Medicare Financial Management Manual
Chapter 3 - Overpayments

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(Rev. 141, 09-12-08)

Transmittals for Chapter 3

Bankruptcy Attachments

NOTE: Revision 3 includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - Overpayments Determined by the FI or Carrier

(Rev. 29, 01-02-04)

Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must attempt collection of claims of the Federal Government for money arising out of the activities of the agency. The FI or carrier will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part, however once an intermediary or carrier determines an overpayment has been made it must attempt recovery of overpayments in accordance with CMS regulations.

The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demands for repayment, and establishment of repayment schedules, suspension of interim payments by intermediaries to institutional providers, and recoupment or setoff, where appropriate.

In addition, The Debt Collection Improvement Act of 1996 requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and offset. CMS is mandated to refer all eligible debt over 180 days delinquent for cross servicing and offset.

This chapter deals with two general types of overpayments.

Aggregate overpayments involve a group or all of a Part A provider's claims, e.g., overpayments discovered at cost-report settlement time or change of FI, overpayments resulting from a pattern of improper application of Medicare coverage provisions, overpayments resulting from a periodic interim payment adjustment, situations involving provider failure to file a cost report, or occasions of fraud or program abuse. Aggregate overpayments are described in §10.1, §20 and §30 of this chapter and Chapter 4, Debt Collection.

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

10.1 - Aggregate Overpayments

(Rev. 29, 01-02-04)

A. Stitutional Providers Serviced By Fis

Aggregate overpayments to providers (overpayments arising in other than individual cases) may occur by:

- A pattern of furnishing and billing for excessive or noncovered services (see Program Integrity Manual);
- Inclusion of non-allowable or excessive costs in the provider's cost report;
- Excessive interim payments made to the provider;
- Failure to repay accelerated payments;
- Failure to file cost reports (Chapter 3, §30);or
- Determination of amounts due upon filing the cost report, during desk review, final settlement and reopening of the cost report.

10.2 - Individual Overpayments

(Rev. 29, 01-02-04)

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

Examples of individual overpayment cases are:

- Payment for provider, supplier or physician services after benefits have been exhausted, or where the individual was not entitled to benefits.
- Incorrect application of the deductible or coinsurance.
- Payment for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.
- Payment based on a charge that exceeds the reasonable charge.
- Duplicate processing of charges/claims.
- Payment to a physician on a non-assigned claim or to a beneficiary on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-entitlement.

20 - Recovery of Cost Report Overpayments- Cost Report Filed

(Rev. 29, 01-02-04)

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

20.1 - Part A Provider is Participating in Medicare and Medicaid

(Rev. 29, 01-02-04)

When the provider files a cost report indicating an overpayment, a final determination is deemed to have occurred if the cost report is not accompanied by payment in full. Where the provider does not remit the overpayment in full, the FI sends the first demand letter notifying the provider that it will reduce or suspend interim payments in 15 days if the provider does not make repayment arrangements.

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

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

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

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

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

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

(Rev. 29, 01-02-04)

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

If the FI discovers an overpayment upon the filing of a cost report, or on determination of program reimbursement, with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund in a lump-sum, if it has not been made.

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

If the terminated provider has sold the entity to a participating provider refer to Chapter 3,

§130 for change of ownership instructions.

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

(Rev. 29, 01-02-04)

If the FI discovers an overpayment upon the filing of a cost report, or on determination of the amount of program reimbursement for a former Medicare provider that is still participating in Medicaid, it shall immediately contact the provider to obtain a refund in a lump sum, if it has not been made.

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

The first demand letter must provide notice (See Chapter 4, §10-20 and §60) that action to withhold its Federal share of Medicaid payments will be requested if repayment arrangements are not made within 15 days of the date of this notice. The second demand letter must provide notice that action to withhold its Federal share of Medicaid payments has been requested and will be initiated if repayment arrangements are not made. The FI shall send the third demand letter 30 days following the second where the provider has not responded, even though procedures for withholding the Federal share of payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury.

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

30 - Recovery of Cost Report Overpayments - Overdue Cost Report

(Rev. 29, 01-02-04)

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

30.1 - Provider is Participating in Medicare and Medicaid

(Rev. 29, 01-02-04)

A. General

For a participating provider, the cost report required for each cost report period is due on or before the last day of the fifth month following the end of that particular cost report period. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

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

extension request has not been received and approved or a reduction in the rate of suspension has not been approved. (See Chapter,)

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

The FI shall make a personal (or telephone) contact with the provider 15 days after mailing the second demand letter. It shall determine any problems the provider might be having in preparing the cost report, and if, and when, the provider expects to complete and submit it. It shall document the provider's response.

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

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

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

(Rev. 29, 01-02-04)

Where a provider's agreement under title XVIII has terminated and one or more cost reports have not been submitted the FI shall send the first demand letter. Requirements for this letter are in Chapter 4, §20. Since this situation involves not only a terminated provider but a provider that has failed to meet the basic obligation (submission of a cost report) for the period when it did participate, the first demand letter provides notice that initiation of the procedure for withholding the Federal share of Medicaid payments will begin in 15 days if the FI does not receive the cost report.

The FI shall continue sending demand letters to the provider. (Chapter 4, §20 for the requirements for the second and third demand letters) The demand letters must be sent at 30-day intervals where the provider has not responded even though the procedures for withholding the Federal share of Medicaid payments have been initiated.) This must be done so that if recoupment efforts and the withholding of Medicaid payments are not effective, the case will be ready for referral to the Department of Treasury.

40 – Recovery of Claims Accounts Receivables from the Provider - FI

(Rev. 29, 01-02-04)

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

40.1 – Demand Letter Contents

(Rev. 29, 01-02-04)

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

The demand letter must include the following information:

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

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

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

Date

Certified Mail

Name/Address

Re: Provider Number
Claims Accounts Receivable

Dear _____:

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

Submit your check payable to _____, to the following address:

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

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

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

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

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

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

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

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

Sincerely,

(name and title)

50 - Recovery of Overpayments When a Provider Changes Its FI- FI Only
(Rev. 29, 01-02-04)

Where CMS approves a change of FI, the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Medicare Claims Processing, Chapter 1, General Billing Requirements.)

50.1 Action By Outgoing FI
(Rev. 29, 01-02-04)

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

A. Notification to Incoming FI

When the outgoing FI is notified by the RO that the provider's request for a change of FI has been approved, it shall notify the incoming FI in writing of all outstanding program overpayments. It shall include:

- The cost reporting period;
- The date the overpayment was determined;
- Explanation of the type of overpayment, e.g., cost report overpayment - desk review, cost report overpayment - audit;
- The current status of collection action, including any withhold that is currently in place to recoup the overpayment; and
- The original balance of the overpayment and the current principal and interest balance of the overpayment.

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

B. Notice of Intent to Suspend Interim Payments

If at the time of the change of FI the outgoing FI is recouping an overpayment by the withholding of interim payments the incoming FI will continue the withhold. The outgoing FI must notify the provider that the withhold will be continued by the incoming FI until the

overpayment is liquidated or an acceptable ERS is approved. In addition, the outgoing FI must notify the incoming FI of the details of the withhold.

If after the change of FI occurs the outgoing FI determines that an overpayment exists the outgoing FI must notify the provider in accordance with normal procedures. The current FI should receive a copy of all NPRs and demand letters. The outgoing FI must contact the current FI to make sure that recoupment begins when necessary.

50.2 – Action by Incoming FI
(Rev. 29, 01-02-04)

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

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

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

A. Reduction of Outstanding Overpayment

Any actions taken by the incoming FI which reduce or eliminate the overpayment made by the outgoing FI shall be communicated, in writing, to the outgoing FI within 5 working days after the month in which the actions occurred. In addition, unless the provider indicates to the contrary, any collections or payment are applied first to the earliest overpayment. See Chapter 5, Financial Reporting for instructions on transferring any payment(s) between FIs.

50.3 - Extended Repayment Plan - Change of FI
(Rev. 29, 01-02-04)

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

Where an extended repayment plan is in effect at a change of intermediaries, and the provider later requests a revision in the terms of the existing repayment, either the incoming or outgoing FI may renegotiate the repayment plan depending upon which receives the provider's request. The need for a revision of the existing repayment plan must be documented in accordance with Chapter 4, §50. The FI that renegotiates the repayment plan notifies the other about the revised repayment plan within 5 working days and collects the required payments. Collections received by the incoming FI pursuant to a repayment plan

negotiated by it are reported to the outgoing FI and RO within 5 working days after the month in which the collections were received.

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

(Rev. 29, 01-02-04)

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

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

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

70 – Determining Liability and Waiver of Recovery for Overpayments

(Rev. 29, 01-02-04)

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

The FI or carrier shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most FI payments for provider services are made to providers on behalf of the beneficiaries who received the services. If payment is made directly to the beneficiary, liability always lies with the beneficiary unless recovery is waived under the limitation of liability provision. Where the provider or physician has been overpaid, it is liable for the

overpayment unless the FI or carrier determines that it was without fault with respect to the overpayment.

If the FI or carrier determines that an overpaid provider or physician was without fault and therefore not liable for the overpayment, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault.

However, recovery from the beneficiary may be waived if you determine the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

70.1- 1879 Determination – Limitation of Liability

(Rev. 29, 01-02-04)

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

A. Limitation on Liability – Indemnification Procedures for Claims Filed under Part B

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

B. Limitation on Liability Where Physician and Beneficiary Did Not Have Prior Knowledge With Respect to Services Found To Be Not Reasonable And Necessary Services (§1879 of Act)

When both the physician and the beneficiary did not have prior knowledge with respect to services found to be not reasonable and necessary, permit Medicare payment to be made under the limitation on liability provision. (See PIM Exhibits, §14.1)

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

70.2 - 1842(l) Determination

(Rev. 29, 01-02-04)

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

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment

(Rev. 29, 01-02-04)

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

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

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

Examples of §1870 determinations:

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

If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The FI or carrier makes these determinations.

B. Beneficiary Liable for Overpayments to Provider That Was Without Fault With Respect to the Overpayment (§§1870(a) and (b) of the Act)

If an overpaid provider was without fault, or is deemed without fault and therefore not liable for refund, liability shifts to the beneficiary. If the overpayment involves services that are

not reasonable and necessary, you should have made a §1879 determination regarding the beneficiary's liability for the overpayment. If the overpayment does not involve medically unnecessary services, then limitation on liability does not apply.

C. Contractor Waiver of Recovery from Beneficiary (§1870(c) of the Act)

If a beneficiary is liable for an incorrect payment, recovery may be waived if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where an overpayment is discovered subsequent to the third calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.)

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

80 – Individual Overpayments Discovered Subsequent to the Third Year

(Rev. 29, 01-02-04)

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

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

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

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

(Rev. 29, 01-02-04)

Only the year of the payment and the year it was found to be an overpayment enter into the determination of the 3-calendar year period. The day and the month are irrelevant. With respect to payments made in 2000, the third calendar year thereafter is 2003. For payments made in 2001, the third calendar year thereafter is 2004, etc. Thus, the rules apply to payments made in 2000 and discovered to be overpayments after 2003, to payments made in 2001 and discovered to be overpayments after 2004, etc.

Where an overpayment to a provider, or a physician assignee for medically unnecessary services or custodial care is discovered (i.e., demanded) subsequent to the third calendar year after the year in which the payment was approved, the provider or physician assignee is prohibited from charging the beneficiary or any other person for the services notwithstanding the fact that the provider or physician assignee has refunded the overpayment if:

- The provider or physician assignee was at fault with respect to the overpayment; and
- The beneficiary was without fault with respect to the overpayment. (Where the overpayment is discovered in, or before, the third calendar year, an "at fault" provider or physician assignee is not prohibited from charging the beneficiary for the overpayment if it has refunded it. However, a without fault beneficiary who pays an at fault provider's or physician assignee's bill for medically unnecessary services or custodial care, can be indemnified in accordance with Medicare Claims Processing, Chapter 30, Limitation on Liability.

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

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

Within 12 months after the date of the determination or decision it may be reopened for any reason;

After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or

At any time, if:

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

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

80.4 - Recovery of Overpayment Due to Overdue Cost Report

(Rev. 61, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Where CMS approves a change of FI, the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Pub 100-04, Medicare Claims Processing Manual, Chapter 1, General Billing Requirements.)

A. Reminder Letter

The outgoing FI is responsible for effecting final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter required under §80.1 to ensure the timely receipt of the cost report.

B. First Demand Letter

If no cost report has been filed by the first day after the due date of the cost report (including extensions), the outgoing FI sends the first demand letter in Chapter 4, Debt Collection, §10, Exhibit l, Column B. It sends copies of the reminder letter and the first demand letter to the RO and incoming FI. Upon receipt of its copy of the letter, the incoming FI suspends the interim payment.

C. Second Demand Letter

If the provider does not respond within 15 days, the outgoing FI sends the second demand letter notifying the provider that interim payments are further suspended. It sends copies of the letter to the RO and the incoming FI. Upon receipt of its copy of the letter, the incoming FI suspends interim payments.

D. Third Demand Letter

The outgoing FI is responsible for personal contact with the provider, issuing the third demand letter, and notifying the RO if appropriate. The FI shall issue a "modified Intent Letter for Unfiled Cost Reports," if the provider has not filed the cost report and the overpayment balance has not been paid. (See Chapter 4 § 20.2 Exhibit 7 for a sample intent letter)

E. Receipt of Delinquent Cost Report

If the delinquent cost report is sent to the incoming FI, it sends the cost report to the outgoing FI to make the final settlement.

After the outgoing FI has completed its review of the delinquent cost report, it notifies the incoming FI whether the cost report is acceptable, and the final settlement. The incoming FI, in accordance with §40.1 and §80.1C, disposes of funds withheld during the suspension of interim payments.

90 - Provider Liability

(Rev. 29, 01-02-04)

A provider is liable for overpayments it received unless it is found to be without fault. The FI or carrier, as applicable, makes this determination.

The FI or carrier considers a provider without fault, if it exercised reasonable care in billing for, and accepting, the payment; i.e.,

- It made full disclosure of all material facts; and
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention.

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

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

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

A. The Provider Furnished Erroneous Information or Failed to Disclose Facts That It Knew or Should Have Known, Were Relevant to Payment of the Benefit.

This includes, among others, situations in which a provider failed to report any additional payments he may have received from the beneficiary and situations in which a provider failed to request applicable information from the beneficiary including, but not limited to, information needed by the FI or carrier to identify cases in which Medicare may be secondary payer, or if it did request such information, it failed to annotate the billing form. (Providers are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help the FI or carrier identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan.) (See Medicare Claims Processing, chapter 29, Coordination With Medigap Insurers.)

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

B. Provider Receives Duplicate Payments.

This includes the following situations:

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

- Provider received payment from Medicare on the basis of an assignment and a beneficiary received payment on an itemized bill and turned the beneficiary payment over to the provider. The provider is liable for only the portion of the total amount paid in excess of the provider's portion of the allowable amount. The beneficiary is liable for the balance of the overpayment. However, if the beneficiary paid any portion of the coinsurance to the provider, the provider is liable for that amount also. If the provider protests recovery of the overpayment on the grounds that the provider applied all or part of the check received from the beneficiary to amounts the beneficiary owed the provider for other services, the beneficiary, rather than the provider, is liable for refunding such amounts.

EXAMPLE: Dr. A and Mr. B each received duplicate payments of $300 based on reasonable charges of $375. Mr. B turned his $300 over to Dr. A. Thus, Dr. A received a total of $600. Mr. B did not owe money to Dr. A for other services. Dr. A is liable for $225, which is the amount he received in excess of the reasonable charge. Mr. B is liable for the remaining $75 of the duplicate payment. If Mr. B had previously paid Dr. A the $75 coinsurance, Dr. A is liable for the entire $300 overpayment.

- Provider receives duplicate payments from Medicare and another insurer or plan (directly or through the beneficiary) which is the primary payer, i.e., an automobile medical or no-fault insurer, a liability insurer, a WC insurer, or, under certain circumstances, an EGHP. (See Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers.) The provider is liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer. (See Medicare Claims Processing, Chapter 29, Coordination With Medigap Insurers and/or Medicare Secondary Payer Manual.) However, if the provider turns the other insurance payment over to the beneficiary, the beneficiary is liable.

C. The Overpayment Resulted Through Misapplication of the Deductible or Coinsurance Requirement or Payment After Exhaustion of Benefits and the Provider Could Have Known From Its Own Records the Beneficiary's Utilization Status

Part A Provider is considered liable if it received a remittance record within the 60 days preceding billing indicating deductible and benefit status. This condition is considered met where, within the 60-day period preceding the admission that gave rise to the overpayment, the beneficiary had been a patient in the same institution or the provider could have known the beneficiary's utilization status from its own records.

The provider is expected to ask the beneficiary, or the person acting on the beneficiary's behalf, at the time of admission if the beneficiary received inpatient services in a hospital or SNF within the past 60 days, and note the response on its records.

EXAMPLE: John Doe entered University Hospital on January 10, 2000. After using all of his benefit days, including lifetime reserve days, he returned home, but reentered the same hospital in fewer than 60 days and stayed an additional 30 days. University Hospital neglected to check its records and billed the FI for 30 days of inpatient hospital care. The FI made payment. Subsequently, the overpayment was discovered. Since the hospital should have known from its own records that Mr. Doe had exhausted his benefit days, the FI shall seek recovery from the hospital.

If the previous stay had been in a different hospital, or if more than 60 days had elapsed between the end of the first stay and the start of the second stay but the benefit period had

remained unbroken because John had been in an SNF or a different hospital, the FI would consider University Hospital "without fault." In this latter situation, the hospital would not have been able to ascertain from its own records that benefit days had been exhausted. The FI would seek recovery from the beneficiary.

D. The Overpayment Was Due to a Mathematical or Clerical Error.

Examples:

- Error in calculation by the FI or carrier in calculating reimbursement;
- Error by the provider in calculating charges, or
- Overlapping or duplicate bills.

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

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

F. The Provider Does Not Submit Documentation to Substantiate That It Performed the Services Billed to the Program Where There Is a Question as to Whether the Services Were Performed.

(See the Program Integrity Manual, which can be found at the following Internet address: www.cms.hhs.gov/manuals/cmsindex.asp, if fraud is suspected.)

G. The Beneficiary Was Not Entitled to Part A Benefits and the Provider Had Reason to Believe That the Beneficiary Was Not Entitled to Such Benefits.

For example, the Social Security Office notified the hospital that the individual was not entitled to hospital insurance benefits.

H. The Provider Billed, or Medicare Paid the Provider for Services that the Provider Should Have Known Were Noncovered.

1. Services Other Than Medically Unnecessary or Custodial Services, e.g., skilled physical therapy services furnished by a nonqualified physical therapist, or services rendered pursuant to an authorization from the VA. (See Medicare Benefit Policy, Chapter 17, Exclusions.)

In general, the provider should have known about a policy or rule, if:

- The policy or rule is in the provider manual or in Federal regulations,
- The FI or carrier provided general notice to the medical community concerning the policy or rule, or
- The FI or carrier gave written notice of the policy or rule to the particular provider.

Generally, a provider's allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met. However, there may

be other circumstances that justify a finding that the provider was not at fault. The FI or carrier shall consider all of the circumstances, including such factors as whether and to what extent a coverage rule is spelled out in regulations, instructions, or in a CMS notice, and whether a FI or carrier misinformed the provider about the rule; in deciding whether a provider acted reasonably in billing for and accepting payment for noncovered services.

2. Medically Unnecessary or Custodial Services.

The FI or carrier shall apply the criteria in Medicare Claims Processing, Chapter 31, Limitation on Liability in determining whether the provider should have known that the services were not covered.

I. For FIs, The Overpayment Resulted From Services Rendered in a Nonparticipating Portion of the Facility or in a Bed Certified for a Type of Care Other Than That Furnished.

J. For Carriers, The Physician Was Paid but Did Not Accept Assignment.
The physician is liable whether or not the beneficiary had also been paid.

K. For Carriers, Overpayment Was for Rental of Durable Medical Equipment and Supplier Billed Under the One-Time Authorization Procedure.

Pursuant to Medicare Claims Processing, Chapter 20, suppliers of durable medical equipment who have accepted assignment may be reimbursed for rental items on the basis of a one-time authorization by the beneficiary; i.e., without the need to obtain the beneficiary's signature each month. A supplier using the procedure must have filed with the carrier a statement that it assumes unconditional responsibility for rental overpayments for periods after the beneficiary's death or while he was institutionalized or while he no longer needed or used the equipment.

L For Carriers, Items or Services Were Furnished by Practitioner or Supplier not Qualified for Medicare Reimbursement

Two examples of such services are:

- A laboratory test performed by a nonqualified independent laboratory, or
- Services rendered by a naturopath.

90.2 - Provider Protests Its Liability

(Rev. 87, Issued: 12-30-05; Effective: 01-01-06; Implementation: 01-03-06)

A provider's reply to a notification that the provider is liable for an overpayment may indicate dissatisfaction with some aspect of the overpayment decision. Such a protest shall be considered a request for an appeal. In most instances, this will be a redetermination which is the first level of appeal for an overpayment determination. However, if the overpayment is identified during the course of the redetermination, the contractor shall consider the provider's protest as a request for reconsideration by the qualified independent contractor (QIC). In conducting the appeal, the FI or carrier shall consider whether

a. There was an overpayment;

b. The amount of the overpayment was correctly calculated; and whether,

The provider is liable for repayment.

100 - Beneficiary Liability
(Rev. 29, 01-02-04)

A beneficiary is liable for:

- Overpayments made to a provider that was without fault with the exception of overpayments for medically unnecessary services or custodial care where the beneficiary, as well as the provider, was without fault. (See Medicare Claims Processing, Chapter 30, Limitation on Liability.)
- Situations in which Medicare pays a provider, and a WC carrier, automobile medical, or no-fault insurer or any liability insurer; or EGHP pays primary benefits to the beneficiary for the same services. (See Medicare Secondary Payer Manual)
- Overpayments made to the beneficiary.

110 - Recovery Where the Beneficiary Is Liable for the Overpayment
(Rev. 29, 01-02-04)

When the FI or carrier has determined the beneficiary to be liable for the overpayment, it shall initiate recovery efforts in accordance with the following sections, as appropriate. The chart below is meant to be a guide. The actual sections shall be reviewed for additional guidance.

MEDICARE BENEFICIARY NON-MSP OVERPAYMENTS

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

$1000-$19999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and make a decision to approve or deny the waiver based on Ch. 3 §70.
$20000 and over	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and make a recommendation to approve or deny the waiver based on Ch. 3 §70. If the recommendation is for approval, refer the waiver request to the Regional Office for concurrence.

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

(Rev. 29, 01-02-04)

When the FI or carrier determines the beneficiary is liable, and the beneficiary carries supplemental health insurance or is covered by another Government health benefits program such as Medicaid, TRICARE, CHAMPVA, or the Federal Employees Health Benefits Program, it may be possible to recover the overpayment from the other plan or program. Payments of deductible or coinsurance amounts and payment for services rendered persons who are not entitled to Medicare are the payments most likely to be recoverable.

If, based on the circumstances of the overpayment and FI or carrier knowledge of the other plan or program, the FI or carrier believes there is a possibility that the other plan will refund the overpayment, it shall attempt to recover from the other plan or program. In this connection, it may be necessary to ask the beneficiary for their policy number or other information concerning their non-Medicare coverage. (See Medicare Claims Processing , Chapter 28, Coordination With Medigap, Medicaid, and Other Complementary Insurers, for procedures to follow where the overpayment is for services that should have been paid for by a WC carrier.)

To facilitate recovery of the Medicare overpayments to the extent possible, where another plan or program is involved, the FI or carrier shall attempt to work out mutually satisfactory arrangements with the other carrier(s). In negotiations with Medicaid agencies or carriers, it may be helpful for the FI or carrier to point out that Medicare will refund directly to Medicaid agencies overpayments for services reimbursed on a charge basis.

The methods listed below have been used successfully. The FI or carrier shall use any one or a combination, as it finds appropriate. The most desirable method in a given situation depends upon the particular circumstances, and the provisions of the other plan or program.

- The FI or carrier shall arrange with the other plan or program for direct refund of overpayments to it. If the FI or carrier is also the carrier under the other plan or program, a transfer of funds is the most convenient method of recovering. If another insurance carrier is involved, the FI or carrier shall send the other insurance carrier a letter requesting refund of the overpayment. The letter should explain how the overpayment occurred and how it was calculated. The FI or carrier shall follow up in 30 days with another letter or a phone call if payment or a letter of explanation has not been received. If this does not bring a meaningful response, it shall write to the President or Chief Administrative Officer of the other carrier.

- If the FI or carrier does not use the above method for provider overpayments, it shall arrange with the other plan or program to make payment to overpaid provider upon the FI's or carrier's request, (even though the provider has not billed the other plan or program) and to notify the FI or carrier of the payment. Upon receiving such a notice, the FI or carrier shall recover the Medicare overpayment from the provider.

- Where neither of the above methods is possible, the FI or carrier shall ask the provider if it would be willing to refund the overpayment and to bill the other plan or program, with the understanding that if it is unable to obtain payment, the FI or carrier will refund the amount recovered to the provider. If the provider does not agree to refund the overpayment before collecting from the other plan or program, the FI or carrier shall ask it to bill the other plan or program and to use the payment to refund the overpayment. If the FI or carrier receives notice that a provider (or a beneficiary) plans to file a claim with another plan or program, it shall suspend recovery efforts for a reasonable period.

If the FI or carrier has questions concerning the proper approach in recovering from a welfare agency, or another insurance plan, it should contact its RO.

If efforts to recover the overpayment are not successful, or if the FI or carrier is certain that the other plan or program will not refund a particular overpayment, it shall seek recovery from the beneficiary in accordance with §110.2. It shall explain in the notice to the beneficiary that the other plan or program will not make payment directly to it. However, if the beneficiary is a Medicaid recipient, the FI or carrier shall not attempt recovery from the beneficiary.

110.2 - Recovery From the Beneficiary

(Rev. 29, 01-02-04)

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

A. Non-MSP Overpayment Is Less Than $50

Take no further recovery action. Do not send a recovery letter, or attempt recoupment. Also do not refer case to CMS for further collection efforts. See §160.2 for termination of collection procedures.

B. Non-MSP Overpayment Amount Is $50 or More

Upon discovering an overpayment of $50 or more, send the beneficiary a recovery letter containing the information in §110.4.

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

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

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

C. Referral to SSA

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

However, if the HI number has a T or M suffix, do not refer the case to SSA since those beneficiaries are not entitled to monthly social security benefits. Offset should be continued in the case of beneficiaries whose HI number ends in T or M. If appropriate, the instructions for termination of collection action (See 110.3D for additional instructions.) should be followed.

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

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

- Referral Form- contains the address of the referring agency (The Centers for Medicare and Medicaid Services (CMS) Central Office, CMS Regional Office, or the Medicare Contractor and information pertaining to the case; and

- Return Notice- for SSA use in recording information for crediting the CMS Trust Fund; and

- Waiver Determination- if the Medicare Contractor or CMS RO determines the beneficiary was at fault for the overpayment.

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

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

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

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

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

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

D. Beneficiary "Write-Off" between $50- $999.99

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

Example:

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

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

for the beneficiary Non-MSP overpayment Write-off.

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

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

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

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

(Rev. 29, 01-02-04)

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

A. The Beneficiary Requests Administrative Appeal, or Questions the Overpayment Decision

The FI or carrier shall make no further recovery efforts until it disposes of the appeal request. (See §110.9.)

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

C. The Beneficiary Is Receiving Welfare Benefits

If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, the FI or carrier shall ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. (See §110.1.) If the welfare agency does not refund the overpayment in full, the FI or carrier shall not attempt recovery from the beneficiary, unless it is apparent that the beneficiary knew or should have known that the payment was incorrect.

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

110.4 - Content of Demand Letter to Beneficiary

(Rev. 29, 01-02-04)

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment which is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the carrier's determination. Clarity is also important because the letter may eventually be used by CMS for further recovery attempts.

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

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

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

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

D. The beneficiary is required to refund the overpayment.

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

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

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

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

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

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

110.5 - Sample Demand Letter to Beneficiary

(Rev. 29, 01-02-04)

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

"Dear Mr. _____:

A. Opening Paragraph:

"In (month and year) we paid (provider's, physician's, supplier's name and location) (you) $_____ more than was due for services furnished by _____ on _____ (from _____ through _____) (on _____). We have reviewed the payment and determined that it was incorrect. The correct payment should have been $_____."

The FI or carrier shall include a clear and complete explanation of how the overpayment arose and how it was calculated.)

It shall add if applicable: "We have recovered $_____ from (specify source). Thus, the total remaining overpayment is $_____.

B. Liability of Beneficiary When Payment Made to Physician or Supplier

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

"Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's, physician's, supplier's name) was not at fault. Therefore, you are liable for the $_____ incorrectly paid for the services you received."

C. Request for Refund

"Please send us a check or money order for $_____, within 30 days. Make the check or money order payable to (FI or carrier name), and mail it in the enclosed self-addressed envelope."

D. Possible Offset

"If other Medicare benefits become payable to you and you have not refunded the incorrect payment we will withhold the amount you owe from those benefits." (In the initial letter the FI or carrier shall add: "beginning 60 days from the date of this letter.")

E. Possible Referral to Social Security Administration

If the overpayment is over $1000, add the following:

“If you do not repay this amount, this overpayment may be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action that, among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled.”

F. Installment Payments

"If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of $_____each month for ___ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often."

G. Possible Recovery from Other Insurance

(The FI or carrier shall not use this paragraph where it has determined that the private insurer will not pay.)

"If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider or physician) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office."

H. Notification of Appeal Rights

The notification of appeal rights must be in accordance with the reopening rules in Medicare Claims Processing, Chapter 29 – Appeals of Claims Decisions.

NOTE: If the overpayment was for medically unnecessary services or for custodial care, The FI or carrier shall begin the first sentence of the appeals paragraph:

"If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services."

I, Notification of Waiver of Recovery Provision

"The law requires that you must repay an overpayment of Medicare benefits unless you meet both of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, and

- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses or would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination."

110.6 - Optional Paragraphs for Inclusion in Demand Letters
(Rev. 29, 01-02-04)

The FI or carrier should use or adapt the following paragraphs in explaining how the overpayment occurred.

A. Inpatient Hospital Deductible or Coinsurance Not Properly Assessed - FI

1. General - FI

“Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first $_____ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of $_____ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is $_____ per day coinsurance for each lifetime reserve day used.

2. Deductible Overpayment

“Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for ____ days in full. However, since these were the first inpatient hospital services furnished in this benefit period you are responsible for the deductible and the $_____ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus (provider's name) was overpaid by $_____.”

3. Coinsurance Overpayment

“Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for ____ full days (less the $____ deductible). However, since you had previously been hospitalized for ____ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as ___ full days and ____ coinsurance days (and/or lifetime reserve days). Therefore (provider's name) has been overpaid on your behalf for _____ coinsurance days at $_____ per day and/or lifetime reserve days at $_____ per day) (less $_____ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is $_____.”

B. Deductible Not Properly Assessed -Carrier

“Under Part B of Medicare, no reimbursement may be made for the first $100 of approved charges incurred by a beneficiary in each calendar year.” (If pertinent, add: “This is true even if you were covered under Medicare for only part of the year.”) In these cases explain the computation of the overpayment.

C. Payment Made Under Workers’ Compensation Law

We paid $_____ in benefits for services furnished you by (provider's, physician's or supplier's name and location) on (dates). However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services that are covered under workers' compensation. Since (provider's, physician's, supplier's name) was not at fault in causing this overpayment, you are required to refund the $_____ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions."

D. Beneficiary Not Entitled to Medicare Benefits

"The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your Medicare Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (FI or carrier name). Therefore, if you disagree with this decision, or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you."

110.7 - Recovery Where Beneficiary Is Deceased

(Rev. 29, 01-02-04)

Where a beneficiary who is liable for an overpayment dies, the FI or carrier shall attempt to recover from such sources as State welfare agencies, or private insurance plans (see §110.1), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative. (See 42 CFR 424.60)

If the entire overpayment cannot be recovered by the above methods, it shall send a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative if known, or to the last known address of the deceased. It shall include the basic information in §110.5, but shall not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The FI or carrier shall not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. It shall not recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

Model Refund Request to Estate of Deceased Beneficiary (FI or carrier shall adapt to Fit the Situation)

Estate of (deceased beneficiary) (or, if known, "Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear M. _____ if estate representative's name is known).

On (date) we paid (provider's, physician's, or supplier's name and location)(deceased beneficiary, if applicable) $ _____ more than was due for services furnished by (_____) on _____ (from _____ through _____)."

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

arose, the amount of the overpayment, how it was calculated, and why the payment was not correct.)

The FI or carrier shall add if applicable:

"We have recovered $ _____ from (specify source). Thus, the total remaining overpayment is $_____.

“If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits.

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

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the (provider, physician) was not at fault in causing the overpayment. In this case ((provider, physician) name) was not at fault. Therefore, the estate of (deceased beneficiary) is liable for the $_____ incorrectly paid to ((provider, physician) name) for the services it furnished (deceased beneficiary).

“Please send us a check or money order in the amount of $ _____ payable to (FI or carrier name) in the enclosed, self-addressed envelope within 30 days.

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

“If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver."

110.8 - Beneficiary Wishes to Refund in Installments

(Rev. 29, 01-02-04)

A. General

If an overpaid beneficiary states that they are unable to refund the full amount of an overpayment at one time, regular monthly installment payments are acceptable. The amount and frequency of the installments should be in reasonable relationship to the amount of the overpayment.

Normally, the installments should be large enough to effect recovery within 3 years; however, the FI or carrier shall allow a longer installment period if the beneficiary is willing to refund at least $50 per month. In notifying a beneficiary that they can refund an overpayment by installments, the FI or carrier shall specify the amount (not less than $10) and the number of monthly installments necessary to recovery the overpayment.

NOTE: These provisions for repayment in installments do not apply to overpayments for which providers are liable.

The FI or carrier shall exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that they cannot afford an installment of at least $10 per month, or that they can afford installments of $10 to $50 per month but the overpayment is so large that recovery would take substantially more than 3 years, the FI or carrier shall treat such statement as a request for waiver. (See §110.9)

B. Notification of Installment Schedule

When agreement is reached with a beneficiary for refund by installments, the FI or carrier shall notify the beneficiary of the installment schedule. Request the beneficiary to sign an installment agreement such as the one in paragraph C below. It shall give one copy of the agreement to the beneficiary, and retain the other.

C. Suggested Installment Agreement

_____ _____

Name of Overpaid Beneficiary Health Insurance Claim Number

Beneficiary's Address

I hereby agree to repay my Medicare overpayment totaling $ _____ to (FI or carrier name), which will receive the payments on behalf of the Centers for Medicare and Medicaid Services. My payments will be made as follows:

DATE PAYMENT DUE (Month, Day, Year)	Amount of Payment
_____	_____
_____	_____
_____	_____

_____

Signature of Beneficiary

_____

Date

D. Beneficiary Fails to Remit Installments

If the beneficiary fails to remit two consecutive installments, or after remitting the overdue installments, fails to remit any subsequent installments, the FI or carrier shall ask the beneficiary the reason for the lapse. If it does not receive a response within 30 days, or is informed that the beneficiary is unable to continue paying any installments the statement should be treated as a waiver request. If the FI or carrier learns that the beneficiary is deceased, see §110.7.

E. Beneficiary Can No Longer Afford Installment Amount But Can Afford a Lesser Amount

If the beneficiary notifies the FI or carrier that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the FI or carrier shall set up a new agreement, provided the new installment is at least $10 per month, and large enough to effect

recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement.

110.9 - Beneficiary Protests

(Rev. 29, 01-02-04)

A beneficiary's reply to a notification of overpayment or request for refund may constitute a request for waiver, or request for appeal, i.e., reconsideration, review, carrier fair hearing, or ALJ hearing as applicable, or a request for both waiver and appeal.

A. Protests To Treat As Requests Administrative Appeal

The FI or carrier shall consider a beneficiary's reply a request for administrative appeal (Part A reconsideration, Part B review, Part B fair hearing, or ALJ hearing (both A & B), as applicable) if the beneficiary protests the existence of an overpayment, the amount of the overpayment, or if the nature of the protest is unclear. (See B below for which protests the FI or carrier shall consider requests for waiver.) It shall take no further recovery action in such cases until the administrative appeal process is completed. (See Pub. 100-4, Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) The FI or carrier shall tell the beneficiary that the request is being considered (or has been forwarded to the Office of Hearings and Appeals, if a hearing request) and that no action is necessary until further notice. If the overpayment case has been referred to SSA, the FI or carrier shall inform SSA of the appeal so that recovery action by SSA may be suspended pending the results of the appeal.

If the appeal determination is that the beneficiary is liable for an overpayment, the FI or carrier shall send the beneficiary another request for refund of the overpayment (including all information in §110.5), unless the beneficiary has also requested waiver. In that event, see B below.

B. Protests To Treat As Requests for Waiver

If an overpaid beneficiary protests on the grounds of hardship, or that recovery would be inequitable, the FI or carrier shall treat the protest as a request for waiver even if it is filed on a form ordinarily used for requesting administrative appeal. Discontinue collection efforts and make a waiver determination if necessary. If the beneficiary offers evidence of financial condition, the FI or carrier shall include it, but shall not solicit such evidence. It shall tell the beneficiary that the overpayment case will be forwarded to the Social Security Administration and that no action is necessary until further notice.

NOTE: If the beneficiary has also requested appeal, the FI or carrier shall conduct the appeal prior to the waiver determination.

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

(Rev. 29, 01-02-04)

The FI or carrier shall consider whether waiver of recovery from the beneficiary is applicable. If the beneficiary is liable and the criteria for waiver of recovery from the

beneficiary are likely to be met, i.e., it appears from the circumstances that the beneficiary was without fault and that recovery is against equity and good conscience or defeats the purpose of the Medicare program (i.e., would cause the individual financial hardship), the FI or carrier makes a waiver determination.

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

- For recovery to be against equity and good conscience an individual must have changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that a payment would be made or because of the overpayment itself. (See 20 CFR §404.509)

- For recovery to defeat the purpose of title II or title XVIII of the Social Security Act the beneficiary must need all of his or her current income to meet ordinary and necessary living expenses. (See 20 CFR §405.508)

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

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

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

110.11 – Recording Overpayment Cases in Which the Provider is Not Liable—FI Only

(Rev. 29, 01-02-04)

If a provider is relieved of liability for refunding an overpayment, and an adjustment bill is required in accordance with Medicare Bill Processing, Chapter 1, General Billing Requirements, the FI shall treat the charges involved in the year-end cost report as though they were covered; i.e., make provision to assure that the overpaid amount is not recovered from the provider at the time of final cost settlement.

If the FI has a system capable of preventing year-end recovery from the provider, where it was relieved of liability for refunding an overpayment, it need not maintain an additional record of the case.

120 - Referral to the Department of Justice (DOJ)
(Rev. 29, 01-02-04)

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

A. General

The DOJ requires the submittal of a Claims Collection Litigation Report (CCLR) for overpayment litigation of claims. The CCLR is a checklist of all administrative collection actions. If need be the RO can assist the FI/Carrier in obtaining a copy of the CCLR. The FI/Carrier will follow the advice received by their RO's OGC in completing the CCLR.

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

Identification of Overpayment(s)

The FI/Carrier shall clearly identify the overpayment(s). Cost report overpayments should be identified for each cost reporting period, by total overpayment amount and each individual overpayment amount if multiple overpayments have occurred (tentative and final settlements, interim rate adjustments…). It shall show any partial payments made by the debtor and clearly distinguish between principal and interest. It shall include documentation to support the overpayment determination. This includes copies of the cost reports, audits, and reviews, copies of all correspondence, and any other information relevant to the overpayment.

Refund Requests

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

Recovery Efforts

The following are required:

- The FI/Carrier's internal communications relative to recovery efforts;
- Detailed reports of all conferences the FI/Carrier held with the provider relative to the overpayment; and

- A detailed narrative of the current situation with the FI/Carrier's evaluation of the cause of the incorrect payment, including setoff against any payments that may have been due the provider.

Provider's Ability to Refund

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

- Corporate financial statement;
- Statement by the debtor showing assets and liabilities;
- Income and expenses (signed by the debtor under penalty of perjury);
- Any other financial data necessary including the age and health of the debtor, potential future income, and the possibility that the debtor concealed or improperly transferred assets.

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

If the FI/Carrier receives any funds, bills for current services, cost report (where one had not been filed), compromise offers, etc., after sending the case for referral to DOJ, it shall notify the RO. It will be advised by the RO as to how to respond to the provider's actions.

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

120.2 - Cases Referred to DOJ for Possible Litigation

(Rev. 29, 01-02-04)

After a provider overpayment case has been referred to DOJ, the FI/Carrier shall not contact or negotiate with the provider, unless authorized to do so by the DOJ or the U.S. Attorney handling the case. Submit all requests for negotiation to the RO.

To avoid extensive legal proceedings and costs by both parties, compromise offers may be made by the provider or the DOJ. If the DOJ contacts the RO with such a request, the RO forwards the information to the FI/Carrier for provider notification. If the provider offers a compromise, the FI/Carrier shall notify the RO and submit the following information:

- Relevant documentation relating to the offer to compromise including, but not limited to, the name, title, and position of the party making the offer, the amount of the compromise offer to settle or otherwise dispose of the overpayment, and the financial standing of the debtors; and
- Recommendations of the U. S. Attorney, if any.

The FI/Carrier shall forward the offer of compromise to the CMS Claims Collection Officer (CCO) through the RO.

In most cases, the U.S. Attorney assigned the Medicare overpayment case will not be fully familiar with Medicare procedures, laws, regulations, or reimbursement. The FI/Carrier may

be requested to provide technical information to supplement the U. S. Attorney's knowledge. As cases are readied for litigation, the RO may contact the FI/Carrier for assistance in documenting the administrative record, e.g., a list of FI potential witnesses and technical advisors.

130 – Change of Ownership (CHOW)

(Rev. 29, 01-02-04)

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

Assignment of Medicare Provider Agreement:

Automatic assignment of the existing provider agreement to the new owner means the new owner is subject to all the terms and conditions under which the existing agreement was issued. (See State Operations Manual, §3210) With assignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless fraud was involved. In addition, the new owner receives benefits of assuming the Medicare provider agreement, such as receiving underpayments discovered after the CHOW.

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

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

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

Nonassignment of a Medicare provider agreement:

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

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

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

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

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

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

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

140.2 - Basic Bankruptcy Terms and Definitions
(Rev. 12, 10-18-02)

140.2.1 - Bankruptcy is Litigation
(Rev. 12, 10-18-02)

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

140.2.2 - Types of Bankruptcies
(Rev. 12, 10-18-02)

Title 11 of the United States Code (the Bankruptcy Code) identifies four types of bankruptcies that may involve Medicare providers: Chapter 7, 9, 11 and 13. We briefly describe each type here to familiarize you with these types of bankruptcy. However, these general descriptions do not replace your attorney's specific advice in a particular bankruptcy case.

1. Chapter 7 - Debtors file Chapter 7 bankruptcies to obtain discharge of their debts. Companies that file under Chapter 7 generally close. A court-appointed trustee accumulates the assets of the debtor, sells them, and distributes the money among those whom the debtor owes (the creditors).

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

3. Chapter 11 - Debtors file Chapter 11 to reorganize the debtor individual or business. To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan"). The Plan indicates the amount and schedule for payments to creditors. Creditors vote on the Plan, and the Court must confirm it. Recovery amounts vary. The Bankruptcy Code provides for discharge of the remainder of the debt.

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

140.2.3 - Filing Bankruptcy Draws a Line in the Sand
(Rev. 12, 10-18-02)

The petition date (i.e., the date the debtor files its petition in bankruptcy with the Bankruptcy Court) draws a line in the sand between prepetition and postpetition actions. Events that

occur on or before the petition date are prepetition. Events that occur after the petition date are postpetition. The automatic stay governs many actions that contractors may take concerning a debtor postpetition. You must therefore consult the RO before you take action concerning the debtor postpetition.

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

140.2.4 Bankruptcy Affects Nearly All Medicare Operations
(Rev. 12, 10-18-02)

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

1. Overpayment Recovery

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

2. Fraud and Abuse

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

3. Reimbursement

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

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

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

4. Payment

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

5. Appeals

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

6. Changes of Ownership

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

140.2.5 - Recoupment and Set-off (see also §140.6.4) -
(Rev. 12, 10-18-02)

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

1. Recoupment

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

2. Set-off

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

Set-off permits making similar adjustments in situations involving one or more contracts or transactions. For example, suppose B owes A $40.00 under one contract and A owes B $50.00 under another contract. If set-off is allowed then A can take her $40 from the $50 she is holding for B (A would only pay B $10.00). Generally, parties can request court permission to set-off. If allowed, parties can set-off prepetition claims against prepetition payments or postpetition claims against postpetition payments. They cannot set-off prepetition claims against postpetition claims.

3. Administrative Freeze

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

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

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

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

Type and timing of Medicare reimbursement the provider receives,

Amounts and types of outstanding overpayments,

Date of pending or planned reopening,

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

Dates and amounts of next Medicare payments if possible,

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

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

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

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

Adversary Proceeding is litigation in bankruptcy court to recover money or property; determine the validity, priority or ranking of an interest in property; get approval for selling an estate's property interest; revoke a discharge or an order of confirmation; and obtain declaratory judgments related to matters of the bankruptcy estate. Litigation against CMS to turn over recouped monies is an example of an adversary proceeding.

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

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

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

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

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

Confirmation is bankruptcy court approval of a plan of reorganization.

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

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

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

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

Dischargeable Debt is a debt for which the Bankruptcy Code allows the debtor's personal liability to be eliminated.

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

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

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

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

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

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

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

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

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

Plan of Reorganization is a debtor's detailed description of how the debtor proposes to pay creditors' claims over a fixed period of time.

Priority is the Bankruptcy Code's statutory ranking of unsecured claims. It determines the order in which unsecured claims will be paid if there is not enough money to pay all unsecured claims in full.

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

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

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

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

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

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

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

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

(Rev. 12, 10-18-02)

140.3.1 - Contractor Staff Must Establish Relationships to Ensure That the RO and Regional Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action
(Rev. 12, 10-18-02)

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

140.3.2 - Contractors Must Recognize and Advise RO Staff About Potential Provider Bankruptcies
(Rev. 12, 10-18-02)

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

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

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

140.3.3 - Contractor Staff Will Establish a Relationship With the RO That has Jurisdiction Over the Bankruptcy
(Rev. 12, 10-18-02)

Contractors will proactively establish and maintain ongoing communications with the RO that has jurisdiction over a particular bankruptcy case. This is important because bankruptcy

law may differ significantly from one jurisdiction to another, due to the structure of the federal court system.

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

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

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

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

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

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

(Rev. 12, 10-18-02)

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

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

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

(Rev. 12, 10-18-02)

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

140.4 - Actions to Take When a Provider Files for Bankruptcy

(Rev. 12, 10-18-02)

140.4.1 - Establish Effective Lines of Communications With

(Rev. 12, 10-18-02)

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

RO, Division of Financial Management Staff
Program Integrity Staff.

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

140.4.2 - Respond to RO Requests for Information

(Rev. 12, 10-18-02)

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

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

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

a. Provider Information:

1. Provider Number

2. Provider Name

3. Provider Address

4. Tax Identification Number (TIN)

b. Information about each overpayment:

1. Cost year end

2. Determination date

3. Original overpayment

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

5. Notice of Program Reimbursement containing overpayment determination

6. Amounts Recouped

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

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

9. Overpayment type

c. Information to Estimate Potential Future Overpayments:

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

2. Cost Reports pending submission with expected dates

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

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

5. Overpayment History by Cost Year for Previous three years

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

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

establish direct communication with both intermediaries.

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

Provider Information:

1. Provider Number
2. Provider Name
3. Provider Address
4. Tax Identification Number (TIN)

a. Overpayment Information:

1. Claim numbers related to the overpayment
2. Dates of service for related claims (check with Regional Counsel on the need for this)
3. Dates of payment for related claims (check with Regional Counsel on the need for this)
4. Determination date of original overpayment
5. Correspondence notifying provider of overpayment
6. Original overpayment
7. Amounts recouped
8. CMS 750/751 Line 7 reflects outstanding receivable balance totals for entire region (both principal and interest)-You must request specific outstanding balances from FI carried for specific providers
9. The date of the CMS 750/751 report on which the receivable was reported
10. Overpayment Type
11. Medical Review overpayments
12. Fraud and Abuse overpayments or investigations

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

140.4.3 - Immediate Contractor Directives From the RO

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(Rev. 12, 10-18-02)
The RO will give the contractors the following guidance as soon as a provider files for bankruptcy.

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

a. Bankruptcy Filed

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

b. Bankruptcy Filing Date.

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

c. Immediate response to requests.

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

d. Obtain approval of all correspondence to provider.

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

e. Lead RO

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

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

a. Interim Rate Adjustment.

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

b. Recoupment.

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

c. Administrative Freeze.

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

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

a. Expedite Cost Report Settlement

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

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

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

c. Part B - Tracking Overpayments and Refunds

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

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

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

4. Contractors Will Track and Report Information to RO.

a. Cost Report Settlements and Claims Processed

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

b. Appeals

If a bankrupt provider files an appeal on an overpayment, contractor staff must keep RO staff informed on the outcome of the appeal. Appeals may take place at

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

5. Record-Keeping.

a. Interest

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

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

b. PORS/PSOR Update

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

c. Bankruptcy Case At Contractor's Location.

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

140.4.4 - Tracking Debts/CO Communications
(Rev. 12, 10-18-02)

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

140.5 - Chain Bankruptcies
(Rev. 12, 10-18-02)

140.5.1 - Chain Providers
(Rev. 12, 10-18-02)

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

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

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

140.5.2 - Single Providers Serviced by a National Contractor
(Rev. 12, 10-18-02)

When a single provider who is serviced by a national contractor files for bankruptcy, the same principle for processing a bankruptcy of a chain provider will apply. The location where the bankruptcy is filed will determine the lead RO. The lead RO will work directly with the national contractor staff on the bankruptcy case. The lead RO will keep the home RO of the national contractor informed in all issues related to the case (e.g., a provider within the jurisdiction of the San Francisco RO files for bankruptcy and their contractor is Mutual of Omaha). The San Francisco RO will assume lead responsibilities and will keep the Kansas City RO informed of all issues related to this case.

140.6 - Affirmative Recovery Actions
(Rev. 12, 10-18-02)

140.6.1 - Working With the RO and Regional Counsel's Office
(Rev. 12, 10-18-02)

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

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

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

140.6.2 - Assumption of the Medicare Provider Agreement
(Rev. 12, 10-18-02)

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

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

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

140.6.3 - Settlement Agreements or Stipulations
(Rev. 12, 10-18-02)

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

140.6.4 - Recoupment
(Rev. 12, 10-18-02)

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

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

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

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

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

payments available to set-off available to freeze for set-off, it is critical to find out about the bankruptcy and the provider's overpayments quickly.

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

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

140.7 - Preparing and Filing Proof of Claim
(Rev. 12, 10-18-02)

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

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

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

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

140.8 - Closure of Bankruptcy Cases and Treatment Of Overpayment Reporting Systems at End of Bankruptcy
(Rev. 12, 10-18-02)

140.8.1 - Closing the Bankruptcy Case
(Rev. 12, 10-18-02)

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

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

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

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

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

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

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

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

(Rev. 12, 10-18-02)

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

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

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

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

140.8.3 - Managing Bankruptcy Debt at the Contractor Location

(Rev. 12, 10-18-02)

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

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

The lead RO is responsible for management of the debt from the initial filing of the Proof of Claim until the closure of the Bankruptcy. The Associate Regional Administrator for the Division of Financial Management will have the authority to terminate collection activity for

cases that meet the criteria for being written off at the Associate Regional Administrator level.

NOTE: Some of the files on this page are available only in Adobe Acrobat - Portable Document Format (PDF). To view PDF files, you must have the Adobe Acrobat Reader (minimum version 4, version 5 suggested). You can check here to see if you have the Acrobat Reader installed on your computer. If you do not already have the Acrobat Reader installed, please go to Adobe's Acrobat download page now.

150 - ACCELERATED PAYMENTS- FI ONLY
(Rev. 29, 01-02-04)

An accelerated payment may be issued where there is:

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

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

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

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

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

150.1 - Eligibility for Accelerated Payment
(Rev. 29, 01-02-04)

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

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

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

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

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

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

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

150.2- Computation of the Accelerated Payment

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

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

2. Subtract the deductibles and coinsurance amounts, and

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

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

(Rev. 29, 01-02-04)

The FI has ten calendar days from the date the accelerated payment is issued to enter a record in the POR System. The POR System shall contain the following information:

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

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

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

150.4- Recoupment of the Accelerated Payment
(Rev. 29, 01-02-04)

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

If the payment is necessitated by abnormal delays in claims processing and/or payment by the FI, recovery by recoupment will be reasonably scheduled to coincide with improvement in the FI's bill processing situation and such recoupment will not impair the provider's cash position. In this situation, recoupment shall be completed within 90 days of the FI processing the provider's claims.

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

EXHIBIT 1

SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCLERATED PAYMENT

1. Provider:_____ Provider Number:_____

Address:_____
_____

2. FI: _____

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

Cash balance is seriously impaired due to:

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

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

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

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

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

c. Anticipated expenditures in next 30 days $_____

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

160 - Termination of Collection Action

(Rev. 29, 01-02-04)

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

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

160.1- Termination of Collection Action – Provider Overpayments

(Rev. 29, 01-02-04)

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

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

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

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

160.2 - Termination of Collection Action – Beneficiary Overpayments

(Rev. 29, 01-02-04)

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

- Beneficiary HIC number
- Current principal amount of overpayment

- Other outstanding overpayments
- Claim Paid Date (Part B)
- Determination Date

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

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

170 – General Overpayment Provisions

(Rev. 29, 01-02-04)

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

170.1 - Offset of Overpayments Against Other Benefits Due – FI

(Rev. 29, 01-02-04)

A. Benefits Payable Under Part B - FI

Where the FI determines that a Part A overpayment has been made to a provider on behalf of a beneficiary, it shall ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (See Medicare Benefit Policy, Chapter 6.) If it appears that Part B benefits are payable, it shall arrange for billings under Part B. It shall use any Part B benefit as an offset against the Part A overpayment.

B. Use of Lifetime Reserve Days - FI

If a Part A overpayment for which a beneficiary is liable was caused by payment for services rendered after exhaustion of benefit period days, the FI shall reduce the amount of the overpayment by the application of the beneficiary's lifetime reserve days, unless the individual elected not to use them. An individual who has been overpaid for services rendered after exhaustion of benefits can elect not to use reserve days only if the individual refunds the overpaid amount. (See Medicare Benefit Policy, Chapter 5.)

170.2 - When the Carrier Does Not Attempt Recovery Action

(Rev. 29, 01-02-04)

The carrier shall not attempt recovery action on individual overpayments if:

A. Total Overpayment Less Than $10

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

B - The Carrier Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless fraud or similar fault is present, a payment determination may not be reopened where the Carrier has not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See Medicare Claims Processing, Chapter 30, Correspondence and Appeals for policies governing the reopening and revision of decisions to allow or disallow a claim.)

C - Payments to Providers for Medically Unnecessary Services or Custodial Care Where Waiver of Liability Applies

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

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

(Rev. 29, 01-02-04)

Occasionally, it may be possible for the FI or carrier to get information or help from the local SSO. For instance, if the beneficiary has moved, the SSO may know the new address, or if the beneficiary has died, it may know the administrator of the estate. If the beneficiary takes a check representing an incorrect payment to the SSO, the SSO forwards the check to the FI or carrier. However, the FI or carrier shall not ask the SSO to collect, or indirectly aid in, the collection of an overpayment.

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

(Rev. 29, 01-02-04)

Where a physician or other individual practitioner who is liable for an overpayment dies, the overpayment should be withheld from other Medicare payments due their estate. If recovery is not possible by recoupment, the carrier shall ascertain whether an administrator or executor has been appointed and then send a letter to the estate of the decedent at the address of the legal representative, if known, or the last known address of the deceased.

If the reply to the letter indicates that the estate will not refund the overpayment, or if a reply is not received within 30 days, the case should be forwarded to CMS for possible litigation. When referring such overpayments, the carrier shall include any information about the

appointment of a legal representative, the size of the estate, etc., and copies of any correspondence with survivors or others concerning the overpayment.

170.5 -Provider Offers to Settle on Compromise Basis

(Rev. 29, 01-02-04)

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

170.6 - Unsolicited Overpayment Refunds

(Rev. 29, 01-02-04)

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

170.7 - Timely Deposit of Overpayment Refund Checks

(Rev. 29, 01-02-04)

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

170.8 – Informal Referral to RO

(Rev. 29, 01-02-04)

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

Attachment A, located after the bankruptcy section, includes a referral checklist that FI/Carrier's should utilize if necessary.

180 - Exhibits

(Rev. 22, 10-03-03)

180.1 - Exhibit 1 - Provider Overpayment Reporting System

(Rev. 22, 10-03-03)

The reporting of outstanding provider overpayments is required to determine providers receiving overpayments, the amounts, and the length of time they are outstanding. To report these overpayments, use the electronic on-line Provider Overpayment Reporting System

(POR). This system serves as a uniform method for reporting overpayment data and as a base for CMS to use in compiling management information on overpayments.

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

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

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

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

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

180.1.1 - Provider Overpayment Report System--Data Entry
(Rev. 22, 10-03-03)

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

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

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

180.1.2 - Provider Overpayment Report Printout
(Rev. 22, 10-03-03)

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

180.1.3 - POR System User Manual
(Rev.64, Issued: 02-11-05, Effective: 03-14-05, Implementation: 03-14-05)

SIGNING ONTO THE POR SYSTEM

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

1. Upon entering the CMS Data Center press enter. You will then be taken to an Application Menu.

2. At the Application Menu enter #3 for the CICS41 System.

3. You will then be prompted to enter your Userid and Password. If you do not have a UserId or Password contact your servicing regional office to obtain instructions for access.

4. After entering your userid and password you will be required to choose the system you wish to enter.

5. Choose #1 for Provider Overpayment Recovery; Then hit Enter.

6. You should now be at the Request Screen.

7. A new Business Segment Identifier (BSI) field has been added to the POR Master Screen.

THE REQUEST SCREEN

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

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - REQUEST SCREEN

REGION # xx INTERMEDIARY # xxxxx BSI xxxx

PROVIDER # xxxxxx PROV TYPE xx

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

FUNCTION: I = ADD NEW OVERPAYMENT RECORD

U = UPDATE AN EXISTING OVERPAYMENT RECORD

B = BROWSE OVERPAYMENT TRANSACTIONS

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

A. Positioning of the Cursor

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

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

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

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

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

3. Intermediary Personnel - Security Level Three (3)

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

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

1. Region Number

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

2. Intermediary Number

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

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

3. Provider Number

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

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

4. Provider Type

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

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

***NOTE:** Provider Type Code 80 has been added to the POR system to only identify all new certified Home Health Agencies that are entered in the POR system. Provider Type Code 10 shall no longer be used to identify HHAs.

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

If the provider is a general hospital (i.e., the third digit of the provider number is equal to zero) the provider may have an overpayment determined for the primary facility (Provider Type = l0) or any of the seven sub units described above (Provider Type = 20, 30, 40, 50, 60, 70 or 80).

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

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

EXAMPLES:

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

0500l2 = Provider Number
30 = Provider Type

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

0500l2 = Provider Number
l0 = Provider Type

5. Cost Report Date

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

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

6. Determination Date

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

7. Overpayment Type (O/P Type)

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

J = Interim Rate Adjustment
K = Hospice
L = Currently Not in Use
M = Unfiled Cost Report- Balance Recouped
X = Interest

8. Function Code

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

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

C. General information about the PORS Request Screen.

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

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

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

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

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

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

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

ADD/UPDATE MASTER SCREEN

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

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - MASTER SCREEN UPDATE

```
REGION # xx            INTERMEDIARY # xxxxx      BSI # xxxx

PROVIDER # xxxxxx PROV TYPE xx PROV NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

  RECOUPED T/D   OPEN BAL      RECOUPED T/Q    ADJUST T/Q         END BAL
 $ xxxxxxxxx          $ xxxxxxxxx      $ xxxxxxxxx          $ xxxxxxxxx          $
xxxxxxxxx

 01 CAUSES x $ xxxxxxxxx          $ xxxxxxxxx          $ xxxxxxxxx          $
xxxxxxxxx      $ xxxxxxxxx
 (F7=ROLL)
 INTERMED CHANGE(Y/N) x    OWNER CHANGE      OWNER TYPE  x      ORG
CHAIN(Y/N) x
 TERMINATED(Y/N) x       PIP(Y/N) x     HHA/PPS x     PPS DATE xxxxxxxx
        NUMBER BEDS xxxx

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

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

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

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

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

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

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

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

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

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

2. Field 8 - PROVIDER NAME

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

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

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

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

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

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

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

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

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

For an ADD - This field contains the underlines.

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

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

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

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

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

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

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

For an ADD - This field initially contains the underlines.

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

8. Field 14 - ENDING BALANCE (END BAL)

This field reflects the current balance of the overpayment case. It is recalculated after every financial transaction is added to the case.
The calculation required to arrive at this figure is the ORIGINAL-OVERPAYMENT-AMOUNT (Field 9) minus RECOUPMENT-TO-DATE (Field 10) minus ADJUSTMENT-TO-DATE (this field is on the master file but was not requested for the screen display.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

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

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

This field will display the current number of causes that have been added to the Master File for this overpayment. Its primary purpose is to alert the User to what the total is, especially if

that figure is more than five (5). If there are more than five causes, the User can use the 'F7=Roll' feature to display the Cause Code and Cause Amount of each of the causes. THIS FIELD IS NOT KEYABLE.

For an ADD - This field contains the underlines.

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

ROLLING THE CAUSE LINE

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

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

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

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

Each of these five fields will contain a valid cause code that has been added to the file. There may be up to 26 cause codes used for one overpayment master record. The screen will show the User five of these at a time, and by using the 'F7=Roll' feature, may review all 26 if necessary.

THIS FIELD IS NOT KEYABLE.

For an ADD - These fields contain the underlines.

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

A. Initial Retroactive Adjustment
B. Non Allowable Excessive Provider Expense
C. Chain Home Office Expense
D. Cost to Related Organization
E. Cost Finding
F. Return on Equity Capital
G. Reimbursement Statistics
H. Excessive Interim Rate
I. Excessive Cost Estimates

J. Excessive Census Days/Visits and/or Charges
K. Excess Cost Limit
L. Excessive Estimates of DRG Discharge
M. Erroneous DRG Designations
N.
O.
P.
Q.
R.
S.
T.
U.
V. Accelerated Payment (Type D)
W. Interim Rate Adjustment (Type J)
X. Unfiled Cost Report (Type H)
Y. Interest (Type X)
Z. Other

NOTE: Cause Codes N through U are reserved for future use.

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

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

These five amount fields correspond directly to the five cause code fields explained in 9 above. Again, there may be up to 26 cause codes and amounts of which the User can see five (5) at a time.

THESE FIELDS ARE NOT KEYABLE.

For an ADD - These fields contain the underlines.

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

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

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

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

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

THIS FIELD, HOWEVER, MAY BE CHANGED.

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

13. Field 19 - OWNER CHANGE

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

This field, on an ADD and UPDATE , will display a blank or 'A' through 'F' which came from the Provider Extract File.

THIS FIELD MAY BE KEYED.

The User may update this field with a valid ownership change code. The update will be edited, as defined above.

14. Field 20 - OWNER TYPE

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

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

THIS FIELD MAY BE KEYED.

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

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

HHAs

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

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

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

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

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

THIS FIELD MAY BE KEYED.

The User can also update this field by keying directly over the existing data.

16. Field 22 - TERMINATED (Y/N)

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

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

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

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

The User shall update this field by keying directly over the existing data.

17. Field 23 - PIP (Y/N)

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

For an ADD function, this field is Mandatory.

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

18. Field 24 - HHA/PPS

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

For an ADD function, this field is mandatory.

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

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

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

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

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

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

For an UPDATE function, this field is optional.

19. Field 25 - PPS DATE

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

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

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

20. Field 26 - NUMBER BEDS

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

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

21. Field 27 - INIT RECOUP DATE

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

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

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

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

The following edits are performed on this date.

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

22. Field 28 - COMP RECOUP DATE

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

For an ADD, this field is OPTIONAL.
For an UPDATE, the User may key the modifications directly over the existing data.

For both functions, the following edits are in effect.

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

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

23. Field 29 - METHOD

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

For an ADD, this field is MANDATORY.

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

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

01 Lump Sum Payment - All Cash
02 Current Interim Payments - Withholdings
04 Periodic Lump Sum Installments - Extended Repayment Plans
08 Offset - Offsetting one year against another; one unit against another in the case of multi-facility providers, or similar types of offset
15 Combination of 01, 02, 04, and 08 - Cash, Withholdings, Extended Repayment Plan and Offset
16 Bankruptcy
17 Combination of 15 and 16 - Cash, Withholdings, Extended Repayment Plan, Offset and Bankruptcy*
18 GME Aggregation Only

* Method of Recoupment Code 17 shall be used when recoupment of the debts have more than one situation occurring simultaneously.

24. Field 30 - TOTAL REIMBURSEMENT

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

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

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

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

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

25. Field 31 - STATUS CODE

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

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

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

26. Field 32 - LOCATION

This field identifies the current workstation of the overpayment case.

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

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

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

**The new Location Code ICC indicates that CMS Central Office is transferring the debt(s) to the intermediaries/carriers from the Debt Collection Center.

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

27. Field 33 - STATUTE DATE

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

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

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

28. Field 34 - CLOSED DATE

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

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

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

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

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

These eight fields, four transaction code fields and four transaction amount fields, are the heart of the ADD/UPDATE MASTER SCREEN and will be discussed together. They are contained on the Transaction Line.
The primary Users have developed a group of two position transaction codes,, which they feel, will accommodate all possible FINANCIAL information to be entered into the system.

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

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

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

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

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

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

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

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

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

NOTE: In doing this you will lose changes you have made to the add/update screen. If you were in an add function, that overpayment case must be added once again starting with the request screen.

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

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

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

ENTERING TRANSACTIONS

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

A. OVERPAYMENT TRANSACTIONS

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

1. ORIGINAL OVERPAYMENT

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

2. OVERPAYMENT ADJUSTMENTS

a. Valid transaction codes are 'OA' through 'OD', 'OI' and 'OZ".
b. The functionality of all of the above codes is exactly the same. There are multiple codes for recording and reporting purposes.
c. The function of these transactions is to adjust the original overpayment amount.
d. The adjustment is accomplished by overlaying (replacing) the original overpayment amount in the master file with the amount on the overpayment adjustment transaction.
e. Although the adjustment amount is 'moved' to the Master File, the following must take place for the Transaction

File update:

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

REMINDER:

When an overpayment adjustment is used to 'adjust' the original overpayment amount this action will probably establish an out of balance condition between the original overpayment amount and the SUM of the Causes. This condition must be resolved before the update will

be accepted. You will have to update the Cause information that currently exists for this overpayment.

3. OVERPAYMENT FULL DELETES

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

a. Valid codes are 'OE', 'OF', 'OG', 'OH', and 'OI'.

b. The functionality of the codes above is exactly the same. There are multiple codes for recording and reporting purposes.

c. The major function of these transactions is to Logically zero balance the case. In doing so, a Closed Date will be Mandatory and the case will be officially closed.

d. All 'FULL DELETED' cases will be bypassed by all quarter and batch reporting programs, therefore the dollar amounts on all fully deleted cases will not be reflected in any report.

e. An OVERPAYMENT FULL DELETE is processed as follows:

1. A valid overpayment full delete transaction code is entered in any one of four transaction code fields on the transaction line.

2. NO AMOUNT IS REQUIRED IN THE TRANSACTION AMOUNT FIELD FOR A FULL DELETE TO PROCESS.

3. The User TAPS the enter key.

4. The PORS program then perform the following:

(a) The program issues an applicable warning message asking the User if they are absolutely sure they want to process a full delete.

(b) If the User wants the full delete to take place, an overpayment full delete transaction code must be re-entered and the enter key TAPPED.

(c) Calculates the current balance of the overpayment case.

(d) Writes a record to the transaction file using the overpayment full delete transaction code and an amount field equal to zeros.

(e) Generates and writes a Recoupment Adjustment record to the transaction file. This record will contain an amount equal to the ending balance calculated in (3) above. The

transaction code will have an 'R' in the leftmost position and the rightmost position will correspond to the rightmost position of the overpayment full delete transaction code.

(f) At this time, the outstanding balance is zero and the program is looking for a valid close date by issuing another warning message and positioning the CURSOR at the CLOSED DATE FIELD.

(g) NOTE:
The User can still back out of the entire full delete procedure by TAPPING the F3 key. This action will abort all updates that have just been discussed and return control to the REQUEST SCREEN.

(h) The User should key in the proper closed date and TAP the enter key.

(i) If the above Close Date is valid, another warning message is issued to the User, stating the case is about to be closed.

(j) If the User is absolutely sure the full delete is correct, the enter key should be TAPPED.

(k) At this point, the full delete transaction has been processed and the case is closed.

B. CAUSE CODE TRANSACTIONS

1. For each determined overpayment case, the CAUSES(s) for that overpayment will be identified and entered into the system using the transaction line on the ADD/UPDATE SCREEN.

2. There are twenty six (26) CAUSE TRANSACTION CODES defined in the PORS System of which 18 are currently active. These codes, ranging from CA through CZ were explained earlier in the instructions for FIELD 16 (five of them).

3. Cause transactions are entered on the transaction line (fields 35 and 36), and after verification, are moved to fields 16 and 17.

4. As an enhancement, we have designed the Master File so we may retain all 26 Cause Codes and Cause Amounts for a given overpayment case.

5. Another enhancement we feel will help maintain the system's integrity, is to balance the sum of all entered Cause Amounts with the Overpayment Amount (field 9). This balancing MUST TAKE PLACE before a case is ADDED to the Master File. We understand that some overpayment cases will be very difficult to 'BALANCE' because of missing information. To allow this kind of overpayment into the system for tracking and recoupment efforts, we have added a Suspense Cause Transaction Code of 'CZ' to the list of valid cause codes.

This suspense cause code is intended for specialized, limited use, and it use will be monitored. The total amount that may be entered using this Cause Code is $10,000.

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

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

a. CAUSE CODE V (Accelerated Payment) must only be used with TYPE D overpayments.

b. CAUSE CODE W (Interim Rate Adjustment) is only valid with TYPE J overpayments.

c. CAUSE CODE X (Unfiled Cost Report) must only be used with TYPE H overpayments.

d. CAUSE CODE Y (Interest) is only valid with TYPE X overpayments.

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

8. When the enter key is TAPPED, the program moves the rightmost character of the Cause Transaction Code (which is the actual cause code) and the Cause Amount to an available set of fields on the 'Cause Line' (fields 16 and 17). It also moves the number of causes entered into the Cause Count Field (field 15). It then adds up all Cause Amounts and compares that SUM to the Overpayment Amount.

9. If the case is in balance, and no more input is required, the case is added to the Master File.

10. If the case is out of balance, the User will see an appropriate message in the message area. The User must balance the case either by keying in an Overpayment Adjustment or by modifying the just entered Cause Transactions.

C. RECOUPMENT TRANSACTIONS

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

1. Regular Recoupment

a. Valid transaction code is 'RO' only.

b. Must be the first 'recoupment' transaction entered for an overpayment case.

c. The amount must be numeric and positive.
d. The transaction code of 'RO' and the amount may be keyed into any one of the 'sets' on the transaction line.

e. When the enter key is TAPPED, the transaction, after being thoroughly edited, is added to the RECOUPED-TO-DATE (field 10) and the RECOUPED-TO-QUARTER (field 12) fields on the screen and also to the appropriate Master File fields.

f. A record including the transaction code and amount is also written to the transaction file.

2. Recoupment Adjustments

a. Valid transaction codes are ‘RA’ through 'RD', 'RI' and 'RZ'.

b. All of the above codes have the exact same functionality. There are multiple codes for reporting purposes.

c. The function of these transactions is to adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars will stay on the Master and Transaction Files, but we will use the appropriate 'Recoupment Adjustment Transaction' to affect the required monetary change.

d. To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, the operator must key in the 'dash/hyphen' after the amount. For a positive value, there is no additional effort involved.

e. The User, after keying in the appropriate Recoupment Adjustment Transaction Code and amount, should TAP the enter key.

f. The amount, after thorough editing, is added to the 'ADJUST-T/Q' field (field 13) on the screen and to the same field in the Master File. It is also to the 'ADJUSTMENT TO DATE' field in the Master File.

g. After the Master File is updated, a record is written to the transaction file with the recoupment adjustment transaction code and amount fields included.

3. Recoupment - Full Deletes

a. Valid codes are 'RE', 'RF' 'RG' and 'RH' and 'RI'.

b. These four transaction codes are 'GENERATED ONLY' by their corresponding 'OVERPAYMENT FULL DELETE' transaction - 'OE', 'OF', 'OG', OH' and 'OI'.

c. The Recoupment - Full Delete transactions ARE NOT KEYABLE BY THE USER.

d. They are generated with appropriate amount fields and written to the transaction file to maintain fiscal integrity.

e. The amounts are also added to the Master File recoupment fields but, as explained earlier, these Master Records are bypassed for all PORS reporting.

30. Field 37 - CNC Date

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

31. Field 38 – CNC Code

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

TRANSACTION HISTORY BROWSE SCREEN

A. General information concerning this Screen.

1. This Screen will be used for inquiry purposes only.

2. This Screen may be displayed only from the PORS REQUEST and PORS ADD/UPDATE Screens.

3. The displaying of information on this screen is governed by the same security hierarchy explained for the Request Screen.

4. There are two primary objectives of this Screen.

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

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

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

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

1. If this screen display was 'requested' from the ADD/UPDATE processing, this header line 'record key' will be a specific 28 position key.

2. If, however. this screen was requested from the PORS REQUEST SCREEN using the 'B' function, the header line 'record key' may have from 2 to 28 positions filled in. This is the generic key search that was described earlier in these instructions.

EXAMPLES:

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

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

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

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

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

1. Field 1 through 7
These fields constitute the overpayment record key. They will be printed according to the instructions contained in A.5 above.

2. Field 8 - SEQUENCE NUMBER
This field was added to ensure uniqueness when writing records to the transaction file.

3. Field 9 - OPERATOR ID
This is primary security code used throughout the system. It is shown on the Browse Screen for obvious reasons.

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

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

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

7. Field 13 - BALANCE

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

HELP SCREEN

A. General information concerning the Screen.

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

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

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

TAP the F3 key for HELP

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

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

B. Specific information concerning the HELP SCREEN.

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

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

180.1.4 - List of Status Codes
(Rev.64, Issued: 02-11-05, Effective: 03-14-05, Implementation: 03-14-05)

POR SYSTEM STATUS CODES- INTERMEDIARY LEVEL

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

		INT)
	AR	Intent letter sent, Unfiled Cost Report debt exempt from referral to Treasury.
CNC	01	Reclass to CNC
	03	CNC- DCIA Letter Sent
	04	Reactivate CNC- Bankruptcy
	05	Reactivate CNC- Payment Received
	06	Reactivate CNC- Appeal/Litigation/Fraud
	07	Reactivate CNC- Compromise
	08	Reactivate CNC- Extended Repayment Plan Approved
	09	CNC Debt Written Off Closed
	00	Reactivate CNC- Other (Deceased, etc)

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

Write-off	BY	Pending Write-Off Authority
	CC	Closed- compromise negotiation by OGC/DOJ, Balance written off
	CD	Closed with a balance- CMS CFO approved compromise
	CE	Closed with a balance due to bankruptcy (Authority to close must be received from lead RO)
	CF	Closed with a balance- ARA DFM approved
Liability	AH	New Owner Assumed Liability
	AI	Assumption of Liability in Question
	AU	New Owner did not Assume Liability
Referred to RO	AK	Referred to Regional Office
Medicaid	AS	Title XIX Suspension in Effect
Cost Reports	AA	Cost Report Filed but Subsequently found to be Unacceptable
	AD	Final Settlement pending current or subsequent cost reports
	AM	Cost Report Filed- Overpayment Recouped
	AY	Cost Report Filed- Pending Acceptance

	BX	Cost Report not Filed- Provider Paid back all interim payments
Other	AN	Medicare Adjustment Bills
	AV	Waiver agreement obtained for Statute of Limitations
	AX	Terminated Provider re-entered Medicare program with New provider number
	BF	Financial Record of Provider in Hands of State- Exact Amount of OP Undetermined or Unknown
	BI	Incoming Intermediary recovering overpayment for Outgoing intermediary
	BW	Waiver State of Demonstration Project
	BZ	Outpatient Non-Physician Services
	CH	Closed/HIGLAS*

* valid closed date required

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

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

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

180.1.5 - Posting Interest Entries
(Rev. 22, 10-03-03)

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

EXAMPLE 1:

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

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

EXAMPLE 2:

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

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

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

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

(Rev. 47, 06-25-04)

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

EXAMPLE of the Business Segment Identifier (BSI)

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

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

180.1.7 – Requesting Report from the AD Hoc Reports Management System (ARMS)
(Rev. 47, 06-25-04)

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

EXAMPLE:

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

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

180.2- Exhibit 2 - Physician/Supplier Overpayment Reporting System (PSOR)
(Rev. 22, 10-03-03)

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

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

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

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

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

180.2.1- Data Entry
(Rev. 22, 10-03-03)

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

180.2.2- PSOR User Manual
(Rev.64, Issued: 02-11-05, Effective: 03-14-05, Implementation: 03-14-05)

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

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

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

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

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

B. System Security.--The system contains a three-level system which safeguards the individual user's data.

The complete functionality of the security system follows:

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

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

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

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

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

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

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

SYSTEM OPERATING PROCEDURES

This contains the instructions to accomplish various system operating procedures.

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

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

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

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

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

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

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

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

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

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

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

REQUEST SCREEN

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

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

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

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

Field by Field Instructions:

1. REGION NUMBER

Only CMS can key in this field. If it is keyed, the value MUST BE 01 through 11.
The Region Name is supplied to the screen by the System Tables File.

2. CARRIER NUMBER

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

The Carrier Name is supplied from the System Tables File.

3. PHYSICIAN-SUPPLIER NUMBER

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

4. CLAIM NUMBER/CARRIER INTERNAL CONTROL NUMBER

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

5. CLAIM PAID DATE

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

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

6. FUNCTION CODE

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

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

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

- General Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TAP the F3 key to return to the Request Screen

2. Field 6 - REGION NAME

This field will automatically be displayed.

IT IS NOT KEYABLE.

3. Field 7 - CARRIER NAME

This field will be displayed automatically.

IT IS NOT KEYABLE.

4. Field 8 - PHYSICIAN-SUPPLIER NAME

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

5. Field 9 - SPECIALTY CODE (SPCLTY CODE)

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

The field is keyable for an ADD only.

SPECIALTY CODES

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology

05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Unassigned
16	Obstetrics/Gynecology
17	Unassigned
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Unassigned
22	Pathology
23	Unassigned
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Unassigned
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Unassigned
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Multi-specialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)

82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

Code	Type of Supplier/Provider
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner

Medical supply company with orthotic personnel certified by an accrediting organization

51	Medical supply company with prosthetic personnel certified by an accrediting organization
52	Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization
53	Medical supply company not included in 5l, 52, or 53
54	Individual orthotic personnel certified by an accrediting organization
55	Individual prosthetic personnel certified by an accrediting organization
57	Individual prosthetic/orthotic personnel certified by an accrediting organization
58	Medical Supply Company with registered pharmacist
59	Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice

67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Supplier/Provider
89	Clinical Nurse Specialist
95	Unassigned
96	Optician
97	Physician Assistant
A0	Hospital
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Nursing Facility, Other
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store

6. Field 10 - STATE

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

This field is keyable for an ADD only.

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

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

This field is keyable for an ADD only.

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

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

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

SOURCE CODES

B -- Medical Review

C -- Utilization Review

D -- End of Line Review

E -- Special Review

F -- MSP Review

G -- CMS Review

H -- Central Office Review

I -- Inspector General (IG) Review

J -- GAO Review

K -- Beneficiary

L -- Physician/Supplier

M --

N --

O -- Other

P –

Q –

R –

S –

T –

U –
V –

W—

X – Advance Payments

Y—

Z--

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

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

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

CAUSE CODES

A -- Duplicate Payment/Duplicate Claim - Carrier Error

B -- Wrong Payee - Carrier

C -- Service Not Rendered

D -- Service Not Necessary

E -- Payment Exceeded Allowable Limit

F -- Payment Exceeded Psy/PT Limit

G -- Service Not Covered

H -- Duplicate Pmt/Clm - Physician/Supplier

I -- Medicare Secondary Payer

J -- Coding/Billing - Errors

K -- Wrong Payee - Physician/Supplier Error

L --

M --

N -- Unallowable Concurrent Service

O -- Other

P –

Q—

R—

S –

T –

U—

V –

W –

X— Advance Payments

Y—

Z –

0 -- Reactivate – Other (Includes Deceased Debtor)

10. Field 14 - ORIGINAL OVERPAYMENT AMOUNT (ORIGINAL)

This field will contain the total overpayment amount.

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

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

IT IS NOT KEYABLE.

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

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

IT IS NOT KEYABLE.

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

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

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

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

IT IS NOT KEYABLE.

For an ADD - This field contains the underlines.

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

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

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

IT IS NOT KEYABLE.

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

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

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

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

IT IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

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

15. Field 19 - ENDING BALANCE (CUR BAL)

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

IT IS NOT KEYABLE.

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

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

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

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

TRANSACTION CODES

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

17. Field 22 - STATUS CODE (STATUS)

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

STATUS CODES

Category	Status Code	Description/When to Use
Demand	I	Initial Entry (first demand letter)

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

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

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

Other Entries	M	Amend/Change Record- Only for Summary
	D	Debtor Deceased - In Probate

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

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

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

18. Field 23 - LOCATION
This field identifies the current location of the overpayment case.

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

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

LOCATION CODES

CAR -- Carrier

ROA -- Regional Office

COA -- Central Office Claims Collection Officer

OIG -- Office of the Inspector General

GAO -- General Accounting Office

GCR -- Office of the General Counsel - RO

GCC -- Office of the General Counsel - CO

DJD -- Department of Justice - DC

DJR -- Department of Justice - RO

DJB -- Department of Justice Bankruptcy

COL -- Collection Agency

DCM -- Central Office – Debts at DCC

CDC -- Carrier - Debts at DCC

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

19. Field 24 - CLOSED DATE

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

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

If the outstanding balance (field 19) is zero, a closed date must be entered.
If the outstanding balance is not zero, the status code must be E, H, N, or P.

20. Field 25 - SCREEN FUNCTION

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

IT IS NOT KEYABLE.

21. Field 26 – STATUTE DATE

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

22. Field 27 – Bankruptcy Y/N?

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

23. Field 28 – BANKRUPTCY TYPE

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

Chapter 7

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

Chapter 9

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

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

Chapter 13

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

24. Field 29 – BANKRUPTCY DATE

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

25. Field 30 – CNC DATE

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

26. Field 31 – CNC CODE

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

Transactions Processing

- When considering the overall process, there are some general comments and/or instructions.

All four sets of fields can be used for any transaction, in any order. There is no rule about starting in the left most set.

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

The AA transaction (the original overpayment) must be the first transaction entered on an ADD.

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

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

If you have displayed the MASTER SCREEN for either an ADD or UPDATE function and you do not wish to continue - For Any Reason - TAP the F3 key and the program will return you to the REQUEST SCREEN.

NOTE: In doing this you will lose changes you have made to the add/update screen. If you were in an Add function, add the overpayment case again starting with the request screen.

If you are keying in a transaction code and you need assistance with what code to use, or what codes are available, TAP the F1 key for HELP. This action will display the HELP SCREEN (see FIGURE 10) which allows the user to select the codes available with their descriptions.

After you have found the necessary information on the HELP screen, TAP the F3 key and the program will return you to the ADD/UPDATE Screen.

If you are working with the ADD/UPDATE screen and you wish to view the detail transactions for this overpayment case, TAP the F4 key. The program will display the TRANSACTIONS HISTORY SCREEN (see FIGURE 9). This screen shows you every financial transaction that was entered for the case.

When you have finished reviewing the TRANSACTIONS HISTORY SCREEN, TAP the F3 key to return to the MASTER SCREEN.

All financial transactions entered into the PSOR System can be divided into three major categories: OVERPAYMENTS, INTEREST and RECOUPMENTS. Following are specific instructions for entering each transaction into the PSOR System using the Transaction Line.

NOTE: See "ENTERING SUMMARY DATA ON OVERPAYMENTS OF LESS THAN $600" for instructions on entering summary information for overpayments of less that $600.

- OVERPAYMENT TRANSACTIONS

This includes three types of overpayment transactions; ORIGINAL OVERPAYMENT, OVERPAYMENT ADJUSTMENT AND OVERPAYMENT FULL DELETES.

ORIGINAL OVERPAYMENT

The only valid transaction code for use in the ADD function is 'AA'.

Must be the first financial transaction entered when adding an overpayment.

The amount field must be numeric.

The amount will be moved to field fourteen (14) on the MASTER SCREEN and into the appropriate master record field when the ADD function is complete.

Enter only one (1) 'AA' transaction for an ADD.

An original overpayment transaction (AA) is invalid for an update.

When the ADD function is complete, the transaction code and amount are written to the Open Transaction File and Open Master File.

OVERPAYMENT ADJUSTMENTS

The only valid transaction code is 'A0'.

It adjusts the original overpayment amount.

The adjustment adds to, or subtracts from, the original overpayment amount in the master file the amount on the overpayment adjustment transaction.

The original amount (AA transaction) is still on the transaction file and cannot be deleted.

This amount, positive or negative will be written to the transaction file along with the transaction code.

All overpayment adjustment amounts must be numeric.

Overpayment adjustments are invalid during the ADD process.

OVERPAYMENT FULL DELETES

These are powerful tools which must be handled with care. There are two codes which functionally are identical, that will logically zero balance an overpayment case and allow that case to be closed.

Valid Codes are 'DE and DH'.

These codes are exactly the same.

A Closed Date is Mandatory and the case will officially be closed.

All "FULL DELETED" cases will be bypassed by all quarter and batch reporting programs; therefore, the dollar amounts on all fully deleted cases will not be reflected in any report.

Process an OVERPAYMENT FULL DELETE as follows:

Enter a valid overpayment full delete transaction code in any of four transaction code fields on the transaction line.

NO AMOUNT IS REQUIRED IN THE TRANSACTION AMOUNT FIELD FOR A FULL DELETE TO PROCESS.

TAP the ENTER key.

The PSOR program performs the following:

(1) The program issues an applicable warning message asking the User if he is absolutely sure he wants to process a full delete.

(2) If you want the full delete to take place, re-enter an overpayment full delete transaction code, and TAP the ENTER key.

(3) Writes a record to the transaction file using the overpayment full delete transaction code and an amount field equal to zeros.

(4) The full delete transaction is processed and the case is closed.

- INTEREST TRANSACTIONS

This includes two types of interest transactions: interest collected and change interest collected.

Interest Collected

Valid transaction code is 'CC'.

The amount must be numeric and positive.

The transaction code 'CC' and the amount may be keyed into one of the "sets" on the transaction line.

When the ENTER key is TAPPED, the transaction, after being thoroughly edited, is added to the Interest Recouped to Date field (field 15) on the screen and to the appropriate Master File fields.

A record including the transaction code is written to the transaction file.

Change Interest Collected

Valid transaction code is 'CI'.

These transactions adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars stay on the Master and Transaction Files. CMS uses the appropriate 'Recoupment Adjustment Transaction' to effect the required monetary change.

To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, key in the 'dash/hyphen' after the amount.

After keying in the appropriate Recoupment Adjustment Transaction Code and amount, TAP the ENTER key.

The amount, after thorough editing, is added to the 'INT REC' field (field 15) on the screen and to the same field in the Master File.

After the Master File is updated, a record is written to the transaction file with the transaction code.

- RECOUPMENT TRANSACTIONS

This includes two types of recoupment transactions: REGULAR RECOUPMENT and RECOUPMENT ADJUSTMENTS.

Regular Recoupment

Valid transaction code is 'BB' only.

Must be the first 'recoupment' transaction entered for an overpayment case.

The amount must be numeric and positive.

The transaction code of 'BB' and the amount may be keyed into one of the 'sets' on the transaction line.

When the ENTER key is TAPPED, the transaction, after being thoroughly edited, is added to the RECOUPED-TO-DATE (field 17) field on the screen and to the appropriate Master File fields.

A record including the transaction code and amount is written to the transaction file.

Recoupment Adjustments

Valid transaction code is 'BR'.

These transactions adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars stay on the Master and Transaction Files. CMS uses the appropriate 'Recoupment Adjustment Transaction' to effect the required monetary change.

To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, key in the 'dash/hyphen' after the amount.

After keying in the appropriate Recoupment Adjustment Transaction Code and amount, TAP the ENTER key.

The amount, after thorough editing, is added to the 'REC.ADJ.' field (field 18) on the screen and to the same field in the Master File.

After the Master File is updated, a record is written to the transaction file with the recoupment adjustment transaction code.

Closed Cases

There are 2 transaction codes used for closing cases: CN, and CP.

When any of these codes are entered, the overpayment is closed on the day the code is entered, unless a closed date is also entered.

When an overpayment is closed and there has not been any collection against it, enter code 'CN'.

When an overpayment is closed while there is still an outstanding balance and collections have been made, enter code 'CP'.

Reopening Closed Cases (Central Office Only)

Use the transaction code 'RO' to open a case that had been closed in the current quarter.

ENTERING SUMMARY DATA ON OVERPAYMENTS OF LESS THAN $600

The following instructions apply only for entering summary information on cases of less than $600:

Enter the new and updated summary records each month using the 25th day of the current month as the claim paid date and the determination date. Enter the information no later than the last working day of the current month:

- Physician overpayments from $10 to $599, along with any recoupments, adjustments, and/or interest collected.

1. PHYS/SUP #: Enter 099999999

2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, the 25th day, and the year for which data is being summarized.

4. FUNCTION: Enter an I, then TAP ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, 25th day, and the year for which the data is being summarized.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records.

9. OPEN CLAIMS: Enter the number of claims being summarized, preceded by zeros. Update this field by overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $10 or more than $599, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record The summary record will remain open on the PSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $25 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago

b. The cases had no collection activity within the 180 days.

c. The original amount of each case is under $25.

The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8 TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

- Supplier overpayments from $10 to $599, along with any recoupments adjustments, and/or interest collected.

1. PHYS/SUP #: Enter 088888888
2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, the 25th day, and the year for which data is being summarized.

4. FUNCTION: Enter an I, then TAP ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, the 25th day, and the year of the month.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter a CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records.

9. OPEN CLAIMS: enter the number of claims being summarized, preceded by zeros. Update this field by overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $10 or more than $599, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record: The summary record will remain open on the PSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $25 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago.

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c. The original amount of each case is under $25.

The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8 TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

- Physician and Supplier overpayments of less than $10, along with any recoupments.

1. PHYS/SUP #: Enter 077777777

2. CLAIM #: Enter the total number of claims being summarized, preceded by zeros.

3. CLM PAID DATE: Enter the month, 25th day, and the year for which data is being summarized.

4. FUNCTION: Enter an I, then tap ENTER to go to the next screen.

5. O/P DETERMINE DATE: Enter the month, 25th day, and the year for which the data is being summarized.

6. O/P SOURCE: Enter the letter 0.

7. O/P CAUSE: Enter the letter 0.

8. TRANSACTIONS: Enter AA followed by the aggregate dollar amount of the new overpaid claims being summarized. Enter BB followed by the total dollar amount of all recoupments. Enter CC followed by the total amount of interest collected, if any. The above entries of BB and CC apply to new overpayments determined during the month as well as any updates for prior months' summary data records

9. OPEN CLAIMS: Enter the number of claims being summarized, preceded by zeros. Update this field by OPEN overwriting the original number of cases to reflect the number of outstanding cases. If the average overpayment cost per claim is less than $1 or more than $9, a "Fails Edit" prompt will appear on the screen. In order to reenter the record, type PORB and tap the Enter key.

10. STATUS: Enter status code "I". Tap the enter key to record the above. When the record is updated enter status code M.

11. Final Disposition of Record: The summary record will remain open on the PSOR system until all the cases are either collected and/or terminated. Only the RO can authorize the termination of outstanding cases. In order to terminate cases under $10 from the PSOR system, the carrier will send a list of cases to the RO requesting authorization to terminate. At a minimum, the list will identify the name of the physician an/or supplier, the current principal amount of the overpayment, the current interest amount of the overpayment, the original amount of the overpayment, whether any other overpayments exist for the physician/supplier, the claim paid date, and the determination date. The RO has the option to request additional information.

The list of cases forwarded to the RO for authorization to terminate must meet the following conditions:

a. The summary cases were entered on the PSOR system over 180 days ago.

b. The cases had no collection activity within the 180 days.

c. The original amount of each case is under $10.

The carriers have 30 calendar days, after the 180 calendar days, to forward a list of cases to the RO that meets the above conditions for termination. The carriers should update changes to the summary record in accordance with item 8 TRANSACTIONS.

12. Close Partial Collection If the RO has authorized the termination of the outstanding cases, the carriers should close the summary record. Move the cursor to the TRANSACTION field and enter CN. Move the cursor down to STATUS and enter N. Move the cursor to CLOSED DATE field and enter the date closed. Tap the ENTER key. Type CP on the transaction field again and tap the ENTER key to update the record.

INSTRUCTIONS FOR PROCESSING THE CMS PHYSICIAN/SUPPLIER OVERPAYMENT REPORTING SYSTEM

TRANSACTIONS HISTORY SCREEN

General Information Concerning This Screen (FIGURE 9)

Use this screen for inquiry purposes only.

This screen may be displayed only from the REQUEST and MASTER Screens.

The information on this screen is governed by the same security hierarchy as for the Request Screen.

There are two primary objectives:

a. To provide an audit trail of all financial transactions that were entered for the list of an active, open case. The audit trail provides the users with instant information about a specific case or groups of cases. It identifies which User entered the data, when it was entered and how that action affected the balance.

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

The screen is divided into the screen header line and the screen body.

The header line is represented by the line of dashes on the second line from the top of the screen.

It contains the entire record key that was requested for the screen to display.

If this screen display was 'requested' from the ADD/UPDATE processing, this header line 'record key' will be a specific 37 position key.

If this screen was requested from the REQUEST SCREEN using the 'B' function, the header line 'record key' may have from 2 to 39 positions filled in. This is the generic key search.

NOTE: An RO User may key in just the region number and 'B' function on the REQUEST SCREEN and TAP the ENTER key. This will display the Transaction History Browse

Screen showing ALL open overpayment cases for that region. Carriers may do the same function, but, because of the security table, carriers must also key in their carrier number on the REQUEST SCREEN.

The screen body consists of sixteen (16) detail lines showing the 11 individual fields on each line.

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

Specific Information Concerning the Fields Displayed.

Fields 1 through 5 (Region No. through Claim Paid Date).
These constitute the overpayment record key. They will be printed.

Field 6 - OPERATOR ID (OP/ID)-This is a primary security code.

Field 7 - TRANSACTION ENTRY DATE (Entry Date)

Field 8 - TRANSACTION CODE (TR CD)

Field 9 - STATUS CODE (ST)-This shows the associated status code.

Field 10 - TRANSACTION AMOUNT ($ Amount of Trans) - This field displays the edited dollar amount which was keyed by the User on the MASTER SCREEN.

Field 11 - BALANCE (Balance Remaining) - This is a 'Running Balance' for the overpayment. It is recalculated after each successful financial update to the PSOR Master File. It provides a display of the current balance.

INSTRUCTIONS FOR PROCESSING THE CMS PHYSICIAN/SUPPLIER OVERPAYMENT REPORTING SYSTEM

HELP SCREEN

General Information Concerning the Screen (FIGURE 10)

The screen contains all current, valid codes in the system along with their descriptions. The HELP screen is only available from the ADD/UPDATE Master Screen.

It provides the terminal User with online assistance at data entry. This happens during code selection and entry on the MASTER SCREEN.

If you forget the code to use or do not remember which ones are available:

TAP the F1 key for HELP

This will display the HELP SCREEN shown in FIGURE 10. When you finish reviewing the HELP SCREEN:

TAP the F3 key to return to the same position on the MASTER SCREEN.

180.2.3 ADVANCE PAYMENTS USER MANUAL

(Rev. 22, 10-03-03)

INSTRUCTIONS FOR PROCESSING THE CMS
ADVANCE PAYMENTS REPORTING SYSTEM

The accompanying pages provide a screen-by-screen instructions for entering part B advance payment data into the Advance Payments Reporting (APR) System. This system is designed for use by the Medicare carriers for adding, updating, and closing advance payments made to physicians/suppliers. The APR System is a modified version of the PSOR System. An advance payment should be entered into the APR System within 10 days of the advance payment being issued. It should stay in the APR System until the advance payment is demanded. Any adjustments, recoupments or updates to the advance payment should be made within 10 days of their occurrence in the APR System. Once the advance payment is demanded, the advance payment should be posted onto the PSOR System.

The pages that follow illustrate each screen on your PC as you reach the next step in the data entry process. Each page contains thePC screen and an instruction that provides the steps needed to complete the entries required on the current screen. As each screen field entries are completed, the next screen will appear on the PC.

HCFA - PART B - ADVANCE/OVER PAYMENTS - INITIAL SCREEN

YOUR OP-ID: ....
SELECT EITHER OVERPAYMENT OR ADVANCED PAYMENT

ENTER "PORB" FOR OVERPAYMENT
ENTER "ADVB" FOR ADVANCE PAYMENT

SELECTION: ....

(MAKE SELECTION AND PRESS <<ENTER>>)

INSTRUCTIONS

- Key in your USER-ID in the “Your OP-ID:” field
- Type “ADVB” in the “Selection:” field and tap the enter key

NOTE: The user has the option of entering the PSOR system by typing “PORB”in the “Selection:” field and tapping the enter key.

HCFA - PART B - ADVANCE PAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 REGION CARRIER # 00000

PHYS/SUP # .....

CLAIM # ..... ADVANCE PAYMENT DATE MMDDCCYY

FUNCTION . I = ADD A NEW ADVANCE PAY RECORD TO THE MASTER FILE,

U = UPDATE AN EXISTING ADVANCE PAY MASTER FILE RECORD,

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

Instructions

- Type in the Physician/Suppler number in the “PHY/SUP #” field and the claim number in the “CLAIM #” field.
- Type in the “ADVANCE PAYMENT DATE” field, the date of the advance payment check.
- Type “I” in the “FUNCTION” field, tap the ENTER key, to add the new advance payment to the master file.

HCFA - PART B - ADVANCE PAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 _____ CARRIER # 00000 _____

PHYS/SUP # 000000000

CLAIM # 000000000000000 ADVANCE PAYMENT DATE 00000000

THIS PROVIDER HAS OUTSTANDING OVERPAYMENTS!

IS ADVANCE PAYMENT JUSTIFIABLE? (Y OR N) .

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

INSTRUCTIONS

- If the physician/supplier has an overpayment balance, the above screen will appear.
- Type "Y" and tap the enter key to continue to the Master Screen.
- Type "N" and tap the enter key to enter another case or log off the system.

NOTE: It is your option whether to continue to enter an advance payment on the system if the physician/supplier has an outstanding overpayment that is delinquent.

HCFA - ADVANCE PAYMENT SYSTEM MASTER SCREEN

REGION # 00 REGION CARRIER # 00000

PHYS/SUP # 000000000 PHYS/SUP NAME SPCLTY CODE 00 STATE

CLAIM # 000000000000000 ADVANCE PAYMENT DATE 00000000

A/P DETERMINE DATE ..... A/P SOURCE X A/P CAUSE X ORIGINAL $ _____

STATUTE DATE _____

BANKRUPT Y/N? . BANKRUPTCY TYPE .. BANKRUPTCY DATE .....

OPEN BAL	RECOUPED	REC. ADJ.	CUR BAL
$ _____	$ _____	$ _____	$ _____

TRANSACTIONS AA $ .... $ .... $ .... $ .....

STATUS . LOCATION CAR CLOSED DATE .....

PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN
PRESS F1 KEY FOR HELP; PRESS F4 KEY FOR TRANSACTIONS BROWSE

INSTRUCTIONS

- Type in the "A/P" DETERMINATION DATE" field, the date of the advance payment check.

- Type “X” in both the “Á/P SOURCE” and “A/P CAUSE” fields.

- Key in the remaining information and follow the instructions in Section 80.2, PSOR USER MANUAL, to update and close the case.

NOTE: This screen will appear if a physician/supplier advance payment is to be entered into the APR System.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Terminal
HCFA DATA CENTER HDC91158

```
                    //
HH     HH   DDDDDDD///     CCCCCCC
HH     HH    DD  ///D    CC     CC
HH     HH    DD  ///DD    CC     CC
HHHHHHHHHH    DD /// DD    CC
HHHHHHHHHH    DD -///DD    CC
HH     HH    DD /// DD    CC     CC
HH     HH    DD///  DD    CC     CC
HH     HH   DD///DDDD      CCCCCCC
               //
   THIS IS THE HCFA ESRV  LPAR

     PLEASE HIT 'ENTER' FOR APPLICATION SELECTION MENU
   (THE ACTION DESK PHONE IS: (410)-786-2580 or 1-800-562-1963)
        (THE HDC STATUS PHONE IS: (410)-786-2599)
!!!!! PLEASE HIT PF12 AT THE APPLICATION MENU FOR  LATEST HCFA NEWS !!!!!

****************** B R O A D C A S T   M E S S A G E S *********************
   ** PLEASE CHECK CMS NEWS FOR THE LATEST SYSTEM INFORMATION ***
   ************** HIT PF12 AT THE APPLICATIONS MENU **************
   ************************************************************
```

FIGURE 1

```
PAGE 1 of 3 ..... A P P L I C A T I O N   M E N U .....................
05/08/03 14:41                              TERMINAL - HDC91115

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

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

        Select application ==>
                                        more . . .
.....................................................................
PFK  1  H E L P        PFK 12   ** HDC NEWS**     PFK  3   HDC LOGO
PFK  7  PAGE BACK                                PFK  8   PAGE FORWARD
PFK  2  APPLICATION INFO                         PFK 11   UTILITIES
```

FIGURE 2

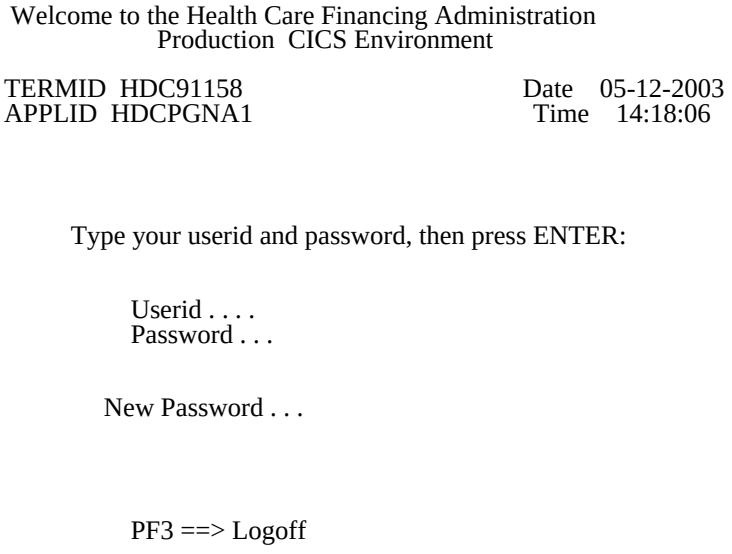


FIGURE 3

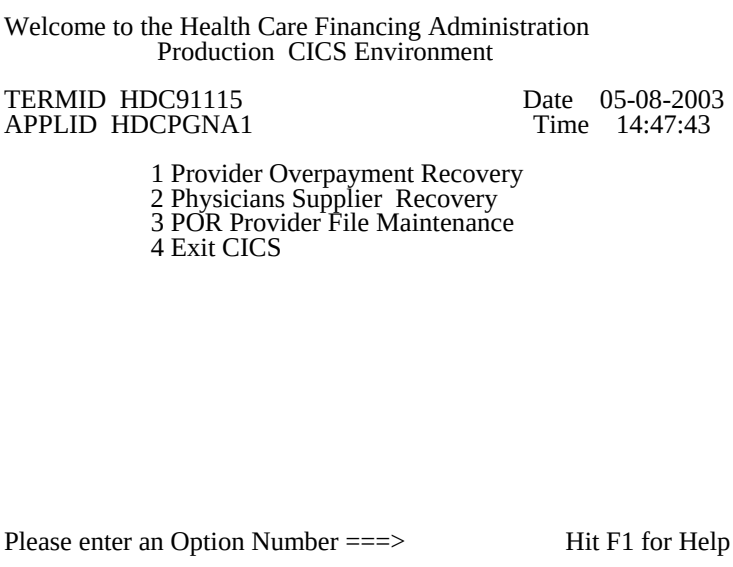


FIGURE 4

PSOR SYSTEMS BROADCAST SCREEN
SYSTEMS UPDATE HISTORY
****

THE HELP SCREEN TEXT HAS BEEN REPOSITIONED

A CNC DATE FIELD HAS BEEN ADDED TO THE MASTER SCREEN

THE PHYSICIAN/SUPPLIER NAME NOW ALLOWS FOR FORTY CHARACTERS

(PRESS <<ENTER>> TO PROCEED)

FIGURE 5

HCFA - PART B - ADVANCE/OVER PAYMENTS - INITIAL SCREEN

YOUR OP-ID: ....
SELECT EITHER OVERPAYMENT OR ADVANCED PAYMENT

ENTER "PORB" FOR OVERPAYMENT
ENTER "ADVB" FOR ADVANCE PAYMENT

SELECTION: ....

(MAKE SELECTION AND PRESS <<ENTER>>)

FIGURE 6

HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - REQUEST SCREEN

REGION # 00 (Region Name) CARRIER # 00000 (Carrier Name)

PHYS/SUP # ..... (LEFT JUSTIFIED)

CLAIM # ..... CLM PAID DATE MMDDYYYY

FUNCTION . I = ADD A NEW OVERPAYMENT RECORD TO THE MASTER FILE,

U = UPDATE AN EXISTING OVERPAYMENT MASTER FILE RECORD,

B = BROWSE OVERPAYMENT TRANSACTIONS

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

FIGURE 7

HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - MASTER SCREEN …25…

REGION # 1 (REGION NAME) CARRIER # 2 (CARRIER NAME)

PHYS/SUP # 3 PHYS/SUP NAME ……..8……. SPEC CODE ..9.. STATE ..10..

CLAIM # 4 CLM PAID DATE 5

O/P DETERMINE DATE …11… O/P SOURCE ..12.. O/P CAUSE …13.. ORIGINAL$ ..14..
STATUTE DATE 26

BANKRUPT Y/N? ..27.. BANKRUPTCY TYPE ..28.. BANKRUPTCY DATE ..29..
CNC DATE ..30..

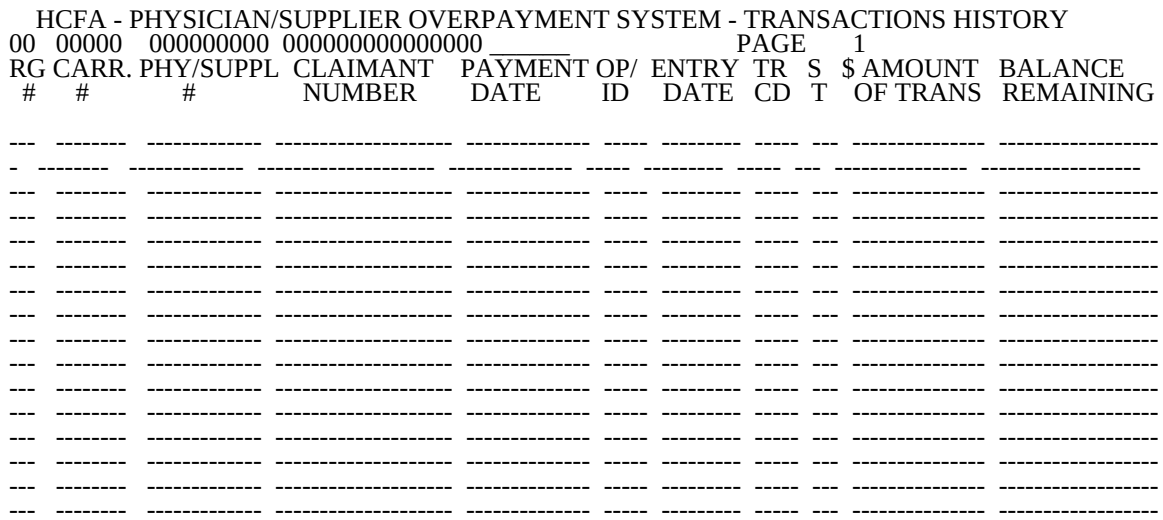
INT REC	OPEN BAL	RECOUPED	REC. ADJ.	CUR BAL
$ ….15….	$ …..16…..	$ …..17……	$ ….18….	$ …19…..

TRANSACTIONS ..20.. $ …..21….. ..20... $ …..21….. ..20..$ …..21….. ..20.. $ …..21…..

OPEN CLAIMS <N/A> STATUS …22… LOCATION …23… CLOSED DATE …24…

PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN
PRESS F1 KEY FOR HELP; PRESS F4 KEY FOR TRANSACTIONS BROWSE

FIGURE 8



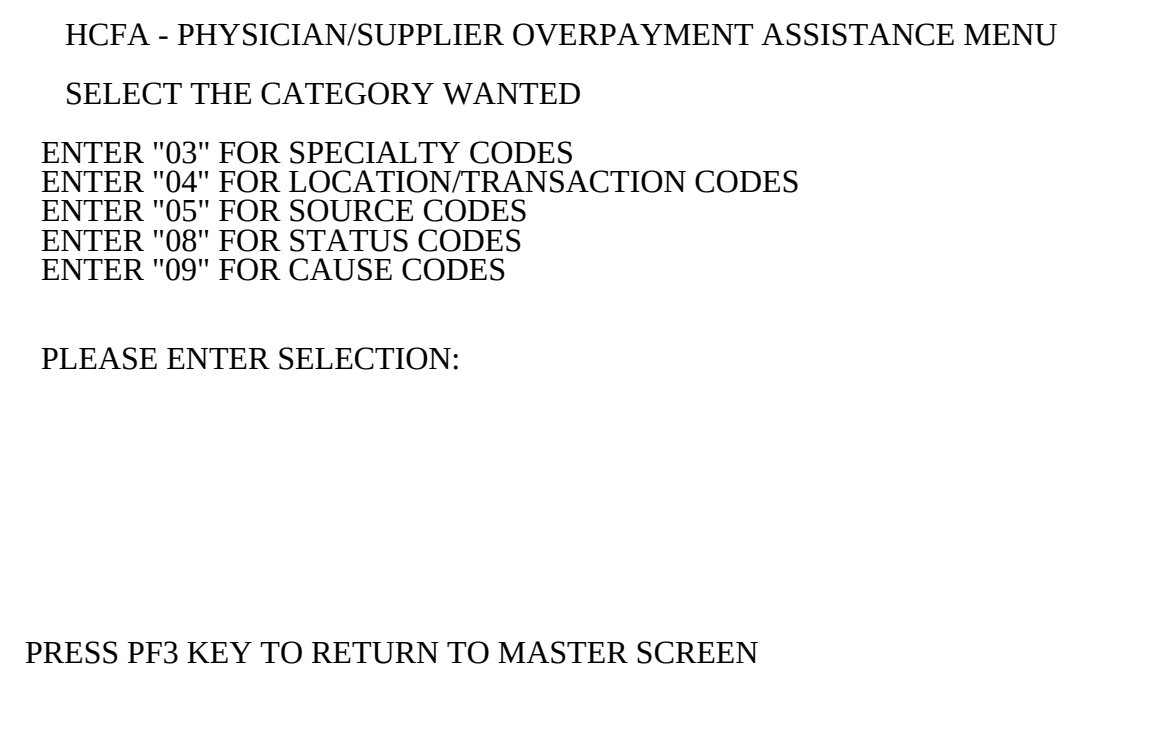
HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT SYSTEM - TRANSACTIONS HISTORY

00 00000 000000000 000000000000000 _____ PAGE 1

RG #	CARR. #	PHY/SUPPL #	CLAIMANT NUMBER	PAYMENT DATE	OP/ ID	ENTRY DATE	TR CD	S T	$ AMOUNT OF TRANS	BALANCE REMAINING

PRESS F7 TO PAGEBACK; F8 TO PAGE FORWARD; F3 TO RETURN TO PREVIOUS SCREEN
TRANSACTION HISTORY ENDS ON THIS PAGE

FIGURE 9



HCFA - PHYSICIAN/SUPPLIER OVERPAYMENT ASSISTANCE MENU

SELECT THE CATEGORY WANTED

ENTER "03" FOR SPECIALTY CODES
ENTER "04" FOR LOCATION/TRANSACTION CODES
ENTER "05" FOR SOURCE CODES
ENTER "08" FOR STATUS CODES
ENTER "09" FOR CAUSE CODES

PLEASE ENTER SELECTION:

PRESS PF3 KEY TO RETURN TO MASTER SCREEN

FIGURE 10

ATTACHMENT A

PART A PROVIDER OVERPAYMENT

REFERRAL CHECKLIST

(CMS Pub. 100-6, §140)

REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Intermediary Name _____ Date Prepared:_____

Intermediary No. that OP is reported under on POR

Intermediary No. that OP is reported under on Accounts Receivable Report (751)

I. Provider & Overpayment Information
(All information that has corresponding field on Provider Overpayment Report (POR) must agree with POR. Discrepancies should be immediately resolved rather than the form delayed.)

A. Provider Name _____ B. Provider No._____

C. Cost Report Period_____

D. Responsible Individual(s) (Most Current)

Name: _____ Title:

_____

Address:

_____

City, State, Zip: _____ Telephone:

_____

E. Overpayment Information (List information for each outstanding overpayment)

**Original Amount _____ **Interest Assessed /Rate

*Principal Recouped _____ *Interest Recouped ___

Principal Referred _____ Interest Referred Through Date

____/____/_____

F. Overpayment Type _____ G. Determination Date _____

_____

___

H. Intermediary Control #_____

NOTE: If unfiled cost report is the overpayment type, indicate the date unfiled cost report is (was) due to be filed, as well as the interim payments.

*Attach detailed information with case regarding recoupments, include dates applied.
**Include copies of the Master screen from the POR, for both principal and interest.

Part A Referral Checklist

II. Accounts Receivable Reporting
(All information reported in I.E. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line	Amount
A. HI Principal Reported on H751 Part A as transferred to RO		
HI Interest Reported on H751 Part A as transferred to RO		
SMI Principal Reported on H751 Part B as transferred to RO		
SMI Interest Reported on H751 Part B as transferred to RO		
Total		

B. Indicate quarter information was reported on the H751 ___/___/___

III. Collection Efforts

(For items III A-C, unless there is a postpetition demand letter, this information would not be relevant to recovering in bankruptcy).

A. Include copies of the First, Second and Third demand letters (Ref. CMS Pub. 13-2, § 2222). If full series of letters was not sent, explain why.

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all; (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other legal entities

D. The contractor must establish whether or not a particular provider is participating in the Medicaid Program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 13-2, § 2226ff.

PARTICIPATING: Yes ____ No ____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

E. Is the provider listed in the Fraud Investigation Data Base? (FID) Yes ____ No ____

IV. Ownership

Check the appropriate ownership affiliation:

A. ____ INCORPORATED
Chain Organization Yes ___ No ___

B. ____ PARTNERSHIP
EIN # _____

If yes, who is the home office intermediary ?
_____

Incorporation Date _____
EIN #_____

1) If partnership, list names and SS#□s of all partners. 2) If Corporation, list names and addresses of officers. 3) If Chain organization, list other provider names, addresses, and provider numbers.

_____

_____

_____

_____

_____

C. Is "Responsible Individual(s)" information the most current? Yes _____ No _____

Provide alternate contact(s), Name, Title, Address and Telephone Number

_____

_____

_____

_____

_____

D. Are claims for services still being submitted? Yes _____ No _____
If yes, why is referral being made.
_____
_____
____

E. Has there been a change of ownership? Yes _____ No _____
If yes, what is the date?_____
Has the new owner assumed the previous owner's provider agreement? Yes No_____
(Provide copy of sales agreement.)

F. Has recoupment from new owner been attempted? Yes No
_
_
_
_
_

Part A Referral Checklist

V. General

A. Is the provider still participating in the Medicare program? Yes _____ No_____

Note: If the provider is still participating in the program and claims recoupments are being made, do not transfer case to the RO.

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes _____ No_____
Copies of pertinent court documents should be submitted. Take the following program safeguard actions when a bankruptcy situation is identified:

- Adjust interim payment calculation to ensure that no overpayment is made
- Consult the CMS RO before applying any disposition regarding cost report underpayments
- Expedite cost report desk reviews and audit settlements
- Tentative settlements should not be made in bankruptcy cases
- Consult the CMS RO regarding any cost reports pending submission and the expected dates of submission

C. Did the provider request an extended repayment schedule (ERS)? Yes
No_____

If yes, was it approved? Yes _____ No_____ Length of ERS
_____

Number of payments made _____
Attach any financial documentation submitted.

D. Did provider request an intermediary or PRRB hearing? Yes _____ No_____
If yes, do not transfer unless the decisions have been rendered. Submit all pertinent information.

Cases pending a Reopening, Bankruptcy, BCA Review, or PRRB Decision, should not be transferred to the CMS-RO until judgment has been rendered. Copies of all decisions must be included.

INSTRUCTIONS: If you do not provide any requested information, you must give a detailed explanation of why you cannot secure the information. We will return incomplete forms with the entire case.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: _____ PROVIDER NUMBER: _____

OVERPAYMENT AMOUNT: $_____ INITIAL DEMAND LETTER DATE: _____

INTEREST RATE: _____% COST REPORT PERIOD: _____

Payment Date	**Period (30 Days)**	**Interest Charges**	**Recouped Amounts**	**Applied to Interest**	**Interest Balance**

PART B PHYSICIAN/SUPPLIER OVERPAYMENT
Referral CHECKLIST
(CMS Pub. 14-3, § 7142.2)

REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Carrier Name _____ Date Prepared: _____

Carrier No. that OP is reported under on PSOR
Carrier No. that OP is reported under on Accounts Receivable Report (751)
_____

I. Physician/Supplier Overpayment Information
(All information that has corresponding field on Physician Supplier Overpayment Report (PSOR) must agree with PSOR)

A. Phy/Supp. Name _____ B. Phy/Supp No. _____

UPIN _____

C. Responsible Individual(s)

Name: _____ Title: _____

Address: _____

City, State, Zip: _____ Telephone: _____

D. Overpayment Information

**Original Amount _____ **Interest Assessed /Rate

*Principal Recouped _____ *Interest Recouped _____

Principal Referred _____ Interest Referred

_____

Through date

_____

Query if overpayment is based on fraud.

*Attach detailed information with case regarding recoupments, include dates applied.

**Include a copy of the Master screen from the PSOR.

Information requested in E though L is needed for all claims involved in overpayment.

E. Discovery Date _____ F. Determination Date

_____

G. DCN _____ H. Cause of OP

_____

I. Claim Number_____ J. Claim Paid Date

_____

K. Beneficiary Name _____ L. HI Claim No._____

Part B Referral Checklist

II. Accounts Receivable Reporting
(All information reported in I.D. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line Amount
A. SMI Principal Reported on H751 Part B as transferred to RO _____ Line Reported on	_____
SMI Interest Reported on H751 Part B as transferred to RO _____ Line Reported on	_____
B. Indicate quarter information was reported on the H751	_____
C. Is this Overpayment reported on the M751	Yes ___ No ___

III. Collection Efforts

A. Include copies of the First and Second demand letters (Ref. CMS Pub. 14-3, Sec. 7142). If full series of letters was not sent, explain why.

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all, (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other numbers).

D. The Carrier must establish whether or not a particular provider is participating in the Medicaid program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 14-3, § 7170.1.
PARTICIPATING: Yes _____ No _____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

Part B Referral Checklist

IV. Ownership

Check the appropriate ownership affiliation:

A. ___ INDIVIDUAL
Tax ID # _____

SS # _____

B. ___ INCORPORATED
Chain Organization Yes
No _____
Incorporation Date
_____
TIN #
_____
_____

C. ___ PARTNERSHIP
TIN # _____

D. Is A Responsible Individual(s)□ information the most current? Yes _____ No _____
Provide alternate contact(s), Name, Title, Address and Telephone Number

_____

_____

_____

_____

_____

E. Is recovery due from the beneficiary or other 3rd party payor? Yes _____ No _____
If yes, why was recovery not made (enclose copies of letters and replies).

F. Are claims for services still being submitted? Yes _____ No _____
If yes, why is referral being made.

G. Are claims for services/supplies being submitted under another physician/supplier number?

Yes _____ No _____ If Yes, provide alternate number_____

Is the tax identification, or social security number the same as debtor's? If yes, recoupment should be attempted.

H. Has there been a change of ownership? Yes _____ No _____

If Yes, Has the new owner assumed any of the previous owner's liabilities? Yes _____

(Provide copy of sales agreement.)

Part B Referral Checklist

V. General

A. Is the physician/supplier still participating in the Medicare program? Yes _____ No _____

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes _____ No _____ Please provide copies of pertinent court documents.

C. Did the physician/supplier request an extended repayment schedule (ERS)?
Yes ____ No
If yes, was it approved? Yes ____ No ____ Length of ERS _____
Number of payments made_____
Attach any financial documentation submitted.

D. Did the physician/supplier request a Fair Hearing or ALJ Hearing?
Yes _____ No _____
If yes, do not transfer unless the both fair hearing and ALJ decisions have been rendered. Submit all pertinent documentation.

THIS FORM MUST BE COMPLETE. IF ANY REQUESTED INFORMATION IS NOT PROVIDED, A DETAILED EXPLANATION MUST BE GIVEN AS TO WHY THE INFORMATION CANNOT BE SECURED. INCOMPLETE FORMS WILL BE RETURNED WITH THE ENTIRE CASE.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: _____ PROVIDER NUMBER:

OVERPAYMENT AMOUNT: $_____ INITIAL DEMAND LETTER DATE:

INTEREST RATE: _____% CLAIM NUMBER:

Payment Date	**Period (30 Days)**	**Interest Charges**	**Recouped Amounts**	**Applied to Interest**	**Interest Balance**

ATTACHMENT B

CONTRACTOR BANKRUPTCY CHECKLIST

- Send the following information to the RO upon learning that a provider has or may soon file for bankruptcy:
- Provider Name
- Provider Medicare Number
- Provider Address
- Provider Tax Identification Number
- Overpayment Determination Date
- Original Overpayment, Amounts Recouped, Current Balance Reported on the CMS 750/751 reports of principal and interest outstanding balances. Date the receivable was included on the CMS 750/751.
- Overpayment Type
- Fraud and Abuse Overpayments or Investigations
- For Part A Intermediaries, the Cost Report Year
- For Part A Intermediaries, the Cost Reports Settlements Pending Inhouse with Expected Completion Dates
- For Part A Intermediaries, the Cost Reports Pending Submission with Expected Dates
- For Part A Intermediaries, Interim Rate Information by Cost Year for Previous Three Years
- For Part A Intermediaries, Overpayment History by Cost Year for Previous Three Years
- For Part B Carriers or DMERCs, the Claim Numbers Relating to Overpayments
- For Part B Carriers or DMERCs, the Dates of Service for Related Claims
- For Part B Carriers or DMERCs, the Dates of Payment for Related Claims
- Medicare Review Overpayments or Reviews
- Anticipated Reopenings

190 – Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

(Rev. 106, Issued: 08-25-06, Effective: 10-01-03, Implementation: 06-26-06)

Effective October 1, 2003, Common Working File (CWF) implemented the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based MA Enrollment coding files described in the CWF System Documentation at http://cms.csc.com/cwf/.

Upon receipt of notification that a beneficiary has previously enrolled in a MA Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive MA enrollment. The CWF compares the period between the MA enrollment start

date and the date of service of the claims in history. Services that fall within the responsibility of the MA Organizations are identified.

The CWF generates an Informational Unsolicited Response (IUR) with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based MA payment rules. The IUR has all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the Health Insurance Claim number. The CWF electronically transmits the IUR to the contractor that originally processed the claim. The IUR is included in the existing CWF response file. The IURs in that file for claims to be adjusted are identified with a unique transaction identifier. The previously submitted claim is not canceled and will remain on the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the IUR the Shared System software reads the trailer for each claim and either a manual or automated adjustment is performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.

Carriers

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the carrier in trailer 11. Carriers are to recover any monies due back to Medicare resulting from these denials, by following the standard or (customary) recovery process. Carriers are also responsible for providing the M/A plan number to the providers in their correspondence.

In the event that a denial is reversed upon appeal, for carrier claims, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Fiscal Intermediaries (FIs)

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the intermediary in trailer 11. To recover any monies due back to Medicare resulting from these denials, claims are to be adjusted and overpayments are to be recovered through the customary recovery process.

In the event that a denial is reversed upon appeal, a 1 byte override code field is created at the header level for FI claims. The FIs should use override code "1" in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the HMO override field. The purpose of using "1" or "2" is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a MA, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an alternate method).

Language for Carriers to Use in Letter to Provider

Carriers

This beneficiary was enrolled in [Plan Alpha Numeric ID]; a risked based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS Internet at http://www.cms.hhs.gov/HealthPlansGenInfo/claimsprocessing20060120.asp#TopOfPage.

Fiscal Intermediaries

The plan number is not required on intermediary communications. Those providers are to determine which plan to contact through an eligibility inquiry or by contacting the beneficiary directly.

New Medicare Summary Notice (MSN)

The MSN code 16.57 - Medicare Part B does not pay for this item or service since our records show that you were in an Medicare + Choice Plan on this date. Your provider must bill this service to the Medicare + Choice Plan.

16.57 - La Parte B de Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Suproveedor debe facturar este servicio a el plan de Medicare + Opción.

200 - Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Section 1893 (f)(2)(a) of the Social Security Act provides limitations on the recoupment of Medicare overpayments. This section provides protection to Providers, Physicians, and Suppliers during the initial stages of the appeal process. The limitations extend to the redetermination and the reconsideration level if the provider meets all conditions. These limitations do not affect a provider's right to appeal and the timeframes associated with appealing; however to stop recoupment a provider must act decidedly to appeal.

When a valid first level appeal request (redetermination) or a valid second level (reconsideration) request is received from a provider on an overpayment subject to these limitations (See § 200.1 below) the Medicare contractor will cease recoupment or not begin recoupment at the normally scheduled time (41 days for 1st level and 76 days for 2nd level).

During this appeal process, the Medicare contractor cannot recoup or demand the debt; however, the debt continues to age. Once both levels of appeal are completed and CMS prevails, collection activities, including demand letters and internal recoupment, may resume within the timeframes set forth.

200.1 - Overpayments That are Subject to Limitation on Recoupment

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Applies to the recovery of funds for all Part B and Part A claims for which a demand letter is issued such as:

A. *Post-pay denial of claims for benefits under Medicare Part A which is determined and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record is subject to this provision);or*

B. *Post-pay denial of claims for benefits under Medicare Part B which is determined and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as result of a post payment review of the medical record is subject to this provision); or*

C. *Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or*

D. *Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).*

1. The providers, physicians and suppliers can appeal the overpayment as a revised initial determination under the Medicare Claims Appeal process at 42 CFR 401 and 405 or

2. As an initial determination for providers, physicians and suppliers MSP duplicate primary payment recoveries.

E. *The final Claims associated with an HHA Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself see below in §200.1.1 (E).*

200.1.1 - Overpayments That are Not Subject to Limitation on Recoupment

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

A. *All other Medicare Secondary Payer recoveries except those identified in Section I (C and D) above.*

B. *Beneficiary overpayments;*

C. *Overpayments that arise from a cost report determination*

D. *Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals.*

E. *HHA Request for Anticipated Payment (RAP): While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the Home Health Prospective Payment System (HH PPS) do not have appeal rights during (1) the 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP to submit the final claim; rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode Refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 10, §§10.1.10 through 10.1.12, 40.1 & 50.*

F. *Hospice Caps calculations*

G. *Provider initiated adjustments*

H. *Accelerated/Advanced Payments*

I. *Certain claims adjustments at the contractors' discretion that will not be subject to 935 (this requires approval by CMS RO or CO)*

200.1.2 - How Does the Rebuttal Process Work with the Limitation on Recoupment?

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

In 42 CFR 405.373 through 405.375, regulations require that providers, physicians and suppliers be given an opportunity to rebut any proposed recoupment action by submitting a statement within 15 days of the notice indicating action to take a recoupment action. These procedures are separate from the requirements of the limitation on recoupment. The rebuttal process ***occurs prior to the appeals process****, and permits the provider a vehicle to indicate why the proposed recoupment should not take place. The Medicare contractor may, based on the rebuttal statement, determine to stop recoupment or proceed with recoupment. In contrast the limitation on recoupment provision mandates that recoupment stop when a valid and timely request for a first level or second level appeal is received.*

200.1.3 - Adjustment of the Part A Claim (or All Claims Adjusted by the Fiscal Intermediary Standard System-This Includes Part B of A Claims)

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare contractors shall determine if the limitations apply to the claim at the time of the adjustment. If the adjustment results in a refund due the providers, physicians and suppliers, Medicare contractors shall follow existing underpayment policies. This will trigger the creation of the first demand letter unless previously issued which will include information for the provider concerning recoupment protections. This will also trigger recoupment to begin on the 41st day after the date of the demand letter.

NOTE: In most instances this instruction supercedes Chapter 4 §70.16, unless the AR's do not qualify; see the above § 200.1.1.

200.1.4 - Adjustment of the Part B Claims (All Claims Adjusted by the Medicare Carrier System or the VMS system)

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare contractors shall adjust claims in the normal process issuing a first demand letter and beginning recoupment no earlier than 41 days after the date of the demand letter.

200.2 - Additional Requirements for Demand Letters

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare contractors must issue demand letters for all overpayments subject to the limitation on recoupment protections.

A. *In addition to the requirements listed in Chapter 3 and 4, on First Demand Letters (excluding Cost Report Demand Letters) the following are specific requirements for overpayments subject to the limitation on recoupment protections:*

1. Medicare contractors shall include a claim level detail report of the claim adjustments that comprise the overpayment along with the demand letter to each provider.

2. Medicare contractors demand letters shall clearly state that the provider may submit a rebuttal statement to any proposed recoupment action and you will review it and consider whether to proceed or stop the offset. The rebuttal is permitted under 42 CFR 405.373 through 375 however, does not mandate that recoupment stops.

3. Medicare contractors shall change the language in the demand letter to state that in order to stop recoupment under the provisions of 935 of the MMA; providers, physicians and suppliers must timely request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter. Submission of a rebuttal statement under 42 CFR 405.374 will not stop recoupment.

4. Medicare contractors shall ensure the language in the demand letter makes clear that the provider may appeal all of the claims from the overpayment demand letter or only part of the claims.

5. Medicare contractors shall insert in the demand letter, language that clearly explains that recoupment will begin on the 41st day from the date of the first demand letter if 1) payment is not received in full, 2) an acceptable request for an extended repayment schedule, (refer to Chapter 4 §50) or 3) a valid request for a contractor redetermination is not date stamped in the mailroom by day 30 from the date of the demand letter.

6. *Medicare contractors shall send the demand letter by first class mail.*

200.2.1 - Example 1- Sample of the 935 First Demand Letter for Part A and B
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Example 1: Contents for the 935 First Demand Letter resulting from the limitation of Recoupment

Date

Provider, Physician and Supplier's Name
Address 1,
Address 2
City, State ZIP Code
First Request

Provider/Physician/other Supplier's Number:
Account Receivable Number:

Dear Provider/Physician/Suppliers' Name,

Contractors should use the appropriate paragraph:

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

or

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

or

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

How this overpayment was determined:

Include explanation of the overpayment determination and the amount due.

When applicable, contractor must explain the authority for reopening the claims (i.e., consistent with 42 CFR 405.980, and Publication 100-04 Medicare Claims Processing Manual, Chapter 34) and explain how the facts of the case allowed you to reopen within the timeframes established in those sections.

NOTE: *This paragraph shall include* ***a clear explanation of how the overpayment arose****, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct. For example: (refer to LCD, NCD, or contractor bulletin, etc.)*

Why you are responsible

NOTE: *For medical necessity determinations, the Part A & B contractor shall insert for* ***each item or service,*** *an explanation (based on §1879 of the Act) stating why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination. (Applicable Authorities: Section 1870(b)(c) of the Social Security Act; §§405.350 - 405.359 of Title 42 CFR §§404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations and 20 CFR.*

For example:

- *Based on Bulletin _____ these procedures are only necessary in limited circumstances,*
- *Based on a prior decision we informed you that these type services are not medically necessary*

Additionally, the Medicare contractor shall insert for each item or service an explanation (under §1870) why the provider was not found to be without fault in causing the overpayment. For example:

- *You can use similar phrases above or any other language that provides evidence of the provider's knowledge that it should have known the services were not covered. Or you were not entitled to payment. Therefore, you are not without fault and are responsible for repaying the overpayment amount.*

I. Make a payment or arrange for payments

What you should do:

1). Make the check payable to Medicare Part A and send it with ***a copy of this letter to****:*
2). If you want to request an Extended Repayment Schedule please send to:

Contractor Name
Address
City, State and Postal ZIP Code

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

II. Payment Withholding*:*

If payment in full is not received by, ***(specify a date from the date of the notification),*** *payments to you can be withheld (Recoupment) until payment in full is receive or if you haven't submitted an acceptable extended repayment request and/or a valid and timely appeal is received.*

III. Rebuttal Process:

Under our existing regulations 42 CFR §405.374, providers, physicians and suppliers will have 15 days from date of this demand letter to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence stating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. If you have reason to believe the withhold should not occur on _____ you must notify this office before ___. CMS will review your documentation. Our office will advise you of our decision in _____days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

The rebuttal statement does not cease recoupment activities consistent with section 935 of the MMA.

IV. How to Stop Recoupment:

Even if the overpayment and any assessed interest have not been paid in full you can stop Medicare from recouping any payments if you act quickly and decidedly. Medicare will permit providers, physicians and suppliers to ***stop recoupment*** *at several points. The first occurs if Medicare receives a valid and timely request for a redetermination within 30 days from the date of this letter, if the appeal is filed later than 30 days, we will also stop recoupment at whatever point that an appeal is received but Medicare may not refund any recoupment already taken.*

We will again stop recoupment if, following an unfavorable or partially favorable redetermination decision, you decide to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor (QIC). The address and details on how to file a request for reconsideration will be included in the redetermination decision letter."

What are the timeframes to stop recoupment:

First Opportunity*: To assist us in expeditiously avoid the recoupment the appeal request must be filed within 30 days of this letter. We request that you clearly indicate on your appeal request that this is an* ***overpayment*** *appeal and you are requesting for a redetermination to:*

Contractor Name
Address
City, State and Postal ZIP Code

***Second Opportunity**: If the redetermination decision is 1) **unfavorable** we can begin to recoup no earlier than the 61st day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter), or, 2) if the decision is **partially favorable**, we can begin to recoup no earlier than the 61st day from the date of the Medicare revised overpayment Notice/Revised Demand Letter or, 3) If the appeal request was received and validated after the 60th day we will stop recoupment. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.*

***What Happens following a reconsideration by a Qualified Independent Contractor**.*

Following decision or dismissal by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to any further level.

***NOTE:** Even when recoupment is stopped, interest continues to accrue.*

V. Interest Assessment:

*If you do not refund in 30 days: **i**n accordance with 42 CFR 405.378 simple interest at the rate of _____ % will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of __ %. In addition, please note that Medicare rules require that payment be either received in our office by _____ or use the United States Postal Service Postmark by that date for the payment for the payment to be considered timely. A metered mail postmark received in out office after _____ will cause an additional month's interest to be assessed on the debt.*

VI. If you wish to appeal this decision:

*If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination 120 days from the date of this letter**. However, if you wish to avoid recoupment from occurring and assessment of interest of this overpayment you need to file your request for redetermination within 30 days from the date of this letter as described above**. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter.*

VII. If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may

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

Should you have any questions please do not hesitate to contact _____ at _____. If we can assist you further in the resolution of this matter, <Contractor Name> shall be glad to do so.

Sincerely,
(Name and title)
Enclosure
cc

200.2.2 - Recoupment After the First Demand: When Does it Begin?

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Timeframe	***Medicare Contractor***	***Provider***
Day 1	*Date of Demand Letter (Date demand letter mailed)*	*Provider receives notification by first class mail of overpayment determination*
Day 1-15	*Day 15 deadline for Rebuttal request. No recoupment occurs*	*Provider must submit a statement within 15 days from the date of demand letter.*
Day 1-40	*No recoupment occurs*	*Provider can appeal and potentially limit recoupment from occurring*
Day 41	*Recoupment begins*	*Provider can appeal and potentially stop recoupment*

Recoupment can proceed on day 41 from the first demand letter unless a valid and timely request for a redetermination is received. To limit recoupment the provider must file the request for a redetermination by the 30th day following the date of the first demand letter. Medicare Contractors shall refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decision to determine what constitutes a valid request for a redetermination. Recoupment can begin no earlier than the 41st day.

NOTE: *Medicare Contractors shall establish internal controls to ensure recoupment does not proceed if a valid request for a redetermination is received. The appeal unit or a qualified appeal staff (in mailroom) who receives the appeal request will have 2-4 business days to validate the appeal and communicate to the Overpayment/Financial Division who will have an additional 2 business days to stop the recoupment process. In general, the process of stopping recoupment based on a valid appeal request should take no more than 6 business days.*

200.3 - What to Do When a Valid Request for Redetermination for Appeal is Received

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

***Action to take**:*

1. Upon receipt of a timely and valid request for a redetermination of an overpayment, Medicare contractors shall cease recoupment of the overpayment that is the subject of the appeal.

2. If the recoupment has not yet gone into effect, Medicare contractors shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a redetermination was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor shall continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue.

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as the following:

Example 2 Receipt Notice:

Current Date

Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter serves to notify you that we have received your request for redetermination for the following_____(i.e., AR/services/ICN) or the services at issue.

Your request for redetermination dated _____ was received in our office and all collection processes have ceased on _____. However, interest will continue to accrue on any outstanding unpaid balance of the overpayment as explained in our demand letter.

You will receive a redetermination notice once the appeals department has concluded their redetermination.

If you have any questions, please contact our office at the appropriate number listed below. You may also visit us through out Web site at www._____.com

Sincerely,
(Name and title)

C. Outcome of a Redetermination (Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 10, § 360.3, Number 1)

*1. **Full reversal** - This is a (Fully Favorable) decision of the Overpayment determination. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with in Chapters 3 and 4 §30. The amount held may be applied to any other debt owed by the provider or supplier; any excess would then be released to the provider, physician or supplier. Following a redetermination favorable decision to the providers, physicians and suppliers, the contractor may effectuate the decision. An Explanation of Benefits (EOB) would be acceptable in place of a written notice. When the reversal in favor of the provider occurs interest may be payable by Medicare if the underpayment is not paid within 30 days of the final determination.*

*2. **Partial reversal** - This is a (Partially Favorable) decision of the overpayment determination in which the decision reduces the debt below the amount already recouped this will require the contractor to recalculate the correct amount of both the underpayment and the overpayment. The Medicare contractor effectuates the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Refer to publication 100-04 Medicare Claims Processing Manual, Chapter 29 §§310.5 and 310.7 for further guidance.*

*3. **Full Affirmation** - This is a (Unfavorable) decision of the overpayment determination, the contractor shall issue the 2nd or 3rd demand letter whichever is appropriate or see D4 below. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with Chapters 3 and 4.*

D. Medicare Overpayment Revised Notice or revised Demand Letter after the Redetermination decision involving Limitation on Recoupment

*1. If the redetermination is a full reversal (**Fully Favorable**) decision of the overpayment determination, Medicare contractors may need to effectuate (when necessary) the*

redetermination decision. Contractors send the applicable notice when necessary, see below (G) example 3 Revised Notice or revised Demand Letter) as explained in Publication 100-04 Medicare Claims Processing Manual, Chapter 29, §310.8)

*2. If the redetermination results in a Partial reversal (**Partially Favorable)** decision which reduces the overpayment amount, the contractor shall effectuate the redetermination decision and issue a revised overpayment notice or a revised (2nd) demand letter to the provider of the revised overpayment amount. This notice/letter must state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination in the absence of a receipt/ notification by the QIC of a timely and valid request for a reconsideration. This notice must also give the provider an opportunity to rebut the proposed recoupment action (See §200.1.2) and you will review it and consider whether to proceed or stop the recoupment. This is still permitted under 42 CFR 405.373 through 375; however it does not mandate that recoupment will stop.*

a. The notice (to effectuate the redetermination decision) must state that in order to stop recoupment under the provisions of 935 of the MMA, providers, physicians and suppliers must timely request a valid appeal (reconsideration) of the overpayment within 60 days from the date the notice (to effectuate the reconsideration decision). Submission of a rebuttal statement under 42 CFR 405.374 will not stop recoupment. (See §200.1.2)

*3. If the redetermination is **a full affirmation, (Unfavorable)** decision the required notice can be one of the following:*

a. The standard Medicare redetermination notice but if and only if the initial demand letter contained language comparable to that shown in §200.2.1 Example 1, which specifically states that the contractor can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice (in the absence of receipt by a QIC of a timely and valid request for a reconsideration. Refer to Publication 100-04 Medicare Claims Processing Manual, Chapter 29 §310.7. Again rebuttal language shall be included.

b. If the 2nd or 3rd demand letter has not been sent (because the overpayment was in appeal status) this can be modified to indicate when recoupment will begin to recoup no earlier than 61st calendar day from the notice of the revised overpayment determination notice (in the absence of receipt by the QIC of a timely and valid request for a reconsideration). Again, rebuttal language shall be included (See §200.1.2). or

c. A brief notice which states when recoupment can begin as stated in a and b above.

E. Recoupment after a redetermination decision.

While the notices should state that recoupment can begin no earlier than the 61st day, contractors will have an additional 15 days to start recoupment on any unpaid balance. The 15 day period between when the provider is informed recoupment can begin (day 61) and when recoupment must begin no later than (day 76) is designed to facilitate communication between the QIC and the contractor (MAC/AC), should a reconsideration request be received or payment is received. However, if you are provided documentation by the provider that a reconsideration request has been sent to the QIC, and you have not heard from the QIC, and the 75th day is approaching, you may but are not required to contact the QIC to check whether in fact an appeal has been received to avoid subsequent problems with the provider.

1. If the debt has been in an appeal status. When you initiate or resume recoupment. The status of the debt shall be changed to reflect "eligible for internal offset" or resume offset.

***NOTE:** Recoupment may not resume and must cease upon receipt of a timely and valid request for a reconsideration by the QIC.*

F. When does Recoupment Begin or Resume after the redetermination?

Timeframe	***Medicare Contractor***	***Provider***
Day 60 following revised notice of overpayment following redetermination	*Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice*	*Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal*
Day 61- 75	*No Recoupment Occurs*	*Provider appeals or pays*
Day 76	*Recoupment Begins or Resumes*	*Provider Can Still Appeal. Recoupment stops on date receipt of appeal*

G. Example Letter for Medicare Overpayment notice/ Revised Demand Letter for Part A & B resulting from the 1st level (redetermination) Appeal decision.

Example 3: Medicare Overpayment Notice/ Revised Demand Letter

Current Date

Provider Name
Address
Address
City, State ZIP Code

Provider Number:

Account Receivable Number:

Dear Provider Name,

This letter is in reference to the Medicare Redetermination decision dated_____, for the overpayment in the amount of $_____ issued to you on the DATE of the Demand letter. This overpayment was for medical services rendered from DATES. Based on the Medicare Redetermination decision, it is noted as Partially Favorable to the provider.

According to our records, the balance on this account is $_____. Payment/Recoupment totaling $_____ were applied to this account.

Or

According to our records, the new balance on the Principal amount is $_____ and the interest amount due is $_____. Payments totaling $_____ are due by _____.

*When the redetermination decision is Partially Favorable and the overpayment amount must be recalculated, we may begin to recoup no earlier than **60 days** after the date of **this [Medicare Overpayment Notice or revised Demand letter]**. Please note that if recoupment is stopped, interest continues to accrue.*

If you have already sent payment, we thank you and ask that you disregard this letter. If you have any questions or concerns in this matter, please write to our office or contact me at (XXX) XXX-XXXX.

Sincerely,

Analyst Name
Title

H. Initiating or resuming recoupment after a Withdrawal or Dismissal

Medicare Contractors can initiate or resume recoupment immediately if a provider, physician, or other supplies has requested a withdrawal of a request for reconsideration, or the QIC issues a dismissal of a request for reconsideration (See CFR 42 §405.972).

200.3.1 - What To Do When a Valid and Timely Request for a Reconsideration is Received

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

The QIC determines the validity and timeliness of a request for a reconsideration. However, to limit recoupment of the overpayment a provider must request a reconsideration and have

it postmarked by the 60th day. Refer to § 200.3 (E) of this section for additional information regarding QIC contractor communication regarding the filing of a request for reconsideration.

A. Actions to take:

1. Upon receiving notification from the QIC of a valid and timely request for a ***Reconsideration****. The Medicare Contractor shall cease recoupment of the overpayment.*

2. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a reconsideration was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor should continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue.

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as this:

Example 4: Receipt of Appeal Request Reconsideration to provider

Current Date

Provider Name
Address
City, State ZIP Code

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter serves to notify you that we have received notification from the Qualified Independent Contractor (QIC), _____[insert OIC Name], that they received your request for reconsideration dated _____ in their office on _____. You requested a reconsideration for the following [AR/services/ICN or the services at issue]. All collection processes have ceased; however, interest will continue to accrue on any outstanding unpaid balance of the overpayment as

explained in our demand letter. You will receive a reconsideration notice once the QIC has concluded its reconsideration."

If you have any questions, please contact our office at the appropriate number listed below. You may also visit us through our website at www._____.com

Sincerely,
(Name and title)

C. Outcome of Reconsideration

The QIC decision may require an effectuation action by the Medicare Administration contractor. Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 §320.9 for additional information on effectuation.

*1. **Full Reversal** - If the QIC reconsideration results in a (Fully Favorable) decision of the overpayment as modified by the redetermination, Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4. The amountheld may be applied to any other debt owed by the provider or supplier; any excess would then be released to the provider or supplier. If the reversal in favor of the provider, physician or other suppliers occurs interest may be payable by Medicare if the underpayment is not paid within 30 days of the final decision.*

*2. **Partial Reversal -** If the final action by the QIC is a reconsideration resulting in a (Partially Favorable) decision which reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to the any other debt, including interest, owed by the provider or supplier to CMS before any excess is released to the provider or supplier. This decision will require an effectuation action by the contractor. It takes an effectuation action only in response to a formal decision and Reconsideration Effectuation Notice from the QIC. In accordance with Publication 100-04, Medicare Claims Processing Manual, Chapter 29 §320.9.*

*3. **Affirmation-** If the QIC reconsideration results in an (Unfavorable) decision of the overpayment recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives time for the provider to request a repayment plan or make payment. Medicare contractors shall follow current policies in adjusting the overpayment and the amount of interest charged in accordance with the interest provision in Chapter 4, §30.*

D. Reconsideration Notices Involving Limitation on Recoupment

The contractor can begin recoupment at day 30 from the date of the QIC decision or from the revised written final determination due to effectuation and shall send a notice that offset will occur on day 30; and the provider or supplier has been afforded the opportunity for a rebuttal in accordance with the requirements of §405.373 through §405.375 within 15 days

of the notice. However, no demand letter (2nd or 3rd) shall be issued for a total of 60 days following the QIC decision. After 60 days the contractor shall issue the 2nd follow up demand letter or 3rd intent to refer letter (whichever is appropriate) and referral to treasury as needed. The overpayment shall remain in "eligible for internal offset" status until it has been paid in full or referred to Treasury through cross-servicing.

1. If the reconsideration decision results in a Favorable decision (Full Reversal) Medicare contractors should effectuate the redetermination decision. Contractors may send an applicable notice if necessary consistent with Publication 100-04, Medicare Claims Processing Manual, Chapter 29, §320.9.

2. If the reconsideration decision results in a partially favorable decision (partial reversal) which reduces the overpayment amount, the contractor shall effectuate the reconsideration decision and issue a notice to the provider of the revised overpayment amount. This notice must state that the contractor can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give providers, physicians and suppliers an opportunity to make payment arrangements. This notice must also give the provider the opportunity to rebut the recoupment according to 42 CFR 405.373 and 375. (See §200.1.2)

3. If the reconsideration decision results in an Unfavorable decision (Full Affirmation), the contractor shall issue a notice. The notice shall state the reconsideration has been issued and Medicare can begin recoupment or resume recoupment on day 30th day from the date of the notice of the revised notice of overpayment. This will give time for the provider to make payment arrangements. This letter must state that the providers, physicians and suppliers has been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 §405.373(2) through §405.375. (See §200.1.2)

Example 5: Medicare Notice /Revised Demand letter for Part A & B resulting from (Reconsideration) Appeal decision

Current Date

Provider Name
Address
Address
City, State ZIP

Provider Number:
Account Receivable Number:

Dear Provider Name,

This letter is in reference to the Medicare reconsideration decision dated_____, for the overpayment in the amount of $_____ issued to you on ***DATE of the Demand Letter.***

*This overpayment was for medical services rendered from **DATES.** Based on the Medicare reconsideration decision, it is noted as Partially Favorable to the provider.*

According to our records, the balance on this account is $_____. Payments/offsets totaling $_____ were applied to this account.

Or

According to our records, the new balance on the Principal amount is $_____ and the interest amount due is $_____. Payments totaling $_____ are due by _____.

*When the reconsideration decision is Partially Favorable and the overpayment amount must be recalculated, we may begin to recoup no earlier than **30 days** after the date of **this Medicare Notice/Demand letter**. Please note that if recoupment is stopped, interest continues to accrue.*

The next level of appeal following a reconsideration is a hearing by an ALJ. Recoupment proceeds regardless of the filing for an ALJ hearing. Following final decision by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level after 30 days from the date of this letter due to the QIC decision or dismissal.

If you have already sent payment, we thank you and ask that you disregard this letter. If you have any questions or concerns in this matter, please write to our office or contact me at (XXX) XXX-XXXX.

Sincerely,

Analyst Name
Title

***E. Initiating or resuming recoupment after a reconsideration decision in the following circumstances**:*

Following final decision or dismissal by the QIC, recoupment can be initiated or resumed whether or not the provider, physician or other suppliers subsequently appeals to the ALJ (third appeal level) and all further levels of appeal.

*1. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day after the date of the written notice to the provider, physician or other suppliers of the revised overpayment amount if the **reconsideration** decision is partially favorable (partial reversal).*

2. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day on the remaining unpaid principal balance and interest if it has not been satisfied in full and

the provider, physician or other suppliers has been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 §405.373 through §405.375.

200.3.2 - Administrative Law Judge (ALJ) Third Level of Appeal

(Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Whether or not the provider, physician or other suppliers subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, the Medicare contractor shall continue to recoup until the debt is satisfied in full. Recoupment remains in effect as provided in CFR 42 §405.373 (e). Refer to Publication 100-04, Medicare Claims Processing Manual, Chapter 29 §330-330.2

200.4 - Extended Repayment Schedules (ERS) With an Appeal That is Subject to Limitation on Recoupment

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

If a provider, physician or other suppliers has been granted an extended repayment schedule (ERS) and submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, the provider or supplier will not be considered in default if payments were not made by the provider. The appeal would supersede the ERS agreement; (under normal circumstances this would have been put on withhold due to default of payment). The contractor shall send a notice to the provider that it must resume its ERS payments or be placed on recoupment according to IOM 100.6 chapter 4 §50.

Payments made by a provider under an ERS are not recoupments for the limitation provision and are not subject to 935 interest if reversed at the ALJ appeal or above. However, if a provider defaults on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupments are subject to payment of interest under the 935 interest requirements. For additional information on the Filing timeframes or instructions on Extended Repayment Schedules refer to Chapter 4 §50.

200.5 - Payment Suspension

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Suspended funds involving providers, physicians and suppliers who have been put on payment suspension under 405.372 (e) are not a "recoupment" for purposes of the limitation on recoupment. Suspended funds is not a "recoupment" as this term is defined in §405.370. CMS is only limited by section 1893(f)(2) of the Act from recouping Medicare payments, we are not restricted in our ability to apply suspended funds to reduce or dispose of an overpayment.

Exception: If the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR § 405.379 "Limitation on Recoupment"provision under §1893(f)(2) of the act will be applicable to any remaining balance still owed to CMS.

200.5.1 - Payments Made Upon Notice of Demand
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Payments made by a provider in response to a demand are not recoupments as defined in 405.372(e). Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are not subject to 935 interest.

200.5.2 - Assessment of 935 Interest
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

The limitation on recoupment provisions also amended the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called 935 interest, which is payable on an underpayment where the reversal occurs at the ALJ level or subsequent levels of administrative appeal based on the period that Medicare recouped the provider's or supplier's funds. Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.

200.6 - Interest Rate and Calculation Periods for Appeal Decisions on Recouped Funds for Purposes of Paying 935 Interest
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

We will pay simple interest rather than compound interest, and ***we will not pay interest on interest; this mirrors the manner in which we assess interest against providers, physicians and suppliers.*** *Monies we recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider. The periods of recoupment will be calculated in full 30-day periods; and interest* ***will not*** *be payable for any periods of less than 30 days in which we had possession of the recouped funds.*

200.6.1 - Calculations for Each 30-Day Period at the ALJ Decision or a Final Determination Date
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest shall be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date). The contractor will have 30 days to calculate and refund the provider from the ALJ Decision date or the final determination Date.

NOTE: *Contractors will need to issue a revised written determination to the provider, physician or other supplier in accordance to Publication 100-04, Medicare Claims Processing Manual, Chapter 29.*

200.6.2 - Computing 935 Interest at the ALJ and Higher Levels
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Interest paid under 935 is only applicable at the ALJ or further appeal level when that decision results in a full or partial reversal of the prior decision and contractors retained recouped fund

What is needed to calculate 935 interest

The simple formula for calculating interest is: 1) Time; 2) Rate; and 3) Amount
For each recoupment action:

1. ***TIME**: Determine the total Julian Days starting from the recoupment date to the ALJ Decision date or date the revised notice with the new overpayment, if applicable. Divide the number of Julian days by 30 to compute the number of 30-day periods. The interest will not be payable for any periods of less than 30 days in which we had possession of the recouped funds.*

2. ***RATE**: Use the Annual Rate of interest at the time of the ALJ decision date or from the revised New Written Determination date from an effectuation and convert interest rate to a monthly interest rate. (For example: The Rate of Interest as of April 18, 2008 is 11.375%). Convert annual Rate to a monthly rate by dividing by 12.*

3. ***AMOUNT**: The amounts that are to be used as the basis on which to compute interest earned by the provider are those amounts that are credited to principal resulting from any involuntary payments from the provider after the elimination/satisfaction of all Medicare debt. Recouped monies applied to interest are not included in determining the 935 interest. Only those principal funds recouped via withholding (e.g. payments recouped under a defaulted ERS or offset) are included. Do not include payments a provider makes under an ERS or other voluntary payments made by the provider.*

200.6.3 - How to Calculate 935 Interest
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Where there are multiple recoupments 935 interest must be calculated separately for each recoupment action and then total for the amount due the provider.

Example:

How to calculate 935 Interest:

(935 interest at the ALJ and higher levels)

Fully Favorable

ALJ Decision Date: Jan 02,2008				
Recoupment Amounts	***Recoup Date***	***Rate of Interest from ALJ Decision Date***	***Length of Time Money Held***	***Interest Owed to Provider***
1) $ 9062	*March 07, 2007*	*12.5%*	*301 Julian Days (10 mos. 1 day)*	*$ 943.95*
2) $ 9806	*May 18, 2007*	*12.5%*	*230 Julian Days (7 mos. 20 days)*	*$ 715.02*
3) $ 9136	*August 08, 2007*	*12.5%*	*148 Julian Days (4 mos. 28 days)*	*$ 380.66*
			Total 935 Interest owed	***$ 2,039.63***

Calculation example: ***Time x Rate x Amount = Interest***

1. *10 x (.125 ÷12) x $ 9062.00 = $943.95*
2. *7 x (.125 ÷12) x $ 9806.00 = $715.02*
3. *4 x (.125 ÷12) x $ 9136.00 = $380.66*
4. *935 Interest amt owed Provider $2,039.63*

200.6.4 - Obligation to Pay the Providers, Physicians, or Suppliers Late Payment Interest

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Medicare has the obligation to pay providers, physicians and suppliers interest if the overpayment determination is reversed at the first (redetermination) and second (reconsideration) level of the administrative appeal process and the decisions are not effectuated timely. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment ***is not paid*** *within 30 days of the final determination decision. See § 30.1 of Chapter 4.*

200.7 - Tracking and Report on Limitation of Recoupment Overpayments

(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Each calendar quarter, the Medicare contractor shall report 935 interest paid based on an ALJ or later decision that fully or partially reverses the previous decision. Reporting will be 935 Interest payment amounts aggregated by provider type. Report will be sent via email to CMS_Medicareoverpayments@cms.hhs.gov. The contractor will have 30 days from the end of the calendar quarter to submit the report to CMS.

Example 8:

1st Quarter: October, November and December 2007

Provider Type	***Total providers'***	***Total amount***
Home Health	*20*	*$ 135,000.00*
Skilled Nursing Facility	*05*	*$ 56,000.00*
Physicians	*02*	*$ 2,500.00*
DME Supplier	*10*	*$ 35,000.00*
Grand Total	***37***	***$ 228,500.00***

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R141FM	09/12/2008	Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments	09/29/2008	6183
R106FM	08/25/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment - replaces Rev 100FM	06/26/2006	5105
R100FM	07/03/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment - Replaced by R106FM	06/26/2006	5105
R97FM	05/26/2006	Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment	06/26/2006	2801
R87FM	1/03/2006	Update to Carrier Demand Letter Appeals Language	01/03/2006	4211
R64FM	02/11/2005	For Fiscal Intermediaries (FIs), a new Provider Type 80, Status Code CH, and Method of Recoupment codes. For Carriers and Durable Medical Equipment Regional Carriers (DMERCs) Status Code 2	03/14/2005	3641
R61FM	12/10/2004	New Location Code ICC, Status Code AR and Modified Intent Letter for Unfiled Cost Reports Only	01/10/2005	3563
R47FM	06/25/2004	Expanded Identification and Workload Reporting for CMS Medicare Systems	10/04/2004	3256
R43FM	04/30/2004	Replaced by Revision 47FM	10/04/2004	3256
R41FM	04/30/2004	Change in Interest Calculation for Medicare Overpayments and Underpayments and Medicare Secondary Payer (MSP) Recoveries	10/04/2004	3163
R29FM	01/02/2004	Revisions to Chapter 3 & 4	02/06/2004	2911
R25FM	11/03/2003	Rates of Interest – FIs and Carriers	11/03/2003	2828
R22FM	10/03/2003	Provider Overpayment Reporting System	10/20/2003	2782
R12FM	10/18/2002	Rewrite of Chapter 3	10/25/2002	2350
R03FM	08/30/2002	Initial Publication of Chapter	N/A	N/A