CMS Manual System

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

Pub. 100-08 Medicare Program Integrity

Transmittal 96 **Date: JANUARY 14, 2005**

CHANGE REQUEST 3626

SUBJECT: Consent Settlements

I. SUMMARY OF CHANGES: Changes were made to the consent settlement instructions in the PIM based on MMA §935(a)(5).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: February 14, 2005
IMPLEMENTATION DATE: February 14, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/3.6.1/Postpayment Review Case Selection
R	3/3.6.2/Location of Postpayment Reviews
R	3/3.6.3/Re-adjudication of Claims
R	3/3.6.4/Calculation of the Correct Payment Amount and Subsequent Over/Underpayment
R	3/3.6.5/Notification of Provider(s) or Supplier(s) and Beneficiaries of the Postpayment Review Results
R	3/3.6.6/Provider(s) or Supplier(s) Rebuttal(s) of Findings
R	3/3.6.8/Evaluation of the Effectiveness of Postpayment Review and Next Steps
N	3/3.8.3.3/Consent Settlement Instructions
N	3/3.8.3.3.1/Background on Consent Settlement
N	3/3.8.3.3.2/Opportunity to Submit Additional Information Before Consent Settlement Offer
N	3/3.8.3.3.3/Consent Settlement Offer
N	3/3.8.3.3.4/Option 1 – Election to Proceed to Statistical Sampling for Overpayment Estimation
N	3/3.8.3.3.5/Option 2 – Acceptance of Consent Settlement Offer
N	3/3.8.3.3.6/Consent Settlement Budget and Performance Requirements for Medicare Contractors

D	4/4.15/Consent Settlement Instructions
D	4/4.15.1/Consent Settlement Budget and Performance Requirements for Medicare Contractors
R	Exhibit 15/Consent Settlement Documents

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 96	Date: January 14, 2005	Change Request 3626

SUBJECT: Consent Settlements

I. GENERAL INFORMATION

A. Background: Changes were made to the consent settlement instructions in the PIM based on MMA §935(a)(5). Also, supplier(s) was added after provider(s) throughout the consent settlement sections.

B. Policy: N/A

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
		FI	PSC	RHHI	Carrier	DMERC	Shared System Maintainers				Other
							FISS	MCS	VMS	CWF	
3626.1	To perform provider or supplier site reviews, all reviewers must present photo identification cards indicating their affiliation with the Medicare contractor to the provider staff and other reviewers on site.	X	X	X	X	X					
3626.2	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, section 935(a)(5) state the provider has the opportunity to submit additional information before being offered a consent settlement. Based on a postpayment review of the medical records, the contractor shall communicate in writing to the provider or supplier the information stated in PIM chapter 3, §3.8.3.3.2.	X	X	X	X	X					
3626.3	PSCs and Medicare contractor BI units shall not offer consent settlements without first requesting approval from the Chief Financial Officer of the Centers for Medicare & Medicaid	X	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)									
		FI	PSC	RHHI	Carrier	DMERC	Shared System Maintainers				Other
							FISS	MCS	VMS	CWF	
	Services. This request shall be emailed to the attention of the CFO/Director of the Office of Financial Management at dbil@cms.hhs.gov										
3626.4	If after 45 days it is determined that there is still an overpayment, then the provider or supplier shall receive a consent settlement offer. If an overpayment was not established, then a follow-up letter shall be sent to the provider or supplier stating that no additional action is deemed necessary.	X	X	X	X	X					
3626.5	After the additional information concerning the medical records for the claims reviewed have been assessed and if it is still determined that there was an overpayment, the contractor shall offer the provider or supplier the opportunity to proceed with statistical sampling for overpayment estimation or a consent settlement.	X	X	X	X	X					
3626.6	The consent settlement correspondence shall describe the two options available to the provider or supplier.	X	X	X	X	X					
3626.7	The provider or supplier is given 60 days from the date of the correspondence to choose an option. If there is no response, Option 1 shall be selected by default.	X	X	X	X	X					

III. 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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 14, 2005 Implementation Date: February 14, 2005 Pre-Implementation Contact(s): Elizabeth Aragona, earagona@cms.hhs.gov Post-Implementation Contact(s): Elizabeth Aragona, earagona@cms.hhs.gov	Medicare contractors shall implement these instructions within their current operating budgets.

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

Medicare Program Integrity Manual
Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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3.6.1 - Postpayment Review Case Selection

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

Postpayment reviews are usually conducted on providers *or suppliers*, whether individuals or groups, who have demonstrated aberrant billing and/or practice patterns. However, some postpay reviews (e.g., widespread Error Validation reviews) may involve multiple providers *or suppliers*.

Contractors must use all available relevant information when selecting postpayment review cases. (See PIM, chapter 3, section 3.2 for Verifying Potential Errors and Setting Priorities.)

There are three types of postpayment reviews:

- Error Validation reviews (see PIM, chapter 3, section 3.2 for more information about Error Validation reviews);
- Statistical Sampling for Overpayment Estimation reviews (see PIM, chapter 3, sections 3.10.1 through 3.10.5 and 3.10.9 through 3.10.11); and
- Consent Settlement reviews (see PIM, chapter 3, section 3.8.3.3).

NOTE: In the process of selecting providers *or suppliers* for postpay review, MR staff should review the*ir* provider tracking system (PTS) and consult with the *PSC or Medicare contractor or* BI unit to ensure duplicate efforts are not being undertaken. (See PIM, chapter 3, section 3.1.2

A. Identifying Providers *or Suppliers* for Error Validation Reviews

PIM, chapter 3, section 3.2 describes the requirements regarding which providers *or suppliers* should be selected for error validation (probe) review.

B. Identifying Providers *or Suppliers* for Statistical Sampling for Overpayment Estimation Reviews

The first step in conducting a statistical sampling review is the identification of all services under review from the provider *or supplier* or group of providers *or suppliers* for the specified time period (this is termed the "universe") followed by selection of a sample of these claims. Contractors work with their statistical staff and follow all statistical sampling guidelines in PIM, chapter 3, sections 3.10.1 through 3.10.5 and 3.10.9 through 3.10.11.

Case selection is based on profiling providers *or suppliers* who have generated one or more assigned claims during the period under review. Generally contractors should not perform postpay review of unassigned claims. Intermediaries use provider *or supplier*

numbers and carriers use UPINs for physicians and individual PINs for non-physicians. DMERCs should use the NSC issued supplier numbers. As with physician UPINs and PINs, it may be appropriate to analyze suppliers by their six-digit base number and their 10-digit (six-digit base plus four-digit) location ID number. It may be necessary to conduct sub-studies of locality practices for physicians using their PINs because physicians with one UPIN may have different practices with multiple PINs. Their patterns of practice may vary across different locations (e.g., hospital-based, office-based, SNF-based), especially when physicians designate different specialties for their different PINs.

C. Identify Overpayment for Consent Settlement

At a minimum, select fifteen (15) claims as a sample from a three (3) to six (6) month period to *identify* the overpayment. Project this sample of claims to the universe where the problem is occurring.

3.6.2 - Location of Postpayment Reviews

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

Contractors must decide whether to conduct the postpay review at the provider *or supplier* site or at the contractor site. Considerations in determining whether to conduct a provider *or supplier* site review are:

- The extent of aberrant patterns identified in their focused review program; (See PIM, chapter 3, section 3.2.);
- The past failure of a provider *or supplier* to submit appropriate and timely medical records; and
- Contractor resources.

A. Contractor Site Reviews

The contractor notifies the provider(s) *or supplier(s)* that they have 30 calendar days from the date of the letter to provide the medical record or other requested documentation. (See PIM Exhibit 7.2 for a sample letter.) Contractors have the discretion to grant an extension of the timeframes upon request.

If the information requested is not received within 45 days, the contractor shall review the claims with the information on hand. Contractors must complete the review and notify the provider *or supplier* in writing of their findings within 60 calendar days from

the start of the review, or receipt of medical records, whichever is later. If the contractor needs more than 60 calendar days, they must request an extension from the RO (for PSCs, the GTL, Co-GTL, and SME).

B. Provider *or Supplier* Site Reviews

Contractors determine what, if any, advance notification of a scheduled review is given to a provider *or supplier*. The contractor may give advance notice when a provider *or supplier* has satellite offices from which medical records will have to be retrieved. When giving advance notice, the contractor must include an explanation of why the review is being conducted.

The list of claims requiring medical records may be included with the advance notice or at the time of the visit at the discretion of the contractor.

Contractors may conduct team reviews when potential problems exist in multiple areas. The team may consist of MR, audit, BI, State surveyors, provider enrollment or Medicaid staff depending on the issues identified. A*t* a minimum, before conducting provider *or supplier* site reviews, consult and share information with other internal and external staff as appropriate to determine if there are issues that the reviewers should be aware of or if a team review is needed.

Annually, contractors must instruct providers *or suppliers* (via bulletin article, Web article, etc.) that any Medicare contractor staff person who visits the provider site must show a photo identification indicating their affiliation with the Medicare contractor*. To perform provider or supplier site reviews, all reviewers must present photo identification cards indicating their affiliation with the Medicare contractor to the provider staff and other reviewers on site.*

During provider site reviews, reviewers shall photocopy pertinent medical records when services are denied, when a physician or other medical consultation is needed, or when it appears that records have been altered. Contractors shall retain these records for appeals or BI purposes.

Reviewers shall hold entrance and exit interviews with appropriate provider *or supplier* staff. A provider *or supplier* representative can also be present while claims are reviewed. Reviewers must answer any questions the provider *or supplier* staff may have.

During entrance interviews, reviewers explain the following:

- Scope and purpose of the review;
- Why postpayment review is being conducted;
- The list of claims that require medical records;
- How recumbent of overpayment is made if claims are denied;

- Answer any questions related to the review; and
- Notify the provider *or supplier* of their rebuttal rights. (See PIM, chapter 3, section 3.6.6.)

During exit conferences, the contractor shall discuss the findings of the review. The provider *or supplier* must be allowed an opportunity to discuss or comment on the claims decisions.

3.6.3 - Re-adjudication of Claims

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

For each claim in the sample, contractors re-adjudicate claims by making a coverage, limitation of liability and/or coding determination in accordance with PIM, chapter 3, section *3.*4.1. Contractors must document all items/services incorrectly paid, denied or under coded (e.g., billed using a HCPCS or other code that is lower than what is supported by the medical record). They report services newly denied as a result of re-adjudication as positive values and they report services that were denied but are reinstated as a result of re-adjudication as negative values. Contractors document the amount of the over/underpayment and how it was determined. Intermediaries must do this in conjunction with Audit/Reimbursement staff. (See PIM, chapter 3, section 3.8.4.) Contractors must assure that their documentation is clear and concise and includes the basis for revisions in each case (this is important for provider appeals). They include copies of the NCD, coverage provision in interpretive manual or LMRP*/LCD* and any applicable references needed to support individual case determinations. Compliance with these requirements facilitates adherence to the provider *or supplier* notification requirements in PIM, chapter 3, section 3.6.5.

3.6.4 - Calculation of the Correct Payment Amount and Subsequent Over/Underpayment

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to two types of postpayment reviews (statistical sampling for overpayment estimation reviews, and consent settlement reviews).

The results of the re-adjudication within the sampling units are used to determine the total overpayment amount for each provider *or supplier* under review. MR shall refer to instructions in PIM Chapter 3, §3.10 and to Exhibits 9, 10, 11 and 12 for projection methodologies based on provider types for claims where PPS was not in effect. For

claims paid under PPS rules, contractors should develop projection methodologies in conjunction with their statistician that are consistent with the requirements found in PIM, chapter 3, section 3.10. Contractors must net out the dollar amount of charges underbilled.

Amounts of the following overpayments are to be included in each provider's *or supplier's* estimate of overpayments for the sample:

- Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 of the Act apply and the provider *or supplier* is liable for the overpayment because: (1) the provider *or supplier* knew or could reasonably have been expected to know that items or services were excluded from coverage, and (2) the provider *or supplier* was not without fault for the overpayment under §1870 of the Act.
- Initially paid claims which are denied on re-adjudication, and for which the provisions of §1879 do not apply, but the provider *or supplier* is liable because it is determined to be not without fault for the overpayment under §1870 of the Act.
- Initially denied claims which are found to be payable on readjudication (in whole or in part). Such claims should be included to reduce the amount of the overpayment sample. For appeal purposes, overpayment estimations will be separately identified for denials in which §1879 of the Act is applied, and denials in which §1879 of the Act does not apply. Where both types of denials occur in the sample, contractors calculate and document separate under/overpayments for the two types of denials. For recovery purposes, however, both denial results are combined.

3.6.5 – Notification of Provider(s) *or Supplier(s)* and Beneficiaries of the Postpayment Review Results

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

A. Provider *or Supplier* Notification

Contractor MR staff must prepare a letter to notify each provider *or supplier* of the results of the postpayment review. These letters may (but are not required to) contain a demand for repayment of any overpayments they may have made. Some contractors may wish to have another department issue the actual demand letter. Contractors must notify the provider(s) that the postpayment review has been completed even in those instances where no corrective actions or overpayments are involved.

Contractors must send the Notification of Postpayment Review Results to each provider *or supplier* within 60 days of the exit conference (for provider *or supplier* site reviews) or receipt of medical records (for contractor site reviews). If the contractors need more than 60 days, they are to contact their RO (for PSCs, the GTL, Co-GTL, and SME) for an extension. Each letter must include:

- Identification of the provider(s) *or supplier(s)*--name, address, and provider *or supplier* number;
- The reason for conducting the review;
- A narrative description of the overpayment situation: state the specific issues involved which created the overpayment and any pertinent issues as well as any recommended corrective actions the provider should consider taking;
- The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded; A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied, the amounts which will not be recovered from the provider *or supplier*, under/overpayment amounts and the §§1879 and 1870 determinations made for each specific claim;
- For statistical sampling for overpayment estimation reviews, any information required by PIM, chapter 3, section 3.10.4.4;
- Total underpayment amounts;
- Total overpayment amounts for which the provider *or supplier* is responsible;
- Total overpayment amounts for which the provider *or supplier* is not responsible because the provider *or supplier* was found to be without fault;
- Intermediaries must include an explanation that subsequent adjustments may be made at cost settlement to reflect final settled costs;
- An explanation of the provider's *or supplier's* right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6);
- An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's *or supplier's* right to request an extended repayment schedule;
- The provider *or supplier* appeal rights; and
- A discussion of any additional corrective actions or follow-up activity the contractor is planning (i.e., prepayment review, re-review in 6 months).

Contractors may send the final notification letter by certified mail and return receipt requested.

Sample letters are in PIM Exhibit 7.3 with attachment Exhibit 7.3.1 and the Part B sample letter is Exhibit 7.4 with attachment Exhibit 7.4.1. Contractors may adapt the language used under each heading to the particular situation they are addressing.

B. Beneficiary Notification

Contractors must also notify each beneficiary when re-adjudication of the claim results in a change to the initial determination. This can be done via an MSN or individual letter. In the case where a sample of claims is extrapolated to the universe, only those beneficiaries in the sample need to be notified.

3.6.6 - Provider(s) *or Supplier(s)* Rebuttal(s) of Findings

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

A. Provider(s) *or Supplier(s)* Timeframes for Submitting Rebuttal Statements

Within 15 calendar days of notification of the results, each provider *or supplier* may submit a rebuttal statement in accordance with 42 CFR 405.374. The rebuttal statement and any accompanying evidence must be submitted within 15 calendar days from the date of the notification letter described in section 3.6.5 unless MR or Audit/Reimbursement (A/R) staff find cause otherwise to extend or shorten the time afforded for submission of the statement.

B. Contractor Review of Rebuttal Statement(s)

Audit/Reimbursement staff should consider all of the evidence concerning the provider's *or supplier's* financial obligation timely submitted to reach a determination regarding whether recoupment should be delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the notification letter in order to review and respond to the rebuttal statement even if the principal of the debt is modified after reviewing the rebuttal statement. (See 42 CFR 405.375(a).)

Prior to recoupment of overpayments, providers *or* suppliers have a right to submit a rebuttal statement in accordance with 42 CFR 405.370-375. The rebuttal statement and any accompanying evidence must be submitted within 15 days from the date of the notification letter unless Audit/Reimbursement staff find cause otherwise to extend or shorten the time afforded for submission of the statement. The provider's *or supplier's*

rebuttal statement should address why the recovery should not be put into effect on the date specified in the notification letter. *Audit/Reimbursement* staff should consider all of the evidence timely submitted to reach a determination regarding whether the recoupment should be delayed. However, recovery of any overpayment will not be delayed beyond the date indicated in the CMR notification letter in order to review and respond to the rebuttal statement. (See 42 CFR 405.375(a).)

Substantive evidence that MR claims determinations were incorrect *shall* not be considered during the rebuttal process unless such evidence relates to the timing of the recoupment of the overpayment.

C. Cost Report Issues

Because of the cost report relationship to the overpayment, it is important to note that the projected overpayment recovered from a provider *or supplier* as a result of a postpayment review using statistical sampling for overpayment estimation is based on the interim payment rate in effect at the time of the review.

3.6.8 – Evaluation of the Effectiveness of Postpayment Review and Next Steps

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

This section applies to all three types of postpayment reviews (error validation reviews, statistical sampling for overpayment estimation reviews, and consent settlement reviews).

Contractors must determine if any other corrective actions are necessary such as:

- In cases where the MR unit uncovers potential fraud in the course of its postpayment review activities, the MR unit shall refer these cases to the Medicare contractor BI unit or the PSC. If it is believed that the overpayment has been caused by fraud, do not request a refund until the fraud issue is resolved (see PIM, chapter 3, section 3.8).
- Initiate provider *or supplier* specific edit to focus prepayment review on the problem provider *or supplier* or group of providers *or suppliers* (see PIM, chapter 3, section 3.5.1) if appropriate;
- Work with the RO (for PSCs, the GTL, Co-GTL, and SME) to suspend payment to the provider or group of providers (see PIM, chapter 3, section 3.9);
- Refer provider certification issues to the State survey agency through the RO (for PSCs, the GTL, Co-GTL, and SME) staff.
- Refer quality issues involving inpatient hospital services, if any, to the QIO;
- Coordinate with the QIO and carrier/intermediary on interrelated billing problems;

Contractors perform a follow-up analysis of the provider(s) *or supplier(s)* periodically for as long as necessary to determine if further corrective actions are required. In some cases, it may be feasible and timely to perform the follow-up analysis of the provider *or supplier* after the 3 month time period. Contractors must continue monitoring the provider *or supplier* or group of providers *or suppliers* until there is a referral to the Medicare contractor BI unit or the PSC, there is evidence that the utilization problem is corrected, or data analysis indicates resources would be better utilized elsewhere.

3.8.3.3 - Consent Settlement Instructions

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

3.8.3.3.1 – Background on Consent Settlement

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 defines consent settlement as an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved. PSCs and Medicare contractor BI units shall not offer a consent settlement without first requesting approval from the CMS CO Chief Financial Officer. This request shall be e-mailed to the attention of the CFO/Director of the Office of Financial Management at dbil@cms.hhs.gov. Consent settlement documents carefully explain, in a neutral tone, what rights a provider waives by accepting a consent settlement. The documents shall also explain in a neutral tone the consequences of not accepting a consent settlement. A key feature of a consent settlement is a binding statement that the provider agrees to waive any rights to appeal the decision regarding the potential overpayment. The consent settlement agreement shall carefully explain this, to ensure that the provider is knowingly and intentionally agreeing to a waiver of rights. Consent settlement correspondence shall contain:

- *A complete explanation of the review and the review findings*
- *A thorough discussion of §1879 and §1870 determinations, where applicable*
- *The consequences of deciding to accept or decline the consent settlement offer*

It is rare that a PSC or Medicare contractor BI unit will offer and develop a consent settlement. However, when the PSC offers and develops a consent settlement, the AC shall administer the settlement. When the Medicare contractor BI unit offers and develops a consent settlement, the appropriate Medicare contractor unit shall administer the settlement.

3.8.3.3.2– Opportunity to Submit Additional Information Before Consent Settlement Offer

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, section 935(a)(5) states the provider has the opportunity to submit additional information before being offered a consent settlement. Based on a postpayment review of the medical records, the contractor shall communicate in writing to the provider or supplier that:

- *The preliminary evaluation of the records indicates there would be an overpayment;*
- *The nature of the problems in the billing and practice patterns identified in the evaluation;*
- *The steps that the provider or supplier can take to address the problems; and*
- *The provider or supplier has forty-five (45) days to furnish additional information concerning the medical records for the claims that have been reviewed.*

If after forty-five (45) days, it is determined that there is still an overpayment, then the provider or supplier shall receive a consent settlement offer. If an overpayment is not warranted after additional review, then a follow-up letter shall be sent to the provider or supplier stating that no additional action is deemed necessary.

3.8.3.3.3 – Consent Settlement Offer

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

After the additional information concerning the medical records for the claims reviewed have been assessed and if it is still determined that there was an overpayment, the contractor shall offer the provider or supplier the opportunity to proceed with statistical sampling for overpayment estimation or a consent settlement. The PSCs and Medicare contractor BI units may choose to present the consent settlement letter to the provider or supplier in a face-to-face meeting. The consent settlement correspondence shall describe the two options available to the provider or supplier. The provider or supplier is given 60 days from the date of the correspondence to choose an option. If there is no response, Option 1 shall be selected by default.

3.8.3.3.4 – Option 1 - Election to Proceed to Statistical Sampling for Overpayment Estimation

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

If a provider or supplier fails to respond, this option shall be selected by default. For providers or suppliers who select this option knowingly or by default, thereby rejecting the consent settlement offer and retaining their full appeal rights, PSCs and Medicare contractor BI units shall;

- *Notify the provider or supplier of the actual overpayment and refer to overpayment recoupment staff; and*

- *Initiate* statistical sampling for overpayment estimation *of the provider's or supplier's claims for the service under review following instructions in the Program Integrity Manual, chapter 3, §3.10*

If the review results in a decision to recoup the overpayment, the overpayment collection shall be initiated within 12 months of the decision.

3.8.3.3.5 – Option 2 - Acceptance of Consent Settlement Offer

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

A provider or supplier accepting Option 2 waives any appeal rights with respect to the alleged overpayment. Providers or suppliers selecting Option 2 that have any additional claims shall not be audited for the service under review within the same time period.

Model language for the consent settlement documents can be found in PIM Exhibit 15.

3.8.3.3.6 - ***Consent Settlement Budget and Performance Requirements for Medicare Contractors***

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

In preparation for the BI BPR requirements, Medicare contractors who have not transitioned BI work to a PSC shall keep a record of the number of consent settlements offered and accepted, and the number of times that statistical sampling for overpayment estimation is used. These workload numbers shall be reported each fiscal year. (For example, BI develops a case and it is not accepted by law enforcement. BI should perform an overpayment estimation and offer the provider a consent settlement or statistical sampling for overpayment estimation.) BI shall track this information and record the counts in the Miscellaneous field for Activity Code 23007.) ACs shall report these costs in the PSC support activity code 23201.

Exhibit 15 - Consent Settlement Documents

(Rev. 96, Issued: 01-14-05, Effective: 02-14-05, Implementation: 02-14-05)

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires several letters to be sent to providers or suppliers regarding consent settlement. Contractors shall send to the provider or supplier a request for additional information letter, a consent settlement offer letter, and a no action letter if an overpayment was not found or if an overpayment was found, a letter requesting the moneys owed.

A. First Letter in the Consent Settlement Process: Opportunity to Submit Additional Information Before Consent Settlement Offer Notification

Before a consent settlement is offered, contractors must communicate in writing to the provider or supplier that they have the opportunity to submit additional information. This document shall:

- *Explain there may be an overpayment due to an initial evaluation of the records;*
- *Highlight the nature of the problems in the provider's or supplier's billing and practice patterns identified as a result of the preliminary audit;*
- *Give steps the provider or supplier can take to address the problems; and*
- *Identify the forty-five (45) day time frame to furnish this additional information.*

List the following information in the heading of the letter:

- *Date of notice;*
- *Name of provider;*
- *Address; and*
- *City, state, and zip code.*

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842 of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers

of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

Based on our preliminary evaluation of your medical records on__________,_ (Fill in date) we have found an indication of a potential overpayment. The purpose of this letter is to describe the nature of the problems identified in our evaluation, the steps that you should take to address these problems, and give you the time frame to furnish additional information concerning the medical records for the claims being reviewed.

During our initial evaluation, we have ascertained the following issues,
(List the problems found.)

To resolve these issues and to determine that there is an overpayment, the following are the steps you may take:
(List action that can be taken to resolve the problems.)

You have forty-five (45) days from the receipt of this letter, ____to submit any additional information concerning the medical records for the claims being reviewed in this evaluation.   Send this information to _________. If you have any questions, please contact me at______.

***B.	Second Letter in the Consent Settlement Process: Consent Settlement Offer***

Consent settlement documents must closely conform to the content of the model language provided below. The consent settlement documents shall explain:

- *The responsibility of CMS in conducting audits of providers or suppliers to ensure that Medicare Part B claims have been billed and paid appropriately;*
- *The date of the initial request for records prior to conducting the audit;*
- *The steps involved in the audit process;*
- *The problems in the provider's or supplier's billing and practice patterns identified as a result of the audit;*
- *To notify the provider or supplier of the potential overpayment calculated as a result of the audit; and*
- *Two options available to the provider or supplier.*

NOTE: *The Consent Settlement Documents shall include information regarding statistical sampling for overpayment estimation. Refer to §3.10 of the Program Integrity Manual (PIM) for instructions for the use of statistical sampling for overpayment estimation.*

List the following information in the heading of the letter:

- *Date of notice;*
- *Name of provider;*
- *Address; and*
- *City, state, and zip code.*

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

Under Section 1842(a)(1)(C) of the Social Security Act, carriers under contract to the Centers for Medicare & Medicaid Services are authorized to "make audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." We are responsible for conducting audits of providers to ensure that Medicare Part B claims have been billed and paid appropriately.

*On __________________, [**Fill-in date of initial request for records prior to conducting audit**.] you received a notification letter stating that you had the opportunity to submit additional information to us after our preliminary evaluation of your records indicated a potential overpayment. On __________________, [**Fill-in date of initial request for records prior to conducting audit**.] you also received our request for records to conduct an audit of your practice. The purpose of this letter and attachments is to describe the steps involved in the audit process, to highlight problems in your billing and practice patterns identified as a result of our audit, to notify you of the potential overpayment calculated as a result of our audit, and to outline two options available to you.*

Our normal full-scale audit process entails the review of records using statistical sampling for overpayment estimation. However, in the interest of economy and expediency for both you and the Medicare program, as a first step, we elected to perform a limited audit. We reviewed claims and medical records for services rendered to beneficiaries over a period of time, from____________to____________. While__________beneficiaries were randomly selected for our sample from a larger universe of beneficiaries for whom you provided services, it is not done based on our instructions for conducting statistical sampling for overpayment estimation.

*You were chosen for an audit because______________________ [**Fill-in the reason for the audit. The reason may be exceeding peer norms or a call from a beneficiary. For example, if the provider exceeded peer norms the contractor might want to use the following language: "You were chosen for an audit because our records indicate you exceeded the average utilization rates of your peers by______% for the same time period. Your specialty is listed as__________________. The peer group consisted of__________ who billed for the same procedure(s)."**] We selected the ____________ beneficiaries by identifying the procedure codes where your billing exceeded the norm for your peers. Included in the universe are only those beneficiaries*

*for whom you rendered and billed at least one of these procedure codes that was paid by Medicare during the review period. From this universe of beneficiaries, a computer is used to randomly select the beneficiaries to be included in the sample. All claims for the procedure codes at issue that were rendered to the sampled beneficiaries and paid within the _______ time period were audited. [**This sentence may be modified depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is stated, all claims would have to actually been paid within the time period. Whichever method is used, you must be consistent.**] The list of sampled beneficiaries, dates of service, and procedure codes is contained in the attachment to this letter.*

*The beneficiaries included in our audit resulted in claims being paid by Medicare between_____________________. [**See note in preceding paragraph. Similar rewording may be required here.**] These claims and their corresponding medical records were audited, resulting in a potential overpayment of $__________including an actual overpayment of $___________for the________ beneficiaries. Item 3 under "Audit Results" explains how we calculated the potential overpayment. Please review the attached documents containing the audit results and options along with an explanation of the Extended Repayment Plan.*

We must have your response to this letter within sixty (60) days from the date of this letter,____________ If we do not receive a response from you by_______________ , statistical sampling for overpayment estimation will be chosen for you by default (see attached discussion of audit results). Be advised that by signing this letter your legal options may be affected. Please also be advised that repayment of the overpayment specified herein in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. You may wish to have legal counsel review this letter before signing it. If you have any questions, please contact me –

at_______________________________.

Sincerely,

Attachments

C. Consent Settlement Attachment 1 Audit Results

IDENTIFYING INFORMATION

List the following information in the heading of the attachment:

- *Date;*
- *Provider Name;*
- *Provider Address; and*

- *Provider Number.*

SCOPE OF AUDIT

*This audit covers services that were paid by Medicare from____________________to____________________. **[Modify this sentence depending upon whether the audit used the date of service or the date of payment for selecting claims. As it is currently stated, all claims would have to have been acutally paid within the time period. Whichever method is used, you must be consistent.]***

The audit revealed the following problems in your billing and practice patterns:

ISSUES/DETERMINATIONS

*A physician reviewer, specializing in **__________________________ [You are required to have a medical specialist involved in the review of the sample claims that are not based on application of clearly articulated existing MR policy. Fill-in the specialty here.]** was consulted during the audit process. The following claims and submitted records of determinations were used in the review.*

[This area lists the problem areas noted above, such as exceeding peer norms and medical necessity/documentation concerns. Additionally, each of the sampled beneficiaries, dates of services, procedure codes, and the Medical Director's determination on each denied service is noted here. Attach newsletters discussing medical policy and documentation requirements for the problem areas found during the audit.]

[This is also the area where you explain the §1879 and §1870 determinations, perhaps using, in part, the following language:

For §1879: "Based on available information, we believe you knew or should have known that..."

For§1870: "We have made the determination that you were not "without fault" in causing the overpayment. Therefore, we are not waiving your obligation to repay. We cannot find you without fault because..."

Rationale for the §1879 and/or §1870 findings might include all or part of the following language:]

"The management of a medical or supplier practice that includes a large number of Medicare beneficiaries must understand the conditions governing which services will be covered and payable under Part B of the Medicare Program. Pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue

number of carrier newsletter], from a meeting you attended on date, and from your peers in the medical community ."

Carriers need to make specific findings for §1879 and §1870. The rationale for finding provider knowledge or fault with regard to a particular claim may not be the same as for another claim. This may be so even for multiple denials for a particular code since MN is a unique and individualized determination. These individual findings are especially important if #167;1879 and/or §1870 determinations are partially favorable. In such cases, specify which of the sample claims are affected, why, and how much this reduces the actual and total potential overpayment amounts (see §1879) or reduces the amount of the actual and total potential overpayments which must be refunded (see §1870).

Because §1879 and 1870 determinations are difficult concepts, it is important to explain to physicians exactly why they are being held responsible under these provisions. Your explanation must go beyond conclusory statements and/or findings.]

CALCULATIONS

A copy of our calculation worksheet is enclosed for your information. To calculate the potential projected overpayment amount for each denied procedure code, the following formula was used:

[In this section, insert a complete explanation of the methodology used to calculate the overpayment and the projected overpayment for each denied procedure code. The explanation must include the formula used when the audited services were down coded rather than denied and when only one example of a procedure code was audited.]

Procedure Code	*Denied Services #Sample*	*Denied Services #Universe*	*Down-coded Services #Sample*	*Down-coded Services #Universe*	*Potential Overpayment*

[This table lists procedure codes, the number of services in the sample and in the universe that were denied or down-coded, and the resulting potential overpayment amount.]

The actual overpayment amount is $_______________. The sum of all potential projected procedure code overpayments, including the actual overpayment amount, is $_______________.

OPTIONS

You must now select one of the two options explained below. Our normal audit process entails the routine use of Option One. However, we are now making another option available to you as a consent settlement.

If you fail to notify us of your selected option, Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation) will automatically be selected for you by default. Be aware that when statistical sampling for overpayment estimation is selected for audit, records for all of the services at issue must be available for review.

Please send in your response to the options listed below within sixty (60) days from the date of this letter,________________ .

*Regardless of the option selected, beneficiaries **may not** be billed for any of the overpayment amount.*

Option One Election to Proceed to Statistical Sampling for Overpayment Estimation

If we do not hear from you within sixty (60) days from the date of this letter, ________________, we will proceed with Option One by default. [This is the second step in the audit process if you have been offered a consent settlement on a potential overpayment but do not accept the offer.] This step utilizes statistical sampling for overpayment estimation for the same universe or time period. Your right to appeal to a Hearing Officer, an administrative law judge or to the court remains if you should choose this option. Also, any rights available to you under §1870 and/or 1879 of the Social Security Act remain.

Be aware that this option, either by your selection or by default, means that you are required to submit medical documentation for all of the services at issue in the statistical sampling for overpayment estimation [(just as you would have had to do if we had not first offered you the opportunity for a consent settlement on a potential overpayment).] You should also be aware that this option, whether selected by you or by default, withdraws the option of a consent settlement, as described in Option Two.

If you elect (or accept by default) Option One, it is important that you understand the following information concerning our actions and your responsibilities with regard to the actual overpayments found for the claims involved in the limited audit:

The potential projected overpayment referred to in this correspondence is based on a sample of ________________ beneficiaries. We audited claims and medical documentation for the________________ beneficiaries in the sample to arrive at an actual overpayment for these claims. The actual overpayment amount was then projected to the universe of procedure codes to develop the potential projected overpayment. (See above for the actual overpayment amount and the potential projected overpayment amount.)

Option Two involves repayment of the potential projected overpayment, which includes the actual overpayment amount. Choosing Option One does not eliminate your obligation to repay the actual overpayment. Recoupment of the actual overpayment identified for the claims in the limited audit will be pursued individually, but their recovery will be credited against any projected overpayment for the universe to which the claims belong.

Your obligation to repay the overpayment for these claims will begin on the date of the official notification of overpayment. You will be notified of your appeal rights on these claims at this same time.

Option Two Acceptance of Consent Settlement Offer

You agree to repay the potential projected overpayment, after providing additional medical documentation relevant to the____ beneficiaries involved in our sample which was in existence at the time the services were rendered.

Review of this information will result in one of three decisions:

- *All services in contention could be determined to be appropriate and allowed as originally processed, and the question of any potential overpayment would be eliminated; or*
- *A portion of the services in question could be determined to be appropriate and allowed as originally processed, and the amount of the potential overpayment would decrease accordingly; or*
- *The audit results could remain the same and the potential projected overpayment would remain at $_______________.*

You may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination.

If you select Option Two, you agree to refund the revised potential overpayment amount, if any, which will not exceed the dollar amount calculated in Item 3 of this attachment and printed above.

The revised potential overpayment amount will not exceed the capped amount.

By selecting this option, regarding repayment, you agree that there was a problem in your billing as identified by the carrier, you intend to correct this problem in future billings, and you understand how we reached the potential overpayment, i.e., you understand the sampling methodology used and the methodology to project the potential overpayment. Because you agree that there was a problem and agree to make changes in your practice to resolve this problem, you waive your right to appeal the sampled individual overpayments, the potential overpayment resulting from the projection and the sampling procedures. The appeal rights you are waiving include a hearing before a Hearing Officer, Administrative Law Judge, or in the Courts. You also waive any rights you have under §1870 and/or 1879 of the Social Security Act. (Please see Items 6 and 7 in this attachment for a discussion of these rights.)

Election of Option Two means that, in the absence of potential fraud, we will not audit your claims for any procedure codes projected in our audit during the audit time frame again. In the event of fraud and/or if you fail to correct the identified problems, we

reserve the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.

ASSESSMENT OF INTEREST

We wish to make you aware, should you elect Option Two, that interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final potential overpayment, if any. Should you choose Option One, interest will be assessed on any balance outstanding thirty (30) days from the date of the letter notifying you of a final overpayment determination. We must assess interest as provided in 42 CFR §405.376. Interest will accrue on the unpaid balance for each thirty (30) day period (or portion thereof) that repayment is delayed. The current interest rate is _______________ %.

LIMITATION OF LIABILITY

Section 1879 of the Social Security Act (42 USC §1395pp, 42 CFR §411.406) permits Medicare payment to be made to providers on assigned claims for certain services otherwise not covered because they were not reasonable or necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or were custodial services if neither the beneficiary nor the provider knew, or could reasonably be expected to know, that the services were not medically necessary or were for custodial care. Services affected are those disallowed as not reasonable or necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member and those disallowed as custodial services.

WAIVER OF OBLIGATION TO REPAY UNDER §1870 OF THE SOCIAL SECURITY ACT

Section 1870 of the Social Security Act (42 USC §1395gg, 42 CFR §405.704(b)(14)) permits you to request waiver of an overpayment on the grounds that you were "without fault" with respect to causing the overpayment. This determination is made after §1879 is considered. If it is determined that you or the beneficiary knew or should have known that the service was not medically necessary and reasonable or constituted custodial care as described under the provisions of §1879, we address §1870 and determine whether you were "without fault" with respect to causing the overpayment.

GENERAL

We wish to ensure that you are aware of regulations and provisions of the law relating to continuation of the problems discussed herein. They include exclusion from the Medicare Program in accordance with §1128(b) of the Social Security Act (42 USC §1320a-7), civil monetary penalties or other actions in accordance with §1128A of the Social Security Act (42 USC 1320a-7a), and/or, if appropriate, withholding payment under 42 CFR 405.370.

Your decision regarding this matter must be in writing and received by this office within sixty (60) days from the date of this letter. If your decision is not received by the above-mentioned date, Option One, Election to Proceed to statistical sampling for overpayment estimation, will be selected for you by default*.*

We have enclosed two copies each of the two option forms for your convenience. Select one of the options, complete and sign both forms corresponding to that option, and send them to my personal attention at the address shown below.

The provider must personally sign the forms. A signature stamp, or the signature of a staff member or attorney is not acceptable. After receipt of the two identical option forms with authorized signatures, we will sign both forms and return one to you*.*

Name:

Title:

Address:

Telephone number:

D. Consent Settlement Attachment 2: Option One - Election To Proceed To Statistical Sampling For Overpament Estimation

Option One - Election to Proceed to Statistical Sampling for Overpayment Estimation

I,______________________________:

- *have read the results of the audit findings in the letter dated _____________.*
- *elect to proceed to your full-scale audit process, involving use of statistical sampling for overpayment estimation for the same universe of procedure codes and time period as the limited audit, as explained in the letter. I understand the full-scale audit process is the normal audit process, and that the limited audit was offered to me only in the interest of economy and expediency. Upon selection of Option One, I understand that the offer of a consent settlement as stated in Option Two is withdrawn.*
- *understand that I and/or my office staff will be required to submit medical documentation for all services at issue in the statistical sampling for overpayment estimation, upon request by the carrier.*
- *understand that all applicable appeals rights, including any right to a hearing officer hearing, an administrative law judge hearing, or court review are available to me. I also retain any rights available under §1879 and/or 1870 of the Social Security Act, as appropriate.*

- *understand that the claims from the above-referenced limited audit will not be selected for inclusion in the statistical sampling for overpayment estimation; the statistical sampling for overpayment estimation will be a new and independent audit.*
- *understand that the overpayment identified for claims in the limited audit will be pursued on an individual basis, and that this overpayment will be subtracted from any overpayment resulting from the statistical sampling for overpayment estimation; that I will be provided with appeal rights regarding the overpayment amount on the claims in the limited audit at a later date; and that any interest on the overpayment amount on the claims in the limited audit will be calculated from the date of this later notice with appeal rights.*
- *understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.*

Provider signature: ___________________________

Date signed: ________________________________

Printed or typed name: ________________________

Title of signatory: ____________________________

Carrier Representative Signature: _______________

Date signed: _______________________________

Printed or typed name: _________________________

Title of signatory: _____________________________

Please submit both copies of the selected option form, with original signatures, in the enclosed envelope. Upon completion, a file copy will be returned to you.

E. Consent Settlement Attachment 3 Option Two - Acceptance of Consent Settlement Offer

I,________________________________:

- *have read the results of the audit findings in the letter dated________________.*
- *understand the issues the carrier presented and the calculation of the projected potential overpayment and agree to settle the issue of a potential projected overpayment by refunding a redetermined amount of up to*

$_________________to Medicare. This amount was derived by reviewing a sample of my claims and determining that a potential overpayment did exist within the universe of my claims.

- *have enclosed additional documentation for you to review for the purpose of redetermining the potential overpayment. I understand that I may request a meeting to explain the additional documentation or to provide other information relevant to the redetermination. I understand the redetermined potential overpayment, if any, will not exceed the amount shown above.*

- *understand that if the redetermined settlement amount is not refunded to Medicare within thirty (30) days from the date of the redetermined potential overpayment notice, the unpaid balance is subject to offset. I may apply for an extended repayment plan and, if approved, may make payments over an approved period of time.*

- *understand that interest on the amount accrues from the date of the final potential overpayment determination, but that this interest will be waived if repayment is made within thirty (30) days from the date of the final potential overpayment determination.*

- *understand that claims paid to me from ______________ to_______________will not be audited in the future. [**Reword this statement to reflect services dates if service dates were used in the audit to select claims instead of dates of payment**.] I further understand that in the event of fraud or if I fail to correct the identified problems, the carrier reserves the right to audit prior years' claims and claims for any procedure codes for the time period considered in this audit.*

- *understand that the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims are in no way affected or limited by selection of this option.*

I,___________________________, agree by settling this:

- *that my right to appeal, which includes a Medicare Part B hearing officer hearing, administrative law judge hearing, or any court appeals regarding this matter, is waived. I also understand any rights available to me under §1879 and/or 1870 of the Social Security Act are waived.*

I,____________________________, do/do not (circle one) wish to request a meeting at this time to discuss the additional documentation I have submitted.

Provider signature:_______________________

Date signed:____________________________

Printed or typed name:____________________

Title of signatory:_________________________

Carrier Representative Signature:____________

Date signed:_________

Printed or typed name:____________________

Title of signatory:__________________________

Please submit both copies of the selected option form, with original signatures, in the *enclosed envelope. Upon completion, a file copy will be returned to you.*

F. Consent Settlement Attachment 4: Extended Repayment Plan (ERP)

It has been determined by an audit that there is a potential overpayment amount due to Medicare. It is expected that you will remit the entire amount in one payment within thirty (30) days of the date of the final potential overpayment determination if you select Consent Agreement Option Two (Acceptance of Consent Settlement Offer), or, if you select Option One (Election to Proceed to Statistical Sampling for Overpayment Estimation), the date of the final overpayment determination. However, if you are unable to repay the amount within that time, we are authorized to consider repayment in installments based on validated financial hardship. ***[Installments are based on the amount of the overpayment as stated in Financial Management, Chapter 4, §§20, 30.]*** *Installments can range from 2-6 months based on the amount of overpayment. Be aware that if repayment is not made within thirty (30) days, interest will be due. If you select Consent Agreement Option Two, interest accrues from the date of the final potential overpayment determination, or if you elect Option One, interest accrues from the date of the final overpayment determination (See 42 CFR 405.378.). Interest will be waived if repayment is made within thirty (30) days of the applicable date cited above for the option chosen. The current rate of interest is _______ percent. If you wish to claim financial hardship, contact ________________________ to obtain the financial statement of debtor form (CMS-379). This form must be completed and returned with your request for approval of an installment schedule. If compliance with the above is not acceptable to you, it is suggested that you seek a private or commercial loan to satisfy the obligation.*

If repayment of the amount due, in a lump sum or on an approved installment plan, is not forthcoming, the Centers for Medicare & Medicaid Services may, at its option; forward the case to the Department of Justice or the Internal Revenue Service (IRS) for enforced collection.

G (1). Third Letter in the Consent Settlement Process: No Action if an

Overpayment Was Not Established

List the following information in the heading of the letter:

- *Date of notice;*
- *Name of provider;*
- *Address; and*
- *City, state, and zip code.*

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on__________,_ (Fill in date) we have not found an indication of an overpayment. No additional action on your part, is deemed necessary.

If you have any questions, please contact me at______.

Sincerely,

G (2). Third Letter in the Consent Settlement Process: Request for Money Owed if Overpayment was Established

List the following information in the heading of the letter:

- *Date of notice;*
- *Name of provider;*
- *Address; and*
- *City, state, and zip code.*

Italics within parentheses indicate insertions and must not be inserted in correspondence going to providers.

You have already received correspondence regarding a potential consent settlement. Thank you for your cooperation in this process. Based on our evaluation of your medical records on__________,_ (Fill in date) we have found an indication of an overpayment and the option of a (state if provider elected the statistical sampling for overpayment estimation or accepted the consent settlement offer) was selected. You owe ___(state the amount of money owed).

If you have any questions, please contact me at_______________________________.

Sincerely,