will be reclassified as CNC without regard to whether or not the debt is in bankruptcy, under fraud and abuse investigation, has an appeal pending at any level, is in litigation/negotiation, *or is for a deceased debtor. However,* if a Medicare contractor believes that a particular A/R meets the criteria for both "write-off - closed" and CNC, the A/R should be recommended for "write-off - closed." Medicare contractors may not recommend CNC for less than the full amount of an outstanding debt.

NOTE: For GHP-based MSP A/R where the demand was issued to the employer, insurer, or third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand to a debtor for a particular beneficiary. For GHP Data Match (DM) recoveries, this would be all of the claims associated with a particular Mistaken Payment and Recovery Tracking System (MPaRTS) Report ID although a single cover letter might have been issued for multiple beneficiaries' Medicare reimbursed claims. For duplicate primary payment recovery demands to a provider/supplier (including physician), the debt includes all claims in the recovery demand regardless of the number of beneficiaries involved. For liability, no-fault, or workers' compensation, the debt includes all claims in the recovery demand.

A debt's eligibility for DCIA referral to a Department of the Treasury designated Debt Collection Center *(DCC)* for further collection efforts, including the Treasury Offset Program (TOP) has no bearing on or relationship to whether or not the debt should be reclassified as CNC. *As such, debts referred to the DCC should also be recommended for CNC reclassification as long as it meets the CNC criteria.*

The Department of the Treasury and the Office of Management and Budget require that Agencies submit reports to them on financial management and performance data so that debt collection programs and policies can be evaluated. Thus, CMS is requiring its Medicare contractors to report and monitor CNC debt on a quarterly basis.

Quarterly Review of Debt for CNC Reclassification & Approval

Medicare contractors must continuously review all debt and quarterly request approval to reclassify debts as CNC. Recommendations for the approval of *MSP and Non-MSP* CNC should be sent to your RO MSP Coordinator *or the RO Debt Collection staff respectively.* These reports should be sent by hard copy *accompanied with a disk* no later than the first day of the second month of each quarter (*i.e.,* November 1, February 1, May 1, and August 1). The CFO of Medicare Operations must sign the hard copy and include a preprinted address label with the hard copy for the return of the approved CNC recommendations. *Medicare contractors are required to submit negative reports if there are no debts eligible for CNC for a particular quarter.*

ROs are responsible for approval or denial of all recommendations for CNC based upon the criteria set forth in these instructions. RO approval will be by the Assistant Regional Administrator (ARA) for Financial Management. ROs will complete their review of the Medicare contractors' recommended CNC and return their approval or denial of such reclassifications by the first *day* of the last month of each quarter (*i.e.,* December 1, March 1, June 1, and September 1). ROs may return a *hard copy via fax or a soft copy via disk*

annotated to show approval or denial by the RO ARA for Financial Management, in order to meet the required time frame for approval, but this must be followed by a hard copy that was signed and dated by the ARA for Financial Management. ROs will also send copies of the signed RO approval or denial letter only, each quarter to CMS CO to the attention of the *Director, Division of Financial Oversight*, Office of Financial Management (for both MSP and Non-MSP approvals). *The ROs must maintain the detailed reports that support the amounts approved/disapproved.*

The CNC action should not be taken nor should any changes be made to the A/R on any *internal* systems (Medicare contractor systems or other systems which Medicare contractors have responsibility for updating) for CNC until the recommendation for CNC has been processed by CMS, approved in writing, and returned to the Medicare contractor. The listing of approved CNC will be returned to the contractors by the ROs. Receipt of this approval authorizes the Medicare contractor to reclassify the A/R, and update the A/R and associated case in all appropriate systems. When the A/R is reclassified as CNC, the associated case file must be annotated to show that a particular A/R was reclassified as CNC and the date/quarter of the action. Reclassification as CNC **does not** close the associated case.

If a full or partial collection for the A/R is received between request and approval of CNC reclassification, then the collection should be applied. The contractor must make the necessary adjustment to the debt to reflect the payment and place the remaining amount, if any, in CNC when the RO approval is received. However, when the approval is received, the contractor must then notify the RO of the change in the amount originally approved for CNC as well as the reason why. If the contractor has this issue with multiple debts recommended for CNC, they need to furnish this information to the RO on a debt specific basis, not just on an aggregated basis. This must be communicated to the RO contact in writing. In addition, this documentation should be maintained for audit/review purposes.

NOTE: MPaRTS does not need to be updated for Data Match debt when the MSP A/R is reclassified as CNC.

The CMS approval of A/R reclassified as CNC must be retained and available upon request (from the Office of the Inspector General or any other internal or external review organization) in accordance with retention procedures in the Medicare Intermediary and Carrier Manuals. This CMS approval must also be annotated by the Medicare contractor to indicate the date/quarter when the A/R was reclassified.

Data Requirements and Format for Recommendations for MSP CNC

MSP A/R recommended for CNC requires the submission of the following information to the Medicare contractor's RO MSP coordinator: (see *Attachment I* for the recommended format)

- Medicare Contractor Name and Number

- Medicare Contractor Mailing Address
- Medicare Contractor Contact Person/Phone/Fax/E-mail
- Type of MSP Debt [GHP or non-GHP (this includes liability, no-fault, and workers' compensation)]
- Beneficiary Health Insurance Claim Number (HICN)
- Beneficiary Name
- Name of Debtor or Insurer for **GHP-based debts** where the current debtor is the insurer/employer/third party administrator/GHP/other plan sponsor
- Type of Debtor [A=insurer/employer/third party administrator/GHP/other plan sponsor; B=provider/supplier (including physicians); C=beneficiary, D=other (must specify)]
- Date of Initial Recovery Demand Letter to current debtor
- *Delinquency Date*
- Original A/R Amount for the current debtor
- Existing A/R Amount (principal and interest listed separately, as well as a total amount for principal plus interest; HI/SMI must also be listed and reported separately)
- Date of Last Payment, Collection, Recoupment, Offset, or Adjustment Activity (provide date or "none")
- Tax Identification Number (TIN) for debtor. The TIN is the Employer Identification Number (EIN) or Social Security Number (SSN)
- *DCS Status Code (if applicable).*

NOTE: The debtor is the individual or entity to whom the last recovery demand was issued. Where the demand was issued to an individual in their capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in their own right, the debtor is the attorney or other representative.

The above listed data elements are mandatory for CNC for all MSP A/R established October 1, 2000 or later. It is also mandatory for all MSP A/R with a recovery demand date of October 1, 2000, or later, regardless of when the MSP A/R was established. For CNC recommendations for MSP A/R established prior to October 1, 2000, Medicare contractors may submit recommendations without the following data elements if the CNC recommendation certifies that these data elements are not readily available: Beneficiary name and HIC number where the beneficiary is not the debtor; Insurer name where the insurer is not the debtor; and Type of debtor.

If a Medicare contractor has bulk MSP A/R on the GTE system for older Data Match and non-Data Match GHP debt, the contractor - for these MSP A/R only - must: 1) Identify the A/R as a bulk receivable on the GTE system, 2) Identify the insurer, 3) Identify the date of the demand, and 4) Identify the associated dollar amounts for principal and interest. Any contractor who created bulk receivables for GHP-based MSP debt using any system other than GTE must contact their RO for assistance. The RO will, in turn, discuss the issue with CO.

Data Requirements and Format for Recommendations for Non-MSP CNC

Non-MSP A/R recommended for CNC require the submission of the following information to the Medicare contractor's RO Debt Collection contact: (see Attachments II & III for the recommended format)

- Medicare Contractor Name and Number
- Medicare Contractor Mailing Address
- Medicare Contractor Contact Person/Phone/Fax
- Provider/Physician/Supplier/Beneficiary Name and Number (if applicable)
- Claim Number (PSOR)
- Claim Paid Date (PSOR) or Cost Report Date (POR)

- Overpayment Determination Date
- POR/PSOR Status Code
- Overpayment Type
- Original Amount of Debt
- Balance Outstanding (principal and accrued interest listed separately)
- Date Interest Accrued Through
- Date of Last Payment, Offset or Recoupment
- POR/PSOR Balance (principal and interest listed separately for POR; for PSOR, principal balance only) - For Part A, indicate POR balance if Contractor submits request for Part B of A separately
- POR/PSOR Location Code
- DCS Status Code (if applicable)
- For FIs Only - Part B of A debt can be submitted on the same listing (principal and interest)

Each listing must contain a written certification that all of the required criteria for CNC are met. The CFO of Medicare Operations must sign CNC recommendations. The CFO's signature constitutes his/her certification to all information/statements contained in the recommendation.

Financial Reporting and Reconciliation of CNC Debts

Debts that have received approval for CNC reclassification must be reported in the following manner:

- On Form CMS-751A/B or CMS-M751A/B the amount reclassified as CNC, including principal and interest, will be recorded on Line 6c, Transfers Out to CNC with a corresponding entry on Line 2, New CNC Debt on Form CMS-C751A/B or CMS-MC751A/B. This will reduce the ending balance reflected on the applicable form.

- Debts that are reclassified as CNC may still be collected. If a collection occurs, the following actions should take place: (1) On Form CMS-C751A/B or CMS-MC751A/B an adjustment for the amount of the collection should be recorded on Line 4a, Reclassified as Active A/R Due to Collection of Cash or Line 4b, Reclassified as Active A/R Due to Collection by Offset; (2) The amount of the collection should also be included in Section C - Collection Information of Form CMS-C751A/B or CMS-MC751A/B; and (3) The amount of the collection should be simultaneously recorded on Line 6b, Transfers in from CNC and Line 4a, Cash/Check Collections or Line 4b, Offset Collections of Form CMS-751A/B or CMS-M751A/B. As such, if a collection takes place, only the collection would be reclassified with the collection being applied against interest first, then principal. If the collection does not satisfy the entire debt, the remaining balance of that debt would remain in CNC.

Medicare contractors must continue to accrue interest for debt that has been reclassified as CNC. Additionally, CMS recognizes that for those systems where interest is updated automatically, the interest submitted with a recommendation for CNC may differ from the interest shown in the Medicare contractor's system at the time the Medicare contractor receives approval for CNC. The CMS approval of the principal and interest recommended for CNC is sufficient support for the subsequent reclassification, including any increase in the interest, as long as the principal remains the same. Any additional interest that accrues prior to CNC reclassification would be reported on Form CMS-751A/B or CMS-M751A/B on Line 3, Interest Earned. Then the debt would be reclassified to the appropriate form.

Medicare contractor systems must be able to maintain transaction level detail of debt that has been reclassified as CNC to enable future collection activities and to maintain a proper audit trail.

Regional Offices will ensure that amounts approved as CNC are properly reported on contractor Forms CMS-751A/B or CMS-M751A/B and CMS-C751A/B or CMS-MC751A/B.

Systems Update - Non-MSP Only

Medicare Contractor Internal Systems and POR/PSOR System:

Contractors are responsible for the timely update of CNC status in the POR/ PSOR systems and internal systems. A CNC date field has been added in the POR/PSOR and additional status codes have been developed. The date of CNC approval (i.e., the date of the cover letter signed by the ARA) must be entered in the CNC date field. The update must be performed within ten calendar days of receiving the CNC approval. Do not change the location code of the debt. Regional Offices will monitor the POR/PSOR systems to ensure contractor compliance.

Additional Status Codes for POR/PSOR:

POR Codes	***PSOR Codes***	***Code Description***
01	*1*	*CNC*
02	*2*	*Write-off Closed (disabled effective 2/6/02)*
03	*3*	*CNC - DCIA Letter Sent*
04	*4*	*Reactivate - Bankruptcy (will no longer be used)*
05	*5*	*Reactivate - Payment Received*
06	*6*	*Reactivate - Appeal/Litigation/Fraud & Abuse Investigation (will no longer be used)*
07	*7*	*Reactivate - Compromise*
08	*8*	*Reactivate - Extended Repayment Agreement*
09	*9*	*CNC Debt - Written-off Closed*
00	*0*	*Reactivate - Other*

NOTE: For debts that are at the DCC location and reclassified to CNC, the "3" (POR) or "03" (PSOR) status code would be used. Furthermore, the "9" must be accompanied by a valid closed date. Cases with a status code of "09" (POR) or "9" (PSOR) and a valid closed date will be rolled to the history file at the end of the quarter. In addition to updating the POR/PSOR with the appropriate status codes for the reactivation, the CNC date previously inputted should be removed. Updating the CNC Date field in the PSOR requires the user to enter zeroes in the CNC Date field and pressing the enter key.

Debt Collection System (DCS)

The CMS' CO Division of Financial Reporting and Debt Referral staff will continue to update the Debt Collection System (DCS) with approved CNC status for debts that have been referred for Cross Servicing/TOP.

Additional Considerations *for MSP A/R*

These instructions only apply to established MSP A/R. They may **not** be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

Some Medicare contractors may still have old MSP-based provider/supplier (including physician) debt or MSP-based beneficiary debt which has not been reported on their Form CMS-M751A/B and which has been referred to the RO under non-MSP rules or otherwise

treated as a non-MSP receivable. Old MSP-based debt that has been treated as non-MSP debt (that is tracked and processed under non-MSP rules) should be treated as non-MSP debt for CNC purposes as well.

Medicare contractors may only recommend CNC for a MSP A/R that is being reported as part of their ending MSP A/R balance. MSP A/R that have been **transferred** to the ROs for referral to other agencies or entities such as, the Department of Justice or Office of General Counsel will be addressed by the ROs. CO will address MSP A/R with CO locations. MSP A/R that have been **referred** to another location, without transfer, remain the responsibility of the Medicare contractor.

Previously some Medicare contractors processed/tracked MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R as non-MSP A/R and did not include such A/R on their Form CMS-M751A/B report. Medicare contractors may no longer do this for new MSP A/R. Any pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R that are not reflected in the Medicare contractor's Form CMS-M751A/B report may not be recommended for MSP CNC. Pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP- based beneficiary A/R that have been tracked/processed, or otherwise treated as non-MSP debt should follow the rules for non-MSP CNC.

View Exhibit 20 - Attachment I MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC.

400.21 - Exhibit 21 - CMS Policy for Recognizing Accounts Receivable - (Rev. 5, 08-30-02)

A1-1960.21, B1-4960.21

CMS Policy for Recognizing Accounts Receivable

Overview

The majority of the Medicare accounts receivable balances reported by CMS in its financial statements are comprised of overpayments made to providers, physicians, suppliers, beneficiaries, insurers, employers and other entities. The primary responsibility for identifying, recording, collecting, and reporting overpayments lies with CMS's Medicare contractors. CMS defines an "overpayment" as Medicare funds that a provider, physician/supplier, beneficiary, insurer, employer, or other entity has received in excess of amounts due and payable under the Medicare statute and regulations. Once a determination of an overpayment has been made, the amount so determined is a debt that is owed to the Medicare program. For financial reporting purposes, this overpayment or debt must be recognized as an accounts receivable and reported as an asset in CMS's financial statements.

CMS has adopted the financial reporting definition for the recognition of an accounts receivable set forth by the Federal Accounting Standards Advisory Board (FASAB). The FASAB recommends generally accepted accounting standards and principles for the

Federal Government. The FASAB sets these standards and principles so that Federal agencies' financial reports include understandable, relevant, and reliable information about the financial position, activities, and results of operations of the United States government and its component units.

According to the FASAB's Statement on Federal Financial Accounting Standard Number 1 (SFFAS No.1), Accounting for Selected Assets and Liabilities,

> "Accounts receivables are amounts that an entity claims for payment from others. They arise from claims to cash or other assets." Additionally, the FASAB recommends, "A receivable should be recognized when a Federal entity establishes a claim to cash or other assets against other entities, either based on legal provisions, such as a payment due date (e.g., taxes not received by the date they are due), or goods or services provided. If the exact amount is unknown, a reasonable estimate should be made."

For financial reporting purposes, recognition means the process of formally recording an item into the financial statements of an entity as an asset, liability, revenue, expense, or the like. In the case of Medicare contractors, recognition would equate to recording the accounts receivable on Form CMS-H750A/B and Form CMS-H751A/B Contractor Financial Reports.

Recognition Policy

CMS and its Medicare contractors will recognize and report an accounts receivable as of the date a demand letter is sent to the debtor. Specifically, contractors will recognize and record an accounts receivable (Non-Medicare Secondary Payer (MSP) and MSP overpayments) as of the date of the demand letter on Line 2a, New Receivables of Form CMS-H751A/B Status of Accounts Receivable Report. The act of sending out the demand letter is the event that triggers the recognition of an accounts receivable. The purpose of the demand letter is to notify the debtor of the existence of the overpayment, and to request payment. Chapter 4, Debt Collection, §§10 and 130 outline the language and information that, at a minimum, a demand letter must contain. A demand letter must contain the name and address of the debtor, the amount of the overpayment, terms of how interest will be assessed, date when repayment is due, and the debtor's rights to appeal. All these items are consistent with the definition recommended by the FASAB as outlined above.

It is important for Medicare contractors to ensure that they retain copies of a demand letter(s) sent. The demand letter provides documentation or evidence of the actual debt and recovery efforts taken. It must be kept in each case file with other associated case documents or correspondence if the case is referred to the Department of Justice; referred for debt cross-servicing; requested by CMS, Office of Inspector General (OIG) or General Accounting Office (GAO) during audits/reviews. This information is necessary and needed to support the debt.

Unless otherwise specifically noted, this policy is applicable to both non-MSP and MSP overpayments. The following are specific circumstances where application of this policy will not apply, i.e., when an accounts receivable would be recognized even though a demand letter has not been issued or, vice versa, where sending a demand letter would not necessarily require the recognition of an accounts receivable.

- Accounts Receivables Due to Unfiled Cost Reports; and

- Consent Settlement Agreements.

These two circumstances are not all inclusive. If there is a specific situation that is not described above, Medicare contractors should consult CMS for further guidance.

Accounts Receivable Due to Unfiled Cost Reports

Through analysis of Federal financial accounting standards and regulations, CMS believes that recognition of a receivable prior to the filing of a cost report significantly overstates net assets and ultimately net position. Furthermore, CMS believes that current accounting procedures for recognizing accounts receivables due to a provider's failure to file a cost report timely does not adhere to the accounting principles articulated in Statement of Federal Financial Accounting Standards Number (SFFAS No.) 1 - Accounting for Selected Assets and Liabilities, SFFAS No. 5 - Accounting for Liabilities of the Federal Government, and SFFAS No. 7 - Nonexchange Revenue (Measurement&Recognition), as well as Generally Accepted Accounting Principles (GAAP) of conservatism and matching. Based on this analysis, the failure to file a cost report does not complete the earnings process, and accordingly, no accounting event has occurred. As such, the recognition of a receivable prior to the completion of the earnings process (receipt or filing of a cost report) is poor matching. In addition, SFFAS Nos. 5 and 7 states that liabilities and nonexchange revenue should only be recognized when a past event or exchange transaction has occurred, use of resources (inflow or outflow) are probable and can be reasonably estimated or measured. Without the actual submission of the cost report, CMS cannot reasonably estimate the amount of the receivable, as required by SFFAS No. 1.

Therefore, unfiled cost report receivables will no longer be reported on the Form CMS-H;750 Contractor Financial Report and Form CMS-H751, Status of Accounts Receivable Report. CMS's current financial reporting instructions require Medicare fiscal intermediaries to place providers who have not filed a timely cost report on 100 percent penalty withhold, and recognize and demand a receivable based on the value of all interim payments made to the provider in, and subsequent to, the cost reporting period, without considering the value of actual services performed during that period. Federal debt collection regulations allow CMS to demand repayment of the full amount paid to a provider during a cost reporting period if a provider fails to comply with the requirements to file a cost report in a timely manner. However, for financial reporting purposes, CMS recognizes that the entire amount being demanded does not truly represent funds owed to CMS. Since the provider has performed services, the true economic value of the receivable demanded is overstated. In fact, CMS may have a liability upon settlement. Cost report receivables should not be accrued

until related cost reports are received, and CMS can support the existence of a receivable through provider agreement, such as filing a cost report, filing a cost report without sufficient payment, or a court ruling in favor of CMS.

As a result, for financial reporting purposes, CMS is revising its policy for reporting unfiled cost reports as an accounts receivable, unless the fiscal intermediary is aware of a unique situation where recording an accounts receivable would be appropriate. Fiscal intermediaries will continue to reflect an overpayment on the Provider Overpayment Reporting (POR) system based on the value of all interim payments made to the provider in, and subsequent to, the cost reporting period.

However, **effective for the March 31, 2001 reporting period, accounts receivable for unfiled cost reports will no longer be reported on Form CMS-H750 and Form CMS-H751**. CMS will continue to monitor and manage the status of unfiled cost reports through the POR system, without overstating accounts receivable on the financial statements. All other processes related to unfiled cost reports remain unchanged. Fiscal intermediaries must continue to: (1) Place the providers on 100 percent penalty withhold, (2) Demand the submission of delinquent cost reports from providers based on current debt collection regulations, and (3) Refer the debt in accordance with the requirements of the Debt Collection Improvement Act of 1996.

Fiscal intermediaries must ensure that Line 7, Ending Balance, of Form CMS-H751 does not include any receivables due to unfiled cost reports. If accounts receivables due to unfiled cost reports were included in the December 31, 2000 Form CMS-H751, these receivables must be zeroed out by recording a downward adjustment for these amounts on Line 5a, Reclassified/Adjustments, on Form CMS-H751 and provide a specific footnote in the remarks section of the report identifying the nature and amount of the adjustment.

Consent Settlement Agreements Resulting from Comprehensive Medical Reviews (CMRs)

Typically, postpayment reviews of claims are conducted for a specified provider/physician/supplier or group in order to evaluate their billing patterns over a selected period of time. CMRs are performed to determine whether a suspected provider/physician/supplier or groups are providing noncovered or medically unnecessary services. A CMR is a thorough analysis of a sample of processed claims and all pertinent data (such as medical record, beneficiary payment history, etc.) for selected providers/physicians/suppliers for a specified time period. CMRs are usually targeted to providers/physicians/suppliers who have demonstrated aberrant billing and/or practice patterns.

If a CMR determines that an incorrect amount of money has been paid to the provider/physician/supplier, the contractor must assess an overpayment based on instructions outlined in the contractor manuals. Per Chapter 3, Overpayments, there are three different types of overpayments that result from a CMR: Actual overpayment, projected overpayment, and limited projected overpayment. The type of sample used during a CMR determines how Medicare contractors are to assess and demand money back from the provider or physician/supplier who was overpaid.

An actual overpayment is, for the actual claims reviewed, the sum of the payments (based on the amount paid to the provider/physician/supplier and Medicare approved amounts) made to a provider/physician/supplier for services which were determined to be not medically necessary or incorrectly billed. If an actual overpayment is assessed, Medicare contractors must send a demand letter for the amount of the actual overpayment and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

A projected overpayment is defined as the numeric overpayment obtained by projecting an overpayment from a statistically valid random sample (SVRS) to all similar claims in the universe under review. Medicare contractors must notify the provider or physician/supplier of the overpayment, and refer the case to the Medicare contractor's overpayment staff to demand and collect the overpayment. Medicare contractors must send a demand letter for the amount of the projected overpayment and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

A limited projected overpayment is the numeric overpayment obtained by projecting an overpayment from a limited sample or limited SVRS subsample to all similar claims in the universe under review. If this type of overpayment is assessed, Medicare contractors have three overpayment assessment options. The Medicare contractor can assess an actual overpayment; a projected overpayment based on a SVRS by performing an expanded CMR; or can offer the provider or physician/supplier a consent settlement based on the potential projected overpayment amount. Again, if an actual or project overpayment is assessed, Medicare contractors must send a demand letter, and recognize an accounts receivable on Line 2a, New Receivables, of Form CMS-H751.

If a consent settlement is offered to the debtor, the consent settlement document must carefully explain what rights a debtor waives by accepting the consent settlement. It must contain a binding statement that a debtor agrees to waive any rights to appeal the decision regarding the potential overpayment determination. If this option is used, the Medicare contractors **must not** recognize an account receivable until a consent settlement is signed and agreed to by the debtor and CMS.

400.22 - Exhibit 22 - Accounts Receivable Trending Analysis Procedures - (Rev. 5, 08-30-02)

A1-1960.22, B1-4960.15

The Centers for Medicare & Medicaid Services (CMS) utilizes contractors to manage and administer the fee-for-service portion of the Medicare program. Medicare contractor financial reports provide a method of reporting financial activities by the contractors as required by the Chief Financial Officers (CFO) Act of 1990. The Medicare contractors are required to maintain accounting records in accordance with federal government accounting principles and applicable government laws and regulations and are required to use double entry bookkeeping and accrual basis accounting. The financial reports are due 21 calendar days after the end of each quarter via the Contractor Administrative and Financial Management (CAFM) system.

The financial reports consist of a Statement of Financial Position (Form CMS-750) and a Status of Accounts Receivable (Form CMS-751). The system accumulates and reports by each trust fund, as there are separate reports for Part A Hospital Insurance (HI) and Part B Supplementary Medical Insurance (SMI). The accounts receivable activity is reported for the fiscal year-to-date for the period of the report. Medicare Secondary Payer (MSP) accounts receivable activity is reported on Form CMS-M751 report. This activity is combined with the Non-Medicare Secondary Payer (Non-MSP) accounts receivable activity on Form CMS-H751. There is no separate Form CMS-751 report for Non-MSP accounts receivable.

Account receivables represent amounts owed by health care providers, insurers, third party administrators, beneficiaries, employers, and other government agencies. Medicare accounts receivable is comprised of various components with the balance derived from MSP and Non-MSP receivables, as well as miscellaneous amounts owed the program from various sources. On Form CMS-H750, the majority of HI Non-MSP accounts receivable balances consist of or are due to cost report settlements, claims accounts receivable, periodic interim payments (PIP) and other overpayments. The detailed activity for these components is included in Form CMS-H751 report. Also on Form CMS-H750 Status of Financial Position, HI MSP accounts receivable balances consist of receivables specific to Data Match, non-Data Match, liability (including workers compensation (WC), auto, no-fault) and MSP beneficiary debts. The detailed activity for these components is included in Form CMS-M751 report.

Contractors must maintain and make available lead schedules and detailed documentation to support all amounts reported.

Objective

To ensure that accounts receivable balances reported are reasonable, Medicare contractors are required to perform trending procedures. Trending procedures can be used as an important tool to identify potential errors, system weaknesses, or inappropriate patterns of accounts receivable accumulation, collections, transfers or write-offs. Trending procedures involve comparisons of recorded amounts to expectations developed by the Medicare contractors. To properly apply trending procedures, it is necessary to take the following steps:

Compare Current Year Amounts with Comparative Financial Data

In comparing current-period financial results with prior-period financial results, there is an implied assumption that the volume of activity in the two periods is comparable. If there has been a substantial change in volume, it is necessary to take this change into account and to quantify the change, when making the comparisons. For example, if a contractor's accounts receivable balance has increased by 10 percent, it is necessary to determine and document the reason for the increase. The increase may be the result of transitions of providers, new legislation, etc.

Understand Identified Variances and Document the Results

Medicare contractors must identify and provide an explanation for variances that meets the thresholds outlined in these procedures. Typically, this will be accomplished primarily through inquiry of operations personnel in the Audit and Reimbursement, MSP, Medical Review, and other areas that report and track accounts receivable balances. If an explanation does not adequately describe the variance, the Medicare contractors must perform additional procedures such as review of detail transactions to identify the underlying cause(s) of any unusual changes.

The causes for the variances should be quantified. For example, if the change was mainly attributable to a contractor transition, then the total amount of receivables transitioned should be identified and included in the Medicare contractors' work papers.

Methodology

Trending & Comparative Analysis for Accounts Receivables
The primary emphasis for performing trend analysis is focusing on the change in the ending principal accounts receivable balance. The ending principal accounts receivable balance is comprised of Non-MSP and MSP accounts receivables. For FIs, the Non-MSP overpayments section consist of four major components (cost report settlements, PIP, claims accounts receivable, and credit balances). For carriers, the Non-MSP overpayment section consists of two main areas: 1) amounts owed from beneficiaries and 2) amounts owed from physicians/suppliers. These two areas consist of two major components (claims accounts receivable and credit balances). For both FIs and carriers,the MSP section consists of three major components (Data Match, non-Data Match, and liability (including WC, auto, no-fault)). In order to properly identify and understand variances, an analysis must be performed at the component level. **Although the instructions specify ending principal accounts receivable balance, Medicare contractors must have available an explanation of any significant change in the ending interest accounts receivable balance and any other sections of the Forms CMS-750/751 that meets the thresholds. The explanation should be available for review by CMS, Office of the Inspector General, General Accounting Office and /or other related parties.**

Prior to the certification and submission of the Forms CMS-750/751 reports, each Medicare contractor must perform the following steps on a quarterly basis, beginning with the quarter ending June 30, 2002. **The CFO for Medicare Operations' certification of these reports is indicative that trending procedures have been performed.**

Accounts Receivable Trending Analysis Procedures

Step (1)

Compare the current quarter Non-MSP overpayments section of Form CMS-H750A/B for FIs (Form CMS-H750B for carriers) component line items to the same component line items in the prior quarter (i.e. 06/30/02 versus 03/31/02) and the current quarter to the prior year's quarter (i.e. 06/30/02 versus 06/30/01). Calculate the dollar and percentage difference for each component line item. (See Attachments I & I-A for the required format)

NOTE: For FIs, due to the seasonal nature of the cost report settlements, PIP, etc., independent quarter activity in the current year should not be the only analysis compared to the preceding quarter. Comparisons should always be performed from current period year-to-date activity to prior period year-to-date activity for the same period of time (i.e. 06/30/01 versus 06/30/02)

Step (2)

Compare the current quarter MSP section of Form CMS-H750A/B for FIs (Form CMS-H750B for carriers) component line items to the same component line items in the prior quarter and prior year. Calculate the dollar and percentage difference for each component line item. (See Attachments II & II-A for the required format)

Step (3)

Verify that the dollar amount for each component line item is supported by lead schedules and/or detailed documentation. Any errors or misstatements identified as a result of this analysis must be corrected prior to the submission of Forms CMS-750/751 reports.

Step (4)

The sum of the components for the Non-MSP overpayments sections (See Attachments I & I-A) plus the sum of the components for the MSP sections (See Attachments II & II-A) must equal the ending balances reported on Line 7, of Form CMS-H751A/B for FIs, (Form CMS-H751B for carriers) (See Attachments III & III-A) for the current and prior quarters. The sum of the components for the Non-MSP overpayments sections must equal the ending balances reported on Line 7, of Attachments IV and IV-A for the current and prior quarters. The sum of the components for the MSP sections must equal the ending balances reported on Line 7, of Form CMS-M751A/B for FIs (Form CMS-H751B for carriers) (See Attachments V & V-A) for the current and prior quarters.

Step (5)

Provide explanations for each component line item where the amount changed meets the threshold of +/-15 percent and the amount changed is +/- 5 percent of the components ending balance. (See Attachments I, I-A, II & II-A)

II - Supporting Analysis

Step (1)

Ensure the current year beginning balance is the same amount as the prior year's ending balance and the beginning balance for the prior year's quarter is the same as the beginning balance of the final quarterly report for that FY (i.e., 06/30/01 and 09/30/01). Additionally, for the second through fourth quarter periods, ensure that the beginning balances are unchanged from the amount reported as the first quarter beginning balances.

Step (2)

Compare the current quarter Form CMS-H751/M751 line items to the same line items in the prior quarter and prior year. Calculate the dollar and percentage difference for each line item for Section A of Form CMS-H751/M751. (See Attachments III & III-A)

NOTE:

The Medicare contractors are not required to perform trending procedures or provide variance explanations on the line items of Forms CMS-H751/M751. However, the above steps should be used to assist the Medicare contractor in identifying the reasons for the variances identified in Attachments I, I-A, II & II-A.

Overall Summary

Step (1)

Document conclusions in a summary memorandum (See Attachment VI) to be included with Attachments I, I-A, II & II-A and submit to the CFO for Medicare Operations for sign off approval.

For example, the Medicare contractor must identify any external and/or internal factors that attributed to the variances.

External factors might include (1) Medicare contractor transitions from the Medicare program, (2) seasonal variances such as provider year-ends, (3) new legislation impacting reimbursement policies, MSP policies, etc., (4) current economic conditions (provider termination, bankruptcy, extended repayment schedules, etc.).

Internal factors might include (1) turnover of key personnel, (2) changes in accounting guidance or CMS priorities/initiatives, (3) reporting system modifications, (4) number of contractor processing sites.

Step (2)

A signed approved copy of the summary memorandum (See Attachment VI) along with Attachments I, I-A, II & II-A will be submitted to the regional office for final approval.

NOTE:

The summary memorandum (See Attachment VI) and the analysis schedules (Attachments I, I-A, II & II-A) will be reviewed and approved by the CFO for Medicare Operations and the region's Associate Regional Administrator, Division of Financial Management (ARA/DFM). The ARA/DFM will review the trend analysis submitted by the Medicare contractor and either approve or request additional explanation and/or documentation. The ARA/DFM must notify the Medicare contractor by phone, email or fax no later than February 15, May 15, August 15, and November 8 as to the approval/disapproval. The ARA/DFM must allow the Medicare

contractor no less than two days (upon receipt of the request) to provide the additional documentation needed to support their variance. Upon receiving the request, the Medicare contractor has no more than four days to provide the additional documentation to the ARA/DFM. The ARA/DFM must contact the central office (CO) (by phone, email or fax) when a Medicare contractor has been notified to submit additional documentation and a date the trend analysis will be forwarded to the CO.

III. Due Date

The analysis must be submitted to each contractor's respective regional office on February 8, May 8, August 8, and November 1. The ARA/DFM must review and approve the Medicare contractors' submissions and forward them to CO by February 15, May 15, August 15, and November 8. If that date occurs on a holiday or a weekend, the report is due the following Federal workday. The Medicare contractor and the ARA/DFM may email or fax the analysis by the due dates and immediately follow up with a signed approved hard copy.

NOTE: The ARA will submit the signed approved copy of the Medicare contractors' summary memorandums and the analysis schedules to the Central Office, Division of Financial Oversight. The CO will review the summary memorandums and the analysis schedules. The CO **is not** responsible for approving or denying the Medicare contractors' trend analysis. The CO may request additional explanation and/or documentation to support the Medicare contractors' analysis schedules. The CO will notify the ARA/DFM (by phone, e-mail or fax) when a request for any additional documentation is needed.

View Attachments I - V - A, Accounts Receivable Trending Analysis

410.1 - General Information

(Rev. 48, 07-09-04)

All Medicare contractors receive unsolicited/voluntary refunds (i.e. monies received not related to an open accounts receivable). Following are detailed instructions on how to identify, process, track and report unsolicited/voluntary refund checks received from providers/physicians/suppliers, and other entities (*e.g.*, beneficiaries, insurers, employers, third party administrators (TPAs), etc.). These instructions shall not supersede other CMS guidance provided regarding the recovery and collection action on “demanded” debt, where an accounts receivable has already been established. If monies are received and the results of a contractor’s investigation identify the existence of an established receivable, then the refund shall not be considered an “unsolicited/voluntary refund” within the context of the following instructions, and would not be reported on Exhibit 2 of these instructions (see section 410.9).

Intermediaries generally receive unsolicited/voluntary refunds from providers in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds from providers and third party payers as checks. Carriers generally receive checks from physicians, suppliers and third party payers. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

Acceptance/deposit of the voluntary refund check in no way limits the rights of the Federal Government or any of its agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

410.2 - Office of the Inspector General (OIG) Initiatives

(Rev. 48, 07-09-04)

The OIG, working with the Department of Justice and CMS, has initiatives to help combat health care fraud and abuse and to encourage health care providers/physicians/suppliers, and other entities to comply with the rules and regulations of Federal health care programs. Some of these initiatives include guidance, corporate integrity agreements (CIAs), and the OIG Self-Disclosure Protocol. The OIG Self-Disclosure Protocol is voluntary while the CIAs are mandatory. These initiatives are designed to ensure that the providers/physicians/suppliers, and other entities refund inappropriately received Medicare monies back to the trust funds.

CIAs are entered into between a health care provider/physician/supplier/other entity and OIG as part of a global settlement of a fraud investigation. Under the CIA (which can be for a period ranging from 3 to 5 years), the provider/physician/supplier or other entity is required to undertake specific compliance obligations, such as designating a compliance officer, undergoing training, and auditing. The provider/physician/supplier or other entity must report regarding their compliance activities on an annual basis to the OIG, which is responsible for monitoring the agreements.

The OIG Self-Disclosure Protocol was produced by the OIG to provide guidance to health care providers/physicians/suppliers and other entities that decide to voluntarily disclose irregularities in their dealings with the Federal health care programs. The decision to follow the OIG Self-Disclosure Protocol rests exclusively with the provider/physician/supplier and other entity. The OIG Self-Disclosure Protocol is intended to facilitate the resolution of only matters that, in the provider/physician/supplier and other entity's reasonable assessment, potentially violates Federal, criminal, civil, or administrative laws. It should be noted that providers/physicians/suppliers and other entities who self-disclose to the OIG sign an agreement stating that any refunds submitted as part of the self-disclosure process are not subject to appeal.

410.3 - Unsolicited/Voluntary Refund Accounts

(Rev. 48, 07-09-04)

All Medicare systems shall be able to separately distinguish and track unsolicited/voluntary refund checks which result from a 1) provider/physician/supplier and other entity under a CIA; 2) Provider/physician/supplier and other entity under the OIG Self-Disclosure Protocol; and 3) Straight Refund (a straight refund is a refund from a provider/physician/supplier, or other entity who is not under a CIA nor the OIG Self-Disclosure Protocol). All Medicare systems shall have the ability to identify and produce a report that distinguishes a refund as a CIA, OIG Self-Disclosure Protocol, or straight refund at the point of disposition (i.e., after investigation of the origin of the refund).

To assist in identifying providers/physicians/suppliers under a CIA, Medicare contractors *should* access the OIG Web site (http://www.oig.hhs.gov/fraud/cias.html) for a list of all providers/physicians/suppliers, and other entities under a CIA. *The OIG Web site will also give the effective date of the CIA. To obtain the termination date of the CIA, click on the CIA agreement. The time period of the CIA is contained within the agreement. If the Web site does not provide enough information to determine whether a CIA agreement is in existence, the contractor shall contact the provider as part of their investigation/resolution of the unsolicited/voluntary refund.* Because OIG Self-Disclosure Protocol agreements are voluntary, contractors may not be aware of this agreement unless a provider/physician/suppliers or other entity specifically notifies them.

Providers/physicians/suppliers under an OIG Self-Disclosure Protocol agreement are not given on the OIG Web site. The OIG will send a letter directing the provider/physician/supplier to refund money back to the Medicare contractor when the OIG has completed the Self-Disclosure matter and determined that an unsolicited/voluntary refund should be collected rather than a civil settlement pursued. *A copy of the letter is included as Exhibit 3.* The OIG will also send a copy of the letter to the attention of the Chief Financial Officer for Medicare Operations at the Medicare contractor. The OIG will direct the provider/physician/supplier to identify that the refund check is the result of an OIG Self-Disclosure Protocol agreement. *The provider/physician/supplier will have 30 days to refund the contractor.* If the contractor does not receive the refund within 30 days, the contractor shall notify the Office of Counsel to the Inspector General (OCIG) attorney assigned to the OIG Self-Disclosure Protocol matter, as identified in the letter.

410.4 - Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information is Provided

(Rev. 48, 07-09-04)

The following instructions shall not supersede the present Program Integrity Manual (PIM) that references procedures for handling unsolicited refunds where there is a voluntary repayment and referral to law enforcement. The following procedures shall be followed when unsolicited/voluntary refund checks are received:

1) Do not return any check submitted by a provider/physician/supplier and other entities that is made payable to the Medicare program.

2) To ensure that repayment of Medicare funds is handled properly, Medicare contractors shall deposit such a check within 24 hours of receipt in accordance with Chapter 5, Financial Reporting Manual, section 100.3 and record the check in the account entitled "Other Liabilities – Unapplied Receipts" per Form CMS-750 instructions *found in Chapter 5, Financial Reporting, Section 210*.

3) If *any* checks are not deposited within the 24-hour period, contractors shall record those *undeposited* checks in the account entitled "Assets/Cash – Undeposited Collections" per Form CMS-750 instructions *found in Chapter 5, Financial Reporting, Section 210*. Medicare contractors shall implement internal controls to ensure the safeguarding of these Medicare checks until deposit.

4) If the specific Patient/Health Insurance Claim (HIC)/Claim Number information was provided, the contractor shall deposit the check and make*/initiate* the appropriate adjustments, depending on the entity making the refund and the purpose of the refund, either to the claims and/or to the claim history file within 60 days from *the check's date of deposit for Non-Medicare Secondary Payer (MSP), or 100 days from the initial ECRS inquiry for MSP*. For those contractors whose checks are received through a locked box, appropriate claims adjustments shall be updated within 60 days of receipt of the bank's notification of deposit *for Non-MSP, and 100 days from the initial ECRS inquiry for MSP*.

5) If the provider/physician/supplier, or other entity is not participating in the Self-Disclosure Protocol, contractors shall ensure that any MSN, or Remittance Advice, generated as the result of the claims adjustment contains appeals language, where appropriate. *If necessary, contractors should determine the proper handling of unsolicited/voluntary refunds on any open or re-openable cost report.*

6) No appeal rights shall be afforded, as stated in Exhibit 1, if the provider/physician/supplier, or other entity 1) does not submit the specific Patient/HIC/Claim Number information, or 2) is participating in a Self-Disclosure Protocol agreement.

7) The Medicare contractor shall establish an accounts receivable in the Medicare system that shall be recognized on line 2a, New Accounts Receivable on Form CMS-751 report within 60 days after the deposit of the voluntary refund *for Non-MSP, or 100 days from initial ECRS inquiry for MSP*. In addition, the Medicare contractor shall reduce the "Other Liabilities" account for the same amount, and shall apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-751 report.

8) The accounts receivable shall be established using the last name of the debtor that issued the check or on whose behalf the check was issued, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

9) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier or other entity including those established as a result of medical review, benefit integrity (BI) review, cost reports, other overpayment demands, and MSP demands. If an outstanding receivable is identified, the contractor shall apply the *remaining* amount of the unsolicited/voluntary refund to the outstanding receivable balance. *If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.*

10) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, *or* written documentation*/evidence clearly* support*s* that Medicare is not entitled to the money or was not the intended recipient of the refund check. *Contractors shall follow the non-MSP provider/physician/supplier refund process when encountering MSP provider/physician/supplier unsolicited/voluntary refunds. Monies voluntarily sent in from beneficiaries (or a representative of) and/or insurers or other third party payers may be refunded* ***only*** *if COBC determines, after 100 days, no issue exists or an issue exists which results in the lead contractor identifying Medicare's claim to be less than the refunded amount. For example, many times an attorney may remit payment for the total conditional amount prior to a formal demand.*

11) The Medicare contractor shall be responsible for completing Exhibit 1 *(or facsimile thereof)* as appropriate and reporting it on Exhibit 2.

12) Contractors are not required to report the established accounts receivable on the P*hysician* S*upplier* O*verpayment* R*eporting System (PSOR)*. (This requirement does not preclude the contractor from reporting the receivable on the PSOR for non-MSP, if current systems already do so. The contractor shall not report MSP accounts receivable on the PSOR.)

410.5 - Handling Checks or Associated Correspondence with Conditional Endorsements

(Rev. 48, 07-09-04)

Conditional endorsements are statements on the face of the check or associated correspondence, which might suggest that the payer has discharged its obligation by writing "paid in full" or like phrases that the payer intends as satisfaction/ extinguishment of the debt. Guidelines from the General Accounting Office (GAO) state that agencies must be extremely careful to avoid an unintended accord and satisfaction (i.e., an agreement to accept a payment in full for an amount less than the amount claimed).

The following instruction shall be applied to checks or associated correspondence with a conditional endorsement:

1) Medicare contractors shall deposit such a check within 24 hours of receipt in accordance with CMS's Medicare Financial Management Manual, Chapter 5 Financial Reporting, section 100.3 and record the check in the account entitled "Other Liabilities – Unapplied Receipts" per Form CMS-750 instructions found in Chapter 5, Financial Reporting, Section 210.

2) If any checks are not deposited within a 24-hour period, contractors shall record those checks in the account entitled "Assets/Cash – Undeposited Collections" per Form CMS-750 instructions found in Chapter 5, Financial Reporting, section 210. Medicare contractors shall implement internal controls to ensure the safeguarding of these Medicare checks until deposit.

3) Contractors shall immediately notify the debtor and/or the entity on whose account the check is drawn, if not the debtor, by certified mail. The following statement is suggested: **This is to acknowledge the receipt of the repayment in the amount of $XX, check number XX. The matter is being researched; however, the amount of the repayment may be insufficient to discharge the obligation and the debt may not be fully extinguished.**

4) *The check(s) shall than be processed as outlined under section 410.4 or 410.6 as applicable.*

The infrequent receipt of checks with conditional endorsements should not negatively impact your production process. The standard letter needed to meet this requirement shall be added to your automated letter processing or generated from a personal computer.

(Rev. 48, 07-09-04)

After depositing unsolicited/voluntary refund checks in accordance with section 410.4 above, Medicare contractors shall do the following:

For Non-MSP Checks

1) If no specific Patient/Health Insurance Claim (HIC)/Claim Number information was provided with the unsolicited/voluntary refund, the contractor shall contact the provider/physician/supplier, or other entity sending the refund check for further information. Exhibit 1 (overpayment refund) contains the minimum claim specific data necessary to process the refund. The contractor *should* use this form during phone inquiry or attach it to a letter to the provider/physician/supplier requesting further information regarding the submitted refund.

2) When there is no identifying information provided, the contractor shall perform the research necessary to obtain the minimum data required to meet the reporting requirements in Exhibit 2 (Summary Report). If the information is being collected via a telephone inquiry, the contractor employee conducting the inquiry shall inform the provider/physician/supplier, or other entity verbally that **if the specific Patient/HIC/Claim # information is not provided, no appeal rights can be afforded.**

   The minimum reporting data shall include:

   a. Provider/physician/supplier, or other entity's name, number, and Tax ID number.

   b. Identification of whether the provider/physician/supplier, or other entity has a CIA with the OIG or are under the OIG Self-Disclosure Protocol; and whether it is a straight refund (i.e., a provider not under a CIA or OIG Self-Disclosure Protocol).

   c. The reason(s) for each refund.

   d. The total number of refund checks *(in the case of a check with multiple providers/reason codes, each instance shall be counted separately).*

   e. The total dollar amount of refunds.

3) Medicare contractors shall have 60 days from deposit of the check to obtain the minimum claim specific data required to apply the check. The contractor shall take at least one documented follow-up action during the 60-day period to obtain the data.
4) If the minimum claim specific data required to apply the refund **is obtained** from the provider/physician/supplier, or other entity within 60 days from *the check's date of deposit*, the contractor shall make*/initiate any* appropriate adjustments to the identified claims and/or the claim history file for the amount of the refund. The contractor shall establish an account(s) receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account within 60 days

after the deposit of the voluntary refund. The contractor shall ensure that any Remittance Advice or MSN generated as a result of the claim adjustment contains the appropriate appeals language, *if applicable*.

5) If the minimum claim specific data required to apply the refund **is not obtained** from the provider/physician/supplier, or other entity within 60 days from *the check's date of deposit*, the "Other Liabilities" account shall be reduced and an accounts receivable due to a straight refund shall be established for the amount of the unapplied unsolicited/voluntary refund. All Medicare systems shall allow contractors the ability to set up accounts receivable using either the provider/physician/supplier, or other entity or beneficiary number.

6) In both instances, the Medicare contractor shall establish an accounts receivable in the Medicare system that shall be recognized on line 2a, New Accounts Receivable on Form CMS-751 report within 60 days after the deposit of the voluntary refund. In addition, the Medicare contractor shall perform a simultaneous transaction to apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-751 report.

7) The accounts receivable shall be established using the last name of the debtor identified on the check, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

8) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier including those established as a result of medical review, BI review, cost reports, other overpayment demands, and MSP demands. If an outstanding receivable is identified, the contractor shall apply the *remaining* amount of the unsolicited/voluntary refund to the outstanding receivable balance. *If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.*

9) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, *or* written documentation*/evidence clearly* support*s* that Medicare is not entitled to the money or was not the intended recipient of the refund check.

10) The Medicare contractor shall be responsible for ensuring the completion of Exhibit 1 *(or facsimile thereof)* and reporting it on Exhibit 2 upon final disposition of the unsolicited/voluntary refund (i.e., after investigation of the origin of the refund).

11) Contractors are not required to report the established accounts receivable on the PSOR. (This requirement does not preclude the contractor from reporting the receivable on the PSOR if current systems already do so.)

For MSP Checks

1) The Medicare contractor shall determine if there is an existing case and/or accounts receivable. If this is an existing case and/or accounts receivable, the contractor shall follow normal recovery procedures. If there is no case and/or accounts receivable, and there is indication of MSP involvement, the contractor shall send an MSP inquiry via the Electronic Correspondence Referral System (ECRS) to the MSP Coordination of Benefits Contractor (COBC) *within 20 days from the check's date of deposit. The 45-day correspondence timeframe is not appropriate for addressing checks either solicited or unsolicited. Contractors shall identify checks during the initial mail sort and place a priority on their resolution and distribution.* **When referring information to the COBC for MSP investigation, the contractor shall forward all pertinent data. All fields on the ECRS Inquiry screen shall be completed if the data is available on the returned check or any accompanying correspondence. Information in the informant fields such as telephone numbers, point of contact, etc. are critical to COBC development efforts.**

2) Medicare contractors shall only allow *100* days from *the date of the ECRS inquiry* for a response *from the COBC* before taking action with respect to the "unapplied receipts." This time period will also allow for the COBC to develop the case. If additional information is obtained after the initial inquiry that would help facilitate the processing and research of information, the COBC Consortia Representative shall be contacted and provided the additional information, via fax or telephone, to assist in completing the research. The contractor shall not send a second ECRS inquiry. *A total of 120 days from the check's date of deposit will be allowed to bring closure to the unapplied receipt.*

3) If the minimum reporting information from the MSP COBC **is provided** within *100* days from *the initial ECRS inquiry*, the contractor shall make*/initiate any* appropriate adjustments to either the identified claims and/or the claim history file for the amount of the refund, depending on the entity making the refund and the purpose of the refund. The Medicare contractor shall establish an account(s) receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account. *If as a result of applying the voluntary refund the contractor identifies additional dollars specific to the issue in CWF, a demand letter shall be sent for the remaining amount owed.*

4) If, within *100* days from *the initial ECRS inquiry*, 1) the minimum reporting information **is not provided,** 2) a response has not been received from the MSP COBC, or 3) a response from the COBC indicates the*y could not obtain a response* (e.*g.*, *CM Code 62*), Medicare contractors shall establish an accounts receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account. *For COBC no response codes specific to a provider/physician/supplier unsolicited/voluntary refund, contractors should do the full claim adjustment but use a non-MSP reason (i.e., billed in error), which would then not need an MSP record to be established on CWF.* The contractor shall report the refund in Exhibit 2

(Unsolicited/Voluntary Refund - Summary Report), and annotate with *reason code* 16. *In addition, Exhibit 1 and/or the contractor's supporting documentation shall specify the refund* as received with no reason for refund *and/or no MSP response*.

5) The Medicare contractor shall establish an accounts receivable in the Medicare system and that shall be recognized on line 2a, New Accounts Receivable on Form CMS-M751 report within *100* days after the *initial ECRS inquiry*. In addition, the Medicare contractor shall perform a simultaneous transaction to apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-M751 report. The contractor shall initiate normal MSP recovery action for any remaining outstanding balance owed.

6) The accounts receivable shall be established using the last name of the debtor that issued the check or on whose behalf the check was issued, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

7) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier or other entity including those established as a result of medical review, BI review, cost reports, other overpayment demands. If an outstanding receivable is identified, the contractor shall apply the *remaining* amount of the unsolicited/voluntary refund to the outstanding receivable balance. *If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.*

8) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, *or* written documentation/*evidence clearly* supports that Medicare is not entitled to the money or was not the intended recipient of the refund check. *Contractors shall follow the non-MSP provider/physician/supplier refund process when encountering MSP provider/physician/supplier unsolicited/voluntary refunds. Monies voluntarily sent in from beneficiaries (or a representative of) and/or insurers or other third party payers may be refunded* ***only*** *if COBC determines, after 100 days, no issue exists or an issue exists which results in the lead contractor identifying Medicare's claim to be less than the refunded amount. For example, many times an attorney may remit payment for the total conditional amount prior to a formal demand.*

9) The Medicare contractor shall be responsible for ensuring the completion of Exhibit 1 *(or facsimile thereof)* and reporting it on Exhibit 2 upon final disposition of the unsolicited/voluntary refund (i.e., after investigation of the origin of the refund).

10) Contractors shall not report the MSP accounts receivable on the PSOR.

410.7 - CMS Reporting Requirements

(Rev. 48, 07-09-04)

CMS shall require that all intermediaries and carriers report, in the provided Exhibit 2 format, the receipt of all unsolicited/voluntary refund checks from providers/physicians/suppliers, and other entities. The reports shall be due quarterly and shall be sent to the regional office (RO), BI Coordinator, by the 15th day of the following month (January 15, April 15, July 15, and October 15). All intermediaries and carriers shall be required to submit a "negative" report even if they have $0 dollar reporting. The RO will compile a list of all intermediaries and carriers that are required to submit a quarterly report and identify those that are not in compliance. The RO will contact those not in compliance and request the submission of the reports. On the last day of *the month* (i.e., January 31, April 30, July 31 and October 31), the RO will send the compiled list of intermediaries and carriers, with copies of all submitted reports to CMS Central office, Director, Division of Benefit Integrity and Law Enforcement Liaison, Mail Stop C3-02-16, 7500 Security Boulevard, Baltimore, Maryland 21244.

410.8 - Exhibit 1 - Overpayment Refund

(Rev. 48, 07-09-04)

Exhibit 1 displays the required information needed to research and document unsolicited/voluntary refunds received. Medicare contractors shall maintain files that include copies of all unsolicited/voluntary refunds received and the completed report, Exhibit 1. These documents shall serve as a tracking mechanism for audit trail purposes.
Contractors are not required to use Exhibit 1 verbatim; however, the alternative documents used shall contain, at a minimum, all of the elements outlined in Exhibit 1.

410.9 - Unsolicited/Voluntary Refund Checks – Summary Report

(Rev. 48, 07-09-04)

Exhibit 2 displays reporting requirements for all CMS unsolicited/voluntary refund checks. The contractor shall report all unsolicited/voluntary refunds from providers/physicians/suppliers, and other entities identified on the OIG Web site, in addition to those that identify themselves as having a CIA, OIG Self-Disclosure Protocol, and/or straight refund. The following data shall be

captured: the provider/physician/supplier, or other entity's name(s), provider number(s) Tax ID(s), reason code for refund, number of refund checks, and the total dollar amount of refund checks. Reason code #16 shall be used to identify that no reason was provided for the refund.

The contractor is not required to list each check received for the quarter individually, but may total all the checks on one line for the same provider/physician/supplier. Therefore, multiple checks for the same provider/physician/supplier when totaled shall be grouped by like categories for the following:

1. *Same Provider/Physician/Supplier*
2. *Same Reason Code*
3. *CIA category*
4. *Self-Disclosure category*
5. *Straight Refund category*

Example 1: Ten checks totaling $100.00 are received from Dr. X for Reason Code 02, but 5 checks are under a CIA and 5 checks are a straight refund.

Exhibit Columns:
Column 1, Provider/Physician/Supplier or Other Entity Name(s): Dr. X
Column 2, Provider/Physician/Supplier Number(s): 99999
Column 3, Tax ID Numbers: 9999999999
Column 4, Reason Codes: 02
Column 5, Line 1 CIA, SDP, Straight Refund: CIA
Column 5, Line 2 CIA, SDP, Straight Refund: Straight Refund
Column 6, Line 1 Total Number of Refund Checks: 5
Column 6, Line 2 Total Number of Refund Checks: 5
Column 7, Line 1 Total Amount of Refunds: $50.00
Column 7, Line 2 Total Amount of Refunds: $50.00

Example 2: Ten checks totaling $100.00 are received from Dr. Y, 8 checks are for Reason Code 02 and 5 of these checks are a CIA and 3 are a straight refund, 2 checks are for Reason Code 03 and 1 check is a CIA and 1 check is a straight refund.

Exhibit Columns:
Column 1, Provider/Physician/Supplier or Other Entity Name(s): Dr. Y
Column 2, Provider/Physician Supplier Number9s): 99999
Column 3, Tax ID Numbers: 9999999999

Column 4, Line 1 Reason Codes: 02
Column 4, Line 2 Reason Codes: 02
Column 4, Line 3 Reason Codes: 03
Column 4, Line 4 Reason Codes: 03
Column 5, Line 1 CIA, SDP, Straight Refund: CIA
Column 5, Line 2 CIA, SDP, Straight Refund: Straight Refund
Column 5, Line 3 CIA, SDP, Straight Refund: CIA
Column 5, Line 4 CIA, SDP, Straight Refund: Straight Refund
Column 6, Line 1 Total Number of Refund Checks: 5
Column 6, Line 2 Total Number of Refund Checks: 3
Column 6, Line 3 Total Number of Refund Checks: 1
Column 6, Line 4 Total Number of Refund Checks: 1
Column 7, Line 1 Total Amount of Refunds: $40.00
Column 7, Line 2 Total Amount of Refunds: $20.00
Column 7, Line 3 Total Amount of Refunds: $20.00
Column 7, Line 4 Total Amount of Refunds: $20.00

410.10 – Education
(Rev. 48, 07-09-04)

On an annual basis, the contractor shall include in the newsletter/bulletin the following information: "The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters *shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.*

411 – Exhibits
(Rev. 48, 07-09-04)

411.1 - Exhibit 1 – Overpayment Refund Form

SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____
Contractor Deposit Control # _____Date of Deposit: _____
Contractor Contact Name: _____ Phone #: _____
Contractor Address: _____
Contractor Fax: _____
_____

SHALL BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER, OR OTHER ENTITY

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER OR OTHER ENTITY NAME: _____
ADDRESS: _____
PROVIDER/PHYSICIAN/SUPPLIER #: _____ TAX ID #: _____
CONTACT PERSON: _____ PHONE #: _____
AMOUNT OF CHECK $: _____ CHECK #: _____ CHECK DATE: _____

REFUND INFORMATION

For each claim, provide the following:
Patient Name: _____ HIC #: _____
Medicare Claim Number: _____ Claim Amount Refunded $: _____
Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim.)

(Please list all claim numbers involved. Attach separate sheet, if necessary)
Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

NOTE: If specific patient/HIC/Claim # information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians/suppliers, and other entities who are submitting a refund under the OIG's Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For Institutional Facilities Only:
Cost Report Year (s) _____

(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? ___ Yes ___ No
Are you a participant in the OIG Self-Disclosure Protocol? ___ Yes ___No

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Exhibit 1 – Overpayment Refund Form (Cont.)

Reason Codes:

Billing/Clerical:	MSP/Other Payer Involvement:	Miscellaneous:
01 – Corrected Date of Service	07 – MSP Group Health Plan Insurance	12 – Insufficient Doc
02 – Duplicate	08 – MSP No Fault Insurance	13 – Patient Enroll HMO
03 – Corrected CPT Code	09 – MSP Liability Insurance	14 – Svcs Not Rendered
04 – Not Our Patient(s)	10 – MSP, Workers Comp.	15 – Medical Necessity
05 – Mod. Add/Remove (Incl Black Lung)		16 – Other-Please Specify
06 – Billed in Error	11 – Veterans Administration	

411.2 - Exhibit 2 - Unsolicited/Voluntary Refund Checks Summary Report (Rev. 48, 07-09-04)

CONTRACTOR'S NAME _____
CONTRACTOR'S NUMBER (S): _____

REPORTING PERIOD FROM _____ TO _____
DATE OF REPORT _____

(1)	(2)	(3)	(4)	(5)	(6)	(7)

PROVIDER/ PHYSICIAN/ SUPPLIER, OR OTHER ENTITY NAME (S)	PROVIDER/ PHYSICIAN/ SUPPLIER NUMBER(S)	TAX ID NUMBER (S)	REASON CODES*	PROVIDERS/PHYSICIANS/SUPPLIERS, AND OTHER ENTITIES UNDER A CIA, OIG SELF-DISCLOSURE OR STRAIGHT REFUNDS (Choose either A, B, or C from description below	TOTAL NUMBER OF REFUND CHECKS	TOTAL AMOUNT OF REFUNDS
Example 1:						
Dr. X	*99999*	*9999999999*	*02*	*CIA*	*5*	*$50*
			02	*Straight Refund*	*5*	*$50*
Example 2:						
Dr. Y	*99999*	*9999999999*	*02*	*CIA*	*5*	*$40*
			02	*Straight Refund*	*3*	*$20*
			03	*CIA*	*1*	*$20*
			03	*Straight Refund*	*1*	*$20*
						TOTAL $

*These codes are found on Exhibit 1

A – Providers/Physicians/Suppliers and Other Entities under a **CIA**
B – Providers/Physicians/Suppliers and Other Entities under **OIG Self-Disclosure Protocol**
C – **Straight Refunds**

THIS REPORT SHALL BE USED TO REPORT ALL UNSOLICITED/VOLUNTARY REFUND CHECKS RECEIVED DURING THIS PERIOD. INCLUDE THOSE REPORTED ON EXHIBIT 1 FOR CIA AND OIG SELF-DISCLOSURE PROTOCOL PROVIDERS/PHYSICIANS/SUPPLIERS, AND OTHER ENTITIES.

411.3 - Exhibit 3 – OIG Law Enforcement Demand Letter

(Rev. 48, 07-09-04)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Office of Investigations

[Date]

[Provider]

Re: Provider Self-Disclosure
[Provider]
OIG Case Number [CIMS#]

Dear [---------]:

We are writing to follow up on your [date of initial submission] disclosure to the Office of Inspector General ("OIG") pursuant to the OIG's Provider Self-Disclosure Protocol. Based upon our review of the materials and information you furnished to us, it appears that [Provider] should refund [$-----] in connection with claims it submitted to [Medicare/Medicaid] from [-------] to [--------]. Please refund this amount to [contractor or state payor] within 30 days. In addition to [Provider]'s refund check, please provide [contractor or state payor] with the following information: (i) why the voluntary refund is being made (i.e., Self-Disclosure Protocol submission); (ii) how it was identified; (iii) what steps were taken to ensure that the issues leading to the Self-Disclosure Protocol submission were corrected; (iv) the dates the corrective actions were in place; (v) the time period and provider numbers involved in the voluntary refund; and (vi) the fact that a full assessment was performed to determine the entire time frame.

To the extent that [Provider] seeks to receive reimbursement for underpayments identified in connection with its investigation of the claims described above, it is our understanding of CMS policy that [Provider] must resubmit those claims in accordance with CMS's [or state payor's] policies and procedures. Medicare Part A claims may only be reopened within the time limits prescribed by 42 C.F.R. § 405.750. See also 42 C.F.R. § 405.1885. Part B claims may only be reopened within the time limits prescribed by 42 C.F.R. § 405.841. See generally 42 C.F.R. §§ 405.701-.1889. In the event that the applicable time limit for resubmission of [Provider]'s [Part A/Part B] claims has already

expired, the fact that [Provider] is making the refund described in the first paragraph above does not extend those time limits.

Please provide [Special Agent Assigned] and [OCIG Attorney Assigned] with written confirmation of [Provider's] repayment of the overpayment described above so that we may close our file. Thank you for bringing this matter to our attention.

Sincerely,

[Name of RIGI]
Regional Inspector General
for Investigations

cc: [OCIG Attorney Assigned]
[CMS Regional Office Contact Person]
[Contractor Benefit Integrity Manager or Coordinator]

500 - Procedures for the Reconciliation of Total Funds Expended for Fiscal Intermediary Shared System (FISS) Medicare Contractors Used in the Preparation of Form CMS-1522¸ Monthly Contractor Financial Report

(Rev. 20, 08-01-03)

The Centers for Medicare & Medicaid Services (CMS) continues to have a material internal control weakness for the reconciliation of total funds expended on Form CMS-1522 resulting from the Chief Financial Officers Audit. The reconciliation of total funds expended to adjudicated claims and standard system reports is an important control that ensures that the amounts reported by Medicare contractors are accurate, supported, complete, and properly classified.

The CMS requires that Medicare contractors provide a reconciliation of total funds expended reported on the monthly Form CMS-1522 report by the 15th day of the following month. Form CMS-1522 is a cash-based document and is prepared primarily from FISS system reports, bank statements, and other internal reports. The financial reconciliation includes adjudicated claims processed, other non-claims based payments, overpayment recoveries, and other financial adjustment transactions.

Total funds expended represent payments made for claim and non-claim transactions during each claims payment cycle (i.e., the total of all checks issued, electronic funds transfers (EFT) payments, voided checks, overpayment recoveries, and other financial adjustments). The claims payment cycle varies at each contractor and can be daily, multi-weekly, or weekly.

Claims data files maintained by the fiscal intermediary, produced from FISS Job #XXXX0054X, include all claims received and processed during a payment cycle – adjudicated claims and non-adjudicated claims. Adjudicated claims represent those claims that were processed for payment and included on the remittance advice report. Non-adjudicated claims do not appear on the remittance advice and include demonstration claims, claims returned to the quality improvement organization (QIO) or

provider, and other exception claims. The FISS Systems Maintainer will generate a detailed claims data file that includes only the adjudicated claims records processed each payment cycle in order for financial reporting personnel to complete the financial reconciliation. Also, the FISS Systems Maintainer will generate a report that summarizes the number and dollar value of adjudicated claims on the detailed claims data file.

Although the enclosed reconciliation format has been tested and proven adequate for most situations, there may be unique situations at selected contractors that result in an "unreconciled" reconciliation. When those situations occur, the contractor should investigate those differences and identify the source of the difference. The standard format can be adjusted to accommodate those differences so that the reconciliation and Form CMS-1522 can be completed. Contractors should report those differences to CMS for further review and adjustment of the standard format.

The lead reconciliation schedule (section 500.4) must be submitted electronically to the appropriate CMS. FISS system reports, bank statements, and other internal reports used to create the lead reconciliation schedule must be maintained and made available upon request for audit and review by CMS financial personnel and other external auditors.

Methodology

Contractors are required to complete the financial reconciliation schedules for each claims processing cycle, and provide a copy of the cumulative monthly totals in the format established in Section 500.4. The reconciliation should be completed at the end of each claims payment cycle to identify any differences as they occur and provide sufficient time to resolve those differences before the next cycle ends. View Exhibit I by clicking on this link to access the electronic spreadsheet in Microsoft® Excel format to complete the following steps.

To complete the reconciliation for each claims payment cycle, FISS contractors must:

1. The FISS system maintainer will identify and summarize the adjudicated claims for each claims payment cycle. The FISS system maintainer will create a detailed claims data file and summary report that must be retained for review and audit purpose (section 500.1).

    a. Obtain the detailed claims data file and summary report from the FISS system maintainer detailed claims data file for each claims payment cycle.

    b. Enter the detailed claims data file totals for each payment cycle onto reference lines 1-1 through 1-2 of the electronic spreadsheet (section 500.3).

    c. Obtain FISS Report #7859R01, Create Claim File Control Report, and enter selected data onto reference lines 2-1 through 2-12 of the electronic spreadsheet (section 500.3).

d. Obtain FISS Report #7859R02, Claim File Control Report, for the prior and current cycles. Identify those claims that have either been suspended for correction by the contractor or those claims that that have been released from suspension. Financial personnel can determine those amounts by identifying and summarizing the difference between the amounts reported on FISS Report #7859R02 from the prior claims payment cycle to the current claims payment.

    i. Claims that have been added to the current FISS Report #7859R02 must be subtracted from the adjudicated amount by entering the dollar amount and number of claims onto reference lines 3-1 and 3-3 of the electronic spreadsheet (section 500.3).

    ii. Claims that have been removed from the prior FISS Report #7859R02 must be added to the adjudicated amount by entering the dollar value and number of claims onto reference lines 3-2 and 3-4 of the electronic spreadsheet (section 500.3).

e. Obtain FISS Report #8074R01, Claim Payment Update Report – Inpatient, and FISS Report #8074R02, Claim Payment Update Report – Outpatient. Enter selected totals from those reports onto reference lines 4-1 through 4-5 and 5-1 through 5-5 of the electronic spreadsheet (section 500.3).

f. Review the Tape Reconciliation Check lines below reference line 5-5. The amounts on those lines must be ZERO; research any differences that are identified and make corrections to any of the amounts entered while performing steps b. through e. above.

2. Obtain financial FISS system reports and enter selected data from those reports onto the electronic spreadsheet.

Obtain copies of the primary financial FISS system reports that are used in the financial reconciliation process. A list of those report numbers and report descriptions is included in section 500.2.

a. Enter selected financial information from FISS system reports into the electronic spreadsheet (section 500.3) on reference lines 6-1 through 16-24. Information should only be entered into cells with a light blue background. All other cells on the spreadsheet are locked to prevent overwriting of the formulas used to complete the reconciliation.

b. The electronic spreadsheet automatically allocates the total for each expenditure amount to the appropriate funding classification -- hospital insurance (HI) or supplemental medical insurance (SMI). In selected cases, the allocation cannot be determined from FISS system reports and the amounts are allocated using the ratio of the dollar value of

inpatient and outpatient claims identified on the Create Claim File Control Report (FISS Report #7859R01) that is summarized on section 500.5.

c. Review the Net Disbursements Check lines below reference line 16-14. The amounts on those lines must be ZERO; research any differences that are identified and make corrections to any of the amounts entered in a. above

d. Enter financial information that is not available from FISS system reports onto reference lines 17-1 through 18-11 of the electronic spreadsheet (section 500.3).

    i. The information for reference lines 17-1 through 17-10 should be obtained from the list of deposits made to the bank account. The labels for each of those lines can be changed in Column B of the electronic spreadsheet (section 500.3) on reference lines 17-1 through 17-10 and the new label will be transferred to the printed schedules.

    ii. The information for reference lines 18-1 through 18-11 should be obtained from the bank statements, the manual check listing, the voided and stale-dated check listing, and other manually maintained listings that identify correcting financial transactions for the month. The labels for each of those lines can be changed in Column B of the electronic spreadsheet (section 500.3) on reference lines 18-1 through 18-11 and the new label will be transferred to the printed schedules.

        1. The information for reference lines 18-1 through 18-4 can be found on the bank statements or from other bank notification documents.

        2. The information for reference lines 18-5 and 18-6 are available for situations that do not occur on a routine basis.

        3. The information for reference lines 18-7, 18-8, and 18-9 relate to the issuance of manual checks. The amount entered on reference line 18-7 should include all manual checks written except for transfers between the disbursement and time accounts. Enter the transfer red amount on reference line 18-8. Because the transferred amount does not impact total funds expended, the amount is also be entered automatically on reference line 18-7 as a negative number.

4. The information for reference lines 18-10 and 18-11 relate to voided checks and stale-dated checks for the month.

e. The allocation of HI and SMI amounts are automatically determined from the information provided in the FISS system reports for reference lines 1-1 through 16-14. The HI and SMI amounts for reference lines 16-15 through 16-24 are partially determined from FISS system reports and partially through the allocated using the ratio of total inpatient and outpatient claims processed during the payment cycle. Reference lines 17-1 through 18-11 are allocated just using the ratio of the total inpatient and outpatient claims process during the claims payment cycle. Those percentage amounts are calculated on line B-13 of section 500.5 and can be found in cells AT278 (HI) and AU278 (SMI). All cells with a red background were calculated using that allocation method. If contractor personnel can provide a more accurate allocation of HI and SMI amounts for any of those lines, those amounts can be entered into any cell with a red background. The amounts entered will override the allocation formulas.

3. Finalize the standard reconciliation report, print the supporting schedules (sections 500.5 through 500.8), and submit the consolidated monthly report to CMS as part of the monthly contractor financial reports (section 500.4).

After completing the process outlined in 1. and 2. above, all of the financial information needed to identify total funds expended has been entered into the standard report format. That information is transferred into five standard reports that are used to document the financial information entered onto Form CMS-1522. Those reports are illustrated in sections 500.4 through 500.8 of this instruction.

a. After entering all of the financial information in reference lines 1-1 through 18-11 the value of total funds expended has been determined. The next step is to verify that the amount allocated by HI and SMI have been properly completed. As noted above, the standard report format performs most of that process automatically. To determine whether there are any differences in that allocation, review Column J on the electronic spreadsheet and research any entry on the schedule line A-1 through E-33 that is not ZERO. If the schedules are reconciled, all entries in Column J must be ZERO.

b. If the contractor has overridden any of the HI and SMI allocation formulas, extra effort should be made to ensure that the allocation amounts equal the total amount for those categories. Again, the formula in Column J should produce a value of ZERO if the line is in balance.

c. The standard report format in section 500.8 calculates the amounts that are reported on the end of the Form CMS-1522 (i.e. the categorization of total funds expended by payment categories). While the standard report format is able to calculate the total dollar value of retroactive adjustments, and FISS system report #8042R01 provides some allocation of the system processed transactions, there is no standard source that provides a sufficient methodology to allocate the non-system processed transactions by the following reporting category used on Form CMS-1522.

i. Itemization of Retroactive Adjustments
(Form CMS-1522, Page 5)

- Lump Sum Interim Rates and Tentative Audit Settlements amounts are obtained from FISS system report #8042R01

- Post Audit Settlements are determined as the difference in the total retroactive adjustment amounts less the lump sum interim rates and tentative audit settlement amounts identified above.

ii. Retroactive Adjustments
(Form CMS-1522, Page 1, Lines 9-11)

- Credit Adjustment are obtained from FISS system report #8042R01

- Supplemental Payments are determined as the difference in the total retroactive adjustment amounts less the credit adjustment amounts identified above.

The total amounts allocated by HI and SMI are calculated using known amounts obtained from FISS system report 8042R01 and the allocation of HI and SMI using the ratio of total inpatient and outpatient claims processed during the payment cycle.

Overall Summary

The methodology used to identify the number and dollar value of adjudicated claims on the detailed claims data file provided in section 500.1, the FISS systems reports identified in section 500.2, the electronic spreadsheet input schedule in Section 500.3, and the standard report formats provided in sections 500.4through 500.8 are a systematic approach to reconcile financial activity for each claims payment cycle at Medicare FISS contractors.

The information contained on the schedules provides a standard methodology to validate financial information contained on FISS system reports to the source claims information contained in the detailed claims data file. The methodology outlined above and the information contained on the standard report formats document a standardized approach to calculate and validate the total funds expended at Medicare contractors.

Also, the standard report formats assist in the preparation of a significant portion of the Form CMS-1522. The methodology does not provide information relating to the Funds Drawn from the Treasury presented on lines 1 through 6 of Form CMS-1522, or for the bank reconciliation information presented on Form CMS-1522, Page 2 and 3, Lines 15 through 23.

Due Date

A copy of the schedule illustrated in section 500.4, Total Funds Expended (Net Disbursements and Adjustments to Net Disbursements), must be provided electronically to the appropriate CMS regional office's Associate Regional Administrator for the Division of Medicare Financial Management, by the 15th day of the following month, concurrent with the submission of other Contractor Financial Reports and submitted electronically to 1522recon@cms.gov. All of the schedules illustrated in sections 500.4 through 500.8 should be retained to support the information submitted to the appropriate CMS regional office.

500.1 – Identification and summarization of Detailed Claims Data Records for Use in the Financial Reconciliation of Total Funds Expended to Fiscal Intermediary Shared System Reports

(Rev. 20, 08-01-03)

The FISS Systems Maintainer will generate a detailed claims data file for each FISS contractor's payment cycle, produced from FISS Job #XXXX0054X. During claims processing, the FISS system maintains a record of all claims processed during the payment cycle, including both adjudicated and non-adjudicated claims. Adjudicated claims include all PIP and non-PIP reimbursement claims, and rejected and denied claims that can be processed by FISS. The non-adjudicated claims include demonstration claims, claims that could not be processed and must be returned to either the provider or the Quality Improvement Organization (QIO), and other exception claims.

The FISS Systems Maintainer will identify only those adjudicated claims that appear on remittance advices and that are identified on FISS Report #7859R01, and will record those claims records onto a detailed claims data file.

The FISS Systems Maintainer will provide an independent report that shows the total number of records on the electronic file and the total dollar value for each of the following fields from FISS Report #7859R01:

Claims Records Out/Paid - Inpatient

Claims Records Out/Paid - Outpatient

Claims Records Out/Modified - Inpatient

Claims Records Out/Modified - Outpatient

Error Records Out/Paid – Inpatient

Error Records Out/Paid - Outpatient

The fiscal intermediary will obtain the detailed claims data file and the summary report from the system maintainer for use in the financial reconciliation of total funds expended that is reported on Form CMS-1522 each month. The fiscal intermediary will retain the detailed data file and the summary report for each payment cycle in order to document the information entered onto the standard electronic spreadsheet and, when required, for use and review by CMS and other audit personnel.

500.2 – Using the Electronic Spreadsheet to Complete the Reconciliation of the Detailed Claims Data File to Fiscal Intermediary Shared System Reports.

(Rev. 20, 08-01-03)

This section describes the methodology to use the electronic spreadsheet (Section 500.3) and identifies the primary FISS system reports needed to complete the financial reconciliation.

The electronic spreadsheet (Exhibit 1) consists of two pages – PrintMenu and Reconciliation. Each of those pages is protected to ensure that the user cannot write over any formulas or linked areas of the spreadsheet. The electronic spreadsheet was created in Microsoft® Excel 2000 and macros must be enabled. When the spreadsheet is loaded, you should receive a message concerning macros. You must 'Enable Macros' for the automatic printing capability to work properly. Following are some general rules to follow when using the electronic spreadsheet.

PrintMenu

This page contains two basic functions: (1) identifying and filling in the cycle dates, and (2) printing the cycle and monthly reports.

1. Cycle Dates. Generally, payment cycle dates are consistent throughout the year (i.e., they occur on the same calendar day(s) each week). Consequently, the actual dates can be determined automatically. At the top of the 'PrintMenu' enter the calendar year as a 4-digit number in block 'I4' and enter the month as a 1- or 2-digit number in block 'I5'. In blocks 'I2' through 'O2" enter an 'X' for each payment cycle day during the week. The monthly cycles and the cycle payment dates will automatically be identified on the left side of the screen in blocks 'A1' thru 'D32', including leap years. Those cycle dates will also be entered onto the top of the cycle columns on the 'Reconciliation' spreadsheet.

2. Printing Reports. The standard format reconciliation reports should be printed after each cycle to document the cycle information and the reconciliation process. Pressing the left mouse button when the cursor is positioned over one of the buttons on the 'PrintMenu' screen and the cursor appears as a pointing hand can print the reports. There are two types of buttons for printing the reports.

    a. Cycle XX (Green text on Gray background). There are 31 buttons in the center of the screen that will print the five reports for each cycle. The spreadsheet will accommodate up to 31 daily cycles for each month. When selected, the report will print the information in Columns A thru G plus the data in the column for the selected cycle. Each report will provide the 'Total Amount to Date' plus the selected Cycle columns. Because there is only one 'Total Amount to Date' column, it will change after the data for each cycle is entered.

    b. Monthly Reports (Red/Blue text on Gray background) – There are six buttons on the right side of the screen that will print either all five of the monthly reports (Red text button) or each of the reports separately (Blue text buttons). The monthly reports will print the information in Columns A thru J that include the total amounts for the month, the allocation by HI and SMI, and the Zero Check field.

Reconciliation

The reconciliation spreadsheet is the where most of the data is entered to complete the financial reconciliation of the Form CMS-1522. As noted at the top of the page, only enter data in designated cells and avoid entering data in selected unprotected cells unless you are sure you want to overwrite the standard formulas. All cells with formulas or transferred data are locked to prevent overwriting, except those with a red background. Those cells contain formulas but if the use has more accurate information, those formulas can be overwritten.

To complete the reconciliation, information from standard FISS system reports is entered into a common data input area of the Reconciliation spreadsheet (see section 500.3). The data input area is located on lines 8 thru 164 the electronic spreadsheet in columns L through AP. The information for individual reports is grouped together for easy input and is identified by references line numbers (found in Column A of the electronic spreadsheet) that begin with a number (for example, FISS Report #7859R01 information is found on reference line numbers 2-1 thru 2-12). The standard FISS reports or other source documents used in the financial reconciliation, including the reference line numbers, are identified in the following table.

1-1 thru 1-2	Claims Payment File Tape Summarization
2-1 thru 2-12	FISS #7859R01 - Claim File Control Report
3-1 thru 3-4	FISS #7859R02 - Claim File Control Report
4-1 thru 4-5	FISS #8074R01 - Claim Payment Update Report - Inpatient
5-1 thru 5-5	FISS #8074R02 - Claim Payment Update Report - Outpatient
6-1 thru 6-22	FISS #8014R01 - Financial Summary Report
7-1	FISS #8015R01 - Part A - Penalty Withholding Report
8-1	FISS #8015R02 - Part B - Penalty Withholding Report
9-1 thru 9-1	FISS #8015R05 - Part A - Accelerated Payment Withholding Report
10-1 thru 10-2	FISS #8015R06 - Part B - Accelerated Payment Withholding Report
11-1 thru 11-2	FISS #8019R01 - Disbursement Control Account
12-1 thru 12-2	FISS #8034R01 - Cash Receipts Journal
13-1 thru 13-4	FISS #8036R01 - Cash Disbursements Journal
14-1 thru 14-7	FISS #8037R01 - Monthly Benefits Reconciliation Update
15-1 thru 15-2	FISS #8037R02 - Monthly Benefits Reconciliation Update
16-1 thru 16-24	FISS #8042R01 – Form CMS-1522 Update Report
17-1 thru 17-10	List of Daily Deposits for the Month
	Bank Statements – Time Account, Disbursement Account, Concentration Account
	Bank Reconciliation
18-1 thru 18-11	List of Manual Checks Issued During the Month
	List of Voided and State-Dated Checks
	List of Other Financial Adjustment Transactions Occurring During the Month

Following are some general rules for using the electronic spreadsheet (Exhibit 1).

1. Entering Data. All data must be entered into a “data entry area” that has references in Column A that are all numeric (lines 1-1 thru 18-11). Those amounts are transferred directly into the reconciliation reports (lines A-1 thru E-57). Consequently, you must

enter data into each cell directly. Do not copy and paste the amounts to different cells, doing so will transfer the link to the reconciliation reports and invalidate the process. If you make an error in a cell, edit it using the F2 function key, delete the entry, or re-enter the correct amount directly.

2. Source FISS System Reports. Column B identifies the source FISS system report for the data to be entered on each line of the "data entry area" on reference lines 1-1 thru 18-11. Column B identifies the primary source FISS system report and alternate sources for the same data on each line of the reconciliation reports on reference lines A1 thru E-57.

3. BLUE Background Cells. Enter financial data only in spreadsheet cells that have a BLUE background. Cycles 1 thru 31 are in Columns L thru AP, respectively. Those lines will have references in Column A that are all numeric (1-1 thru 18-11).

4. GRAY Background Cells. Do not enter financial data in spreadsheet cells that have a GRAY background. Those cells transfer data from other cells and the formulas in those cells cannot be changed without affecting the reconciliation process.

5. RED Background Cells. Data in spreadsheet cells with a RED background contain formulas that allocate total amounts by HI and SMI using the ratio of Inpatient to Outpatient claims paid to date for the month. Unlike the formulas in spreadsheet cells with GRAY backgrounds that are locked, the formulas in the spreadsheet cells with RED backgrounds are unlocked and can be overwritten. Only write over those formulas in those cells if you have more accurate HI/SMI amounts that differ significantly from the amounts calculated by the spreadsheet formulas and only during the end of month processing.

6. GREEN Background Cells. Spreadsheet cells with a GREEN background are check fields to ensure that the data entered from one FISS system report reconciles with data entered from other FISS system reports into the data entry section. In all cases, the amount must be zero or the financial reconciliation will be unreconciled.

    a. Spreadsheet lines 43, 44, 45, and 48 verify the accuracy of the claims processing tape file reconciliation. Any amounts other than zero indicate that there is an imbalance between the tape and the FISS system report. Those amounts are also shown on reference lines B-29, B-30, B-32, and B-45 on the reconciliation report.

    b. Spreadsheet lines 122 verify the accuracy of the net disbursements using the total of checks and EFT transactions and comparing it to other FISS system reports (principally the 8014R01 report). That amount is also shown on reference line A-34 on the reconciliation report.

    c. Reference lines C-15, C-16, and C-17 on the reconciliation report verify the accuracy of the Non-PIP payment amounts used in the financial reconciliation

d. reports. There may be minor difference identified on those lines that compare the amount on the 8037R02 report. Since the implementation of CELIP, the interest amounts on that report are not always accurate.

7. YELLOW Background Cells. Data in spreadsheet cells with a YELLOW background contain either totals for cells directly above it or data transferred from one of the other reconciliation worksheets. Those cells are protected and cannot be changed.

Section 500.3 - Electronic Spreadsheet Input Schedule

(Rev. 20, 08-01-03)

This section is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information from the claims processed file and FISS reports.

Reconciliation of CMS Form 1522
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Section 500.3 - Electronic Spreadsheet - Input Schedule

Only Enter Financial Data in blocks that have a BLUE background (Cycle 1 is in Column L)
Do NOT enter Financial Data in blocks that have a GREY background - these are calculated fields)

RED blocks contain formulas that allocate totals to HI and SMI based on the ratio of Inpatient/Outpatient Claims Paid
However, RED blocks can be overwritten -- but do so only if actual HI/SMI amounts are known

	FISS Report #		Cycle Date	Cycle 1 9/4/2001	Cycle 2 9/11/2001	Cycle 3 9/18/2001	Cycle 4 9/25/2001
1-1		+	Total Amount - Detail Claims Data File	62,682,430.97	52,752,137.73	57,271,950.82	95,276,197.90
1-2		+	Total Claims - Detail Claims Data File	45,001	41,778	37,076	73,419
2-1	7859R01	+	Claims Records Out/Paid -Inpatient Amount	54,569,938.68	44,760,195.57	50,553,146.01	75,746,121.25
2-2	7859R01	+	Claims Records Out/Paid - Outpatient Amount	8,091,428.84	7,980,945.51	6,714,513.47	19,490,021.41
2-3	7859R01	+	Claims Records Out/Modified - Inpatient Amount	19,442.45	6,996.79	533.07	29,783.40
2-4	7859R01	+	Claims Records Out/Modified - Outpatient Amount	1,621.00	3,999.86	3,504.97	10,357.30
2-5	7859R01	+	Error Records Out/Paid - Inpatient Amount	-	-	-	-
2-6	7859R01	+	Error Records Out/Paid - Outpatient Amount	-	-	-	-
2-7	7859R01	+	Claims Records Out/Paid - Inpatient Claims	10,428	8,143	10,116	16,016
2-8	7859R01	+	Claims Records Out/Paid - Outpatient Claims	34,552	33,618	26,948	57,364
2-9	7859R01	+	Claims Records Out/Modified - Inpatient Claims	8	2	2	7
2-10	7859R01	+	Claims Records Out/Modified - Outpatient Claims	13	15	9	30
2-11	7859R01	+	Error Records Out/Paid - Inpatient Claims	-	-	-	-
2-12	7859R01	+	Error Records Out/Paid - Outpatient Claims	-	-	-	-
3-1	7859R02	+/-	Transaction Value DROPPED 7859R02 Report	-	-	-	-
3-2	7859R02	+/-	Transaction Value ADDED to 7859R02 Report	-	-	(253.30)	85.46
3-3	7859R02	+/-	Claim Transactions DROPPED 7859R02 Report	-	-	-	-
3-4	7859R02	+/-	Claim Transactions ADDED to 7859R02 Report	-	-	(1)	(2)
4-1	8074R01	+	PIP Reimbursements - Part A	16,082,345.79	10,561,393.45	24,515,686.76	21,318,223.87
4-2	8074R01	+	Non-PIP Reimbursements - Part A	38,876,529.44	34,263,000.78	26,360,306.40	54,423,239.69
4-3	8074R01	+	IME / Outliers - Part A	369,494.10	57,201.87	322,314.08	(34,441.09)
4-4	8074R01	+	Hemophilia - Part A	-	-	-	-
4-5	8074R01	+	Inpatient Interest - Part A	972.71	2,682.12	1,396.84	812.03
5-1	8074R02	+	PIP Reimbursements - Part B	-	-	-	-
5-2	8074R02	+	Non-PIP Reimbursements - Part B	8,093,049.84	7,984,945.37	6,718,018.44	19,500,378.71
5-3	8074R02	+	IME / Outliers - Part A	-	-	-	-
5-4	8074R02	+	Hemophilia - Part A	-	-	-	-
5-5	8074R02	+	Outpatient Interest - Part B	191.45	257.81	171.33	120.06

Tape Reconciliation Check	*Dollar Value of Claims (Tape and System Reports)*			
✔	Check lines 1-1, 2-1 thru 2-6, 3-1 thru 3-2 if not ZERO =>	-	-	-	-
✔	Check lines 1-1, 3-1 thru 3-2, 4-1 thru 4-5, 5-1 thru 5-5 if not ZERO =>	-	-	-	-
✔	Check lines 2-1 thru 2-6, 4-1 thru 4-5, 5-1 thru 5-5 if not ZERO =>	-	-	-	-

Tape Reconciliation Check	*Number of Claims (Tape and System Report)*			
✔	Check line 1-2, 2-7 thru 2-12, 3-3 thru 3-4 if not ZERO =>	-	-	-	-

6-1	8014R01	+	PIP Payments at 100%	-	34,264,981.00	-	35,303,181.00
6-2	8014R01	+	Pass Thru Payments at 100%	-	1,065,417.00	-	1,065,417.00
6-3	8014R01	+	Claim Payments at 100%	46,969,951.48	42,248,407.30	33,080,828.34	73,938,838.03
6-4	8014R01	+	Release of Penalty	18,677.43	-	18,694.10	462.04
6-5	8014R01	+	Settlement Payment (including Interest)	1,383,492.00	3,156,604.81	3,087,812.00	3,123,894.98
6-6	8014R01	+	Claims Accounts Receivable - HI	114,020.92	9,263.33	28,838.83	41,699.58
6-7	8014R01	+	Claims Accounts Receivable - SMI	38,768.28	5,501.14	23,096.89	4,391.31
6-8	8014R01	+	Accelerated Payments	-	-	-	-
6-9	8014R01	+	Refund Provider Payments	136,939.06	22,788.23	32,426.65	10,163.44
6-10	8014R01	+	Refund Other Payee Payments	-	-	-	-
6-11	8014R01	+	Claim Interest Payments	1,164.16	2,939.93	1,568.17	932.09
6-12	8014R01	+	Other Payee Payments	-	-	-	-
6-13	8014R01	-	PIP Payment Discount	-	-	-	-
6-14	8014R01	-	Pass Thru Payment Discount	-	-	-	-
6-15	8014R01	-	Claims Payment Discount	-	-	-	-
6-16	8014R01	-	Penalty Withholdings	(6,792.97)	(229,804.98)	(57,927.77)	(329,811.79)
6-17	8014R01	-	Settlement Withholdings (including Interest)	(71,921.49)	(95,748.64)	(97,434.34)	(402,734.64)
6-18	8014R01	-	Claims Accounts Receivable Withholdings - HI	(15,979.83)	(41,029.21)	(5,058.78)	(120,485.51)
6-19	8014R01	-	Claims Accounts Receivable Withholdings - SMI	(2,601.22)	(11,283.32)	(11,390.46)	(48,265.92)
6-20	8014R01	-	Accelerated Payment Withholdings	-	-	-	-
6-21	8014R01	-	ESRD Network Reduction	(372.20)	(461.15)	(2,503.50)	(15,219.63)
6-22	8014R01	-	Penalty Recoupment	-	-	-	-
7-1	8015R01	+	Penalty Withholding Released - Part A	6,987.96	-	17,304.62	241.64
8-1	8015R02	+	Penalty Withholding Released - Part B	11,689.47	-	1,389.48	220.40
9-1	8015R05	+	Accelerated Payments - Part A	-	-	-	-
9-2	8015R05	-	Accelerated Payment Withholdings - Part A	-	-	-	-

Prepared by: _____ **Printed on 3/21/2003 at 8:38 AM** **Reviewed by:** _____

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

				Cycle 1	Cycle 2	Cycle 3	Cycle 4
10-1	8015R06	+	Accelerated Payments - Part B	-	-	-	-
10-2	8015R06	-	Accelerated Payment Withholdings - Part B	-	-	-	-
11-1	8019R01	+	System Checks Issued	2,518,695.59	5,071,189.04	1,967,293.95	4,719,939.86
11-2	8019R01	+	EFTs Issued	46,046,650.03	75,326,386.40	34,111,656.18	107,852,522.12
12-1	8034R01	+/-	Total Overpayment Interest Received	(794.93)	(794.93)	(794.93)	(794.93)
12-2	8034R01 (prior cycle)	+/-	Total Overpayment Interest Received	-	(794.93)	(794.93)	(794.93)
13-1	8036R01	+	Part A Settlement (excluding Interest)	1,313,242.16	4,285,699.01	7,350,460.01	10,181,159.68
13-2	8036R01 (prior cycle)	+	Part A Settlement (excluding Interest) - Prior Cycle	-	1,313,242.16	4,285,699.01	7,350,460.01
13-3	8036R01	+	Part B Settlement (excluding Interest)	(1,267.00)	89,084.00	14,710.00	(48,217.28)
13-4	8036R01 (prior cycle)	+	Part B Settlement (excluding Interest) - Prior Cycle	-	(1,267.00)	89,084.00	14,710.00
14-1	8037R01	+	Hospital Insurance	54,958,875.23	44,824,394.23	50,875,993.16	75,741,463.56
14-2	8037R01	+	Supplemental Medical Insurance	8,093,049.84	7,984,945.37	6,718,018.44	19,500,378.71
14-3	8037R01	+	PIP Claims	16,082,345.79	10,561,393.45	24,515,686.76	21,318,223.87
14-4	8037R01	-	Suspended Claim Payment Withheld - Part A	(2,291.20)	(222,724.09)	(54,574.13)	(306,579.75)
14-5	8037R01	-	Suspended Claim Payment Withheld - Part B	(4,501.77)	(7,080.89)	(3,353.64)	(21,232.04)
14-6	8037R01	+	Suspended Payment Released - Part A	6,987.96	-	17,304.62	241.64
14-7	8037R01	+	Suspended Payment Released - Part B	11,699.47	-	1,389.48	220.40
15-1	8037R02	-	Claims Timeliness Interest Received - Total	(1,095.46)	(374.62)	(576.29)	(315.95)
15-2	8037R02	+	Claims Timeliness Interest Paid - Total	2,384.05	1,248.04	1,445.19	796.10
16-1	8042R01	-	Overpayment Interest Recovered - Part A	(1,199.58)	(1,831.98)	(9.34)	(76,645.85)
16-2	8042R01	+	Overpayment Interest Paid - Part A	-	-	-	28,551.28
16-3	8042R01	-	Claims Timeliness Interest Recovered - Part A	(1,055.85)	(293.90)	(662.80)	(271.09)
16-4	8042R01	+	Claims Timeliness Interest Paid - Part A	2,028.68	2,976.02	1,959.64	1,083.12
16-5	8042R01	-	Overpayment Interest Recovered - Part B	-	(119.70)	-	(766.00)
16-6	8042R01	+	Overpayment Interest Paid - Part B	-	-	-	2,446.52
16-7	8042R01	-	Claims Timeliness Interest Recovered - Part B	(39.61)	(80.72)	(13.49)	(44.86)
16-8	8042R01	+	Claims Timeliness Interest Paid - Part B	231.06	338.53	184.82	164.92
16-9	8042R01	+	Total Benefits - Part A - Chronic Renal Disease	685,328.43	467,713.09	380,701.83	668,162.78
16-10	8042R01	+	Total Benefits - Part A - Disabled	5,001,225.27	3,884,356.20	3,112,199.57	5,204,937.30
16-11	8042R01	+	Total Benefits - Part A - Premium Paying Enrollees	14,603.76	27,708.02	-	28,730.90
16-12	8042R01	+	Total Benefits - Part B - Chronic Renal Disease	170,526.17	251,735.96	399,867.99	1,792,101.58
16-13	8042R01	+	Total Benefits - Part B - Disabled	1,264,140.11	1,222,364.19	1,108,671.44	3,209,984.89
16-14	8042R01	+	Total Benefits - Part B - Premium Paying Enrollees	63,041.79	52,121.20	56,430.28	158,298.62
			Total Distribution Check (Lines 7-1 through 7-5)				
✓	Check the entries on Lines 6-1 through 16-14 if this in not ZERO =>						
	Itemization of Retroactive Adjustments (As Reported by FISS)						
16-15	8042R01		Lump Sum Interim Payments - Part A	1,372,034.00	1,979,407.00	2,934,862.00	2,467,953.43
16-16	8042R01		Tentative Settlements - Part A	(23,340.00)	-	-	-
16-17	8042R01		Post Audit Settlement - Part A	(210,491.88)	(208,081.15)	(216,521.50)	382,748.24
16-18	8042R01		Lump Sum Interim Payments - Part B	-	-	-	69,904.52
16-19	8042R01		Tentative Settlements - Part B	215.00	-	-	-
16-20	8042R01		Post Audit Settlement - Part B	2,396.00	92,514.00	(95,829.00)	(132,931.80)
	Source of Benefit - Retroactive Adjustments (As Reported by FISS)						
16-21	8042R01		Credit Adjustments - Part A	(246,525.88)	(1,418,296.15)	(453,940.50)	(1,074,173.33)
16-22	8042R01		Supplemental Payments - Part A	1,384,759.00	3,088,622.00	3,172,281.00	3,904,873.00
16-23	8042R01		Credit Adjustments - Part B	(1,611.00)	(4,310.00)	(162,536.00)	(194,666.80)
16-24	8042R01		Supplemental Payments - Part B	4,222.00	96,824.00	66,707.00	131,039.52
17-1	Deposit Summary	-	MSP - Medicare Secondary Payer	(43,585.32)	(111,935.43)	(319,129.91)	(24,609.71)
17-2	Deposit Summary	-	Credit Balance	-	(4,647.00)	-	-
17-3	Deposit Summary	-	2781A	-	-	-	-
17-4	Deposit Summary	-	2781B - Tentative Settlements	-	-	-	-
17-5	Deposit Summary	-	2781C - Final Settlements	(521,884.00)	(40,543.00)	(15,827.75)	(335,412.00)
17-6	Deposit Summary	-	2781 - Other PIP	(892,806.00)	-	-	-
17-7	Deposit Summary	-	Interest (A & B)	-	-	-	-
17-8	Deposit Summary	-	Claims Refund	-	-	-	(5,552.82)
17-9	Deposit Summary	-	Fraud & Abuse	-	-	-	-
17-10	Deposit Summary	-	Other & 2783	-	-	-	-
18-1	Bank or Schedule	-	Returned EFTs - Voided (posted to Bank Account)	-	-	-	-
18-2	Bank or Schedule	+	Returned Deposit Items	-	-	-	-
18-3	Bank or Schedule	+/-	Other Miscellaneous Debits	-	-	-	-
18-4	Bank or Schedule	+/-	Other Miscellaneous Credits	-	-	-	-
18-5	Bank or Schedule	+/-	Other Financial Adjustments	-	-	-	-
18-6	Bank or Schedule	+/-	Correction for Prior Month Error	-	-	-	-
18-7	Bank or Schedule	+	Manual Checks & Wires	-	898.51	-	35.08
18-8	Bank or Schedule	+	Manual Check - Transfer to Time Account	-	-	-	-
18-9	Bank or Schedule	-	Manual Check - Receipt into Time Account	-	-	-	-
18-10	Bank or Schedule	-	Stale Dated Checks	-	-	-	-
18-11	Bank or Schedule	-	Voided Checks	-	-	-	-

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Section 500.4 – Total Funds Expended (Net Disbursements and Adjustments to Net Disbursements)

(Rev. 20, 08-01-03)

This section calculates the total system and non-system payments that equate to the Total Funds Expended amount report on the Form CMS-1522. It also documents the source FISS system report used in determining the amounts to report. This standard reconciliation format is the only document required to be submitted to CMS, in addition to monthly financial reports (Form CMS-1522).

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #		Cycle Date	Cycle 1 09/04/2001	Cycle 2 09/11/2001	Cycle 3 09/18/2001	Cycle 4 09/25/2001
Section 500.4 - Total Funds Expended (Net Disbursements and Adjustments to Net Disb							
A-1	8019R01 8021R01		System Checks Issued	2,518,695.59	5,071,189.04	1,987,293.95	4,719,939.86
A-2	8019R01 8021R02		EFTs Issued	46,046,650.03	75,326,386.40	34,111,656.18	107,852,522.12
A-3	*A-1 + A-2*		***Total System Checks and EFTs***	**48,565,345.62**	**80,397,575.44**	**36,098,950.13**	**112,572,461.98**
A-4	Tape, 7859R01 / R02		**Detail Claims Data File Amounts**	62,682,430.97	52,752,137.73	57,271,697.52	95,276,283.36
A-5	8074R01		Outlier Payments	369,494.10	57,201.87	322,314.08	(34,441.09)
A-6	8074R01		Hemophilia	-	-	-	-
A-7	*A-4 + A-5 + A-6*		Total Reimbursements Plus Outliers	**63,051,925.07**	**52,809,339.60**	**57,594,011.60**	**95,241,842.27**
A-8	Line 2-2 & 2-3	-	PIP Claims Processed	(16,082,345.79)	(10,561,393.45)	(24,515,686.76)	(21,318,223.87)
A-9	8074R01		Non-PIP Payments	**46,969,579.28**	**42,247,946.15**	**33,078,324.84**	**73,923,618.40**
			Admittance Advice Debits & Credits				
A-10	8042R01 8037R02		Claim Interest Recovered	(1,095.46)	(374.62)	(576.29)	(315.95)
A-11	8042R01 8037R02		Claim Interest Paid	2,259.62	3,314.55	2,144.46	1,248.04
A-12	*A-10 + A-11*		***Net Claim Interest Payments***	**1,164.16**	**2,939.93**	**1,568.17**	**932.09**
A-13	*A-9 + A-12*		***Total Claims Debits & Credits***	**46,970,743.44**	**42,250,886.08**	**33,079,893.01**	**73,924,550.49**
A-14	8014R01 8037R02 8016R01		PIP Payments at 100%	-	34,264,981.00	-	35,303,181.00
A-15	8014R01 8037R02 8016R01		PIP Payment Discount	-	-	-	-
A-16	8014R01 8037R02 8016R01		Pass Thru Payments at 100%	-	1,065,417.00	-	1,065,417.00
A-17	8014R01 8037R02 8016R01		Pass Thru Payment Discount	-	-	-	-
A-18	8014R01 8037R02 8048R01		Settlement Payment (including Interest)	1,383,492.00	3,156,604.81	3,087,812.00	3,123,894.98
A-19	8014R01 8037R02 8068R01		Settlement Withholdings (including Interest)	(71,921.49)	(95,748.64)	(97,434.34)	(402,734.64)
A-20	8014R01 8037R02 8015R05 8015R06		Accelerated Payments	-	-	-	-
A-21	8014R01 8037R02 8015R05 8015R06		Accelerated Payment Withholdings	-	-	-	-
A-22	8014R01 8037R01 8015R03		Claims Accounts Receivable - HI	114,020.92	9,263.33	28,838.83	41,699.58
A-23	8014R01 8037R01 8015R03		Claims Accounts Receivable Withholdings - HI	(15,979.83)	(41,029.21)	(5,058.78)	(120,485.51)
A-24	8014R01 8037R01 8015R08		Claims Accounts Receivable - SMI	38,768.28	5,501.14	23,096.89	4,391.31
A-25	8014R01 8037R01 8015R08		Claims Accounts Receivable Withholdings - SMI	(2,601.22)	(11,283.32)	(11,390.46)	(48,265.92)
A-26	8015R01 8015R02 8014R01 8037R01		Release of Penalty	18,677.43	-	18,694.10	462.04
A-27	8015R01 8015R02 8014R01 8037R01		Penalty Withholdings	(6,792.97)	(229,804.98)	(57,927.77)	(329,811.79)
A-28	8014R01 8037R01 8015R01 8015R02		Penalty Recoupment	-	-	-	-
A-29	8014R01 8048R01		Refund Provider Payments	136,939.06	22,788.23	32,426.65	10,163.44
A-30	8014R01 8060R01		Refund Other Payee Payments	-	-	-	-
A-31	8014R01 8033R01		Other Payee Payments	-	-	-	-
A-32	*A-14 thru A-31*		***Total non-Claims Debits & Credits***	**1,594,602.18**	**38,146,689.36**	**3,019,057.12**	**38,647,911.49**
A-33	*A-13 + A-32*		***Net Disbursements***	**48,565,345.62**	**80,397,575.44**	**36,098,950.13**	**112,572,461.98**
A-34	*A-3 - A-33*	PROOF	**Total Payments = Net Disbursements**	-	-	-	-

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #		Cycle Date	Total		HI	SMI	ZERO
Section 500.4 - Total Funds Expended (Net Disbursements and Adjustments to Net Disbursements)								
A-35	***A-33***		***Net Disbursements***	**277,634,333.17**		**235,376,449.15**	**42,257,884.02**	-
			Receipts Providers & Beneficiaries					
A-36	**Deposit Summary**	-	MSP - Medicare Secondary Payer	**(499,260.37)**	*	**(420,460.79)**	**(78,799.58)**	-
A-37	**Deposit Summary**	-	Credit Balance	**(4,647.00)**	*	**(3,913.55)**	**(733.45)**	-
A-38	**Deposit Summary**	-	2781A	-	*	-	-	-
A-39	**Deposit Summary**	-	2781B - Tentative Settlements	-	*	-	-	-
A-40	**Deposit Summary**	-	2781C - Final Settlements	**(913,666.75)**	*	**(769,460.32)**	**(144,206.43)**	-
A-41	**Deposit Summary**	-	2781 - Other PIP	**(892,806.00)**	*	**(751,892.08)**	**(140,913.92)**	-
A-42	**Deposit Summary**	-	Interest (A & B)	-	*	-	-	-
A-43	**Deposit Summary**	-	Claims Refund	**(5,552.82)**	*	**(4,676.40)**	**(876.42)**	-
A-44	**Deposit Summary**	-	Fraud & Abuse	-	*	-	-	-
A-45	**Deposit Summary**	-	Other & 2783	-	*	-	-	-
A-46	***A-36 thru A-45***		***Total Deposits***	**(2,315,932.94)**		**(1,950,403.14)**	**(365,529.80)**	-
			Other Bank and Check Related Adjustments					
A-47	**Bank or Schedule**	-	Returned EFTs - Voided (posted to Bank Account)	-	*	-	-	-
A-48	**Bank or Schedule**	+	Returned Deposit Items	-	*	-	-	-
A-49	**Bank or Schedule**	+/-	Other Miscellaneous Debits	-	*	-	-	-
A-50	**Bank or Schedule**	+/-	Other Miscellaneous Credits	-	*	-	-	-
A-51	**Bank or Schedule**	+/-	Other Financial Adjustments	-	*	-	-	-
A-52	**Bank or Schedule**	+/-	Correction for Prior Month Error	-	*	-	-	-
A-53	**Bank or Schedule**	+	Manual Checks & Wires	**933.59**	*	**786.24**	**147.35**	-
A-54	**Bank or Schedule**	+	Manual Check - Transfer to Time Account	-	*	-	-	-
A-55	**Bank or Schedule**	-	Manual Check - Receipt into Time Account	-	*	-	-	-
A-56	**Bank or Schedule**	-	Stale Dated Checks	-	*	-	-	-
A-57	**Bank or Schedule**	-	Voided Checks	-	*	-	-	-
A-58	***A-47 thru A-57***		***Total Other Adjustments***	**933.59**		**786.24**	**147.35**	
A-59	***A-58 + A-46***		***Total Adjustments to Net Disbursements***	**(2,314,999.35)**		**(1,949,616.90)**	**(365,382.45)**	-
A-60	***A-33 + A-59***		***Total Funds Expended***	**275,319,333.82**		**233,426,832.25**	**41,892,501.57**	-

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500.5 -- Reconciliation of Detailed Claims Data File to FISS System Reports

(Rev. 20, 08-01-03)

This section shows the reconciliation of the claims process tape file to the FISS system reports and identifies the transactions used in reconciling those two amounts.

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #		Cycle Date	Total	HI	SMI	ZERO
Section 500.5 - Reconciliation of Claims Processed Tape File to FISS System Reports							
	Paid Claims Tape Summary (Value of Claims)						
B-1	Tape		Totals Claims Paid Tape	267,982,717.42			
B-2	7859R02	+	Transactions DROPPED 7859R02 Report	-			
B-3	7859R02	-	Transactions ADDED to 7859R02 Report	(167.84)			
B-4	B-1 thru B-3		*Net Total Paid Claims*	267,982,549.58	225,686,157.22	42,296,392.36	-
	FISS Report #MAFD7859R01 - Create Claim File Control Report						
			Claims Records Out/Paid				
B-5	7859R01		Inpatient	225,629,401.51	225,629,401.51		-
B-6	7859R01		Outpatient	42,276,909.23		42,276,909.23	-
			Claims Records Out/Modified				
B-7	7859R01		Inpatient	56,755.71	56,755.71		-
B-8	7859R01		Outpatient	19,483.13		19,483.13	-
			Error Records Out/Paid				
B-9	7859R01		Inpatient	-	-		-
B-10	7859R01		Outpatient	-		-	-
B-11	B-5 + B-7 + B9		*Total Inpatient*	225,686,157.22	225,686,157.22		-
B-12	B-6 + B8 + B10		*Total Outpatient*	42,296,392.36		42,296,392.36	-
B-13	B-11 + B-12		*Total Create Claim File Control Report*	267,982,549.58	225,686,157.22	42,296,392.36	-
	Basis of HI/SMI Split						
	FISS Report #MAFD8074R01/-2 - Claim Payment Update Report - Inpatient/Outpatient						
			Inpatient				
B-14	8074R01		PIP Reimbursements	72,477,649.87	72,477,649.87		-
B-15	8074R01		Hemophilia	-	-		-
B-16	8074R01		Non-PIP Reimbursements	153,923,076.31	153,923,076.31		-
B-17	B-14 thru B-16		*Total Inpatient*	226,400,726.18	226,400,726.18		-
			Outpatient				
B-18	8074R02		PIP Reimbursements	-		-	-
B-19	8074R02		Hemophilia	-		-	-
B-20	8074R02		Non-PIP Reimbursements	42,296,392.36		42,296,392.36	-
B-21	B-18 thru B-20		*Total Outpatient*	42,296,392.36		42,296,392.36	-
			Subtotals				
B-22	B-14 + B-18		PIP Reimbursements	72,477,649.87	72,477,649.87		-
B-23	B-15 + B-19		Hemophilia	-	-	-	-
B-24	B-16 + B-20		Non-PIP Reimbursements	196,219,468.67	153,923,076.31	42,296,392.36	-
B-25	B-22 + B-24		*Subtotal - Before Exclusions*	268,697,118.54	226,400,726.18	42,296,392.36	-
B-26	8074R01 8074R02	-	Total IME / Outliers (Part A & B)	(714,568.96)	(714,568.96)		-
B-27	8074R01 8074R02	-	Total Hemophilia (Part A & B)	-	-	-	-
B-28			*Adjusted Total Claim Payment Report*	267,982,549.58	225,686,157.22	42,296,392.36	-
	Calculated Differences						
B-29	B-4 - B-13			-	-	-	-
B-30	B-4 - B-28			-	-	-	-
B-31	B-13 - B-28			-	-	-	-
	Paid Claims Tape Summary (Number of Claims)						
B-32	Tape		Totals Claims Paid Tape	197,274			
B-33	7859R02	+	Transactions DROPPED 7859R02 Report	-			
B-34	7859R02	-	Transactions ADDED to 7859R02 Report	(3)			
B-35	B-32 thru B-34		*Net Total Paid Claims*	197,271	44,722	152,549	-
	FISS Report #MAFD7859R01 - Create Claim File Control Report						
			Claims Records Out/Paid				
B-36	7859R01		Inpatient	44,703	44,703		-
B-37	7859R01		Outpatient	152,482		152,482	-
			Claims Records Out/Modified				
B-38	7859R01		Inpatient	19	19		-
B-39	7859R01		Outpatient	67		67	-
			Error Records Out/Paid				
B-40	7859R01		Inpatient	-	-		-
B-41	7859R01		Outpatient	-		-	-
B-42	B-36 + B-38 + B-40		*Total Inpatient*	44,722	44,722		-
B-43	B-37 + B-39 + B-41		*Total Outpatient*	152,549		152,549	-
B-44	B42 + B43		*Total Create Claim File Control Report*	197,271	44,722	152,549	-
B-45	B-35 - B-44		Calculated Difference	-	-	-	-

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500.6 - Reconciliation of Non-PIP Payments on FISS System Reports

(Rev. 20, 08-01-03)

The non-PIP payments are identified on various FISS system reports and this section reconciles those amounts to ensure that the amounts are equal and consistent among those reports. The non-PIP payment amounts are a key amount used in the calculation for Total Funds Expended identified in Section 500.4 above.

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #		Cycle Date	Total	HI	SMI	ZERO
Section 500.6 - Reconciliation of Non-PIP Payments on FISS System Reports							
C-1	*B-17*		Reimbursements - Inpatient	226,400,726.18	226,400,726.18		-
C-2	8074R01	-	PIP Reimbursements - Inpatient	(72,477,649.87)	(72,477,649.87)		-
C-3	8037R01 - 8074R01	-	PIP Reimbursements - Reconciling Amount	-	-		-
C-4	*C-1 thru C-3*		Non-PIP Reimbursements - Inpatient	153,923,076.31	153,923,076.31		-
C-5	8074R02		Non-PIP Reimbursements - Outpatient	42,296,392.36		42,296,392.36	-
C-6	*C-4 + C-5*		***Total Non-PIP Payments***	196,219,468.67	153,923,076.31	42,296,392.36	-
C-7	8014R01		Claim Payments at 100%	196,238,025.15	153,923,076.31	42,314,948.84	-
C-8	8014R01	-	ESRD Network Reduction	(18,556.48)		(18,556.48)	-
C-9	8014R01	-	Claims Payment Discount	-	-	-	-
C-10	*C-7 thru C-9*		***Total Non-PIP Payments***	196,219,468.67	153,923,076.31	42,296,392.36	-
C-11	8037R01		Hospital Insurance	226,400,726.18	226,400,726.18		-
C-12	8037R01		Supplemental Medical Insurance	42,296,392.36		42,296,392.36	-
C-13	8037R01	-	PIP Claims	(72,477,649.87)	(72,477,649.87)		-
C-14	*C-11 thru C-13*		***Total Non-PIP Payments***	196,219,468.67	153,923,076.31	42,296,392.36	-
	Differences in non-PIP Payments						
C-15	*C-6 less C-10*			-	-	-	-
C-16	*C-6 less C-14*			-	-	-	-
C-17	*C-10 less C-14*			-	-	-	-

500.7 - Reconciliation of Interest Received and Paid on FISS system reports

(Rev. 20, 08-01-03)

The interest amount paid or received for overpayment interest or claims timeliness are identified on various FISS system reports and this section reconciles those amounts to identify any differences. Differences in the interest amounts reported on those FISS system reports have been identified since the implementation of CELIP but those differences should be minor. The financial reconciliation uses the most reliable interest amounts from those different reports. Major differences should be researched and corrective action should be taken if those amounts are not minor.

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #	*Cycle Date*	Total	HI	SMI	*ZERO*
Section 500.7 - Reconciliation of Interest Received and Paid on FISS System Reports						
		Part A				
D-1	8042R01	Overpayment Interest Recovered	(79,886.75)	(79,886.75)		-
D-2	8042R01	Overpayment Interest Paid	28,551.28	28,551.28		-
D-3	*D-1 + D-2*	***Net Overpayment Interest - Part A***	(51,335.47)	(51,335.47)		-
D-4	8042R01	Claims Timeliness Interest Recovered	(2,183.64)	(2,183.64)		-
D-5	8042R01	Claims Timeliness Interest Paid	8,047.34	8,047.34		-
D-6	*D-4 + D-5*	***Net Claims Timeliness Interest - Part A***	5,863.70	5,863.70		-
		Part B				
D-7	8042R01	Overpayment Interest Recovered	(885.70)		(885.70)	-
D-8	8042R01	Overpayment Interest Paid	2,448.52		2,448.52	-
D-9	*D-7 + D-8*	***Net Overpayment Interest - Part B***	1,562.82		1,562.82	-
D-10	8042R01	Claims Timeliness Interest Recovered	(178.68)		(178.68)	-
D-11	8042R01	Claims Timeliness Interest Paid	919.33		919.33	-
D-12	*D-10 + D-11*	***Net Claims Timeliness Interest - Part B***	740.65		740.65	-
		Total				
D-13	*D-1 + D-7*	Overpayment Interest Recovered	(80,772.45)	(79,886.75)	(885.70)	-
D-14	*D-2 + D-8*	Overpayment Interest Paid	30,999.80	28,551.28	2,448.52	-
D-15	*D-13 + D-14*	***Net Overpayment Interest - Total***	(49,772.65)	(51,335.47)	1,562.82	-
D-16	*D-4 + D-10*	Claims Timeliness Interest Recovered	(2,362.32)	(2,183.64)	(178.68)	-
D-17	*D-5 + D-11*	Claims Timeliness Interest Paid	8,966.67	8,047.34	919.33	-
D-18	*D-16 + D-17*	***Net Claims Timeliness Interest - Total***	6,604.35	5,863.70	740.65	-
		Interest - Claim Payment Update Reports				
D-19	8074R01	Inpatient	5,863.70	5,863.70		-
D-20	8074R02	Outpatient	740.65		740.65	-
D-21	*D-19 + D-20*	***Total Claims Timeliness Interest***	6,604.35	5,863.70	740.65	-
D-22	8014R01	**Total Claims Timeliness Interest**	6,604.35	5,863.70	740.65	-
		Monthly Benefits Reconciliation Interest				
D-23	8037R02	Interest Received	(2,362.32)	(2,183.64)	(178.68)	-
D-24	8037R02	Interest Paid	5,873.38	4,946.37	927.01	-
D-25	*D-23 + D-24*	***Total Claims Timeliness Interest***	3,511.06	2,762.73	748.33	-
		Differences				
D-26	*D-18 - D-21*	Claims Timeliness Interest	-	-	-	-
D-27	*D-18 - D-22*	Claims Timeliness Interest	-	-	-	-
D-28	*D-18 - D-25*	Claims Timeliness Interest	3,093.29	3,100.97	(7.68)	-
D-29	*D-21 - D-22*	Claims Timeliness Interest	-	-	-	-
D-30	*D-21 - D-25*	Claims Timeliness Interest	3,093.29	3,100.97	(7.68)	-
D-31	*D-22 - D-25*	Claims Timeliness Interest	3,093.29	3,100.97	(7.68)	-

500.8 - Categorization of Total Funds Expended by Category

(Rev. 20, 08-01-03)

This section takes the financial information that was input by the user and allocates those amounts to the various descriptive categories identified on the Form CMS-1522 report. The amounts can generally be used to complete the Form CMS-1522 with little additional effort.

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #	*Cycle Date*	Total	HI	SMI	*ZERO*
Section 500.8 - Categorization of Total Funds Expended by Category						
E-1	8074R01	**PIP Reimbursements (Memo Entry Only)**	72,477,649.87	72,477,649.87	-	-
		PIP Payments				
E-2	8014R01	PIP Payments @ 100%	69,568,162.00	69,568,162.00	-	-
E-3	8014R01	PIP Payment Discount	-	-	-	-
E-4	*E-2 + E-3*	***Net PIP Payments***	69,568,162.00	69,568,162.00	-	-
		Reduced or Suspended Payments				
E-5	8037R01	Payments Suspended During the Month	(624,337.51)	(588,169.17)	(36,168.34)	-
E-6	8037R01	Payments Released During the Month	37,833.57	24,534.22	13,299.35	-
		Retroactive Adjustments				
E-7	*Calculated*	Part A - Hospital Insurance	8,404,448.10	8,404,448.10		-
E-8	*Calculated*	Part B - Supplemental Medical Insurance	(373,906.71)		(373,906.71)	-
E-9	*E-7 + E-8*	**Total Retroactive Adjustments**	8,030,541.39	8,404,448.10	(373,906.71)	-
		Interest Payments				
E-10	8042R01	Net Overpayment Interest	(49,772.65)	(51,335.47)	1,562.82	-
E-11	8042R01	Net Claims Timeliness Interest	6,604.35	5,863.70	740.65	-
		Accelerated Payment				
E-12	8014R01	Payments Made	-	-	-	-
E-13	8014R01	Payments Withholdings	-	-	-	-
		Total Benefits Paid				
E-14	8074R01	non-PIP Reimbursments	196,219,468.67	153,932,494.87	42,286,973.80	-
E-15	8014R01	plus: Pass Thru Payments	2,130,834.00	2,130,834.00	-	-
E-16	8014R01	less: Pass Thru Payment Discounts	-	-	-	
E-17	*E-14 thru E-16*	***Total Benefits Paid***	198,350,302.67	156,063,328.87	42,286,973.80	-
E-18	*A-60*	**Totals Funds Expended**	275,319,333.82	233,426,832.25	41,892,501.57	-
		Total Benefits Paid - Part A				
E-19	8042R01	Disabled	17,203,219.34	17,203,219.34		-
E-20	8042R01	Chronic Renal Disease	2,101,906.13	2,101,906.13		-
E-21	8042R01	Premium Paying Enrollees	71,042.67	71,042.67		-
E-22	*E-23 - E-21 - E-20 - E-19*	Aged	136,677,742.17	136,677,742.17		-
E-23	*E-33 - E-28*	***Total Benefits Paid***	156,053,910.31	156,053,910.31		-
		Total Benefits Paid - Part B				
E-24	8042R01	Disabled	6,803,040.63		6,803,040.63	-
E-25	8042R01	Chronic Renal Disease	2,614,221.70		2,614,221.70	-
E-26	8042R01	Premium Paying Enrollees	329,891.89		329,891.89	-
E-27	*E-28 - E-26 - E-25 - E-24*	Aged	32,549,238.14		32,549,238.14	-
E-28	*B-19*	***Total Benefits Paid***	42,296,392.36		42,296,392.36	-
		Total Benefits Paid				
E-29	*E-19 + E-24*	Disabled	24,006,259.97	17,203,219.34	6,803,040.63	-
E-30	*E-20 + E-25*	Chronic Renal Disease	4,716,127.83	2,101,906.13	2,614,221.70	-
E-31	*E-21 + E-26*	Premium Paying Enrollees	400,934.56	71,042.67	329,891.89	-
E-32	*E-33 - E-31 - E-30 - E-29*	Aged	169,226,980.31	136,677,742.17	32,549,238.14	-
E-33	*E-12*	***Total Benefits Paid***	198,350,302.67	156,053,910.31	42,296,392.36	-

Prepared by: _____

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Reviewed by: _____

500.8 - Categorization of Total Funds Expended by Category

(Rev. 20, 08-01-03)

This section takes the financial information that was input by the user and allocates those amounts to the various descriptive categories identified on the Form CMS-1522 report. The amounts can generally be used to complete the Form CMS-1522 with little additional effort.

Reconciliation of CMS Form 1522
Total Funds Expended and Supporting Lead Schedules

	FISS Report #	Cycle Date	Total	HI	SMI	ZERO
Section 500.8 - Categorization of Total Funds Expended by Category						
		Itemization of Retroactive Adjustments - Part A				
E-34	8042R01	Lump Sum Interim Payments	8,653,256.43	8,653,256.43		-
E-35	8042R01	Tentative Settlements	(23,340.00)	(23,340.00)		-
E-36	*E-37 - E-34 - E-35*	Post Audit Settlement	(225,468.33)	(225,468.33)		-
E-37	*E-7*	*Total*	8,404,448.10	8,404,448.10		-
		Itemization of Retroactive Adjustments - Part B				
E-38	8042R01	Lump Sum Interim Payments	69,904.52		69,904.52	-
E-39	8042R01	Tentative Settlements	215.00		215.00	-
E-40	*E-41 - E-38 - E-39*	Post Audit Settlement	(444,026.23)		(444,026.23)	-
E-41	*E-8*	*Total*	(373,906.71)		(373,906.71)	-
		Itemization of Retroactive Adjustments - Total				
E-42	*E-34 + E-38*	Lump Sum Interim Payments	8,723,160.95	8,653,256.43	69,904.52	-
E-43	*E-35 + E-39*	Tentative Settlements	(23,125.00)	(23,340.00)	215.00	-
E-44	*E-36 + E-40*	Post Audit Settlement	(669,494.56)	(225,468.33)	(444,026.23)	0.00
E-45	*E-42 thru E-44*	*Total*	8,030,541.39	8,404,448.10	(373,906.71)	-
				-		
	Source of Benefit	**Retroactive Adjustments - Part A**				
E-46	8042R01	Credit Adjustments	(3,192,936.86)	(3,192,936.86)		-
E-47	*Calculated*	Supplemental Payments	11,597,384.96	11,597,384.96		-
E-48	*E-46 + E-47*	*Total*	8,404,448.10	8,404,448.10	-	-
		Retroactive Adjustments - Part B				
E-49	8042R01	Credit Adjustments	(363,323.80)		(363,323.80)	-
E-50	*Calculated*	Supplemental Payments	(10,582.91)		(10,582.91)	-
E-51	*E-49 + E-50*	*Total*	(373,906.71)		(373,906.71)	-
		Retroactive Adjustments - Total				
E-52	*E-46 + E-49*	Credit Adjustments	(3,556,260.66)	(3,192,936.86)	(363,323.80)	-
E-53	*E-47 + E-50*	Supplemental Payments	11,586,802.05	11,597,384.96	(10,582.91)	-
E-54	*E-52 + E-53*	*Total*	8,030,541.39	8,404,448.10	(373,906.71)	-
E-55	*E-9 - E-45*	*Differences*	-	-	-	-
E-56	*E-9 - E-54*	*Differences*	-	-	-	-
E-57	*E-45 - E-54*	*Differences*	-	-	-	-

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510 – Procedures for the Reconciliation of Total Funds Expended for Multi-Carrier System (MCS) Medicare Contractors Used in the Preparation of Form CMS-1522, Monthly Contractor Financial Report

(Rev. 21, 08-01-03)

The Centers for Medicare & Medicaid Services (CMS) continues to have a material internal control weakness for the reconciliation of total funds expended on Form CMS-1522 resulting from the Chief Financial Officers Audit. The reconciliation of total funds expended to adjudicated claims and standard system reports is an important control that validates that the amounts reported by Medicare contractors are accurate, supported, and complete.

The CMS requires that Medicare contractors provide a reconciliation of total funds expended reported on the monthly Form CMS-1522 report by the 15th day of the following month. Form CMS-1522 is a cash-based document and is prepared primarily from MCS system reports, bank statements, and other internal reports. The financial reconciliation includes adjudicated claims processed, other non-claims based payments, overpayment recoveries, and other financial adjustment transactions.

Total funds expended represent payments made for claim and non-claim transactions during each claims payment cycle (i.e., the total of all checks issued, electronic funds transfers (EFT) payments, voided checks, overpayment recoveries, and other financial adjustments). The claims payment cycle varies at each contractor and can be daily, multi-weekly, or weekly.

All claims submitted during a payment cycle include both adjudicated claims and non-adjudicated claims. Adjudicated claims represent those claims that were processed for payment (i.e., payments, denials, or adjustments) and included on the remittance advice report. Non-adjudicated claims do not appear on the remittance advice and include demonstration claims, returned to provider claims, and other exception claims. Each MCS contractor must retain the electronic file received from the MCS Systems Maintainer that documents the detailed claims records that supports the MCS Summary Report #2002 for each payment cycle.

Although the enclosed reconciliation format has been tested and proven adequate for most situations, there may be unique situations at selected contractors that result in an "unreconciled" difference. When those situations occur, the contractor should investigate those differences and identify the source and cause for the difference. The standard format can be adjusted to accommodate those differences so that the reconciliation and Form CMS-1522 can be completed. Contractors should report those differences to CMS for further review and adjustment of the standard format.

The lead reconciliation schedule (Section 510.3) must be submitted electronically to the applicable CMS regional office. MCS system reports, bank statements, and other internal reports used to create the lead reconciliation schedule must be maintained for three years,

and made available upon request for audit and review by CMS financial personnel and other external auditors.

Methodology

Contractors are required to complete the financial reconciliation schedules for each claims processing cycle, and provide a copy of the cumulative monthly totals in the format established in Section 510.3. The reconciliation should be completed at the end of each claims payment cycle to identify any differences as they occur and provide sufficient time to resolve those differences before the next cycle ends. View Exhibit I by clicking on this link to access the electronic spreadsheet in Mircrosoft Excel® format to complete the following steps.

To complete the reconciliation for each claims payment cycle, MCS contractors must:

1. Identify and summarize the detailed claims data file. (Section 510.1)

    a. Obtain and retain detailed claims data records that are produced by the MCS Systems Maintainer (Section 510.1).

    b. Identify, summarize, and retain a report of the number and dollar value of adjudicated claims that are included on the detailed claims data file. Adjudicated claims include all paid, denied and adjusted claims processed by MCS. The non-adjudicated claims include demonstration claims, claims that could not be processed and must be returned to either the provider or other exceptions claims. Enter the first day of each month in Column A, line 38 of the electronic spreadsheet (Section 510.4). For the following specific fields, enter the claim payments, adjustments, reissues, special issues, recoupments, and manual issues from the detailed claims data file for each payment cycle into Columns B, C, D, E, F, and H, respectively of the electronic spreadsheet (Section 510.5), on reference lines 71 through 101.

    c. Obtain MCS Report #2002 or HBDR 2002, Financial Report Month-To-Date Analysis of Payments, and enter the claim payments, adjustments, reissues, special issues, recoupments, and manual issues in Columns B, C, D, E, F, and H, respectively of the electronic spreadsheet (Section 510.6) on reference lines 105 to 135.

    d. Review the daily claim and adjustment differences in Columns D and G, respectively, on lines 38 to 68 (Section 510.4). The amounts on those lines should be ZERO; research any differences that are identified and make corrections to any of the amounts entered in Steps 1b and 1c above.

2. Obtain financial MCS system reports for each claims processing cycle and enter selected data from those reports onto the electronic spreadsheet (Sections 510.6 through Section 510.8). The CMS will provide an electronic spreadsheet in Excel® format. For those contractors that have multiple sites, the electronic spreadsheet has separate tabs, to allow data input for up to 5 sites. The data input for each site will be consolidated into a separate tab.

Obtain copies of the primary financial MCS system reports that are used in the financial reconciliation process. A list of those report numbers and report descriptions is included in Section 510.2.

a. Enter selected financial information from MCS system reports into the electronic spreadsheet (Sections 510.6 through Section 510.8) that have a yellow background and were not completed as part of Steps 1b, 1c, or 1d.

b. Review the Net Disbursements Check values in Columns F, lines 171 to 201 (Section 510.8). The amounts on those lines must be ZERO; research any differences that are identified and make corrections to any of the amounts entered in Step 2a above.

c. Enter financial information that is not available from MCS system reports onto lines 204 to 234 of the electronic spreadsheet (Section 510.9).

i. The information for refunds/deposits listed in Column E lines 204 to 234 (Section 510.9) generally will be supported by cash logs or deposit tickets that were made to record deposits to the contractor's bank account. These refunds/deposits are generally different from the recoupments generated within MCS claims processing system and reported on line F of the MCS HBDR 2002 report. These recoupments are generally controlled by edits within the MCS system and represent system withholdings and offsets.

d. The information for voids, stale checks, and stop pays listed in Columns B, C, and D, lines 204 to 234 (Section 510.9) are generally supported from the bank statements, bank reports, the manual check listing, the voided and stale-dated check listing, and other manually maintained listings that identify correcting financial transactions for the month. Experience has shown that HBSR0342, HBSR0346, and HBSR0350 can be used to report monthly voids, stops, and stale dates, respectively. Enter the amount of Do Not Forward (DNF) checks into Column G, lines 204 to 234 (Section 510.9). The amount of DNF checks for each payment cycle are generally found in contractor report, HBDR 6003, Provider Check Register.

3. Finalize the standard reconciliation report (Section 510.3) and submit to CMS as part of the monthly contractor financial reports.

After completing the process outlined in Steps 1 and 2 above, all of the financial information needed to identify total funds expended should have been entered into the standard report format (Section 510.3) automatically.

Overall Summary

The methodology used to identify and summarize the detailed claims data file provided in Section 510.1, the MCS systems reports identified in Section 510.2, and the standard report format provided in Section 510.3 are a systematic approach to reconcile financial activity for each claims payment cycle at MCS Medicare contractors.

The information contained on the attachments provides a standard methodology to validate financial information contained on the summary level MCS system reports to the detail claims data or transaction level support. The methodology outlined above and the information contained on the standard report formats document a standardized approach to calculate and validate the total funds expended at Medicare contractors.

Also, the standard report formats assist in the preparation of a significant portion of the Form CMS-1522. The methodology does not provide information relating to the Funds Drawn from the Treasury presented on lines 1 through 6 of Form CMS-1522, or for the bank reconciliation information presented on Form CMS-1522, Page 2 and 3, Lines 15 through 23.

Due Date

A copy of Section 510.3, Standard MCS 1522 Reconciliation Schedule, must be provided electronically to the appropriate CMS regional office's Associate Regional Administrator for the Division of Medicare Financial Management by the 15th day of the following month concurrent with the submission of other Contractor Financial Reports and submitted electronically to 1522recon@cms.gov. All of the Sections (510.3 through 510.9) should be retained to support the information submitted to the appropriate regional office.

510.1 - Reconciliation of Detailed Claims Data File to Multi-Carrier System (MCS) Reports

This section provides the requirements for the detailed claims data file that the MCS Systems Maintainer must generate for all MCS contractors.

(Rev. 21, 08-01-03)

This instruction provides a standard format to perform the reconciliation for contractors that use the MCS and requires the MCS Systems Maintainer to generate an electronic file for each contractor's payment cycle, which includes all detail claim records that support the totals found on MCS Report #2002. Also the MCS System Maintainer will provide an independent report that shows the total number of records on the electronic file and the total dollar value for each of the following fields.

A. Claim Payments

B. Adjustments

C. CPT Interest

D. Reissues

E. Special Issues

F. Recoupments

G. System Issues

H. Manual Issues

I. Total Issues

J. Voids

K. Stale Dates

L. Refunds

M. Stop Pays

N. Net Reimbursement

Each MCS Medicare contractor must enter the summary totals from each line item as noted above (A through N) from the detailed claims data file into the Excel® spreadsheet (Exhibit 1). By reconciling the summary totals from the detailed claims data file on a payment cycle basis, to the summary totals from MCS Report #2002, each MCS contractor will have assurance that the system report is supported by the detail.

The detailed claims data file must be retained and made available in a format that can be reviewed by CMS or its external auditors.

510.2 - List of Primary MCS Reports Used in the Reconciliation of Total Funds Expended – This section identifies the primary MCS system reports needed to complete the financial reconciliation.

(Rev. 21, 08-01-03)

HBDR2002 - Financial Report Month-To-Date Analysis of Payments
HBDR2055 - EFT Transaction Report
HBDR6000 - Register Summary Report
HBDR6003 – Provider Check Register
HBSR0342 - Monthly Voids
HBSR0346 - Monthly Stops
HBSR0350 - Monthly Stale Dates

Beneficiary Check Register
Bank Statements – Time Account, Disbursement Account, Concentration Account
Bank Reconciliation
List of Daily Deposits for the Month
List of Manual Checks Issued During the Month
List of Voided and State-Dated Checks
List of Other Financial Adjustment Transactions Occurring During the Month

Comment:

The EFT payments reflected on MCS HBDR2055 Report are part of the provider payments shown in the HBDR6000 report. As a result, the contractor can perform a simple reconciliation to identify how payments were disbursed (i.e., EFT payments, provider check payments, and beneficiary check payments).

510.3 - Standard MCS 1522 Reconciliation Lead Schedule – This section calculates the total system and non-system payments that equate to the Total Funds Expended amount reported on the Form CMS-1522.

(Rev. 21, 08-01-03)

Line #	Description	Total Amount	Source Document
	Detailed Claims Data Reconciliation Activity		
1	Detailed Claims Data Totals	15,810,912.00	Detailed Claims Data File/Report
2	Detailed Adjustment Totals		
3			
4	Subtotal	15,810,912.00	From Line 1
5			
6			
7	Claim Payments per MCS	15,597,653.42	HBDR2002 Report, Line A
8	Adjustments per MCS	215,103.80	HBDR2002 Report, Line B
9			
10	Subtotal	15,812,757.22	Sum of lines 7 & 8
11			
12	***Difference***	(1,845.22)	Line 4 - Line 10

	Detailed Claims Data and Non-Claim System Issues			
13	Detailed Claims Data Totals		15,810,912.00	From Line 4
14				
15				
16	Add: Reissues		42,631.55	HBDR2002 Report, Line D
17	Add: Special Issues		30,670.89	HBDR2002 Report, Line E
18	Less: Recoupments		(18,362.54)	HBDR2002 Report, Line F
19			0.00	
20	Net Disbursements (System Issues)		15,865,851.90	Sum of Lines 13, 16, 17, & 18
21				
22	Add: Manual Issues		0.00	HBDR2002 Report, Line H
23				
24	Total Issues Per MCS		15,865,851.90	Line 20 + Line 22
	Non-System/Manual adjustments (Cash Activity)			
25	Voids	(55,088.48)		Bank Recs/HBSR 0342/General ledger
26	Stales	0.00		Bank Recs/HBSR 0350/General ledger
27	Stop Pays	0.00		Bank Recs/HBSR 0346/General ledger
28	Refunds/Deposits	(112,947.78)		Bank Recs/HBDR 2002/General ledger
39	Journal Entry Adjustments	0.00		Adjusting journal entries
30	Less: DNF (Do Not Forward)			HBDR6003 Report
31				
32	Subtotal - Other Adjustments		(168,036.26)	Sum of lines 25 to 30
33	**Net Funds Expended Per Reconciliation**		15,697,815.64	Line 25 - Line 32
34				
35	Net Funds Expended Per CMS-1522 Report		15,699,660.86	Form CMS-1522, Line 5D
36				
37	***Calculated Difference***		(1,845.22)	Line 33 - Line 35

510.4 – Reconciliation of Claim Payments from the Detailed Claims Data File/Report to the Month-to-Date Analysis of Payment (MCS Report #2002 or HBDR2002) - This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input the dollar value of the specific line items from the detailed claims data file on a cycle basis.

(Rev. 21, 08-01-03)

Section 510.4: Reconciliation of Claim Payments from the Detailed Claims Data File/Report to the Month-to-Date Analysis of Payment (H

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	
		DETAILED		DAILY DIFFERENCE	DETAILED		DAIL
		CLAIM PAYMENTS	CLAIM PAYMENTS	CLAIM PAYMENTS	ADJUSTMENTS	ADJUSTMENTS	AD
LINE	DATE	*Report Title ##*	HBDR2002	(B-C)	*Report Title ##*	HBDR2002	
38	12/1/2002	0.00	0.00	0.00	0.00	0.00	
39	12/2/2002	0.00	0.00		0.00	350,782.36	
40	12/3/2002	0.00	0.00		0.00	386,166.12	
41	12/4/2002	0.00	0.00		0.00	504,327.28	
42	12/5/2002	0.00	0.00		0.00	309,629.56	
43	12/6/2002	0.00	0.00		0.00	451,525.15	
44	12/7/2002	0.00	0.00		0.00	0.00	
45	12/8/2002	0.00	0.00		0.00	0.00	
46	12/9/2002	0.00	0.00		0.00	360,978.06	
47	12/10/2002	0.00	0.00		0.00	363,366.69	
48	12/11/2002	0.00	0.00		0.00	361,998.44	
49	12/12/2002	0.00	0.00		0.00	352,961.21	
50	12/13/2002	0.00	0.00		0.00	372,426.91	
51	12/14/2002	0.00	0.00		0.00	0.00	
52	12/15/2002	0.00	0.00		0.00	0.00	
53	12/16/2002	0.00	0.00		0.00	299,624.59	
54	12/17/2002	0.00	0.00		0.00	695,311.73	
55	12/18/2002	0.00	0.00		0.00	448,313.96	
56	12/19/2002	0.00	0.00		0.00	378,403.93	
57	12/20/2002	0.00	0.00		0.00	391,304.93	
58	12/21/2002	0.00	0.00		0.00	0.00	
59	12/22/2002	0.00	0.00		0.00	0.00	
60	12/23/2002	0.00	0.00		0.00	338,378.43	
61	12/24/2002	0.00	0.00		0.00	0.00	
62	12/25/2002	0.00	0.00		0.00	0.00	
63	12/26/2002	0.00	0.00		0.00	416,537.31	
64	12/27/2002	0.00	0.00		0.00	347,191.72	
65	12/28/2002	0.00	0.00		0.00	0.00	
66	12/29/2002	0.00	0.00		0.00	0.00	
67	12/30/2002	0.00	0.00		0.00	286,326.18	
68	12/31/2002	0.00	0.00		0.00	0.00	
69							
70	Totals	15,810,912.00	15,597,653.42	(1,845.22)	0.00	215,103.80	

510.5 - Proof of Net Disbursements and Total Issues per Detailed Claims Data File/Report - *This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information from the detailed claims data file and MCS reports.*

(Rev. 21, 08-01-03)

Section 510.5: Proof of Net Disbursements and Total Issues per Detailed Claims Data File/Report

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
							Net Disbursements / System Issues
		CLAIMS	ADJUSTMENTS	REISSUES	SPECIAL ISSUES	RECOUPMENTS	*per Report Title##*
LINE	DATE	*per Report Title##*	*per Report Title##*	*per Report Title##*	*per Report Title##*	*per Report Title##*	(B + C + D + E - F)
71	12/1/2002	10,912.00	0.00	0.00			0.00
72	12/2/2002	0.00	0.00				0.00
73	12/3/2002	0.00					0.00
74	12/4/2002	0.00					0.00
75	12/5/2002	13,000,000.00					0.00
76	12/6/2002	0.00					0.00
77	12/7/2002	0.00					0.00
78	12/8/2002	0.00					0.00
79	12/9/2002	0.00					0.00
80	12/10/2002	0.00					0.00
81	12/11/2002	0.00					0.00
82	12/12/2002	0.00					0.00
83	12/13/2002	0.00					0.00
84	12/14/2002	2,000,000.00					0.00
85	12/15/2002	0.00					0.00
86	12/16/2002	0.00					0.00
87	12/17/2002	750,000.00					0.00
88	12/18/2002	0.00					0.00
89	12/19/2002	50,000.00					0.00
90	12/20/2002	0.00					0.00
91	12/21/2002	0.00					0.00
92	12/22/2002	0.00					0.00
93	12/23/2002	0.00					0.00
94	12/24/2002	0.00					0.00
95	12/25/2002	0.00					0.00
96	12/26/2002	0.00					0.00
97	12/27/2002	0.00					0.00
98	12/28/2002	0.00	215,103.80				0.00
99	12/29/2002	0.00					0.00
100	12/30/2002	0.00					0.00
101	12/31/2002	0.00					0.00
102							
103	Totals	15,810,912.00	215,103.80	0.00	0.00	0.00	0.00

510.6 - Proof of Net Disbursements and Total Issues Per MCS Report #2002- This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information from the detailed claims data file and MCS reports

(Rev. 21, 08-01-03)

Section 510.6: Proof of Net Disbursements and Total Issues per MCS Report 2002

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
LINE	DATE	Claim Payments per 2002 Rpt	Adjustments per 2002 Rpt	Reissues per 2002 Rpt	Special Issues per 2002 Rpt	Recoupments per 2002 Rpt	Net Disbursements System Issues per 2002 Rpt (B + C + D + E - F)
105	12/1/2002	0.00	0.00	0.00	0.00	0.00	0.00
106	12/2/2002	56,837,614.91	350,782.36	0.00	0.00	19,577.76	57,168,819.51
107	12/3/2002	28,657,694.40	386,166.12	446,167.54	31,232.72	62,446.16	29,458,814.62
108	12/4/2002	25,836,609.72	504,327.28	458,444.77	4,215.56	24,027.84	26,779,569.49
109	12/5/2002	1,611,374.85	309,629.56	1,621,431.99	5,486.74	6,527.87	3,541,395.27
110	12/6/2002	36,459,555.90	451,525.15	993,362.07	6,094.26	25,019.12	37,885,518.26
111	12/7/2002	0.00	0.00	0.00	0.00	0.00	0.00
112	12/8/2002	0.00	0.00	0.00	0.00	0.00	0.00
113	12/9/2002	61,886,815.20	360,978.06	151,348.03	1,990.18	55,071.84	62,346,059.63
114	12/10/2002	6,746,915.52	363,366.69	281,943.38	4,916.06	10,154.04	7,386,987.61
115	12/11/2002	1,560,978.91	361,998.44	412,686.95	7,019.02	9,052.52	2,333,630.80
116	12/12/2002	1,438,627.03	352,961.21	110,819.57	22,974.50	4,249.05	1,921,133.26
117	12/13/2002	45,570,085.67	372,426.91	424,291.27	5,656.62	26,999.81	46,345,460.66
118	12/14/2002	0.00	0.00	0.00	0.00	0.00	0.00
119	12/15/2002	0.00	0.00	0.00	0.00	0.00	0.00
120	12/16/2002	54,844,402.41	299,624.59	130,391.23	348,707.86	73,868.17	55,549,257.92
121	12/17/2002	31,679,689.47	695,311.73	201,368.02	88,705.27	37,226.64	32,627,847.85
122	12/18/2002	24,924,910.27	448,313.96	311,922.33	283,847.01	15,539.89	25,953,453.68
123	12/19/2002	1,730,017.16	378,403.93	161,007.85	2,533.69	4,923.56	2,267,039.07
124	12/20/2002	38,248,499.74	391,304.93	221,290.52	18,299.27	26,548.11	38,852,846.35
125	12/21/2002	0.00	0.00	0.00	0.00	0.00	0.00
126	12/22/2002	0.00	0.00	0.00	0.00	0.00	0.00
127	12/23/2002	75,308,262.54	338,378.43	355,736.19	4,717.85	61,550.75	75,945,544.26
128	12/24/2002	0.00	0.00	0.00	0.00	0.00	0.00
129	12/25/2002	0.00	0.00	0.00	0.00	0.00	0.00
130	12/26/2002	25,424,150.73	416,537.31	141,062.01	2,293.54	24,470.26	25,959,573.33
131	12/27/2002	38,298,027.24	347,191.72	254,271.45	2,661.11	21,756.08	38,880,395.44
132	12/28/2002	0.00	0.00	0.00	0.00	0.00	0.00
133	12/29/2002	0.00	0.00	0.00	0.00	0.00	0.00
134	12/30/2002	75,414,126.51	286,326.18	132,848.84	1,521.28	95,808.02	75,739,014.79
135	12/31/2002	0.00	0.00	0.00	0.00	0.00	0.00
136							
137	Totals	15,597,653.42	215,103.80	42,631.55	30,670.89	(18,362.54)	15,865,851.90

510.7 - Reconciliation of Net Disbursements and System Issues from the Detailed Claims Data File/Report to the Month-to-Date Analysis of Payment (HBDR2002) - *This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information from the detailed claims data file and MCS reports.*

(Rev. 21, 08-01-03)

Section 510.7: Reconciliation of Net Disbursements and System Issues from the Detailed Claims Data File/Report to the Month-to-Date Analysis of Payment (HBDR2002)

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
		Net Disbursements System Issues (Col. G)	Net Disbursements System Issues (Col. G)	DAILY DIFFERENCE DISBURSEMENTS	Total Issues (Col. I)	Total Issues (Col. I)	DAILY DIFFERENCE ISSUES
LINE	DATE	*Report Title ##*	HBDR2002	(B-C)	*Report Title ##*	HBDR2002	(E-F)
138	12/1/2002	0.00	0.00	0.00	0.00	0.00	0.00
139	12/2/2002	0.00	57,168,819.51	(57,168,819.51)	0.00	57,168,819.51	(57,168,819.51)
140	12/3/2002	0.00	29,458,814.62	(29,458,814.62)	0.00	29,459,715.02	(29,459,715.02)
141	12/4/2002	0.00	26,779,569.49	(26,779,569.49)	0.00	26,779,569.49	(26,779,569.49)
142	12/5/2002	0.00	3,541,395.27	(3,541,395.27)	0.00	3,541,395.27	(3,541,395.27)
143	12/6/2002	0.00	37,885,518.26	(37,885,518.26)	0.00	37,885,518.26	(37,885,518.26)
144	12/7/2002	0.00	0.00	0.00	0.00	0.00	0.00
145	12/8/2002	0.00	0.00	0.00	0.00	0.00	0.00
146	12/9/2002	0.00	62,346,059.63	(62,346,059.63)	0.00	62,420,963.57	(62,420,963.57)
147	12/10/2002	0.00	7,386,987.61	(7,386,987.61)	0.00	7,386,987.61	(7,386,987.61)
148	12/11/2002	0.00	2,333,630.80	(2,333,630.80)	0.00	2,333,953.99	(2,333,953.99)
149	12/12/2002	0.00	1,921,133.26	(1,921,133.26)	0.00	1,921,133.26	(1,921,133.26)
150	12/13/2002	0.00	46,345,460.66	(46,345,460.66)	0.00	46,345,460.66	(46,345,460.66)
151	12/14/2002	0.00	0.00	0.00	0.00	0.00	0.00
152	12/15/2002	0.00	0.00	0.00	0.00	0.00	0.00
153	12/16/2002	0.00	55,549,257.92	(55,549,257.92)	0.00	55,549,257.92	(55,549,257.92)
154	12/17/2002	0.00	32,627,847.85	(32,627,847.85)	0.00	32,627,847.85	(32,627,847.85)
155	12/18/2002	0.00	25,953,453.68	(25,953,453.68)	0.00	25,953,453.68	(25,953,453.68)
156	12/19/2002	0.00	2,267,039.07	(2,267,039.07)	0.00	2,267,039.07	(2,267,039.07)
157	12/20/2002	0.00	38,852,846.35	(38,852,846.35)	0.00	38,852,846.35	(38,852,846.35)
158	12/21/2002	0.00	0.00	0.00	0.00	0.00	0.00
159	12/22/2002	0.00	0.00	0.00	0.00	0.00	0.00
160	12/23/2002	0.00	75,945,544.26	(75,945,544.26)	0.00	75,945,544.26	(75,945,544.26)
161	12/24/2002	0.00	0.00	0.00	0.00	0.00	0.00
162	12/25/2002	0.00	0.00	0.00	0.00	0.00	0.00
163	12/26/2002	0.00	25,959,573.33	(25,959,573.33)	0.00	25,959,573.33	(25,959,573.33)
164	12/27/2002	0.00	38,880,395.44	(38,880,395.44)	0.00	38,880,436.54	(38,880,436.54)
165	12/28/2002	0.00	0.00	0.00	0.00	0.00	0.00
166	12/29/2002	0.00	0.00	0.00	0.00	0.00	0.00
167	12/30/2002	0.00	75,739,014.79	(75,739,014.79)	0.00	75,739,039.82	(75,739,039.82)
168	12/31/2002	0.00	0.00	0.00	0.00	0.00	0.00
169							
170	Totals	0.00	15,865,851.90	(646,942,361.80)	0.00	647,018,555.46	(647,018,555.46)

510.8 - Proof of Net Disbursement per MCS Register Summary Report (HBDR6000) to the Month-to-Date Analysis of Payments (HBDR2002 Report, Line G)

- This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information from the detailed claims data file and MCS reports.

(Rev. 21, 08-01-03)

Section 510.8: Proof of Net Disbursement per MCS Register Summary Report (HBDR6000) to the Month-to-Date Analysis of Payments (HBDR2002 Report, Line G)

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
LINE	DATE	Provider Amounts Per HBDR6000	Beneficiary Amounts Per HBDR6000	Total Amounts (B + C)	Net Disbursement (System Issues) HBDR2002 Line G / Detail Data Report	Differences (D - E)	REASON
171	12/1/2002	0.00	0.00	0.00	0.00	0.00	
172	12/2/2002	56,797,987.94	370,831.57	57,168,819.51	57,168,819.51	0.00	
173	12/3/2002	29,260,656.54	198,158.08	29,458,814.62	29,458,814.62	0.00	
174	12/4/2002	26,639,387.24	140,182.25	26,779,569.49	26,779,569.49	0.00	
175	12/5/2002	3,517,320.61	24,074.66	3,541,395.27	3,541,395.27	0.00	
176	12/6/2002	37,581,035.44	304,482.82	37,885,518.26	37,885,518.26	0.00	
177	12/7/2002	0.00	0.00	0.00	0.00	0.00	
178	12/8/2002	0.00	0.00	0.00	0.00	0.00	
179	12/9/2002	62,035,371.68	310,687.95	62,346,059.63	62,346,059.63	0.00	
180	12/10/2002	7,304,404.76	82,582.85	7,386,987.61	7,386,987.61	0.00	
181	12/11/2002	2,307,689.22	25,941.58	2,333,630.80	2,333,630.80	0.00	
182	12/12/2002	1,887,402.09	33,731.17	1,921,133.26	1,921,133.26	0.00	
183	12/13/2002	45,991,947.26	353,513.40	46,345,460.66	46,345,460.66	0.00	
184	12/14/2002	0.00	0.00	0.00	0.00	0.00	
185	12/15/2002	0.00	0.00	0.00	0.00	0.00	
186	12/16/2002	55,267,001.36	282,256.56	55,549,257.92	55,549,257.92	0.00	
187	12/17/2002	32,468,909.40	158,938.94	32,627,848.34	32,627,847.85	0.49	
188	12/18/2002	25,867,280.72	86,172.96	25,953,453.68	25,953,453.68	0.00	
189	12/19/2002	2,233,805.64	33,233.43	2,267,039.07	2,267,039.07	0.00	
190	12/20/2002	38,529,814.78	323,031.57	38,852,846.35	38,852,846.35	0.00	
191	12/21/2002	0.00	0.00	0.00	0.00	0.00	
192	12/22/2002	0.00	0.00	0.00	0.00	0.00	
193	12/23/2002	75,527,135.84	418,408.42	75,945,544.26	75,945,544.26	0.00	
194	12/24/2002	0.00	0.00	0.00	0.00	0.00	
195	12/25/2002	0.00	0.00	0.00	0.00	0.00	
196	12/26/2002	25,872,664.06	86,909.27	25,959,573.33	25,959,573.33	0.00	
197	12/27/2002	38,612,629.55	267,765.89	38,880,395.44	38,880,395.44	0.00	
198	12/28/2002	0.00	0.00	0.00	0.00	0.00	
199	12/29/2002	0.00	0.00	0.00	0.00	0.00	
200	12/30/2002	75,266,723.33	472,291.46	75,739,014.79	75,739,014.79	0.00	
201	12/31/2002	0.00	0.00	0.00	0.00	0.00	
202							
203	Totals	642,969,167.46	3,973,194.83	646,942,362.29	646,942,361.80	0.49	

510.9 - Input Sheet for Cash Activity Items - This attachment is an illustration of the electronic spreadsheet (Exhibit 1) that will be used to input selected financial information that is not available from MCS system reports.

(Rev. 21, 08-01-03)

Section 510.9: Input Sheet for Cash Activity Items

	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
LINE	DATE	Voids	Stale Checks	Stop Pays	Refunds/Deposits	Journal Entry Adjustments	Do Not Forward
204	12/1/2002	0.00	0.00	0.00	0.00	0.00	
205	12/2/2002	0.00	14,703.51	0.00	210,449.81	0.00	
206	12/3/2002	411,354.19	0.00	67,887.51	122,233.34	0.00	
207	12/4/2002	486,321.97	0.00	54.98	70,959.51	0.00	
208	12/5/2002	1,634,262.78	0.00	243.45	169,532.86	0.00	
209	12/6/2002	987,998.85	0.00	9,652.67	67,502.88	0.00	
210	12/7/2002	0.00	0.00	0.00	0.00	0.00	
211	12/8/2002	0.00	0.00	0.00	0.00	0.00	
212	12/9/2002	154,369.09	0.00	9,346.12	206,965.75	0.00	
213	12/10/2002	263,936.94	0.00	25,719.05	79,635.48	0.00	
214	12/11/2002	408,658.22	0.00	12,780.47	96,806.14	0.00	
215	12/12/2002	91,313.72	0.00	25,012.61	58,085.88	0.00	
216	12/13/2002	420,237.34	0.00	5,594.63	133,095.66	0.00	
217	12/14/2002	0.00	0.00	0.00	0.00	0.00	
218	12/15/2002	0.00	0.00	0.00	0.00	0.00	
219	12/16/2002	126,330.56	0.00	25,884.59	99,784.51	0.00	
220	12/17/2002	200,225.96	0.00	2,460.61	93,383.17	0.00	
221	12/18/2002	322,815.37	0.00	114,260.96	51,931.80	0.00	
222	12/19/2002	173,552.81	0.00	5,989.32	116,754.07	0.00	
223	12/20/2002	144,426.08	0.00	78,315.05	134,309.62	0.00	
224	12/21/2002	0.00	0.00	0.00	0.00	0.00	
225	12/22/2002	0.00	0.00	0.00	0.00	0.00	
226	12/23/2002	372,536.52	0.00	0.00	396,332.04	0.00	
227	12/24/2002	0.00	0.00	0.00	0.00	0.00	
228	12/25/2002	0.00	0.00	0.00	0.00	0.00	
229	12/26/2002	136,346.03	0.00	4,980.70	128,880.21	0.00	
230	12/27/2002	278,585.61	0.00	41.10	128,987.55	0.00	
231	12/28/2002	0.00	0.00	0.00	0.00	0.00	
232	12/29/2002	0.00	0.00	0.00	0.00	0.00	
233	12/30/2002	133,114.31	0.00	0.00	93,635.05	0.00	
234	12/31/2002	0.00	0.00	0.00	0.00	0.00	
235							
236	Totals	(55,088.48)	0.00	0.00	112,947.78	0.00	0.00