Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-03-072 **Date: AUGUST 22, 2003**

CHANGE REQUEST 2810

SUBJECT: Instructions for Provider Credit Balance Reporting Related Activities

Background:

This Program Memorandum (PM) replaces existing contractor instructions related to provider reporting of Medicare credit balances. Prior instructions for contractor activities related to provider credit balance reporting were issued by memorandum.

In accordance with 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. In accordance with these provisions, all participating providers must file a Medicare Credit Balance Report (CMS-838) with their fiscal intermediary on a quarterly basis. This process helps ensure that provider credit balances owed to the Medicare program are repaid in a timely manner.

Contractors are responsible for monitoring and ensuring provider compliance with the credit balance reporting process. This responsibility includes activities to ensure that providers complete and submit reports timely and properly as well as all associated activities such as associated claims adjustments, suspension of payments for failure to submit reports (as appropriate), issuing demand letters (as appropriate), and associated financial reporting activities.

Credit Balance Report Form CMS-838:

Contractors may see the Attachment 1 to this PM for a copy of the revised Medicare Credit Balance Report Certification page that was approved in 2002. Both the certification page and the CMS-838 form can be accessed at www.cms.hhs.gov/forms.

See the Attachment 2 to this PM– Provider Credit Balance Reporting Requirements. Contractors are charged with the responsibility for carrying out all contractor activities that may be necessitated by these instructions. Updated provider manuals are being issued simultaneously with this PM.

Providers must pay all amounts owed (column 9 of the report) at the time the credit balance report is submitted. Payment must be submitted with the report and may be made by check or adjustment bill.

- o Submission of the detail information on CMS-838 by itself does not constitute a claim adjustment. The claim adjustment (i.e., adjustment bill) must be submitted separately, either electronically or by hard copy (e.g., UB-92). (The instructions for column 11 of the CMS-838 now reflect the type of payment made.)

- o If the credit balances are repaid by check, the provider must still submit adjustment bills for any individual credit balances that pertain to open cost reporting periods. (The contractor will ensure that the monies are not collected twice.)

Quarterly Reporting of Credit Balance Summary Reports and Suspension Listings:

Contractors' quarterly credit balance summary reports and suspension listings should continue to be completed in accordance with existing instructions.

Contractor Controls:

The contractor's Chief Financial Officer for Medicare Operations must ensure that all contractor credit balance reporting related processes and activities are completed timely and accurately. Contractors must have procedures to ensure the timely processing and resolution of all such processes and activities.

Minimum requirements include the following:

1. A designated centralized area to receive credit balance reports.

2. All CMS-838 and accompanying documents, such as adjustment bills, must be retained in the centralized area. The sole exceptions are the originals of the accompanying check and/or an accompanying claim adjustment.

   - A copy of any accompanying check or accompanying claim adjustment must be retained with the other original documents.
   - All other documents must be copied if the information they contain must be furnished to another area for the resolution of any matter related to provider credit balance reporting.
   - The envelope shall be retained to substantiate the date of receipt of the report.
   - Related correspondence must be kept with the appropriate file in this centralized area or readily accessible for any audit if it is not physically maintained in this centralized area. For example, if related Suspension Warning Letters are handled by another area, the centralized area must have sufficient documentation to know whether such a letter was issued,(i.e., when, where, why, etc.), and be able to produce a copy of the actual letter upon request.

3. A designated point of contact for receipt and the resolution of credit balance reporting related issues, including verification that all contractor activities related to credit balance reporting are completed timely, even if such activities are performed in other areas of the contractor.

4. A listing of all providers required to submit a CMS-838, with written procedures, to ensure that this listing is reviewed and updated quarterly.

5. Written policies and procedures for monitoring and validating receipt of a timely and complete CMS-838 from all providers. (Examples: Are all fields on the report complete or has the proper certification been received from a low Medicare utilization provider? Is there an accompanying check and/or appropriate hard copy or electronic adjustment bill?)

6. Appropriate tracking and/or reports for provider credit balances reporting related activities. (For example, the contractor should have appropriate tracking and/or reporting to show that all activities such as related claims adjustments, Suspension Warning Letters and suspensions, verification of low Medicare utilization providers with claims data, demand letters, financial reporting activities, credit balance summary reports, suspension listings, etc., have been performed with respect to the credit balance reports due or received for a given calendar quarter.)

7. A desk guide or manual detailing contractor procedures and internal controls for all credit balance collection and reporting related activities.

Contractor Action if a Credit Balance Report Is Not Submitted:

The contractor must issue a Suspension Warning Letter if it does not receive a credit balance report from a provider within 30 days of the close of each calendar quarter. This letter must be issued within 5 days of the deadline for the report. The Suspension Warning Letter must state that the contractor will suspend all claims payments within 15 calendar days from the date of issuance of the letter if a credit balance report is not received by that date and that the suspension will continue until a credit balance report is received. Medicare regulations at 42 CFR § 405.372 require that the provider be notified of the intention to suspend payment and the reasons for the suspension.

The contractor must ensure that any necessary suspensions are implemented timely and maintained, as appropriate.

NOTE: A provider with extremely low Medicare utilization does not have to submit the CMS-838 form. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, §2414.4.B, or files less than 25 Medicare claims per year.

Recovery Demand Letters/Interest Issues:

Contractors must issue demand letters within 15 calendar days of the due date of the CMS-838 for which payment (by check or adjustment bill) was not made with the submission of the CMS-838. Once a demand letter is issued, an accounts receivable must be established in the contractor's financial reporting system and must be reported on the quarterly forms CMS 750/751 reports.

Interest is assessed in accordance with 42 CFR § 405.378.

The interest specified in the recovery demand letter accrues from the date of the demand letter. The only exception is where the credit balance is a Medicare Secondary Payer (MSP) credit balance. Federal regulations at 42 CFR 489.20(h) state that if the provider receives payment for the same services from Medicare and another payer that is primary to Medicare the provider has 60 days to make repayment to Medicare. For MSP credit balances interest accrues from the later of either the date of the demand letter for the credit balance due or 60 days from the date the provider received the credit balance. If the provider does not specify the date of receipt of the MSP credit balance, accrue interest from the date of the demand letter.

If the provider believes that the repayment of the amount owed Medicare is so large that it will cause financial hardship, a request can be made for an extended repayment schedule in accordance with Medicare Financial Management Manual Chapter 4 §20.

Financial Reporting:

Contractors should follow existing procedures within their Financial Management manual in reporting, tracking and adjudicating this debt.

Credit Balance Reporting Completion Standard and Backlog Issues:

All contractors must notify their Regional Office (RO) regarding whether or not they are current with respect to their credit balance reporting workload. "Current" is defined as meeting the specific time frames set forth in these instructions and the completion of all activities associated with credit balance reporting for a given calendar quarter within 90 days of the due date for the CMS-838 for that quarter.

Contractors are responsible for being able to document that their credit balance workload is current for all quarters from January 1, 1999, forward.

Contractors who are not current must submit a plan for bringing this workload into compliance to their RO within 30 days of the issuance of this PM.

The *effective date* for this PM is August 8, 2003.

The *implementation date* for this PM is August 8, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after August 1, 2004.

If you have any questions, contact Deborah Miller at Dmiller3@cms.hhs.gov.

Attachments

Attachment 1

FORM CMS-838
Medicare Credit Balance Report
Certification Page

MEDICARE CREDIT BALANCE REPORT CERTIFICATION

The Medicare Credit Balance Report is required under the authority of Sections 1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER (S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared
by

______________________________ ______________________________
Provider Name Provider 6-Digit Number

for the calendar quarter ended _____________ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

(Sign) ____
Officer or Administrator of Provider

(Print) ____
Name and Title

(Print) ____
Date

CHECK ONE:
[ ]Qualify as a Low Utilization Provider.
[ ]The Credit Balance Report Detail Page(s) is attached.
[ ]There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached.)

______________________________ ______________________________
Contact Person Telephone Number

FORM APPROVED
OMB NO. 0938-0600 (10/2002)

Attachment 2

Provider Credit Balance Reporting Instructions

General:

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses this information. In accordance with 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. In accordance with these provisions, all providers participating in the Medicare program are to complete a Medicare Credit Balance Report (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Only Medicare credit balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the manual [each provider manual will have the appropriate cite for that manual] that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

Submitting the CMS-838.--Submit a completed CMS-838 to your fiscal intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

Completing the CMS-838.--The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. This page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you have reported. An electronic file (or hard copy) of the detail page is available from your FI.

You may submit the detail page(s) on a diskette furnished by your contractor or by a secure electronic transmission as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE: Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

o The full name of the facility;

o The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;

o The month, day and year of the reporting quarter, e.g., 12/31/*02*;

o An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;

o The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and

o The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1 - The last name and first initial of the Medicare beneficiary, (e.g., Doe, J.).

Column 2 - The Medicare Health Insurance Claim Number (HICN) of the Medicare Beneficiary.

Column 3 - The multi-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

Column 4 - The 3-digit number explaining the type of bill, e.g., 111 -inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions, [each provider manual has the appropriate cite for the manual.])

Columns 5/6 - The month, day and year the beneficiary was admitted and discharged, if an inpatient claim; or "From" and "Through" dates (date service(s) were rendered), if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 1/1/02).

Column 7 - The month, day and year (e.g., 1/1/02) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and ICN number correspond to the most recent payment.

Column 8 - An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)

Column 9 - The amount of the Medicare credit balance that was determined from your patient/accounting records.

Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the CMS-838 to your intermediary.)

Column 11 - A "C" when you submit a check with the CMS-838 to repay the credit balance amount shown in column 9, an "A" if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the CMS-838, and a Z" if payment is being made by a combination of check and adjustment bill with the CMS-838. Use an "X" if an adjustment bill has already been submitted electronically or by hard copy.

Column 12 - The amount of the Medicare credit balance that remains outstanding (column 9 minus column 10). Show a zero if you made full payment with the CMS-838 or a claim adjustment had been submitted previously, including electronically.

Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons". Provide an explanation on the detail page for each credit balance with a "3".

Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability. For code description, see [each provider manual has the appropriate cite for that manual.])

12 - Working Aged
13 - End Stage Renal Disease
14 - Auto/ No Fault
15 - Workers' Compensation
16 - Other Government Program
41 - Black Lung
42 - Department of Veterans Affairs (VA)
43 - Disability
44 - Conditional Payment
47 - Liability

Column 15 - The name and billing address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report.

Payment of Amounts Owed Medicare:.- Providers must pay all amounts owed (column 9 of the report) at the time the credit balance report is submitted. Providers must submit payment, by check or adjustment bill.

- o Payments by check must also be accompanied by a separate adjustment bill, electronic or hard copy, for all individual credit balances that pertain to open cost report periods. The FI will ensure that the monies are not collected twice.
- o Submission of the detail information on the CMS-838 will not be accepted by the FI as an adjustment bill.
- o Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy*)*. If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).
- o There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that "if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare…" the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.
- o If the amount owed Medicare is so large that immediate repayment would cause financial hardship, you may contact your FI regarding an extended repayment schedule.

Records Supporting CMS-838 Data.-Develop and maintain documentation that shows that each patient record with a credit balance (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for preparation of the CMS-838. At a minimum, your procedures should:

- o Identify whether or not the patient is an eligible Medicare beneficiary;
- o Identify other liable insurers and the primary payer;
- o Adhere to applicable Medicare payment rules; and
- o Ensure that the credit balance is due and refundable to Medicare.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

Provider-Based Home Health Agencies (HHAs).-Provider-based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it may be different from the FI servicing the parent facility.

Exception for Low Utilization Providers.-Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, §2414.4.B, or files less than 25 Medicare claims per year.

Compliance with MSP Regulations.-MSP regulations at 42 CFR 489.20(h) require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a CMS-838 and adherence to CMS's instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it in the CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.