

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 99	Date: JUNE 30, 2006
	Change Request 5084

SUBJECT: Instructions for Medicare Credit Balance Reporting Activities.

I. SUMMARY OF CHANGES: This transmittal replaces existing fiscal intermediary (FI) and provider instructions that were previously published in the paper-based manuals and as a Program Memorandum (CR2810) related to provider reporting of Medicare credit balances. The instructions also include revised and new material for the Non-MSP and MSP Medicare credit balance reporting process.

NEW / REVISED MATERIAL

EFFECTIVE DATE: October 2, 2006

IMPLEMENTATION DATE: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N	12/Table of Contents
N	12/10/ Instructions to Fiscal Intermediaries (FIs) for the Medicare Credit Balance Report
N	12/10/.1/ Medicare Credit Balance Report (CMS-838)
N	12/10/.1.1/ FI Internal Controls
N	12/10/.1.2/ Minimum Requirements for Internal Controls
N	12/10.1.3/ Processing CMS-838 Claims Adjustments
N	12/10/.2/Checks Submitted by Providers
N	12/10/.3/Suspension Warning Letter (FI Action if a Credit Balance Report is not Submitted)
N	12/10/.3.1/ Sample Suspension Warning Letter
N	12/10/.4/ Issuance of Notification/Rejection Letter to Providers

	Regarding Non-Payment of Medicare Credit Balances or Missing/Inaccurate Information on the CMS-838 Report
N	12/10/.4.1/ Sample Notification /Reminder Letter
N	12/10/.5/ FI Recovery of Non-MSP/MSP Accounts Receivables and Claims Accounts Receivables
N	12/10/.6/ FI Issuance of a Credit Balance Demand Letter
N	12/10/.7/ Interest Assessment for Non-MSP and MSP Medicare Credit Balances
N	12/10/.8/ Extended Repayment Schedule
N	12/10/.9/ Credit Balance Reporting Completion Standard and Backlog Issues
N	12/10/.10/ Medicare Credit Balance Summary Report
N	12/10/.10.1 Instructions for Completing the Medicare Credit Balance Summary Report
N	12/10/11./Exhibit 3: Medicare Credit Balance Summary Report
N	12/20/ Provider Instructions for the Medicare Credit Balance Report
N	12/20/.1/Submitting the CMS-838
N	12/20/.2/Completing the CMS-838
N	12/20/.3/Payments of Amounts Owed Medicare
N	12/20/.4/ Records Supporting CMS-838 Data
N	12/20/.5/Provider-Based Home Health Agencies (HHAs)
N	12/20/6/Exception for Low Utilization Providers
N	12/20/.7/Compliance with MSP Regulations
N	12/20/.8/ Exhibit I : Medicare Credit Balance Report Certification Page
N	12/20/.9/ Exhibit II: Medicare Credit Balance Report Detail Page

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Manual Instruction Business Requirements

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 99	Date: June 30, 2006	Change Request 5084
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SUBJECT: Instructions for Medicare Credit Balance Reporting Activities.

I. GENERAL INFORMATION

A. Background: This Change Request (CR) informs all Fiscal Intermediaries (FIs) of the implementation on the instructions for the Medicare Credit Balance Reporting Requirements. This CR manualizes the existing contractor instructions that were previously published in the paper based manuals and also as a Program Memorandum (CR2810) related to provider reporting of Medicare credit balances. In accordance with section (§) 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, § 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, providers are to complete a Medicare Credit Balance Report (CMS-838) to ensure that monies owed to Medicare are repaid in a timely manner.

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. They determine the number and amount of these balances for refunding the Medicare program. 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 money due to 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 such as 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 is responsible for identifying and repaying all of the monies from these credit balance accounts to the Medicare program.

The current version of the Medicare Credit Balance Report (Certification Page and Detail Page) and instructions for its completion are available at www.cms.hhs.gov/forms.

B. Policy: 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 sections 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.

Fiscal Intermediaries (FIs) are responsible for monitoring and ensuring provider compliance with the credit balance reporting process. This responsibility includes the following activities: ensure that providers submit properly completed CMS-838 reports on time, claims adjustments to Medicare credit balances are properly made, payments to providers are suspended for untimely submission of CMS-838 reports, demand letters are appropriately issued to providers that have not repaid their Medicare credit balances, and

outstanding Medicare credit balances are included in Medicare financial reports. FIs are charged with the responsibility for performing all necessary activities to implement these instructions. Providers must pay all amounts owed (column 9 of the Detail Page) 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. Submission of the completed Detail Page 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 in paper format). The instructions for column 11 of the Detail Page reflect the type of payment made. 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 FI will ensure that the monies for these balances are not collected twice.)

The FI's Chief Financial Officer for Medicare Operations shall ensure that all FI credit balance reporting related processes and activities are completed timely and accurately.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.1	FIs shall have a designated centralized area to receive Medicare credit balance reports.	X	X							
5084.2	FIs shall have all CMS-838 reports and accompanying documents retained in the centralized area. The sole exceptions are the originals of the accompanying check and/or accompanying claim adjustment bill.	X	X							
5084.2.1	FIs shall retain a copy of any accompanying check or accompanying claim adjustment bills with the other original documents.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.2.2	FIs shall copy all other documents if the information they contain is needed by another area for the resolution of any matter involving provider credit balance reports.	X	X							
5084.2.3	FIs shall retain the envelopes or copy them to validate the receipt date of the CMS-838.	X	X							
5084.2.4	FIs should convert these materials into image files (e.g., PDF files) for electronic storage and archival purposes.	X	X							
5084.2.5	FIs shall provide their projected level of costs and savings from eliminating this paper requirement in FY 2007 to Douglas Nock (Douglas.Nock@cms.hhs.gov) by the end of this review period.	X	X							
5084.2.5.1	FIs shall implement the above requirement(s) if the savings in FY '07 outweigh the costs.									
5084.2.6	FIs should accept faxed credit balance reports that are within 30 calendar days of the close of each calendar quarter as timely filed.	X	X							
5084.3	If FI accepts faxes, they shall ensure these faxes are received over electronically secure transmission lines, and placed in a limited access work area.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.4	FIs shall determine a designated point of contact for receipt and resolution of credit balance reporting related issues. This individual must verify that all FI activities related to credit balance reporting are completed timely and accurately in all areas of the FI. (The designated point of contact shall be determined by the FI.)	X	X							
5084.5	FIs shall have a listing of all providers required to submit the CMS-838. FIs shall have written procedures to ensure this listing is reviewed and updated each calendar year quarter.	X	X							
5084.6	FIs shall have written procedures for monitoring and validating receipt of timely, accurate, and complete CMS-838s from all providers.	X	X							
5084.7	FIs shall have appropriate tracking and/or reports for these provider credit balances reporting related activities.	X	X							
5084.7.1	FIs shall have internal controls in place to ensure the accurate and timely processing and reporting of credit balances.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.8	FIs shall meet the time frame for processing claims adjustments for Medicare credit balances from start to finish is 90 days from the receipt date of acceptable credit balance reports. (Contact your RO if you need additional time.)	X	X							
5084.9	FIs shall establish and maintain a desk guide or manual with published internal control policies and standard operating procedures for implementing the credit balance reporting process.	X	X							
5084.10	The FI shall review the reported credit balances to ensure that the claims were paid and the amounts listed appear to be appropriate.	X	X							
5084.10.1	FIs shall accept electronic or hard copy adjustments bills for repayment of Medicare credit balances from providers.	X	X							
5084.10.2	FIs should decide after the amount of the credit balance has been determined, if an adjustment or a canceled claim is to be performed in FISS to recoup the monies owed.	X	X							
5084.11	FIs should establish and maintain control of all credit balance adjustments and adjustment bills from the time of receiving them.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.12	FIs shall ensure that if a check is submitted by a provider for repayment of Medicare credit balances, that the provider has also submitted a completed CMS-838 report (Detail and Certification Pages) with hardcopy UB-92’s.	X	X							
5084.12.1	FIs shall accept checks when a provider has terminated from the program and is no longer submitting claims.	X	X							
5084.12.2	FIs shall ensure that monies for these credit balances are not collected from the provider twice, when checks are deposited and adjustment bills are processed.	X	X							
5084.13	FIs shall issue a Suspension Warning Letter if it does not receive a credit balance report from a provider by the 15 th calendar day after 30 calendar days from the end of each calendar year quarter.	X	X							
5084.13.1	FIs shall have the Suspension Warning Letter state that the FI will suspend all claims payments at 100% in 15 calendar days from the date of issuance of this letter if the credit balance report is not received during this time period.	X	X							
5084.13.2	FIs shall continue the suspension until receipt of credit balance report.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.13.3	FIs shall ensure that any necessary suspensions are implemented timely and maintained, as appropriate. (Refer to Medicare Financial Management Manual Pub.100-06, Chapter 4, § 40.1, Recoupment by Withholding Payments). Federal regulations at 42 CFR § 405.372 require that the provider be notified of the intention to suspend payment and the reasons for the suspension.	X	X							
5084.14	FIs shall have the responsibility to ensure that if providers change from submitting a low utilization cost report to a full cost report, then they shall comply with all credit balance reporting requirements.	X	X							
5084.15	FIs should use the sample suspension warning letter to notify the provider.	X	X							
5084.16	FIs shall have a process in place to resolve non-payment of Medicare credit balances or missing/inaccurate information on received CMS-838 reports.	X	X							
5084.17	FIs should (at its option) issue a Notification/Rejection letter on the thirtieth-day after the due date of the CMS-838 report, if they are unsuccessful in reaching the provider within 30 calendar days from the due date of the CMS-838 report.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.17.1	FIs shall place the provider on 100% withhold of claims payments on the 15th calendar day from the date of this letter, if the FI sends this letter out. In addition, this letter shall contain the FI’s written intent.	X	X							
5084.17.2	FIs shall issue a demand letter to the provider if a balance remains outstanding 60 days after the due date of the CMS-838 and/or after the Notification/Rejection letter was sent and the provider was placed on 100% withhold up to the total amount owed.	X	X							
5084.18	FIs should use the sample notification letter to notify the provider. (optional)	X	X							
5084.19	FIs shall report any credit balance that has not been recovered and/or the balance remains outstanding on the FI’s financial reporting system and appears in the CMS-751 report.	X	X							
5084.20	FIs shall follow their existing instructions for recovering MSP A/R’s.	X	X							
5084.21	FIs shall issue a demand letter, when a Medicare credit balance is not fully recovered to the Medicare Trust Fund through the adjustment bill process (or through check submission) and this balance remains outstanding 60 days after the due date of the CMS-838.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.21.1	FIs shall issue demand letters within 60 calendar days from the due date of the CMS-838 reports.	X	X							
5084.21.2	FIs shall start the 100% withholding of claims payment on day 16 (if they haven’t already placed providers on 100% from their 1 st Notification/ Rejection letter) if full payment is not received 15 days after the date of the first demand letter.	X	X							
5084.21.3	FIs shall follow the existing instructions in the Medicare Financial Management Manual Pub. 100-06, Chapter 4, §§ 10 and 20 if no response is received from the provider within 30 days after the date of the first demand letter.	X	X							
5084.21.4	FIs shall allow the provider to submit a request for an extended repayment schedule in accordance with the Medicare Financial Management Manual, Pub. 100-06, Chapter 4, § 50 if the provider believes that prompt repayment of the amount owed Medicare is so large that it will cause financial hardship.	X	X							
5084.21.5	FIs shall contact their Regional Office (RO) for guidance on specific provider issues as needed.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.21.6	FIs should refer to the Medicare Financial Management Manual, Pub. 100-06, Chapter 3 § 40.2 for sample Demand Letter for Claims Accounts Receivables. For MSP, refer to Pub. 100-05, Chapter 7, § 60.10.1 “Intent to Refer” letter.	X	X							
5084.22	FIs shall continue to assess interest under the former method on Non-MSP debts established prior to October 1, 2004 until the debt is recovered in full. Refer to the Medicare Financial Management Manual, Pub. 100-06, Chapter 4, § 30.3 Non-MSP (Debt Collection).	X	X							
5084.22.1	FIs shall follow the existing instructions for debts prior to October 1, 2004 for assessment of interest on MSP Credit Balances. Refer to Pub. 100-05, Chapter 7, revised § 30.1.5- Interest on MSP Recovery Claims.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.22.2	FIs shall follow this rule: MSP recovery demand letters involving a credit balance there is an exception to the general rule that interest accrues from the date of the recovery demand letter. 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.	X	X							
5084.23	FIs shall allow providers to request an extended repayment schedule in accordance with the Medicare Financial Management Manual, Pub. 100-06, Chapter 4, § 50 if, at the time of submitting the CMS-838 report, the provider believes that the repayment of the amount owed Medicare is so large that it will cause financial hardship,	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.24	FIs shall notify their 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 year quarter which is 90 calendar year days after the receipt of acceptable CMS-838s for that quarter.	X	X							
5084.24.1	FIs shall be responsible for documenting the “current status” of their credit balance workload for all quarters from January 1, 1999 to date.	X	X							
5084.24.2	FIs shall submit a plan to their RO for bringing their “non-current” credit balance workloads into compliance within 30 days of the issuance of this manual instruction.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.25	FIs shall prepare their summary reports in Excel (an electronic file of this report is available from Central Office (CO) by e-mail to: CMS_SCBR@cms.hhs.gov), and to include their five digit FI number in the file name (i.e., CBSFI#####.xls). In addition, FIs shall complete the “Prepared/Approved by:” section at the bottom of their reports.	X	X							
5084.25.1	FIs shall submit their Medicare credit balance summary reports to CO via e-mail (CMS_SCBR@cms.hhs.gov) no later than 45 days after provider credit balance reports are due.	X	X							
5084.26	FIs shall follow these instructions: No. of Providers Required to Submit CMS Form 838 for This Quarter-- Show the total number of providers, by type of provider, which were required to submit a credit balance report for the reporting quarter. Do not include low utilization providers or any other providers that were not required to submit a credit balance report.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.26.1	FIs shall follow instruction: No. of Providers With Submission of CMS Form 838 for This Quarter -- Show the total number of providers, by type of provider that submitted a credit balance report for the reporting quarter.	X	X							
5084.26.2	FIs shall follow instruction: Number of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter -- Count the number of identified Medicare credit balance amounts that were reported, by type of provider, from column 9 of the provider’s CMS-838 Detail Page for this quarter.	X	X							
5084.26.3	FIs shall follow instruction: Amount of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter -- Show the total amount of identified Medicare credit balance amounts that were reported, by type of provider, from column 9 of the provider’s CMS-838 Detail Page for this quarter.	X	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.37	Providers shall be required to report a MSP credit balance, if this credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, in the credit balance report. However, payment of the credit balance does not have to be made at the time they submit the CMS-838, but within the 60 days allowed.									X
5084.38	Providers shall continue to use the Medicare Credit Balance Report Certification Page.									X
5084.39	Providers shall continue to use the Medicare Credit Balance Report Detail Page.									X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5084.40	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLNMatters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within	X	X							X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN-Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date: October 2, 2006</p> <p>Implementation Date: October 2, 2006</p> <p>Pre-Implementation Contact(s): Debbie Miller (Deborah.Miller3@cms.hhs.gov)</p> <p>Post-Implementation Contact(s): Debbie Miller (Deborah.Miller3@cms.hhs.gov) @ 410-786-0331 or Milt Jacobson (Milton.Jacobson@cms.hhs.gov) @ 410-786-7553</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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Attachment

Contacts for Credit Balance Reporting

Regional & Contractors	Contact Expert	Non-MSP/MSP	Address	Phone #	Fax #	Email
Region I Boston	Ceci Garber	Non-MSP & MSP	JFK Federal Bld Government Center Rm 2375 Boston, MA 02203	617-565-1690	617-565-3856	Ceci.garber@cms.hhs.gov
	Sedric Goutier backup	Non-MSP & MSP	JFK Federal Bld. Government Center, Rm 2375 Boston, MA 02203	617-565-1228	617-565-3856	sedric.goutier@cms.hhs.gov
Contractors						
Associated Hospital Service 180/181	Charlie Gold Manager, Medicare Claims	Non-MSP	AHS 1515 Hancock Street Quincy, MA 02169	617-689-2630	617-689-2609	charlie.gold@anthem.com
Anthem Health Plans 270	Charlie Gold, Manager, Medicare Claims	Non-MSP	AHS 1515 Hancock Street Quincy, MA 02169	617-689-2630	617-689-2609	charlie.gold@anthem.com
Region II New York	Shantella Jackson Financial Controls Branch/Divison of Medicare Financial Management	Non-MSP	US HHS/CMS 26 Federal Plaza, Rm. 38-130 New York, NY 10278	(212) 616-2507	(212) 264-3503	Shantella.Jackson@cms.hhs.gov
	Contractors					
Empire	Jean Brooks	Non-MSP/MSP	Medicare Credit Balance Dept, 400 south Salina st Syracuse NY 13202	(315) 442-4087	315-442-4256	jean.brooks@empireblue.com
COSVI	Louise Cummings	Non-MSP/MSP	Medicare Credit Balance Dept, 400 south Salina st Syracuse NY 13202	315-442-4505		
Region III Philadelphia	Kenneth Thompson	Non-MSP	Suite 216 The Public Ledger Building 150 S. Independence Mall West Phila., PA 19106	215-861-4784	215-861-4254	Kenneth.Thompson@cms.hhs.gov
	Contractors					
Highmark Medicare Services	Terry Ligday	Non-MSP	Highmark Medicare Services 1800 Center Street Camp Hill, PA 17089-0089	412-544-3649	412-544-1971	terry.ligday@veritusmedicare.com

Region IV Atlanta	Cherie Weatherington	Non-MSP	Financial Management Branch 61 Forsyth Street SW, 4T20 Atlanta, Georgia 30303-8909	(404) 562-7319	(404) 562-7350	Cherie.weatherington@cms.hhs.gov
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Contractors

Cahaba GBA - Alabama (BCBS of Alabama - 00010)	Brian Fisher	Non-MSP	Cahaba GBA 400 E Court Ave. DeMoines, IA 50309-2017	(515) 471-7263		
First Coast Service Options Florida (00090)	Tammie Beyerlein	Non-MSP	First Coast Service Options Medicare Part A 532 Riverside Ave. 16T Jacksonville, FL 32202	(904) 791-6687	(904) 357-6097	Tammie.Beyerlein@fcsso.com
Blue Cross Blue Shield of Georgia (00101)	Tina Moss	MSP Claims	Blue Cross Blue Shield of GA 2357 Warm Springs Road P.O. Box 9048 Columbus, GA 31908-9048	(706) 571-5038	(706) 571-5431	Tmoss@bcbsga.com
TriSpan Health Services Mississippi (00230)	Greg Eiler	MSP Claims	TriSpan Health Services 1064 Flynt Drive Flowood, MS 39232-9570 OR TriSpan Health Services P.O Box 23046 Jackson, MS 39225-3046	(601) 664-4563	(601) 939-9791	JGEiler@trispn.com
Palmetto Government Benefits Administrator (GBA) South Carolina (00380)	Mark Robertson	Non-MSP	Palmetto GBA 17 Technology Circle Columbia, SC 29203-9511	(803) 382-6285	(803) 763-7777	Mark.Robertson@palmettogba.com
Riverbend Government Benefits Administrator (GBA) Tennessee (00390)	Kelly Scoggins	Non-MSP	Riverbend GBA 730 Chestnut Street Chattanooga, TN 37402-1790	(423) 752-8373	(423) 763-3651	Kelly_Scoggins@bcbst.com Underscore after Kelly

Region V Chicago	Ha Nguyen	Non-MSP	Fiscal Integrity Branch 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519	(312) 353-9372	(312) 353-9474	Ha.Nguyen@cms.hhs.gov
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			Fiscal Integrity Branch 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519	(312) 886-2749	(312) 353-9474	Paul.Sobocinski@cms.hhs.gov
Paul Sobocinski, Manager	Non-MSP		MSP Dept 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519			
Nancy Zahn	MSP			(312) 353-0592		Nancy.Zahn@cms.hhs.gov

Contractors

			P.O. Box 145482 Cincinnati, Ohio 45203 or 801 A West 8th Street Cincinnati, Ohio 45250-5482	(513) 852-4236	(513) 419-3622	diana.feldman-smith@anthem.com
AdminaStar Federal A&R Associates	Diana Feldman-Smith	Manager				
		Non-MSP				

<http://www.adminastar.com/Providers/Intermediary/AuditAndReimbursement/ARCreditBalance.html>

Illinois and Indiana	Andy Bard Sr Fin Ops Consultant	Non-MSP	AdminaStar Federal PO Box 35190 Louisville, KY 40233-5190	(502)423-2624	(502) 329-8544	andy.bard@anthem.com
	Mirek Wlodowski Fin Ops Specialist	Sr Non-MSP	Medicare Audit and Reimbursement Attn: Mirek Wlodowski P.O. Box 812904 Chicago, IL 60681-2904 or Overnight Delivery 225 N. Michigan Avenue, 22nd Floor, Chicago, IL 60601	(312) 297-4557	(312) 297-4596	mirek.wlodowski@anthem.com
Kentucky	Jennell Thorpe, Fin Ops Specialist	Sr Non-MSP	Medicare Audit and Reimbursement Attn: Jennell Thorpe P. O. Box 35190 Louisville, KY 40233-5190 or Overnight Delivery 9901 Linn Station Road Louisville, Kentucky	(502) 423-2188	(502) 329-8544	jennell.thorpe@anthem.com
Ohio WI/MI/VA/CA UGS -Management	Sonja Schute Fin Ops Specialist	Sr Non-MSP	AdminaStar Federal, Inc. Attn:Sonja Schute 801 A West 8th Street Cincinnati, Ohio 45203 or overnight at P.O. Box 145482 Cincinnati, Ohio 45250-5482	(513) 852-4275	(513) 419-3622	sonja.schute@anthem.com
	Heather LeBeau Accounting	Provider Non-MSP		(414) 226-5959	(414) 226-5959	heather.lebeau@ugswlp.com
	Bertha Anthony - Claims	Non-MSP		(414) 226-6254		bertha.anthony@ugswlp.com
	Operations- Michael Scholz Accounting Technicians involved in the logging in of reports process	Non-MSP	UGS Provider Accounting 6775 W Washington St Milwaukee, WI 53214	(414) 226-2880	(414) 226-6006	michael.scholz@ugswlp.com
Debra Napoleon	Non-MSP	UGS 6775 W Washington St Milwaukee, WI 53214	(414) 226-5757	(414) 226-6006	debra.napoleon@ugswlp.com	

	JoAnn Richards	Non-MSP	UGS 6775 W Washington St Milwaukee, WI 53214	(414) 226-5694	(414) 226-6006	Joann.richards@ugswlp.com
	David Runyon	Non-MSP	UGS 6775 W Washington St Milwaukee, WI 53214	(414) 226-2889	(414) 226-2889	david.runyon@ugswlp.com
	Professional involved in interest assessment and collection					
	Jared Griep	Non-MSP	UGS 6775 W Washington St Milwaukee, WI 53214	414-226-2833	414-226-6007	jared.griep@ugswlp.com
	Manager Lawrence Bankston	Non-MSP		(502) - 329-8574	(502)339-5463	

**Region VI
Dallas**

	Ronda L. Jones, Accountant	Non-MSP	1301 Young Street, Room #833 Dallas, TX 75202	214-767-6464	214-767-4440	Ronda.Jones@cms.hhs.gov
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Contractors

**TrailBlazer Health
Enterprises, LLC**

	Brenita Powell (CFO Reporting/Credit Balance Manager)	Non-MSP	TrailBlazer Health Enterprises, LLC, Provider Audit & Reimbursement, 8330 LBJ Freeway, Dallas, TX 75243	469-372-6496	469-372-0611	Brenita.Powell@TrailBlazerHealth.com
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**Chisholm Administrative
Services**

	Mary Jo Stulz (Credit Balance Reporting)	Non-MSP	Chisholm Administrative Services, Medicare Part A, 1215 South Boulder, P. O. Box 3404, Tulsa, OK 74101-3404	918-560-2114	918-560-3506	Mstulz@ChisholmAdmin.com
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**Pinnacle Business
Solutions, Inc.**

	Darlene Rhodes (Credit Balance Reporting)	Non-MSP	Pinnacle Business Solutions, Inc., Medicare Part A, P. O. Box 1418, Little Rock, AR 72203-1418	501-210-9044	501-210-9137	LDRhodes@PinnacleBSI.com
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**Region VII
Kansas City**

	LeAnn Robinson (overpayments)	Non-MSP	Richard Bolling Fed Bldg 601 East 12th St., Rm 235 Kansas City MO 64106	816-426-6397	816-235-7336	LeAnnRobinson@cms.hhs.gov
	Wayne Smetana (CFO)	Non-MSP	Richard Bolling Fed Bldg 601 East 12th St., Rm 235 Kansas City MO 64106	816-426-6562	816-2357337	WayneSmetana@cms.hhs.gov

	Jim Frisbie Audit Reimbursement	Non-MSP	Richard Bolling Fed Bldg 601 East 12th St., Rm 235 Kansas City MO 64107	816-426-6389	816-426-6389	JimFrisbie@cms.hhs.gov
	John Phelps (CFO)	Non-MSP	Richard Bolling Fed Bldg 601 East 12th St., Rm 235 Kansas City MO 64106	816-426-6392	816-235-7335	JohnPhelps@cms.hhs.gov
	Phil Chiarelli (ARA)	Non-MSP	Richard Bolling Fed Bldg 601 East 12th St., Rm 235 Kansas City MO 64106	816-426-6407	816-426-3760	PhillipChiarelli@cms.hhs.gov

Contractors

Kansas Blue Cross	Chris Lewis	Non-MSP	Kansas BC/BS 1133 Topeka Blvd. P.O. Box 3543 Topeka, KS 66601	785-291-4428	785-291-4834	Chris.Lewis@bcbsks.com
	Rick Morris (Man.)	Non-MSP	Kansas BC/BS 1133 Topeka Blvd. P.O. Box 3543 Topeka, KS 66601	785-291-4432	785-291-4834	Rick.Morris@bcbsks.com
Mutual of Omaha	Robin Millsap	Non-MSP	Mutual of Omaha P.O. Box 1602 Omaha, NE 68101	402-351-8522	402-351-3521	robin.millsap@mutualofomaha.com
	Marlina Tooker	Non-MSP	Mutual of Omaha P.O. Box 1602 Omaha, NE 68101	402-351-4382	402-351-3521	marlina.tooker@mutualofomaha.com
	Denise DeWitt (Supervisor)	Non-MSP	Mutual of Omaha P.O. Box 1602 Omaha, NE 68101	402-351-6070	402-351-1401	denise.dewitt@mutualofomaha.com
	Kris.Martin (Manager)	Non-MSP	Mutual of Omaha P.O. Box 1602 Omaha, NE 68101	402-351-8973	402-351-1401	kris.martin@mutualofomaha.com
Cahaba GBA	Sandy Larson	Non-MSP	Cahaba GBA 400 East Court Avenue Suite 200 Des Moines, IA 50309	515-471-7565	515-471-7477	slarson@cahabagba.com
	Therese Johnson	Non-MSP	Cahaba GBA 400 East Court Avenue Suite 200 Des Moines, IA 50309	(515) 471-7526	(515) 471-7477	theresejohnson@cahabagba.com
	Pam Anderson (Reim. Manager)	Non-MSP	Cahaba GBA 400 East Court Avenue Suite 200 Des Moines, IA 50309	(515) 471-7463	(515) 471-7477	panderson@cahabagba.com
Nebraska Blue Cross	Matthew Pleggenkuhle (Reim. Manager)	Non-MSP	Nebraska BC P.O. Box 24563 Omaha, NE 68124-0563	(402) 548-4385	(402) 548-4385	matthew.pleggenkuhle@bcbsne.com

Region VIII Denver	Margot Warren	Non-MSP	1600 Broadway, Suite 700 Denver, CO 80202	(303) 844-2124	(303) 844-3753	margaret.warren@cms.hhs.gov
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Contractors

Noridian	Julie Ness, Credit Balance Reporting	Non-MSP	901 40th Street South, Suite 1 Fargo, ND 58103-2146	(701) 277-6903	(701) 277-6572	Julie.Ness@noridian.com
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Blue Cross Blue Shield of Wyoming	Catheryne Gerber, Credit Balance Reporting	Non-MSP	P.O. Box 908 Cheyenne, WY 82003-0908	(307) 432-2847	(307) 432-2901	Catheryne.gerber@bcbswyc.com
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Blue Cross Blue Shield of Montana	Sandi Arrotta, Credit Balance Reporting	Non-MSP	3360 Tenth Ave. South P.O. Box 5017 Great Falls, MT 59403-5017	(406) 791-4107	(406) 791-4159	Sandi_Arrotta@bcbsmt.com
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United Gov't Services (UGS)	Rosa Helena Bezada, Provider Audit & Accounting	Non-MSP	5151-B Camino Ruiz Bldg. G Camarillo, CA 93012-8646	805-367-0709		
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Blue Cross/Blue Shield of Arizona, (BCAZ)	Sarah Annis, Provider Audit & Reimbursements	Non-MSP	2331 West Royal Palm Rd Suite 115 Phoenix, AZ 85069-7700		602-864-4163	
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National Heritage Insurance Co. (NHIC)	Margarita Navas Overpayment Recovery Section	Non-MSP	1055 7th Street Suite 500 Los Angeles, CA 90017	213-593-6097	213-593-5915	
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National Heritage Insurance Co. (NHIC),	Kathy Riddle Overpayment Recovery Section	Non-MSP	620 J Street Marysville, CA 95901	530-630-7427	530-634-7530	
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Region XI Seattle	Nancy Shioyama	Non-MSP	MS RX-46, 2201 Sixth Avenue, Seattle, WA 98121	(206) 615-2381	(206) 615-3804	Nancy.Shioyama@cms.hhs.gov
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Contractors

Noridian Administrative Services (00320, 00322)	Jim Olson (Audit Manager)	Non-MSP	901 40th St. S., Suite 1, Fargo, North Dakota 58108	(701) 277-2298	(701) 277-6556	Jim.Olson@noridian.com
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Noridian Administrative Services (00325 after 5/1/06)	Jade Huey (Team Leader)	Non-MSP	P. O. Box 6726, Fargo, North Dakota 58108	(503) 944-8832	(503) 944-8814	Jade.Huey@noridian.com
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Brenita Powell (CFO
Reporting/Credit Balance
Manager)

TrailBlazer Health
Enterprises, LLC, Provider
Audit & Reimbursement,
8330 LBJ Freeway, Dallas,
TX 75243

Medicare Financial Management Manual

Chapter 12

Instructions for Medicare Credit Balance Report Activities

Table of Contents

(Rev. 99, 06-30-06)

10- Instructions to Fiscal Intermediaries (FIs) for the Medicare Credit Balance Report

10.1- Medicare Credit Balance Report (CMS-838)

10.1.1- FI Internal Controls

10.1.2- Minimum Requirements for Internal Controls

10.1.3- Processing CMS-838 Claims Adjustments

10.2- Checks Submitted by Providers

10.3- Suspension Warning Letter (FI Action if a Credit Balance Report is not Submitted)

10.3.1- Sample Suspension Warning Letter

10.4- Issuance of Notification/Rejection Letter to Providers Regarding Non-Payment of Medicare Credit Balances or Missing/Inaccurate Information on the CMS-838 Report

10.4.1- Sample Notification/Rejection Letter

10.5- FI Recovery of Non-MSP/MSP Accounts Receivables and Claims Accounts Receivables

10.6- FI Issuance of a Credit Balance Demand Letter

10.7- Interest Assessment for Non-MSP and MSP Medicare Credit Balances

10.8- Extended Repayment Schedule

10.9- Credit Balance Reporting Completion Standard and Backlog Issues

10.10- Medicare Credit Balance Summary Report

10.10.1- Instructions for Completing the Medicare Credit Balance Summary Report

10.11- Exhibit 3: Medicare Credit Balance Summary Report

20- Provider Instructions for the Medicare Credit Balance Report

20.1- Submitting the CMS-838

20.2- Completing the CMS-838

20.3- Payments of Amounts Owed Medicare

20.4- Records Supporting CMS-838 Data

20.5- Provider-Based Home Health Agencies (HHAs)

20.6- Exception for Low Utilization Providers

20.7- Compliance with MSP Regulations

20.8- Exhibit I: Medicare Credit Balance Report Certification Page

20.9- Exhibit II: Medicare Credit Balance Report Detail Page

10- Instructions to Fiscal Intermediaries (FIs) for the Medicare Credit Balance Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

General

In accordance with section (§) 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, § 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, providers are to complete a Medicare Credit Balance Report (CMS-838) to ensure that monies owed to Medicare are repaid in a timely manner.*

Fiscal intermediaries (FIs) are responsible for monitoring and ensuring provider compliance with the credit balance reporting process. This responsibility includes the following activities: ensure that providers submit properly completed CMS-838 reports on time, claims adjustments to Medicare credit balances are properly made, payments to providers are suspended for untimely submission of CMS-838 reports, demand letters are appropriately issued to providers that have not repaid their Medicare credit balances, and outstanding Medicare credit balances are included in Medicare financial reports.

10.1- Medicare Credit Balance Report (CMS-838)

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. They determine the number and amount of these balances for refunding the Medicare program. 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 money due to 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 such as 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 is responsible for identifying and repaying all of the monies from these credit balance accounts to the Medicare program.

The current version of the Medicare Credit Balance Report (Certification Page and Detail Page) and instructions for its completion are available at www.cms.hhs.gov/forms. This report is identified as CMS Form 838 on the CMS web site, and a replica of this form is in section 20 of this chapter.

FIs are charged with the responsibility for performing all necessary activities to implement these instructions.

Providers must pay all amounts owed (column 9 of the Detail Page) 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.

- Submission of the completed Detail Page 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 Detail Page reflect the type of payment made.
- If the credit balances are repaid by check, the provider must still submit adjustment bills for any individual credit balances. (The FI will ensure that the monies for these balances are not collected twice.)

10.1.1- FI Internal Controls

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

The FI's Chief Financial Officer for Medicare Operations shall ensure that all FI credit balance reporting related processes and activities are completed timely and accurately.

10.1.2- Minimum Requirements for Internal Controls

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

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

B. *FIs shall have all CMS-838 reports and accompanying documents retained in the centralized area. The sole exceptions are the originals of the accompanying check and/or accompanying claim adjustment bill.*

- A copy of any accompanying check or accompanying claim adjustment bills must be retained with the other original documents.
- All other documents must be copied if the information they contain is needed by another area for the resolution of any matter involving provider credit balance reports.
- *The envelopes shall be retained or copied to substantiate the date of receipt of the CMS-838 report.*

Note: *FIs may convert these materials into image files (e.g., PDF files) for electronic storage and archival purposes.*

C. *Faxed credit balance reports that are within 30 calendar days of the close of each calendar quarter should be accepted as timely.*

- *Retain the coversheet to substantiate the date of receipt of the CMS-838 report.*

Note: When the FI accepts faxes, the FI shall ensure that these faxes are received over electronically secure transmission lines, and placed in a limited access work area.

D. The FI shall designate a point of contact for receipt and the resolution of credit balance reporting related issues. This individual is to verify that all FI activities related to credit balance reporting are completed timely and accurately in all areas of the FI.

E. The FI shall have a listing of all providers required for submitting the CMS-838. FIs shall have written procedures to ensure this listing is reviewed and updated each calendar year quarter.

F. Written policies and procedures for monitoring and validating receipt of timely, accurate, and complete CMS-838s from all providers.

For example:

- Is the name and title of the certifying officer or administrator of the provider on the Certification Page, and are all data fields completed for Medicare credit balances on the Detail Page? Did the Detail Page come with an accompanying check and/or appropriate hard copy or electronic adjustment bills?
- Were the monies for the reported credit balances timely recouped to the Medicare Trust Fund?

G. FIs shall have appropriate tracking and/or reports for provider credit balances reporting related activities.

For example:

- Such as related claims adjustments, Suspension Warning Letters and suspensions, verification of low Medicare utilization providers with claims data, demand letters, financial reporting, credit balance summary reports, etc., that have been performed with respect to credit balance reports due or received for a given calendar year quarter.

H. The FI shall have internal controls in place to ensure the accurate and timely processing and reporting of credit balances.

- *The time frame for processing claims adjustments for Medicare credit balances from start to finish is 90 days from the receipt date of acceptable credit balance reports. (Contact your RO if you need additional time.)*

I. A desk guide or manual with published internal control policies and standard operating procedures for implementing the credit balance reporting process.

10.1.3-Processing CMS-838 Claims Adjustments

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. *The FI shall review the reported credit balances to ensure that the claims were paid by Medicare and the amounts listed appear to be appropriate.*

- *The FI shall accept electronic or hard copy adjustment bills for repayment of Medicare credit balances from providers.*
- *Based on the FI's review of the credit balance, the FI should decide to do an adjustment or perform a canceled claim in FISS/HIGLAS to recoup the monies owed.*

For example:

1. *Canceling-out the claim if the claim is entirely incorrect, a duplicate payment, a wrong HIC number, or if the Medicare credit balance resulted from an outpatient claim; or*
2. *Establish a claims adjustment if part of the claim needs modification and the remainder of the claim is correct; or*
3. *Perform a claims recoupment by withholding claim amounts from future Medicare claims. These withheld amounts are to be included in remittance advices to providers.*

B. *Establish and maintain control of all adjustments and adjustment bills from the time you receive them.*

10.2-Checks Submitted by Providers

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

If a check is submitted by a provider for repayment of Medicare credit balances, the provider must also submit a complete CMS-838 report (Detail and Certification Pages) with hardcopy UB-92's.

- *A check is necessary when a provider has terminated from the program and is no longer submitting claims.*
- *When checks are deposited and adjustment bills are processed, the FI shall ensure that monies for these credit balances are not collected from the provider twice.*

10.3-Suspension Warning Letter (FI Action if a Credit Balance Report is not Submitted)

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. *The FI shall issue a Suspension Warning Letter if it does not receive a credit balance report from a provider by the 15th calendar day after 30 calendar days from the end of each calendar year quarter (45 calendar days from the end of each calendar year quarter).*

- *The Suspension Warning Letter shall state that the FI will suspend all claims payments at 100% in 15 calendar days from the date of issuance of this letter if the credit balance report is not received during this time period.*
- *This suspension will continue until the FI receives a credit balance report.*

- The FI shall ensure that any necessary suspensions are implemented timely and maintained, as appropriate. (Refer to Pub.100-06, Chapter 4, § § 40 - 40.2). In addition, Federal regulations at 42 CFR § 405.372 require that the provider be notified of the intention to suspend payment and the reasons for the suspension.

B. The FI shall have the responsibility to ensure that if providers change from submitting a low utilization cost report to a full cost report, then they shall comply with all credit balance reporting requirements.

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 or files less than 25 Medicare claims per year.

10.3.1 – Sample Suspension Warning Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

*This is a sample suspension warning letter, which the FIs may use to notify the provider.
(Optional)*

Exhibit 1 - Sample Suspension Warning Letter

Date:

[Name], [Job Title]

[Company Name], [Provider Number]

[Address]

[City], [State] [Zip]

***RE: Past Due Quarterly Credit Balance Report
Suspension Warning Letter***

Quarter Ended: _____

Dear [Title] [Last Name]:

The Medicare Credit Balance Report, CMS-838, for the quarter ending _____ was due on _____. Our records show the Medicare Credit Balance Report for the quarter is overdue.

Since we have not received your report, this letter is notification that, fifteen (15) days from the above date of this correspondence, Medicare will implement a 100% withholding of your payments until the Credit Balance Report is received.

If you have any questions regarding this matter, please contact _____ at (____) _____.

Sincerely,

[Name]

[Title]

10.4- Issuance of a Notification/Rejection Letter to Providers Regarding Non-Payment of Medicare Credit Balances or Missing/Inaccurate Information on the CMS-838 Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. The FI shall have a process in place to resolve non-payment of Medicare credit balances or missing/ inaccurate information on received CMS-838 reports.

For example:

- Review each credit balance entry individually on the CMS-838 report to determine whether it is missing information such as: is it being repaid by check or hardcopy adjustment bill?*
- Contacting the provider via telephone, to obtain missing information on the CMS-838 report. (Phone calls should be documented).*
- If the FI is successful at reaching the provider, the provider may fax over the requested information at the FI's discretion.*

B. If the FI is unsuccessful in reaching the provider within 30 calendar days from the due date of the CMS-838 report, the FI should issue a letter on the thirtieth-day after the due date of the CMS-838 report.

- This letter shall state that the FI will place the provider on 100% withhold up to the total amount owed if the provider does not send a check or adjustment bills for these balances in **15 calendar days** from the date of this letter.*
- After the Notification/Rejection letter has been sent and the provider is placed on 100% withhold up to the total amount owed and a balance remains outstanding 60 days after the due date of the CMS-838, the FI must issue a demand letter to the provider. Refer to Section 10.6- FI Issuance of a Credit Balance Demand Letter.*

10.4.1- Sample Notification/Rejection Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

This is a sample notification letter, which FIs may use to notify the provider.

(Optional)

Exhibit 2 – Notification/Rejection Letter

Date:

[Name], [Job]

[Company Name], [Provider Number]

[Address]

[City], [State], [Zip]

RE: Notification/Rejection Letter

Quarter Ended: _____

Dear [Title], [Last Name]:

During our review of your submitted Medicare Credit Balance Report (CMS-838) Detail Page for the quarter ending _____, we noted that _____ was not included with your report.

In accordance with published Centers for Medicare and Medicaid Services (CMS) manual instructions, your office must include an adjustment bill for each reported credit balance listed in column 9 of the Detail Page. You should refer to your Provider Instructions for a detailed description of the published guidelines, or visit us on our website, www._____.com.

We must receive \$_____ for your payment of reported credit balances within fifteen (15) days from the date of this letter. If we do not receive a check and/or hard copy adjustment bills (UB-92 claim form) or electronic adjustment bills for these balances within 15 days from the date of this letter, your facility will be placed on one-hundred percent (100%) withhold up to the total amount owed to recoup the above liability on day 16.

Make sure to include your Medicare Provider Number on your check. Your check should be mailed to the following address: _____

If you have any questions related to this letter, please call me at (999) 123-4567.

Sincerely,

[Name]

[Title]

10.5- FI Recovery of Non-MSP/MSP Accounts Receivables and Claims Accounts Receivables

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

A. Non-MSP Accounts Receivables (A/R) -

- *When the credit balance adjustments are entered in the FI's claims processing system, they will remain in the system until the amounts for these adjustments are recouped.*
- *These adjustments are normally recovered through the recoupment of future claims, and they are included in remittance advices to providers. If the credit balance has not been recovered, the balance remains outstanding in the FI's financial reporting system and appears in the CMS-751 report.*

Note: Refer to Pub. 100-06, chapter 4, § 40

B. Non-MSP Claims AR's

The established A/R is included in the FI's balances of new receivables for Medicare credit balances, and these balances appear in Line 2a of the CMS-751. (Pub. 100-06, Chapter 5, § 270.2)

Note: Follow your existing instructions for recovering MSP A/R's.

10.6- FI Issuance of a Credit Balance Demand Letter

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

When a Medicare credit balance is not fully recovered to the Medicare Trust Fund through the adjustment bill process (or through check submission) and this balance remains outstanding 60 days after the due date of the CMS-838, the FI shall issue a demand letter to the provider.

- *The FI shall issue demand letters within 60 calendar days from the due date of the CMS-838 report.*
- *If a full payment is not received 15 days after the date of the first demand letter, the FI shall start the 100% withholding of claims payment up to the total amount owed on day 16, (if they haven't already placed providers on 100% from their 1st Notification/Rejection letter)*

Refer to Pub. 100-06, Chapter 4, §§ 40 and 40.1.

- *If no response is received from the provider within 30 days after the date of the first demand letter, follow the existing instructions in Pub. 100-06, Chapter 4, §§ 10 and 20.*
- *If the provider believes that prompt repayment of the amount owed Medicare is so large that it will cause financial hardship, the provider may complete a request for an extended repayment schedule in accordance with Pub. 100-06, Chapter 4, § 50.*
- *Contact your Regional Office (RO) for guidance on specific provider issues as needed.*

Refer to Pub. 100-06, Chapter 3, § 40.2 for sample Demand Letter for Claims Accounts Receivables. For MSP, refer to Pub. 100-05, Chapter 7, § 60.10.1 “Intent to Refer” letter.

10.7- Interest Assessment for Non-MSP and MSP Medicare Credit Balances (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Calculation of Interest on Medicare Credit Balances

Effective October 1, 2004, 42 CFR § 405.378 and 411.24 (m) (1) was amended to change how interest is calculated on Non-MSP/MSP recoveries. Section 1862(b)(2)(B)(i) of the Act provides express authority to assess interest on MSP debts. Under this new rule, interest is assessed for each full 30-day period that payment is not made on time. This change applies to debts established on or after October 1, 2004.

A. Assessment of Interest on Non-MSP Credit Balances

Interest on Non-MSP debts established prior to October 1, 2004 will continue to be assessed under the former method, until the debt is recovered in full.

Note: *Refer to Pub. 100-06, Chapter 4, § 30.3 – Non-MSP (Debt Collection).*

B. Assessment of Interest on MSP Credit Balances

Refer to Pub. 100-05, Chapter 7, revised § 30.1.5- “Interest on MSP Recovery Claims” for information on the calculation of interest.

For MSP recovery demand letters involving credit balances, there is an exception to the general rule that interest accrues from the date of the recovery demand letter. 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.

10.8- Extended Repayment Schedule (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

If, at the time of submitting the CMS-838 report, 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 Pub. 100-06, Chapter 4, § 50.

10.9- Credit Balance Reporting Completion Standard and Backlog Issues (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

All FIs shall notify their 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 year quarter which is 90 calendar year days after the receipt date of acceptable CMS-838s for that quarter.

- FIs are responsible for documenting the “current status” of their credit balance workloads for all quarters from January 1, 1999 to date.
- Those FIs who do not have “current” credit balance workloads must submit a plan to their RO for bringing their workloads into compliance within 30 days of the issuance of this manual instruction.

10.10- Medicare Credit Balance Summary Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

- FIs shall prepare their summary reports in Excel (an electronic file of this report is available from Central Office (CO) by e-mail to: CMS_SCBR@cms.hhs.gov), and to include their five digit FI number in the file name (i.e., CBSFI#####.xls). In addition, FIs shall complete the “Prepared/Approved by:” section at the bottom of their reports.
- See Exhibit 3 below for a sample Medicare Credit Balance Summary Report.
- FIs shall submit their Medicare credit balance summary reports to CO via e-mail (CMS_SCBR@cms.hhs.gov) no later than 45 days after provider credit balance reports are due.

10.10.1- Instructions for Completing the Medicare Credit Balance Summary Report

(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Below are FI instructions for completion of the Medicare Credit Balance Summary Report.

Credit Balance Activities by Type of Provider for This Quarter

No. of Providers Required to Submit CMS Form 838 for This Quarter-- Show the total number of providers, by type of provider, which were required to submit a credit balance report for the reporting quarter. Do not include low utilization providers or any other providers that were not required to submit a credit balance report.

No. of Providers With Submission of CMS Form 838 for This Quarter-- Show the total number of providers, by type of provider, that submitted a credit balance report for the reporting quarter.

Number of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter-- Count the number of identified Medicare credit balance amounts that were reported, by type of provider, from column 9 of the provider’s CMS-838 Detail Page for this quarter.

Amount of Identified Medicare Credit Balances by Provider on CMS Form 838 For This Quarter-- Show the total amount of identified Medicare credit balances that were reported, by type of provider, from column 9 of the provider's CMS-838 Detail Page for this quarter.

Total - Sum all columns.

10.11- Exhibit 3: MEDICARE CREDIT BALANCE SUMMARY REPORT
(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Fiscal Intermediary: (Name and Number)

Quarter Ended: _____

Credit Balance Activities by Type of Provider for This Quarter

Type of Provider	No. of Providers Required to Submit CMS Form 838 For This Quarter	No. of Providers That Submitted CMS Form 838 For This Quarter	Number of Identified Medicare Credit Balances on CMS Form 838 For This Quarter	Amount of Identified Medicare Credit Balances on CMS Form 838 For This Quarter
Hospital	-----	-----	-----	\$-----
SNF	-----	-----	-----	-----
HHA	-----	-----	-----	-----
ESRD	-----	-----	-----	-----
Other	-----	-----	-----	-----
TOTAL	=====	=====	=====	\$=====

Note: See the next page for a sample of a completed summary report.

Prepared by: _____ Date Prepared: _____

Approved by: _____ Date Approved: _____

Exhibit 3 (Continued)

SAMPLE REPORT

MEDICARE CREDIT BALANCE SUMMARY REPORT

Fiscal Intermediary: Blue Cross Blue Shield of XXXXXXXX 00xxx
Quarter Ended: 9/30/2004

Credit Balance Activities by Type of Provider for this Quarter:

Type of Provider	No. of Providers Required to Submit CMS Form 838 For This Quarter	No. of Providers That Submitted a CMS Form 838 For This Quarter	Number of Identified Medicare Credit Balances on CMS Form 838 For This Quarter	Amount of Identified Medicare Credit Balances on CMS Form 838 For This Quarter
Hospital	300	257	1,348	\$643,278
SNF	278	215	288	86,441
HHA	0	0	0	0
ESRD	21	21	0	0
Other	<u>34</u>	<u>33</u>	<u>15</u>	<u>3,065</u>
TOTAL	<u>633</u>	<u>526</u>	<u>1,651</u>	<u>\$732,784</u>

Prepared by: _____ Date Prepared: _____

Approved by: _____ Date Approved: _____

20- Provider Instructions for Medicare Credit Balance Report ***(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)***

General

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses the information. In accordance with sections 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" due to Medicare. A credit balance is an improper or excess payment made to a provider as the 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 to Medicare.

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 applicable provider manual that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

20.1- Submitting the CMS-838 ***(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)***

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.

20.2- Completing the CMS-838 ***(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)***

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 the CMS web site (e.g., www.cms.hhs.gov/forms) or 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 also available from the CMS web site or your FI.

You may submit the detail page(s) on a diskette/CD or by secure electronic transmission to your FI 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:

- The full name of the facility;
- 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);
- The month, day and year of the reporting quarter, e.g., 12/31/02;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- 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
- 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 multiple-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 section(s) for the Uniform Billing instructions in the applicable provider 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 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 FI.)
- Column 11- Choose one of the following:
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;
A "Z" if payment is being made by a combination of check and hard copy adjustment bill with the CMS-838; or
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 ("0") if you made full payment with the CMS-838 or a claim adjustment has been submitted and has been fully processed to recoup the Credit Balance.
- 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 the code applicable to the payer with the largest liability. For code description, see the section(s) in the applicable provider manual for the listed codes.)

- 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.

20.3- Payments of Amounts Owed Medicare (Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

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

- Payments by check must also be accompanied by a **separate** adjustment bill for all individual credit balances. The FI will ensure that the monies are not collected twice.
- Submission of credit balance information on the CMS-838 detail page will not be accepted by the FI as a substitute for adjustment bills.
- 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).
- 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.
- 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.

20.4- Records Supporting CMS-838 Data *(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)*

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 the preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether the patient is an eligible Medicare beneficiary;
- Identify other liable insurers and the primary payer;
- Adhere to applicable Medicare payment rules; and
- 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.

20.5- Provider-Based Home Health Agencies (HHAs) *(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)*

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.

20.6- Exception for Low Utilization Providers *(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)*

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, section 2414.4.B, or files less than 25 Medicare claims per year.

20.7- Compliance with MSP Regulations *(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)*

Federal regulations at 42 CFR 489.20(h) requires 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 the 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 on 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 the 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.

20.8- Exhibit I: Medicare Credit Balance Report Certification Page
(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

**MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE**

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 OMITTS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

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

20.9- Exhibit II: Medicare Credit Balance Report Detail Page
(Rev. 99, Issued: 06-30-06; Effective/Implementation Dates: 10-02-06)

Department of Health & Human Services
 Centers for Medicare & Medicaid Services

Form Approved
 OMB No. 0938-0600

**Medicare Credit Balance Report
 Detail Page**

Provider Name: _____

Page _____ of _____

Provider Number: _____

Contact Person: _____

Quarter Ending: _____

Phone Number (_____) _____ - _____

Medicare Part: _____ (Indicate "A" or "B")

(1) Beneficiary Name	(2) HIC Number	(3) ICN Number	(4) Type of Bill	(5) Admission Date (MM/DD/YY)	(6) Discharge Date (MM/DD/YY)	(7) Paid Date (MM/DD/YY)	(8) Cost Report (Open/Closed)	(9) Amount of Medicare Credit Balance	(10) Amount of Medicare Credit Balance Repaid	(11) Method of Payment	(12) Amount of Medicare Credit Balance Outstanding	(13) Reason for Medicare Credit Balance	(14) Value Code	(15) Primary Payer (Name & Billing Address)