Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-41 **Date: MAY 2000**

CHANGE REQUEST 1024

SUBJECT: **Procedures for the Benefit Integrity (BI) and Medical Review (MR) Units on Unsolicited/Voluntary Refund Checks**

The purpose of this Program Memorandum (PM) is to provide program integrity guidance from a MR and BI perspective on unsolicited/voluntary refund cases from providers/suppliers (including physicians and other practitioners) who have sent a refund check.

I. General Information--All Medicare contractors receive voluntary refunds (amounts received for which there was no established accounts receivable). Providers may identify overpayments through internal compliance efforts or ad hoc internal investigations. Subsequently, providers should refund such identified overpayments. Fiscal intermediaries generally receive voluntary refunds in the form of an adjustment bill, but may receive some voluntary refunds as checks or reported as credit balances. Carriers generally receive unsolicited refund checks.

II. BI and MR Review of Unsolicited Voluntary Refund Cases--Voluntary refund checks payable to the Medicare program must not be returned regardless of the amount of the refund. Refer to the Carriers Manual (Part 3, §14017, Intermediary Manual §3974, and the future Program Integrity Manual) for the acknowledgment of voluntary refunds. Ask the provider why the voluntary refund was made, how it was identified, what sampling techniques were employed, what steps were taken to assure that the issue leading to the overpayment was corrected, the dates the corrective action was in place, claims and claims information involved in inappropriate payments, methodology used to arrive at the amount of the refund, and if a full assessment was performed to determine the entire time frame and the total amount of refund for the period during which the problem existed that caused the refund.

When a provider returns an overpayment equal to or greater than 20% of your total annual Medicare payments for that provider (or in any other circumstances in which you suspect patterns of inappropriate payment), perform data analysis for patterns of inappropriate program payment (e.g., payment for services not rendered, payment for medically unnecessary services, or payment for upcoded services) rather than isolated instances. The data analysis should be for the period that is the subject of the voluntary refund. Decide if further medical review is appropriate. As part of the decision to perform further medical review, consider whether the refund accurately reflects the full disclosure of the debt and that appropriate adjustments were made to the claims and the claims history files. You may want to consider if the provider is currently the subject of a prepayment or postpayment review. You may also want to access the FID to determine if the provider is subject to any program safeguard activity. The BI and MR units should share their findings with each other. In cases where there are patterns of inappropriate payments, determine the appropriate corrective actions to take (e.g., provider education, prepayment and postpayment edits, creation of local medical review policies (LMRP), referral to law enforcement). Follow the guidelines in the Medicare manuals to determine the appropriate corrective action(s). If fraud is suspected, refer the case to the BI unit expeditiously for appropriate action.

These instructions do not supersede the present Carriers Manual (Part 3, §14017), Intermediary Manual (Part 3, §3974), and the future Program Integrity Manual instructions that reference procedures for handling unsolicited voluntary refunds where there is a strong suspicion of fraud or an active investigation.

These instructions should be implemented within your current operating budget.

The *effective date* for this PM is July 1, 2000.

The *implementation date* for this PM is July 1, 2000.

This PM may be discarded after July 2, 2001.

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