CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 315	**Date: May 17, 2019**
	Change Request 11211

SUBJECT: Update to Publication (Pub.) 100-06 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Pub. 100-06 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: June 18, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 18, 2019

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
R	3/40/40.1/Demand Letter Contents
R	3/110/110.2/Recovery From the Beneficiary
R	3/110/110.8/Beneficiary Wishes to Refund in Installments
R	3/140/140.1/Bankruptcy Forms
R	3/160/160.2/Termination of Collection Action – Beneficiary Overpayments
R	3/190/Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment
R	4/70/Exhibit 5 – Treasury Cross-Servicing Dispute Resolution
R	5/400/400.20/Exhibit 20 - Procedures for Reporting Currently Not Collectible (CNC) Debt
R	5/410/410.4/Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information is Provided
R	5/410/410.6/Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information is not Provided
R	5/411/411.1/Exhibit 1 – Overpayment Refund Form
R	6/80/80.6/Recording Savings
R	6/330/330.3/Section B - Cause of Overpayments
R	6/440/440.6/Recording Savings
R	6/450/450.3/Body of Report
R	6/460/460.2/Section I – Redeterminations
R	12/10/10.1.3/Processing CMS-838 Claims Adjustments
R	12/20/20.2/Completing the CMS-838
R	12/20/20.9/Exhibit II: Medicare Credit Balance Report Detail Page

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 315	Date: May 17 2019	Change Request: 11211

SUBJECT: Update to Publication (Pub.) 100-06 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: June 18, 2019
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 18, 2019

I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub. 100-06.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11211.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100-06.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Financial Management Manual
Chapter 3 - Overpayments

40.1 – Demand Letter Contents
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

The demand letter must include the following information:

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

110.2 - Recovery From the Beneficiary
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

A. Non-MSP Overpayment Is Less Than $50

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

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

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

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

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

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

C. Referral to SSA

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

However, if the *beneficiary* has a *Beneficiary Identification Code (BIC) that is either* T or M, do not refer the case to SSA since those beneficiaries are not entitled to monthly social security benefits. Offset should be continued in the case of beneficiaries whose *BIC is either* T or M. If appropriate, the instructions for termination of collection action (See 110.3D for additional instructions.) should be followed.

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

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

- Referral Form- contains the address of the referring agency (The Centers for Medicare and Medicaid Services (CMS) Central Office, CMS Regional Office, or the Medicare Contractor and information pertaining to the case; and
- Return Notice- for SSA use in recording information for crediting the CMS Trust Fund; and
- Waiver Determination- if the Medicare Contractor or CMS RO determines the beneficiary was at fault for the overpayment.

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

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

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

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

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

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

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

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

Example:

Region #	Carrier #	*Medicare beneficiary identifier*	Claim #
xx	xxxxx	xxxxxxxxxx	xxxxxxxxxxxxxxxx

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

beneficiary Non-MSP overpayment Write-off.

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

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

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

110.8 - Beneficiary Wishes to Refund in Installments

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

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A. General

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

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

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

The FI or carrier shall exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that they cannot afford an installment of at least $10 per month, or that they can afford installments of $10 to $50 per month but the overpayment is so large that

recovery would take substantially more than 3 years, the FI or carrier shall treat such statement as a request for waiver. (See §110.9)

B. Notification of Installment Schedule

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

C. Suggested Installment Agreement

_____ _____

Name of Overpaid Beneficiary *Medicare beneficiary identifier*

Beneficiary's Address

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

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

_____

Signature of Beneficiary

_____

Date

D. Beneficiary Fails to Remit Installments

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

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

If the beneficiary notifies the FI or carrier that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the FI or carrier shall set up a new agreement, provided the new installment is at least $10 per month, and large enough to effect recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement.

140.1 - Bankruptcy Forms

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

EXHIBIT 1

REFERRAL CHECKLIST

(CMS Pub. 100-06, Chapter 3, §140)

REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Contractor Name _____ Date Prepared:_____

Contractor NPI that O/P is reported under:_____.

Contractor NPI that O/P is reported under on Accounts Receivable Report (751):_____

I. Provider & Overpayment Information

A. Provider Name _____ B. Provider No._____

C. Cost Report Period_____

D. Responsible Individual(s) (Most Current)

Name: _____ Title: _____

Address: _____

City, State, Zip: _____ Telephone:_____

E. Overpayment Information (List information for each outstanding overpayment)

**Original Amount _____ **Interest Assessed _____/Rate

*Principal Recouped _____ *Interest Recouped _____

Principal Referred _____ Interest Referred

Through Date ____/____/____

F. Overpayment Type _____ G. Determination Date _____

H. Contractor Control # _____

I. Cause of Overpayment_____

NOTE: If unfiled cost report is the overpayment type, indicate the date unfiled cost report is (was) due to be filed, as well as the interim payments.

*Attach detailed information with case regarding recoupments, include dates applied.

**Include copies of the screens from either the share systems or HIGLAS SCREENS for the HIGLAS users, for both principal and interest.

EXHIBIT 2

II. Accounts Receivable Reporting
(All information reported in I.E. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line	Amount
A. HI Principal Reported on H751 Part A as transferred to RO	_____	_____
Line Reported on	_____	
HI Interest Reported on H751 Part A as transferred to RO	_____	_____
Line Reported on	_____	
SMI Principal Reported on H751 Part B as transferred to RO	_____	_____
Line Reported on	_____	
SMI Interest Reported on H751 Part B as transferred to RO		_____
Line Reported on	_____	
Total		_____
B. Indicate quarter information was reported on the H751		___/___/___

III. Collection Efforts

(For items III A-C, unless there is a post-petition demand letter, this information would not be relevant to recovering in bankruptcy).

A. Include copies of the Initial and Intent to Refer demand letters (Ref. CMS Pub. 13-2, § 2222). If full series of letters was not sent, explain why.

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all; (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other legal entities

D. The contractor must establish whether or not a particular provider is participating in the Medicaid Program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 13-2,§ 2226ff.

PARTICIPATING: Yes ____ No ____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

E. Is the provider listed in the Fraud Investigation Data Base? (FID) Yes ____ No ____

EXHIBIT 2 cont.

IV. Ownership

Check the appropriate ownership affiliation:

A. ___ INCORPORATED
Chain Organization Yes ___ No ___
If yes, who is the Medicare Part A contractor:_____
Incorporation Date _____
EIN #_____

B. ____ PARTNERSHIP
EIN # _____

1) If partnership, list names and SS#=s of all partners.

_____

_____

2) If Corporation, list names and addresses of officers.

_____

_____

3) If Chain organization, list other provider names, addresses, and provider numbers.

_____

B. Is "Responsible Individual(s)" information the most current? Yes _____ No _____

Provide alternate contact(s), Name, Title, Address and Telephone Number:

_____

_____

_____

_____

C. Are claims for services still being submitted? Yes_____ No _____

If yes, why is referral being made: _____

_____

D. Has there been a change of ownership? Yes _____ No _____
If yes, what is the date?_____

Has the new owner assumed the previous owner's provider agreement? Yes _____ No_____
(Provide copy of sales agreement.)

E. Has recoupment from new owner been attempted? Yes _____ No_____

EXHIBIT 2 cont.

V. General

A. Is the provider still participating in the Medicare program? Yes_____ No_____

Note: If the provider is still participating in the program and claims recoupments are being made, do not transfer case to the RO.

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes_____ No_____

Copies of pertinent court documents should be submitted. Take the following program safeguard actions when a bankruptcy situation is identified:

- Adjust interim payment calculation to ensure that no overpayment is made
- Consult the CMS RO before applying any disposition regarding cost report underpayments
- Expedite cost report desk reviews and audit settlements
- Tentative settlements should not be made in bankruptcy cases
- Consult the CMS RO regarding any cost reports pending submission and the expected dates of submission.

C. Did the provider request an extended repayment schedule (ERS)? Yes_____ No_____
If yes, was it approved? Yes _____ No_____ Length of ERS _____
Number of payments made _____
Attach any financial documentation submitted.

D. Did provider request an Appeal, Yes _____ No_____or PRRB hearing? Yes_____ No_____
If yes, do not transfer unless the decisions have been rendered. Submit all pertinent information.

Cases pending a Reopening, Bankruptcy, Appeal Review, or PRRB Decision, should not be transferred to the CMS-RO until judgment has been rendered. Copies of all decisions must be included.

INSTRUCTIONS: If you do not provide any requested information, you must give a detailed explanation of why you cannot secure the information. We will return incomplete forms with the entire case.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

EXHIBIT 3

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: ___________________________________ PROVIDER NUMBER: ______________________

OVERPAYMENT AMOUNT: $__________________ INITIAL DEMAND LETTER DATE:___________

INTEREST RATE: ________% COST REPORT PERIOD:____________________

Payment Date	**Period (30 Days)**	**Interest Charges**	**Recouped Amounts**	**Applied to Interest**	**Interest Balance**	**Applied to Principal**	**Principal Balance**

EXHIBIT 4

PART B PHYSICIAN/SUPPLIER OVERPAYMENT
Referral CHECKLIST
(CMS Pub. 100-06 chapters 4 & 5)

REFERRALS WILL NOT BE ACCEPTED WITHOUT A COPY OF THE 855

Medicare Contractor Name _____ Date Prepared:_____

Contractor Jurisdiction that the overpayment is reported under:_____

Contractor Jurisdiction and/or ID No. that overpayment is reported under on Accounts Receivable Report (751): _____

I. Physician/Supplier Overpayment Information
   A. Phy/Supp. Name
   B. Phy/Supp No. _____
      UPIN _____
   C. Responsible Individual(s)

      Name: _____ Title: _____

      Address: _____

      City, State, Zip: _____ Telephone: _____

   D. Overpayment Information

      **Original Amount _____ **Interest Assessed _____/Rate

      *Principal Recouped_____*Interest Recouped_____

      Principal Referred _____Interest Referred _____

      Through date _____

      Query if overpayment is based on fraud.

      *Attach detailed information with case regarding recoupments, include dates applied.

      **Include a copy of the Master screen from the share system and/or from the HIGLAS SCREENS when applicable.
      Information requested in E though L is needed for all claims involved in overpayment.

      E. Discovery Date _____ F. Determination Date

_____

      G. DCN _____ H. Cause of OP

_____

      I. Claim Number_____ J. Claim Paid Date _____

      K. Beneficiary Name _____ L. *Medicare beneficiary identifier*_____

Part B Referral Checklist

EXHIBIT 4 - cont.

II. Accounts Receivable Reporting
(All information reported in I.D. must reconcile with amounts reported on the Accounts Receivable Report (H751)) (N/A is not acceptable)

	Line	Amount
A. SMI Principal Reported on H751 Part B as transferred to RO	_____	_____
Line Reported on		_____
SMI Interest Reported on H751 Part B as transferred to RO	_____	
Line Reported on	_____	
B. Indicate quarter information was reported on the H751	_____	
C. Is this Overpayment reported on the M751	Yes ___ No ____	

III. Collection Efforts

A. Include copies of the Initial and Intent to Refer demand letters (Ref. CMS Pub. 14-3, Sec. 7142). If full series of letters was not sent, explain why._____

_____

_____

B. Include copies of all correspondence, telephone contacts, etc. pertinent to this transfer.

C. List additional actions you have taken to recoup overpayment and include copies of all, (e.g., attempts to locate through directory assistance, AMA, post office forwarding addresses; disconnected phones, flags against other numbers, etc.).

D. The Contractor must establish whether or not a particular provider is participating in the Medicaid program so that the Federal Share of Medicaid payments can be withheld, if appropriate, in accordance with CMS Pub. 14-3,
PARTICIPATING: Yes _____ No _____

Medicaid Number/State: _____
(If Yes, Medicaid # and State must be included)

EXHIBIT 4 - cont.

IV. Ownership

Check the appropriate ownership affiliation:

A. ___ INDIVIDUAL
Tax ID # _____
SS # _____

B. ___INCORPORATED
Chain Organization Yes ___ No___
Incorporation Date _____
TIN # _____

C. ___PARTNERSHIP TIN # _____

D. Is A Responsible Individual(s)≅ information the most current? Yes _____No_____
Provide alternate contact(s), Name, Title, Address and Telephone Number
_____
_____
_____
_____
_____

E. Is recovery due from the beneficiary or other 3rd party payor? Yes_____No _____
If yes, why was recovery not made (enclose copies of letters and replies).

F. Are claims for services still being submitted? Yes_____No _____
If yes, why is referral being made:

G. Are claims for services/supplies being submitted under another physician/supplier number?
Yes _____ No _____ If Yes, provide alternate number_____.

Is the tax identification, or social security number the same as debtor's? If yes, recoupment should be attempted.

H. Has there been a change of ownership? Yes _____ No _____
If Yes, Has the new owner assumed any of the previous owner's liabilities? Yes_____No_____
(Provide copy of sales agreement.)

EXHIBIT 4 - cont.

V. General

A. Is the physician/supplier still participating in the Medicare program? Yes _____ No _____

B. Are you aware of any bankruptcy proceedings planned or commenced on behalf of the provider transferred? Yes _____No _____ Please provide copies of pertinent court documents.

C. Did the physician/supplier request an extended repayment schedule (ERS)?
Yes ____ No _____
If yes, was it approved? Yes ____ No ____ Length of ERS _____
Number of payments made_____
Attach any financial documentation submitted.

D. Did the physician/supplier request a Fair Hearing or ALJ Hearing?
Yes _____ No _____
If yes, do not transfer unless the both fair hearing and ALJ decisions have been rendered. Submit all pertinent documentation.

THIS FORM MUST BE COMPLETE. IF ANY REQUESTED INFORMATION IS NOT PROVIDED, A DETAILED EXPLANATION MUST BE GIVEN AS TO WHY THE INFORMATION CANNOT BE SECURED. INCOMPLETE FORMS WILL BE RETURNED WITH THE ENTIRE CASE.

Signature: _____

Name: _____

Title: _____

Telephone: _____

Date: _____

EXHIBIT 5

INTEREST/RECOUPMENT COMPUTATION

PROVIDER NAME: _____ PROVIDER NUMBER:_____

OVERPAYMENT AMOUNT: $_____ INITIAL DEMAND LETTER DATE:_____

INTEREST RATE: _____% CLAIM NUMBER:_____

Payment Date	Period (30 Days)	Interest Charges	Recouped Amounts	Applied to Interest	Interest Balance	Applied to Principal	Principal Balance

EXHIBIT 6

CONTRACTOR BANKRUPTCY CHECKLIST

- Send the following information to the RO upon learning that a provider has or may soon file for bankruptcy:
- Provider Name
- Provider Medicare Number
- Provider Address
- Provider Tax Identification Number
- Overpayment Determination Date
- Original Overpayment, Amounts Recouped, Current Balance Reported on the CMS 750/751 reports of principal and interest outstanding balances. Date the receivable was included on the CMS 750/751.
- Overpayment Type
- Fraud and Abuse Overpayments or Investigations
- For Part A Contractor, the Cost Report Year
- For Part A Contractor, the Cost Reports Settlements Pending In-house with Expected Completion Dates
- For Part A Contractor , the Cost Reports Pending Submission with Expected Dates
- For Part A Contractor, Interim Rate Information by Cost Year for Previous Three Years
- For Part A Contractor , Overpayment History by Cost Year for Previous Three Years
- For Part B Contractor, the Claim Numbers Relating to Overpayments
- For Part B Contractor , the Dates of Service for Related Claims
- For Part B Contractor , the Dates of Payment for Related Claims
- Medicare Review Overpayments or Reviews
- Anticipated Reopenings

160.2 - Termination of Collection Action – Beneficiary Overpayments

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

- *Medicare beneficiary identifier*
- Current principal amount of overpayment
- Other outstanding overpayments
- Claim Paid Date (Part B)
- Determination Date

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

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

190 – Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Effective October 1, 2003, Common Working File (CWF) implemented the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based MA Enrollment coding files described in the CWF System Documentation at http://cms.csc.com/cwf/.

Upon receipt of notification that a beneficiary has previously enrolled in a MA Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive MA enrollment. The CWF compares the period between the MA enrollment start date and the date of service of the claims in history. Services that fall within the responsibility of the MA Organizations are identified.

The CWF generates an Informational Unsolicited Response (IUR) with trailers 05 & 24 containing the identifying information regarding the claim subject to the risk based MA payment rules. The IUR has all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the *Medicare beneficiary identifier*. The CWF electronically transmits the IUR to the contractor that originally processed the claim. The IUR is included in the existing CWF response file. The IURs in that file for claims to be adjusted are identified with a unique transaction identifier. The previously submitted claim is not canceled and will remain on the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the IUR the Shared System software reads the trailer for each claim and either a manual or automated adjustment is performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.

Carriers

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the carrier in trailer 11. Carriers are to recover any monies due back to Medicare resulting from these denials, by following the standard or (customary) recovery process. Carriers are also responsible for providing the M/A plan number to the providers in their correspondence.

In the event that a denial is reversed upon appeal, for carrier claims, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Fiscal Intermediaries (FIs)

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the intermediary in trailer 11. To

recover any monies due back to Medicare resulting from these denials, claims are to be adjusted and overpayments are to be recovered through the customary recovery process.

In the event that a denial is reversed upon appeal, a 1 byte override code field is created at the header level for FI claims. The FIs should use override code “1” in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the HMO override field. The purpose of using “1” or “2” is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the carrier receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a MA, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an alternate method).

Language for Carriers to Use in Letter to Provider

Carriers

This beneficiary was enrolled in [Plan Alpha Numeric ID]; a risked based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS Internet at
http://www.cms.hhs.gov/HealthPlansGenInfo/claimsprocessing20060120.asp#TopOfPage.

Fiscal Intermediaries

The plan number is not required on intermediary communications. Those providers are to determine which plan to contact through an eligibility inquiry or by contacting the beneficiary directly.

New Medicare Summary Notice (MSN)

The MSN code 16.57 - Medicare Part B does not pay for this item or service since our records show that you were in an Medicare + Choice Plan on this date. Your provider must bill this service to the Medicare + Choice Plan.

16.57 - La Parte B de Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de Medicare + Opción. Suproveedor debe facturar este servicio a el plan de Medicare + Opción.

Medicare Financial Management
Chapter 4 - Debt Collection

Exhibit 5
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Treasury Cross-Servicing Dispute Resolution

DMS Request Date: Total Number of Pages: _____
SBU
FedDebt Case ID.: Principal Amt: $
Creditor Agency Debt ID: PCA Code:
Debtor:

Program: For CMS Use Only:
Creditor Agency Contact Name: *Medicare beneficiary identifier*:
Creditor Agency Contact Phone: Beneficiary Name:
Creditor Agency Facsimile:

Dispute Number:
Dispute request reason: Miscellaneous Dispute
Additional comments:

If you have any questions regarding the dispute, please call Valencia Thompson at 205-912-6327. Creditor Agency must return response to Bosch Stanley via facsimile 205-912-6374 with 60 days of request date.

Creditor Agency (CA) Dispute Resolution Section:
Please indicate a response by checking one of the following reasons: Please attach supporting documentation.

DAIC ___ CA agrees. Debt amount is incorrect. Requires financial adjustment.
DACC ___ CA disagrees. Debt amount is correct. Continue collection efforts.

MDAA ___ CA agrees. Miscellaneous dispute, stop collection activity.
MDFF ___ CA agrees. Miscellaneous dispute. Requires financial adjustment, continue collection efforts.
MDDD ___ CA disagrees. Miscellaneous dispute. Continue collection efforts.

VDWD ___ CA agrees. Wrong debtor, stop collection activity.
VDRD ___ CA disagrees. This is not the wrong debtor, continue collection efforts.

VDPP ___ CA agrees. Previously paid, stop collection activity.
VDNP ___ CA disagrees. Not previously paid, continue collection efforts.

VDPR ___ CA agrees. Previously resolved, stop collection activity.
VDNR ___ CA disagrees. Not previously resolved, continue collection efforts.

Financial Adjustment Information (To Be Completed By Creditor Agency):
Principal Amount $_____
Interest Amount $_____
Penalty Amount $_____
Admin Cost Amount $_____
Total Balance Owed $_____

Please check one of the following:
□ Adjustment reflects the total balance currently owed by the debtor, and has been made by our Agency.
□ Adjustment has not been made in FedDebt by the Agency, and should be made by DMS.
Creditor Agency Response Date: _____ Creditor Agency Response Contact: _____
Additional Comments By Creditor Agency:
_____
_____
_____
_____

Medicare Financial Management Manual

Chapter 5 - Financial Reporting

400.20 - Exhibit 20 - Procedures for Reporting Currently Not Collectible (CNC) Debt

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A1-1960.19, A1-1960.20, B1-4960.12, B1-4960.13

As part of its effort to improve financial reporting, CMS has implemented the category of currently not collectible (CNC) for delinquent debt that is unlikely to be collected within a reasonable time frame. The CMS' CNC policy provides that CNC debt will not be recognized as an active accounts receivable (A/R) for financial statement reporting purposes because to do so would overstate the true economic value of the assets on the financial statements. While CNC debts are not A/R reported on the financial statements, Medicare contractors must continue appropriate recovery efforts for these debts until they are recommended and approved by CMS for "write-off - closed" as such, these debts must remain in their internal system for interest accrual and offset. The CNC process permits and requires the use of tools of the Debt Collection Improvement Act (DCIA) of 1996. By using these tools delinquent debt will be worked until the end of its statutory collection life cycle.

Criteria for Selection

All A/R, whether it is classified as Medicare Secondary Payer (MSP) or Non-MSP, that are 180 days delinquent must be recommended for CNC reclassification. The A/R must be 180 days delinquent (i.e., 240 days old if the repayment time frame is 60 days or 210 days old if the repayment time frame is 30 days) as of the last day of the quarter prior to the quarter in which the CNC recommendation is submitted for RO approval.

All MSP A/R means all demanded debt, without regard to whether the debt is Group Health Plan (GHP) based or liability/no-fault/workers' compensation based and without regard to the type of debtor (employer, insurer, beneficiary, provider/supplier, etc.). Where the MSP recovery demand letter stated that the debt was due and payable 30 days from the date of the demand, the debt is delinquent on day 31 if it has not been paid in full or there is no valid documented defense for the unpaid amount. Where the MSP recovery demand letter stated that the debt was due and payable 60 days from the date of the demand, the debt is delinquent on day 61 if it has not been paid in full or there is no valid documented defense for the unpaid amount.

All Non-MSP A/R means all demanded debt without regard to whether the debt is provider/physician/supplier or beneficiary-based. This includes debts that are not normally reported (separately or in summary entries) in the POR/PSOR systems, as long as they meet the CNC criteria. These debts should be listed separately, must be identified as not on the POR/PSOR, and the type of debt must be listed on the CNC request form in the comments section. Debts that are excluded from this definition are as follows:

- Debts with a principal balance of less than $25. Although these debts may satisfy the CNC criteria, Medicare contractors should recommend the termination of collection activity and request approval by the Regional Office (RO) to write this debt off as "write-off closed" in accordance with Title 42 of the Code of Federal Regulations, Section 405.376(e)(3), since the cost of further collection action is likely to exceed any recovery.

- Debts with a collection within the last 180 days. Hence, the debt must be 180 days delinquent without any collection/recoupment activity within the last 180 day time period for CNC reclassification.

Additionally, all accounts receivable that meet the CNC criteria will be reclassified as CNC without regard to whether or not the debt is in bankruptcy, under fraud and abuse investigation, has an appeal pending at any level, is in litigation/negotiation, or is for a deceased debtor. However, if a Medicare contractor believes that a particular A/R meets the criteria for both "write-off - closed" and CNC, the A/R should be recommended for "write-off - closed." Medicare contractors may not recommend CNC for less than the full amount of an outstanding debt.

NOTE: For GHP-based MSP A/R where the demand was issued to the employer, insurer, or third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand to a debtor for a particular beneficiary. For GHP Data Match (DM) recoveries, this would be all of the claims associated with a particular Mistaken Payment and Recovery Tracking System (MPaRTS) Report ID although a single cover letter might have been issued for multiple beneficiaries' Medicare reimbursed claims. For duplicate primary payment recovery demands to a provider/supplier (including physician), the debt includes all claims in the recovery demand regardless of the number of beneficiaries involved. For liability, no-fault, or workers' compensation, the debt includes all claims in the recovery demand.

A debt's eligibility for DCIA referral to a Department of the Treasury designated Debt Collection Center (DCC) for further collection efforts, including the Treasury Offset Program (TOP) has no bearing on or relationship to whether or not the debt should be reclassified as CNC. As such, debts referred to the DCC should also be recommended for CNC reclassification as long as it meets the CNC criteria.

The Department of the Treasury and the Office of Management and Budget require that Agencies submit reports to them on financial management and performance data so that debt collection programs and policies can be evaluated. Thus, CMS is requiring its Medicare contractors to report and monitor CNC debt on a quarterly basis.

Quarterly Review of Debt for CNC Reclassification & Approval

Medicare contractors must continuously review all debt and quarterly request approval to reclassify debts as CNC. Recommendations for the approval of MSP and Non-MSP CNC should be sent to your RO MSP Coordinator or the RO Debt Collection staff respectively. These reports should be sent by hard copy accompanied with a disk no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). The CFO of Medicare Operations must sign the hard copy and include a preprinted address label with the hard copy for the return of the approved CNC recommendations. Medicare contractors are required to submit negative reports if there are no debts eligible for CNC for a particular quarter.

ROs are responsible for approval or denial of all recommendations for CNC based upon the criteria set forth in these instructions. RO approval will be by the Assistant Regional Administrator (ARA) for Financial Management. ROs will complete their review of the Medicare contractors' recommended CNC and return their approval or denial of such reclassifications by the first day of the last month of each quarter (i.e., December 1, March 1, June 1, and September 1). ROs may return a hard copy via fax or a soft copy via disk annotated to show approval or denial by the RO ARA for Financial Management, in order to meet the required time frame for approval, but this must be followed by a hard copy that was signed and dated by the ARA for Financial Management. ROs will also send copies of the signed RO approval or denial letter only, each quarter to CMS CO to the attention of the Director, Division of Financial Oversight, Office of Financial Management (for both MSP and Non-MSP approvals). The ROs must maintain the detailed reports that support the amounts approved/disapproved.

The CNC action should not be taken nor should any changes be made to the A/R on any internal systems (Medicare contractor systems or other systems which Medicare contractors have responsibility for updating) for CNC until the recommendation for CNC has been processed by CMS, approved in writing, and returned to the Medicare contractor. The listing of approved CNC will be returned to the contractors by the ROs. Receipt of this approval authorizes the Medicare contractor to reclassify the A/R, and update the A/R and associated case in all appropriate systems. When the A/R is reclassified as CNC, the associated case file must be annotated to show that a particular A/R was reclassified as CNC and the date/quarter of the action. Reclassification as CNC does not close the associated case.

If a full or partial collection for the A/R is received between request and approval of CNC reclassification, then the collection should be applied. The contractor must make the necessary adjustment to the debt to reflect the payment and place the remaining amount, if any, in CNC when the RO approval is received. However, when the approval is received, the contractor must then notify the RO of the change in the amount originally approved for CNC as well as the reason why. If the contractor has this issue with multiple debts recommended for CNC, they need to furnish this information to the RO on a debt specific basis, not just on an aggregated basis. This must be communicated to the RO contact in writing. In addition, this documentation should be maintained for audit/review purposes.

NOTE: MPaRTS does not need to be updated for Data Match debt when the MSP A/R is reclassified as CNC.

The CMS approval of A/R reclassified as CNC must be retained and available upon request (from the Office of the Inspector General or any other internal or external review organization) in accordance with retention procedures in the Medicare Intermediary and Carrier Manuals. This CMS approval must also be annotated by the Medicare contractor to indicate the date/quarter when the A/R was reclassified.

Data Requirements and Format for Recommendations for MSP CNC

MSP A/R recommended for CNC requires the submission of the following information to the Medicare contractor's RO MSP coordinator: (see Attachment I for the recommended format)

- Medicare Contractor Name and Number
- Medicare Contractor Mailing Address
- Medicare Contractor Contact Person/Phone/Fax/E-mail
- Type of MSP Debt [GHP or non-GHP (this includes liability, no-fault, and workers' compensation)]
- Beneficiary *Medicare beneficiary identifier*
- Beneficiary Name
- Name of Debtor or Insurer for GHP-based debts where the current debtor is the insurer/employer/third party administrator/GHP/other plan sponsor
- Type of Debtor [A=insurer/employer/third party administrator/GHP/other plan sponsor; B=provider/supplier (including physicians); C=beneficiary, D=other (must specify)]
- Date of Initial Recovery Demand Letter to current debtor
- Delinquency Date
- Original A/R Amount for the current debtor

- Existing A/R Amount (principal and interest listed separately, as well as a total amount for principal plus interest; HI/SMI must also be listed and reported separately)

- Date of Last Payment, Collection, Recoupment, Offset, or Adjustment Activity (provide date or "none")

- Tax Identification Number (TIN) for debtor. The TIN is the Employer Identification Number (EIN) or Social Security Number (SSN)

- DCS Status Code (if applicable).

NOTE: The debtor is the individual or entity to whom the last recovery demand was issued. Where the demand was issued to an individual in their capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in their own right, the debtor is the attorney or other representative.

The above listed data elements are mandatory for CNC for all MSP A/R established October 1, 2000 or later. It is also mandatory for all MSP A/R with a recovery demand date of October 1, 2000, or later, regardless of when the MSP A/R was established. For CNC recommendations for MSP A/R established prior to October 1, 2000, Medicare contractors may submit recommendations without the following data elements if the CNC recommendation certifies that these data elements are not readily available: Beneficiary name and *Medicare beneficiary identifier* where the beneficiary is not the debtor; Insurer name where the insurer is not the debtor; and Type of debtor.

If a Medicare contractor has bulk MSP A/R on the GTE system for older Data Match and non-Data Match GHP debt, the contractor - for these MSP A/R only - must: 1) Identify the A/R as a bulk receivable on the GTE system, 2) Identify the insurer, 3) Identify the date of the demand, and 4) Identify the associated dollar amounts for principal and interest. Any contractor who created bulk receivables for GHP-based MSP debt using any system other than GTE must contact their RO for assistance. The RO will, in turn, discuss the issue with CO.

Data Requirements and Format for Recommendations for Non-MSP CNC

Non-MSP A/R recommended for CNC require the submission of the following information to the Medicare contractor's RO Debt Collection contact: (see Attachments II & III for the recommended format)

- Medicare Contractor Name and Number

- Medicare Contractor Mailing Address

- Medicare Contractor Contact Person/Phone/Fax

- Provider/Physician/Supplier/Beneficiary Name and Number (if applicable)

- Claim Number (PSOR)

- Claim Paid Date (PSOR) or Cost Report Date (POR)

- Overpayment Determination Date

- POR/PSOR Status Code

- Overpayment Type

- Original Amount of Debt
- Balance Outstanding (principal and accrued interest listed separately)
- Date Interest Accrued Through
- Date of Last Payment, Offset or Recoupment
- POR/PSOR Balance (principal and interest listed separately for POR; for PSOR, principal balance only) - For Part A, indicate POR balance if Contractor submits request for Part B of A separately
- POR/PSOR Location Code
- DCS Status Code (if applicable)
- For FIs Only - Part B of A debt can be submitted on the same listing (principal and interest)

Each listing must contain a written certification that all of the required criteria for CNC are met. The CFO of Medicare Operations must sign CNC recommendations. The CFO's signature constitutes his/her certification to all information/statements contained in the recommendation.

Financial Reporting and Reconciliation of CNC Debts

Debts that have received approval for CNC reclassification must be reported in the following manner:

- On Form CMS-751A/B or CMS-M751A/B the amount reclassified as CNC, including principal and interest, will be recorded on Line 6c, Transfers Out to CNC with a corresponding entry on Line 2, New CNC Debt on Form CMS-C751A/B or CMS-MC751A/B. This will reduce the ending balance reflected on the applicable form.
- Debts that are reclassified as CNC may still be collected. If a collection occurs, the following actions should take place: (1) On Form CMS-C751A/B or CMS-MC751A/B an adjustment for the amount of the collection should be recorded on Line 4a, Reclassified as Active A/R Due to Collection of Cash or Line 4b, Reclassified as Active A/R Due to Collection by Offset; (2) The amount of the collection should also be included in Section C - Collection Information of Form CMS-C751A/B or CMS-MC751A/B; and (3) The amount of the collection should be simultaneously recorded on Line 6b, Transfers in from CNC and Line 4a, Cash/Check Collections or Line 4b, Offset Collections of Form CMS-751A/B or CMS-M751A/B. As such, if a collection takes place, only the collection would be reclassified with the collection being applied against interest first, then principal. If the collection does not satisfy the entire debt, the remaining balance of that debt would remain in CNC.

Medicare contractors must continue to accrue interest for debt that has been reclassified as CNC. Additionally, CMS recognizes that for those systems where interest is updated automatically, the interest submitted with a recommendation for CNC may differ from the interest shown in the Medicare contractor's system at the time the Medicare contractor receives approval for CNC. The CMS approval of the principal and interest recommended for CNC is sufficient support for the subsequent reclassification, including any increase in the interest, as long as the principal remains the same. Any additional interest that accrues prior to CNC reclassification would be reported on Form CMS-751A/B or CMS-M751A/B on Line 3, Interest Earned. Then the debt would be reclassified to the appropriate form.

Medicare contractor systems must be able to maintain transaction level detail of debt that has been reclassified as CNC to enable future collection activities and to maintain a proper audit trail.

Regional Offices will ensure that amounts approved as CNC are properly reported on contractor Forms CMS-751A/B or CMS-M751A/B and CMS-C751A/B or CMS-MC751A/B.

Systems Update - Non-MSP Only

Medicare Contractor Internal Systems and POR/PSOR System:

Contractors are responsible for the timely update of CNC status in the POR/ PSOR systems and internal systems. A CNC date field has been added in the POR/PSOR and additional status codes have been developed. The date of CNC approval (i.e., the date of the cover letter signed by the ARA) must be entered in the CNC date field. The update must be performed within ten calendar days of receiving the CNC approval. Do not change the location code of the debt. Regional Offices will monitor the POR/PSOR systems to ensure contractor compliance.

Additional Status Codes for POR/PSOR:

POR Codes	PSOR Codes	Code Description
01	1	CNC
02	2	Write-off Closed (disabled effective 2/6/02)
03	3	CNC - DCIA Letter Sent
04	4	Reactivate - Bankruptcy (will no longer be used)
05	5	Reactivate - Payment Received
06	6	Reactivate - Appeal/Litigation/Fraud & Abuse Investigation (will no longer be used)
07	7	Reactivate - Compromise
08	8	Reactivate - Extended Repayment Agreement
09	9	CNC Debt - Written-off Closed
00	0	Reactivate - Other

NOTE: For debts that are at the DCC location and reclassified to CNC, the "3" (POR) or "03" (PSOR) status code would be used. Furthermore, the "9" must be accompanied by a valid closed date. Cases with a status code of "09" (POR) or "9" (PSOR) and a valid closed date will be rolled to the history file at the end of the quarter. In addition to updating the POR/PSOR with the appropriate status codes for the reactivation, the CNC date previously inputted should be removed. Updating the CNC Date field in the PSOR requires the user to enter zeroes in the CNC Date field and pressing the enter key.

Debt Collection System (DCS)

The CMS' CO Division of Financial Reporting and Debt Referral staff will continue to update the Debt Collection System (DCS) with approved CNC status for debts that have been referred for Cross Servicing/TOP.

Additional Considerations for MSP A/R

These instructions only apply to established MSP A/R. They may not be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

Some Medicare contractors may still have old MSP-based provider/supplier (including physician) debt or MSP-based beneficiary debt which has not been reported on their Form CMS-M751A/B and which has been referred to the RO under non-MSP rules or otherwise treated as a non-MSP receivable. Old MSP-based debt that has been treated as non-MSP debt (that is tracked and processed under non-MSP rules) should be treated as non-MSP debt for CNC purposes as well.

Medicare contractors may only recommend CNC for a MSP A/R that is being reported as part of their ending MSP A/R balance. MSP A/R that have been transferred to the ROs for referral to other agencies or entities such as, the Department of Justice or Office of General Counsel will be addressed by the ROs. CO will address MSP A/R with CO locations. MSP A/R that have been referred to another location, without transfer, remain the responsibility of the Medicare contractor.

Previously some Medicare contractors processed/tracked MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R as non-MSP A/R and did not include such A/R on their Form CMS-M751A/B report. Medicare contractors may no longer do this for new MSP A/R. Any pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP-based beneficiary A/R that are not reflected in the Medicare contractor's Form CMS-M751A/B report may not be recommended for MSP CNC. Pre-existing MSP-based provider/supplier (including physician) A/R and/or MSP- based beneficiary A/R that have been tracked/processed, or otherwise treated as non-MSP debt should follow the rules for non-MP CNC

Exhibit 20 - Attachment I

MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC

Medicare Contractor Name and Number:
Medicare Contractor Contact Person/Phone/Fax/E-mail Address:
Medicare Contractor Mailing Address:

Part A-HI, or Part B-SMI - as applicable (show which)
Intermediaries report Part A and/or Part B
Carriers report Part B only

Type of MSP Debt	Bene. *Medicare beneficiary identifier*	Bene. Name	Debtor Name	Debtor Type	Date of Initial Demand	Original AR Amount	Current Principal Balance (HI)	Current Interest Balance (HI)	Current Principal Balance (SMI)	Current Interest Balance (SMI)	Total Principal and Interest	Date of Last Payment, Offset, Recoup. Or Adjustment	TIN of Current Debtor

(Provide totals for each column if applicable)

CFO of Medicare Operations:_____ (signature required)
(Signature constitutes certification that all CMS specified criteria for CNC reclassification are met.)

Associate Regional Administrator/Division of Financial Management: (signature required) ___ Concur ___NonConcur

Date of Referral to RO : _____
Date of RO decision: _____
Date/quarter when approved MSP A/R were reclassified as CNC: _____

Attachment II

This is an exact duplicate of Attachment 1, "MSP Accounts Receivable: Contractor Recommendation for Reclassification as CNC" for Part B Intermediary Claim Activity. The heading at the top of the spreadsheet is "Part B of A" - SMI, instead of "Part A - HI." Intermediaries report their SMI data on this report.

410.4 - Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information is Provided

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

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The following instructions shall not supersede the present Program Integrity Manual (PIM) that references procedures for handling unsolicited refunds where there is a voluntary repayment and referral to law enforcement. The following procedures shall be followed when unsolicited/voluntary refund checks are received:

1) Do not return any check submitted by a provider/physician/supplier and other entities that is made payable to the Medicare program.

2) To ensure that repayment of Medicare funds is handled properly, Medicare contractors shall deposit such a check within 24 hours of receipt in accordance with Chapter 5, Financial Reporting Manual, section 100.3 and record the check in the account entitled “Other Liabilities – Unapplied Receipts” per Form CMS-750 instructions found in Chapter 5, Financial Reporting, Section 210.

3) If any checks are not deposited within the 24-hour period, contractors shall record those undeposited checks in the account entitled “Assets/Cash – Undeposited Collections” per Form CMS-750 instructions found in Chapter 5, Financial Reporting, Section 210. Medicare contractors shall implement internal controls to ensure the safeguarding of these Medicare checks until deposit.

4) If the specific Patient/*Medicare beneficiary identifier* information was provided, the contractor shall deposit the check and make/initiate the appropriate adjustments, depending on the entity making the refund and the purpose of the refund, either to the claims and/or to the claim history file within 60 days from the check’s date of deposit for Non-Medicare Secondary Payer (MSP), or 100 days from the initial ECRS inquiry for MSP. For those contractors whose checks are received through a locked box, appropriate claims adjustments shall be updated within 60 days of receipt of the bank’s notification of deposit for Non-MSP, and 100 days from the initial ECRS inquiry for MSP.

5) If the provider/physician/supplier, or other entity is not participating in the Self-Disclosure Protocol, contractors shall ensure that any MSN, or Remittance Advice, generated as the result of the claims adjustment contains appeals language, where appropriate. If necessary, contractors should determine the proper handling of unsolicited/voluntary refunds on any open or re-openable cost report.

6) No appeal rights shall be afforded, as stated in Exhibit 1, if the provider/physician/supplier, or other entity 1) does not submit the specific Patient/*Medicare beneficiary identifier* information, or 2) is participating in a Self-Disclosure Protocol agreement.

7) The Medicare contractor shall establish an accounts receivable in the Medicare system that shall be recognized on line 2a, New Accounts Receivable on Form CMS-751 report within 60 days after

the deposit of the voluntary refund for Non-MSP, or 100 days from initial ECRS inquiry for MSP. In addition, the Medicare contractor shall reduce the "Other Liabilities" account for the same amount, and shall apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-751 report.

8) The accounts receivable shall be established using the last name of the debtor that issued the check or on whose behalf the check was issued, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

9) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier or other entity including those established as a result of medical review, benefit integrity (BI) review, cost reports, other overpayment demands, and MSP demands. If an outstanding receivable is identified, the contractor shall apply the remaining amount of the unsolicited/voluntary refund to the outstanding receivable balance. If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.

10) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, or written documentation/evidence clearly supports that Medicare is not entitled to the money or was not the intended recipient of the refund check. Contractors shall follow the non-MSP provider/physician/supplier refund process when encountering MSP provider/physician/supplier unsolicited/voluntary refunds. Monies voluntarily sent in from beneficiaries (or a representative of) and/or insurers or other third party payers may be refunded **only** if COBC determines, after 100 days, no issue exists or an issue exists which results in the lead contractor identifying Medicare's claim to be less than the refunded amount. For example, many times an attorney may remit payment for the total conditional amount prior to a formal demand.

11) The Medicare contractor shall be responsible for completing Exhibit 1 (or facsimile thereof) as appropriate and reporting it on Exhibit 2.

12) Contractors are not required to report the established accounts receivable on the Physician Supplier Overpayment Reporting System (PSOR). (This requirement does not preclude the contractor from reporting the receivable on the PSOR for non-MSP, if current systems already do so. The contractor shall not report MSP accounts receivable on the PSOR.)

410.6 - Receiving and Processing Unsolicited/Voluntary Refund Checks When Identifying Information is not Provided

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

After depositing unsolicited/voluntary refund checks in accordance with section 410.4 above, Medicare contractors shall do the following:

For Non-MSP Checks

1) If no specific Patient/*Medicare beneficiary identifier* information was provided with the unsolicited/voluntary refund, the contractor shall contact the provider/physician/supplier, or other entity sending the refund check for further information. Exhibit 1 (overpayment refund) contains the minimum claim specific data necessary to process the refund. The contractor should use this form during phone inquiry or attach it to a letter to the provider/physician/supplier requesting further information regarding the submitted refund.

2) When there is no identifying information provided, the contractor shall perform the research necessary to obtain the minimum data required to meet the reporting requirements in Exhibit 2 (Summary Report). If the information is being collected via a telephone inquiry, the contractor employee conducting the inquiry shall inform the provider/physician/supplier, or other entity verbally that **if the specific Patient/** *Medicare beneficiary identifier* **information is not provided, no appeal rights can be afforded.**

   The minimum reporting data shall include:

   a. Provider/physician/supplier, or other entity's name, number, and Tax ID number.

   b. Identification of whether the provider/physician/supplier, or other entity has a CIA with the OIG or are under the OIG Self-Disclosure Protocol; and whether it is a straight refund (i.e., a provider not under a CIA or OIG Self-Disclosure Protocol).

   c. The reason(s) for each refund.

   d. The total number of refund checks (in the case of a check with multiple providers/reason codes, each instance shall be counted separately).

   e. The total dollar amount of refunds.

3) Medicare contractors shall have 60 days from deposit of the check to obtain the minimum claim specific data required to apply the check. The contractor shall take at least one documented follow-up action during the 60-day period to obtain the data.

4) If the minimum claim specific data required to apply the refund **is obtained** from the provider/physician/supplier, or other entity within 60 days from the check's date of deposit, the contractor shall make/initiate any appropriate adjustments to the identified claims and/or the claim history file for the amount of the refund. The contractor shall establish an account(s) receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account within 60 days after the deposit of the voluntary refund. The contractor shall ensure that any Remittance Advice or MSN generated as a result of the claim adjustment contains the appropriate appeals language, if applicable.

5) If the minimum claim specific data required to apply the refund **is not obtained** from the provider/physician/supplier, or other entity within 60 days from the check's date of deposit, the "Other Liabilities" account shall be reduced and an accounts receivable due to a straight refund shall be established for the amount of the unapplied unsolicited/voluntary refund. All Medicare systems shall allow contractors the ability to set up accounts receivable using either the provider/physician/supplier, or other entity or beneficiary number.

6) In both instances, the Medicare contractor shall establish an accounts receivable in the Medicare system that shall be recognized on line 2a, New Accounts Receivable on Form CMS-751 report within 60 days after the deposit of the voluntary refund. In addition, the Medicare contractor shall

perform a simultaneous transaction to apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-751 report.

7) The accounts receivable shall be established using the last name of the debtor identified on the check, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

8) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier including those established as a result of medical review, BI review, cost reports, other overpayment demands, and MSP demands. If an outstanding receivable is identified, the contractor shall apply the remaining amount of the unsolicited/voluntary refund to the outstanding receivable balance. If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.

9) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, or written documentation/evidence clearly supports that Medicare is not entitled to the money or was not the intended recipient of the refund check.

10) The Medicare contractor shall be responsible for ensuring the completion of Exhibit 1 (or facsimile thereof) and reporting it on Exhibit 2 upon final disposition of the unsolicited/voluntary refund (i.e., after investigation of the origin of the refund).

11) Contractors are not required to report the established accounts receivable on the PSOR. (This requirement does not preclude the contractor from reporting the receivable on the PSOR if current systems already do so.)

For MSP Checks

1) The Medicare contractor shall determine if there is an existing case and/or accounts receivable. If this is an existing case and/or accounts receivable, the contractor shall follow normal recovery procedures. If there is no case and/or accounts receivable, and there is indication of MSP involvement, the contractor shall send an MSP inquiry via the Electronic Correspondence Referral System (ECRS) to the MSP Coordination of Benefits Contractor (COBC) within 20 days from the check's date of deposit. The 45-day correspondence timeframe is not appropriate for addressing checks either solicited or unsolicited. Contractors shall identify checks during the initial mail sort and place a priority on their resolution and distribution. **When referring information to the COBC for MSP investigation, the contractor shall forward all pertinent data. All fields on the ECRS Inquiry screen shall be completed if the data is available on the returned check or any accompanying correspondence. Information in the informant fields such as telephone numbers, point of contact, etc. are critical to COBC development efforts.**

2) Medicare contractors shall only allow 100 days from the date of the ECRS inquiry for a response from the COBC before taking action with respect to the "unapplied receipts." This time period will also allow for the COBC to develop the case. If additional information is obtained after the initial inquiry that would help facilitate the processing and research of information, the COBC Consortia Representative shall be contacted and provided the additional information, via fax or telephone, to assist in completing the research. The contractor shall not send a second ECRS inquiry. A total of 120 days from the check's date of deposit will be allowed to bring closure to the unapplied receipt.

3) If the minimum reporting information from the MSP COBC **is provided** within 100 days from the initial ECRS inquiry, the contractor shall make/initiate any appropriate adjustments to either the identified claims and/or the claim history file for the amount of the refund, depending on the entity making the refund and the purpose of the refund. The Medicare contractor shall establish an account(s) receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account. If as a result of applying the voluntary refund the contractor identifies additional dollars specific to the issue in CWF, a demand letter shall be sent for the remaining amount owed.

4) If, within 100 days from the initial ECRS inquiry, 1) the minimum reporting information **is not provided,** 2) a response has not been received from the MSP COBC, or 3) a response from the COBC indicates they could not obtain a response (e.g., CM Code 62), Medicare contractors shall establish an accounts receivable and apply the balance of the check to the account(s) receivable from the "Other Liabilities" account. For COBC no response codes specific to a provider/physician/supplier unsolicited/voluntary refund, contractors should do the full claim adjustment but use a non-MSP reason (i.e., billed in error), which would then not need an MSP record to be established on CWF. The contractor shall report the refund in Exhibit 2 (Unsolicited/Voluntary Refund - Summary Report), and annotate with reason code 16. In addition, Exhibit 1 and/or the contractor's supporting documentation shall specify the refund as received with no reason for refund and/or no MSP response.

5) The Medicare contractor shall establish an accounts receivable in the Medicare system and that shall be recognized on line 2a, New Accounts Receivable on Form CMS-M751 report within 100 days after the initial ECRS inquiry. In addition, the Medicare contractor shall perform a simultaneous transaction to apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-M751 report. The contractor shall initiate normal MSP recovery action for any remaining outstanding balance owed.

6) The accounts receivable shall be established using the last name of the debtor that issued the check or on whose behalf the check was issued, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.

7) If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier or other entity including those established as a result of medical review, BI review, cost reports, other overpayment demands. If an outstanding receivable is identified, the contractor shall apply the remaining amount of the unsolicited/voluntary refund to the outstanding receivable balance. If there are multiple outstanding accounts receivables, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.

8) Medicare contractors shall not automatically refund excess recoupments to the provider/physician/supplier, or other entity. Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists, or written documentation/evidence clearly supports that Medicare is not entitled to the money or was not the intended recipient of the refund check. Contractors shall follow the non-MSP provider/physician/supplier refund process when encountering MSP provider/physician/supplier unsolicited/voluntary refunds. Monies voluntarily sent in from beneficiaries (or a representative of) and/or insurers or other third party payers may be refunded **only** if COBC determines, after 100 days, no issue exists or an issue exists which results in the lead contractor identifying Medicare's claim to be less than the refunded amount. For example, many times an attorney may remit payment for the total conditional amount prior to a formal demand.

9) The Medicare contractor shall be responsible for ensuring the completion of Exhibit 1 (or facsimile thereof) and reporting it on Exhibit 2 upon final disposition of the unsolicited/voluntary refund (i.e., after investigation of the origin of the refund).

10) Contractors shall not report the MSP accounts receivable on the PSOR.

411.1 - Exhibit 1 – Overpayment Refund Form

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____
Contractor Deposit Control # _____Date of Deposit: _____
Contractor Contact Name: _____ Phone #: _____
Contractor Address: _____
Contractor Fax: _____

SHALL BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER, OR OTHER ENTITY

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER OR OTHER ENTITY NAME:
_____
ADDRESS: _____
PROVIDER/PHYSICIAN/SUPPLIER #: _____ TAX ID #: _____
CONTACT PERSON: _____ PHONE #: _____
AMOUNT OF CHECK $: _____ CHECK #: _____ CHECK DATE: _____

REFUND INFORMATION

For each claim, provide the following:
Patient Name: _____ *Medicare beneficiary identifier*:
_____
Medicare Claim Number: _____ Claim Amount Refunded $: _____
Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim.)

(Please list all claim numbers involved. Attach separate sheet, if necessary)
Note: If Specific Patient/*Medicare beneficiary identifier* Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

NOTE: If specific patient *Medicare beneficiary identifier* information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians/suppliers, and other entities who are submitting

a refund under the OIG's Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For Institutional Facilities Only:
Cost Report Year (s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? ___ Yes ___ No
Are you a participant in the OIG Self-Disclosure Protocol? ___ Yes ___No

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Exhibit 1 – Overpayment Refund Form (Cont.)

Reason Codes:

Billing/Clerical:	MSP/Other Payer Involvement:	Miscellaneous:
01 – Corrected Date of Service	07 – MSP Group Health Plan Insurance	12 – Insufficient Doc
02 – Duplicate	08 – MSP No Fault Insurance	13 – Patient Enroll HMO
03 – Corrected CPT Code	09 – MSP Liability Insurance	14 – Svcs Not Rendered
04 – Not Our Patient(s)	10 – MSP, Workers Comp.	15 – Medical Necessity
05 – Mod. Add/Remove (Incl Black Lung)		16 – Other-Please Specify
06 – Billed in Error	11 – Veterans Administration	_____

Medicare Financial Management Manual
Chapter 6 - Part A and Part B Medicare Administrative Contractors (A/B MACs) Reports

80.6 - Recording Savings
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The intermediary controls all claims from which it extracts MSP savings and is able to verify all amounts recorded on the CMS-1563.

A. MSP Savings File - It retains claims specific key identifying information on each claim counted as savings on the CMS-1563. At a minimum, it records the beneficiary's name, *Medicare beneficiary identifier*, type/dates of service, claim control number, billed charges and savings amounts reported.

B. Savings Data From Non-Medicare Sources - If it records savings from data it obtained from its "private side" records or any other "outside" source, it must be able to extract the same claims specific information noted above, i.e., it must verify that Medicare covered services are involved and be able to calculate "what Medicare would have paid." In addition, it must compare this data with the data contained in its MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, it counts them as savings on the CMS-1563 and enters them into its MSP savings file.

330.3 - Section B - Cause of Overpayments
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This solicits the reasons for overpayments in which a determination was made **during the quarter** that an overpayment had been made to, or on behalf of, the beneficiary. The data include both the number of claims on which beneficiary-recoverable overpayments were discovered and the amount of overpayment (not over-allowance) involved.

Where more than one cause of overpayment exists, the carrier reports the claim and dollar amount of the overpayment on only one of the lines 14 through 23 according to the principal reason for overpayment. The principal reason is that which involves the greatest dollar amount.

The number of claims and amounts of beneficiary overpayments for reasons 14 through 23 combined should equal the number of claims and amount reported in Section A on line 4.

Line 14. Beneficiary Not Entitled - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted because payments were made to, or on behalf of, a beneficiary for services rendered during a period of non-entitlement or for claims processed under the wrong *Medicare beneficiary identifier*. (See Medicare Carrier Quality Assurance Handbook §290.1).

Line 15. Services Not Covered - The carrier enters the number and dollar amount of overpayments which resulted because payments were made for non-covered services other than medically unnecessary services. (See Medicare Carrier Quality Assurance Handbook §290.2).

Line 16. Charge Exceeded Reasonable Charge - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted when improper charges, higher than the reasonable charge amount, were allowed. (See Medicare Carrier Quality Assurance Handbook §290.3).

Line 17. Payment Made to Wrong Payee - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted when a person other than the proper payee received the payment (e.g., the beneficiary is paid on an assigned claim). It reports duplicate payments made to the wrong payee in line 18 instead of here.

Line 18. Duplicate Payment - The carrier enters under the appropriate columns the number and dollar amount of overpayments which occurred when payment was made to, or on behalf of, the beneficiary more than once for the same service.

Line 19. Medically Unnecessary Services - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which arose because of payments for services later determined to be medically unnecessary.

Line 20. Services Not Rendered - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which arose because of payments for services not actually rendered. It includes claims which involve forgery or fraudulent billing for noncovered services and other identified program abuses.

Line 21. Medicare Secondary Payor - The carrier enters under the appropriate columns the number and dollar amounts of overpayments which arose because Medicare is secondary to prime insurers (e.g., Department of Labor, BL, WC, VA, auto, medical or no fault, liability, EGHP under the working aged or ESRD provision or LGHP under the disabled provision).

Line 22. Documentation/Coding/Data Entry - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted from:

- Insufficient documentation to support the payment action. (This could involve a claims processor's failure to resolve questions concerning entitlement, coverage, utilization, or reasonable charge)
- Incorrect or incomplete coding; and
- Errors in the transferring of data from an external document into a machine readable form, including errors in keypunching and other methods for data entry. (See Medicare Carrier Quality Assurance Handbook §§210.5-210.6).

NOTE: If a documentation/coding data entry error results in an overpayment which may be categorized into any of lines 14 - 21, the carrier uses one of lines 14 - 21 instead of using line 22.

Line 23. Other - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which are not specifically provided for in lines 14-22 above.

440.6 - Recording Savings

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the

Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The carrier controls all claims from which it extracts MSP savings and is able to verify all amounts recorded on the CMS-1564.

MSP Savings File - The carrier retains claims specific key identifying information on each claim counted as savings on the CMS-1564. At a minimum, it records the beneficiary's name, *Medicare beneficiary identifier*, claim control number, type/dates of service, billed charges and savings amounts reported.

Savings Data from Non-Medicare Sources - If the carrier records savings from data which it has obtained from its "private side" records or any other "outside" source, it must be able to extract the same claims specific information noted above; i.e., it must verify that Medicare covered services are involved and be able to calculate "what Medicare would have paid." In addition, it compares these data with the data contained in its MSP savings file to ensure that savings have not previously been recorded for the same claim. If savings have not previously been taken, it counts them as savings on the CMS-1564 and enters them into its MSP savings file.

450.3 – Body of Report

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. General Report Content Requirements

The words “adjudicated,” “processed to completion” and “processed” are used in some of the instructions for completion of CROWD Form 5. A claim is considered to be “adjudicated” or “processed to completion” on the date of its payment (date a check is produced or Electronic Funds Transfer (EFT) authorization is issued), or the date the remittance advice is issued in the event no check/EFT was due. A National Council for Prescription Drug Program (NCPDP) claim is considered “processed” on the date when it has passed all front end edits and is passed to the Core System for processing.

Every column in CROWD Form 5 does not apply to each type of data, and there are different types of columns in some areas of the report. No data is to be entered into any shaded fields.

All of the data to be reported on CROWD Form 5 is for the prior calendar month. CROWD Form 5 data must be entered by the A/B and DME MACs by the 15th of each month. Data due from a shared system must be available for the A/B and DME MACs use by the 5th of the month following the month during which the data were collected. Certain types of data must be collected by individual A/B and DME MACs. When applicable, that data must also be tracked for each calendar month.

Institutional and professional blocks have been added to the identification area at the top of the form. A/B MACs process both institutional and professional claims but are expected to separately report their professional and institutional data in CROWD. One CROWD Form 5 must be submitted for professional data and another for institutional data. This corresponds to the separate professional and institutional reporting always done by the A/B and DME MAC. Every CROWD Form 5 submitted must have a check mark next to either institutional or professional. This will enable CMS to compare statistics received from the A/B MACs against historical data separately submitted by carriers and FIs.

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by A/B and DME MACs. They cannot currently be filed by shared system or CWF maintainers. Appropriate rows have been identified for the reporting of 4010A1 data. Appropriate additional rows have also been added to allow for the reporting of version 5010 data. Where no version is appropriate for a row there is no version listed.

Line 1 – Line 1 –Shared systems shall track and report the number of claim status flat file requests sent from each of their A/B and DME MAC. Each A/B and DME MAC is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the ASC X12 276, use TRN02 or REF02 of the 2200D loop) as a separate claim status request

Line 2 – Responses to Claim Status Inquiries – Shared systems must track the number of claim status flat file responses sent to each of their A/B and DME MAC for translation into ASC X12 277 transactions. Each A/B and DME MAC is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the ASC X12 277, use TRN02 or REF02 of the 2200E loop) as a separate claim status response. Include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason, such as unable to locate a claim for that *Medicare beneficiary identifier* on that day) responses in the count, but do not include queries that were rejected as incomplete or incorrect.

Line 3 – Remittance Advices-Number Sent – Shared systems are to track the number of ASC X12 835 flat files sent to their A/B and DME MAC. They must report each occurrence of an ASC X12 835 ST to SE segment sent as a separate electronic remittance advice (ERA) transaction for counting purposes. If a provider is sent both an electronic and a paper remittance advice for the same group of claims, they are to count them separately as one electronic and one non-electronic remittance advice. The A/B and DME MACs must report the total number of ERAs in column 1.

The shared system must also track the number of standard paper remittance (SPR) files sent their users for printing in each calendar month. A/B and DME MACs must report this total in column 2.

The A/B and DME MACs must track and report the number of remittance advices posted to the Internet/Portal. This count shall include the number of Internet Remittance Advices posted no matter if the provider is receiving a remittance advice in another format. A/B and DME MACs must report this total in column 3 (INTERNET/PORTAL).

Line 4 – Number of Payments to Providers or Suppliers– Shared systems are to track the number of electronic fund transfers (EFTs) and paper checks for provider claim payments that the A/B and DME MACs were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an ASC X12 835 ERA or an SPR. The paper check total must be the total of paper checks sent in conjunction with an SPR or an ASC X12 835. In some cases, a remittance advice might not have any payment because all the claims were denied, entire payment due a provider is being withheld to recoup an overpayment, or payments to a provider are being held in an escrow account pending completion of an investigation. As result, the number of payments does not always equal the number of SPRs and ERAs issued. A/B and DME MACs must report the EFT total in column 1 and the paper check total in column 2.

Line 5 – Dollar Amounts Associated w/Payments – Shared systems must track the dollar value of the EFTs and checks issued by their A/B and DME MACs for provider claim payments each month. The A/B and DME MAC must report the dollar value of the EFTs in column 1 and of the paper checks in column 2.

Line 6 – Electronic Claims Processed—Shared systems must track the following information which each A/B and DME MAC and must enter as indicated in CROWD Form 5:

- In the column 1, the total of processed electronic ASC X12 837 claims (exclude Direct Data Entry (DDE) claims sent to A/B MACs (A)) for version 4010 and 5010.

- In the column 2, all electronic claims processed that were submitted via DDE screens. (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of received ASC X12 837 claims.) Non- A/B MACs (A), who do not accept claims via DDE, must enter zero.

Line 7 —DDE Claim Adjustments Received—FISS must track the number of adjustments submitted via DDE for claims (it does not matter for reporting in this line whether the claims themselves were submitted via DDE). If multiple adjustments are made during the same connection session to the same claim, they must be reported as one adjustment. If multiple claims are adjusted during the same session by a provider or clearinghouse, FISS must count each claim separately regardless of the number of fields modified in each of those claims. The A/B MACs (A) must report the total number of adjustments in column 2.

Line 8 —DDE Claim Status Responses—Shared systems must track the number of claim status responses issued via a DDE screen. A/B and DME MAC must report that number in column 2. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The A/B and DME MAC must report that number in column 2. The A/B and DME MAC shall report the number of remittance advices posted to the Internet/Portal in Column 3.

Line 9 —Paper Claims Processed—Shared systems shall track the total number of paper claims processed per contractor and each A/B and DME MAC shall report their UB-04 or CMS-1500 total in column 2.

Line 10 – National Council of Prescription Drug Plans (NCPDP) Retail Pharmacy Drug Claims processed. VMS shall track the number of NCPDP claims processed. VMS is to count each unique occurrence of a claims control number as a separate claim. The DME MACs are to report this number is column 1.

460.2 - Section I – Redeterminations

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section concerns data from Part A and Part B of A appeals processed by A/B MACs (A) as well as Part B appeals processed by A/B MACs (B) and DME MACs.

Redeterminations. The number of redeterminations requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.

A redetermination is the first level of appeal following an initial determination of a Part A claim or Part B claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 29, Section 310.)

Do not count duplicate redetermination requests or redetermination requests received before you have made an initial determination on a claim. Do not count inquiries. Count one redetermination per request received.

With the exception of those lines for which claims counts are specifically requested in the report, count only cases. Do not count a duplicate request for appeal as a processed appeal. Duplicate requests can be reflected in Line 2 (Adjustment to Pending) of the CMS-2592 Report for the subsequent month.

Redeterminations fall into the following categories:

Column (1) Part A Cases- Use Column 1 to report information on Part A services processed by the A/B MAC (A).

Column (2) Part B of A Cases- Use Column 2 to report information on Part B services processed by the A/B MAC (A).

Column (3) Part B Cases- Use Column 3 to report information on Part B services processed by the A/B MAC (B) or DME MAC.

Line 1. Opening Pending - Show under columns 1-3, the number of redetermination cases reported on Line 21 as the closing pending redetermination cases on the previous month's report.

Line 2. Adjustments to Pending - CMS understands that it is often necessary to revise the categorization of data from the original categorization given when a case was initially received at the contractor. Likewise, it is often necessary to move data from one line to another in order to maintain accuracy. Prior to the submission of the monthly 2592 report to CMS, contractors are permitted to make changes to data during the reporting month to ensure that appeal workloads are accurately reflected.

Once the monthly 2592 report has been submitted to CMS, any changes to the closing pending figure of the report must be reflected in the Adjustments to Pending line of the subsequent month's report. If it is necessary to revise the pending figure for the close of the **previous** month's report because of inventories or reporting errors, enter the adjustment. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending count in the subsequent month. Examples include any instances where something originally categorized as an appeal was determined not to be an appeal, or vice-versa. Duplicate requests for redetermination are also reflected here. If the contractor receives a request for appeal near the end of the reporting month but the case arrives too late to be reflected as a receipt in the CMS-2592 report for that month, count the case in the Adjustment to Pending line of the subsequent month's report. The purpose of the Adjustments to Pending line is to allow the contractor to modify Opening Pending counts, thereby correcting errors resulting from inventory or reporting problems that were identified after the submission of the CMS-2592 previous month's report to CMS.

Do not make adjustments to the Pending line or other lines of the 2592 report once the report has been submitted to CMS. If there is an entry for Line 2, it should be preceded by a "+" or "-", as appropriate.

Line 3. Adjusted Pending - Enter the result of Line 1 + Line 2 (taking into account the "-" sign, if any).

Line 4. Requests Received - Show, under the appropriate columns, the number of requests for redeterminations received during the reporting month. Include requests transferred to you by other A/B or DME MACs or remanded by the Qualified Independent Contractor (QIC).

NOTE: See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

Line 4.a. Adjusted Requests Received - As a result of actions taken by the A/B and DME MACs to process appeals during the reporting month, show on this line the number of receipts that have actually been validated by the MAC to be a redetermination. This line should include both RAC and non-RAC redeterminations.

NOTE: See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

Line 4.1. Number of Claims Received – Show the total number of redetermination claims involved in Line 4.a.

Line 4.2. Recovery Audit Contractor (RAC) Requests Received - Of the redetermination requests reported in Line 4.a, show the number that are Recovery Audit related. Line 4.2 is a subset of Line 4.a and should contain only RAC redeterminations.

Line 4.2.1. Number of RAC Claims Received – Show the number of redetermination claims involved in Line 4.2.

Line 5. Misrouted Requests Forwarded to Another Contractor - Show under columns 1 through 3 the number of redetermination requests the contractor forwarded to other contractors, because they were misrouted to you and you did not process the original claim(s). For columns 1-3, if you have reported a redetermination as forwarded, do not report any information regarding it on Lines 6-29. The forwarding of the misrouted request is the final action.

NOTE: This line is not intended for QIC reconsideration requests that were misrouted.

Line 6. Requests Cleared - Show, under the appropriate columns, the total number of redeterminations completed during the month. Report all completed redeterminations, regardless if the final outcome was an affirmation, reversal, withdrawal, or dismissal. Do not count cases that were transferred to another contractor because they were misrouted.

NOTE: A/B MACs (A) should count received and completed MSP redetermination cases in Columns 1 of Lines 4 and 6, as appropriate, regardless of whether claims involved are Part A, Part B or a combination. Do not count or report claims involved in MSP cases. MSP cases should be counted in Lines 4, 6, 7, 8, 9, 10 and 11. Do not count MSP claims on Lines 4.1, 6.1, 7.1, 8.1, 9.1, 10.1 and 11.1.

A/B MACs (B) that handle MSP cases should count them in Column 3.

Line 6.1. Number of Claims Cleared – Show the total number of claims involved in Line 6.

NOTE: For Lines 6.1 through 11.1 (letters a through i), enter the number and type of claim processed. If no claims from a certain claim type are processed, enter NA. Refer to instructions for the CMS-1565 and 1566, as well as appropriate sections of the Claims Processing Manual for guidance on determining the categories and types of claims processed by A/B MACs and DME MACs.
Line 6.1a – Report the number of SNF claims included in Line 6.1. Line 6.1b – Report the number of Home Health claims included in Line 6.1. Line 6.1c – Report the number of Inpatient Hospital claims included in Line 6.1. Line 6.1d – Report the number of Outpatient claims included in Line 6.1. Line 6.1e – Report the number of Lab claims included in Line 6.1. Line 6.1f – Report the number of Ambulance claims included in Line 6.1. Line 6.1g – Report the number of DME claims included in Line 6.1. Line 6.1h – Report the number of Physician claims reported in Line 6.1. Line 6.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 6.1.

Consider a redetermination cleared when:

- For affirmations, when all claims of the case are included in the decision and the decision letter is mailed to the parties

- For full and partial reversals:

(1) all claims within the case are included in the decision and the decision letter is mailed to the parties, and

(2) the contractor completes the action that sets in motion correct payment of the claim.

- For withdrawals and dismissals, the dismissal notice is mailed to the parties.

Note that sending a letter to the mailroom does not constitute mailing the letter. Letters must be mailed to the appellant on or before the 60th day in order for the requirement to be met.

NOTE: Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs.

Line 6.2. Recovery Audit Contractor (RAC) Redeterminations Cleared - Of the cases reported in Line 6, how many are RAC related?

Line 6.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 6.2.

Line 7. Cleared -- Evidence Submitted After Request - Of the cases reported in Line 6, show under the appropriate columns, the total number of redetermination cases for which additional documentation was submitted by the party on his or her own or when the documentation was requested by the contractor after the request was received.

Line 7.1. Number of Claims Involved – Show the total number of claims involved in Line 6.1 for which evidence was submitted after the request was received.

Lines 7.1a through 7.1i are Not Applicable. Line 7.1a – Report the number of SNF claims included in Line 7.1. Line 7.1b – Report the number of Home Health claims included in Line 7.1. Line 7.1c – Report the number of Inpatient Hospital claims included in Line 7.1. Line 7.1d – Report the number of Outpatient claims included in Line 7.1. Line 7.1e – Report the number of Lab claims included in Line 7.1. Line 7.1f – Report the number of Ambulance claims included in Line 7.1. Line 7.1g – Report the number of DME claims included in Line 7.1. Line 7.1h – Report the number of Physician claims reported in Line 7.1. Line 7.1i - Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 7.1.

Line 7.2. RAC Redeterminations Cleared With Additional Documentation - Of the cases reported in Line 7, how many are RAC related?

Line 7.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 7.2.

Note about Lines 8-11:

Count the cases in the following manner:

- If a case has multiple claims and all are affirmed, count the case as an affirmation.

- If a case has multiple claims, some of which are affirmed and others are partially reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

- If a case has multiple claims, some of which are partially reversed and others are fully reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

- If a case has multiple claims, all of which are fully reversed, count the case as a full reversal.

- If a case has multiple claims, some of which are fully reversed and the others are dismissed or withdrawn, count the case as a full reversal.

- If a case has multiple claims, one of which is affirmed, one of which is a partial reversal and one of which is dismissed, count the case as a partial reversal.

- If a case has multiple claims which are fully reversed, affirmations and withdrawals/dismissals, count the case as a partial reversal.

- If a case has two claims, one of which is affirmed and the other is dismissed, count the case as an affirmation.

Full	Partial	Affirmation	Dismissal/ Withdrawal	=	Report As
X					Full
	X				Partial
		X			Affirmation
			X		Dismissal/ Withdrawal
X	X				Partial
X		X			Partial
X			X		Full
X	X	X			Partial
X	X	X	X		Partial
	X	X			Partial
	X		X		Partial
		X	X		Affirmation
	X	X	X		Partial

Line 8. Affirmations - Under the appropriate columns, show the number of completed redeterminations from Line 6 in which the previous determinations were completely upheld; i.e., no change was made. All claims in a case must be upheld in order for the case to be counted as an affirmation. In instances where claims some are affirmed, but all others are dismissed or withdrawn, count the case as an affirmation. (Do not include partial reversals in this line. See Line 9 for partial reversals). Include those instances where the decision was affirmed, but a change in liability was noted.

Line 8a. Waiver of Liability Amount Paid Not Applicable - Show the amount paid under waiver of liability, on the basis that the party did not know that the service wasn't payable under Medicare.

Line 8.1. Number of Claims Affirmed – Show the number of claims involved in Line 6.1 for which the decision was affirmed.

NOTE -- The following example is counted as an affirmation: A claim is denied at the initial determination level and a redetermination is requested. At the redetermination level, the denial is upheld but the denial is for a reason other than was determined to be applicable at the initial determination level. Count the claim as an affirmation.

Line 8.1a – Report the number of SNF claims included in Line 8.1. Line 8.1b – Report the number of Home Health claims included in Line 8.1. Line 8.1c – Report the number of Inpatient Hospital claims included in Line 8.1. Line 8.1d – Report the number of Outpatient claims included in Line 8.1. Line 8.1e – Report the number of Lab claims included in Line 8.1. Line 8.1f – Report the number of Ambulance claims included in Line 8.1. Line 8.1g – Report the number of DME claims included in Line 8.1. Line 8.1h – Report the

number of Physician claims reported in Line 8.1. Line 8.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 8.1.

Line 8.2. RAC Redeterminations Affirmed- Of the affirmation cases reported in Line 8, how many are RAC related?

Line 8.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 8.2.

Line 9. **Partial Reversals** - Under the appropriate columns, show the number of completed redeterminations, from Line 6 in which part of the prior determination decision of the appealed lines was reversed. That is, a change was made and some part of the new determination was in favor of the appellant. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 9.1. Number of Claims Partially Reversed – Show the number of claims involved in Line 6.1 for which the decision is partially reversed. Note: It is possible to have zero claims in Line 9.1, even when cases are recorded in Line 9.

Line 9.1a – Report the number of SNF claims included in Line 9.1. Line 9.1b – Report the number of Home Health claims included in Line 9.1. Line 9.1c – Report the number of Inpatient Hospital claims included in Line 9.1. Line 9.1d – Report the number of Outpatient claims included in Line 9.1. Line 9.1e – Report the number of Lab claims included in Line 9.1. Line 9.1f – Report the number of Ambulance claims included in Line 9.1. Line 9.1g – Report the number of DME claims included in Line 9.1. Line 9.1h – Report the number of Physician claims reported in Line 9.1. Line 9.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 9.1.

Line 9.2. RAC Redeterminations Partially Reversed– Of the partially reversed cases reported in Line 9, how many are RAC related?

Line 9.2.1 Number of RAC Claims Involved – Show the number of claims involved in Line 9.2.

Line 10. Full Reversals - Under the appropriate columns, show the total number of completed redeterminations from Line 6 in which the previous determination decision of the appealed lines was completely reversed. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 10.1. Number of Claims Fully Reversed – Show the number of claims involved in Line 6.1 for which the decision is fully reversed.

Line 10.1a – Report the number of SNF claims included in Line 10.1. Line 10.1b – Report the number of Home Health claims included in Line 10.1. Line 10.1c – Report the number of Inpatient Hospital claims included in Line 10.1. Line 10.1d – Report the number of Outpatient claims included in Line 10.1. Line 10.1e – Report the number of Lab claims included in Line 10.1. Line 10.1f – Report the number of Ambulance claims included in Line 10.1. Line 10.1g – Report the number of DME claims included in Line 10.1. Line 10.1h – Report the number of Physician claims reported in Line 10.1. Line 10.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 10.1.

Line 10.2 RAC Redeterminations Fully Reversed – Of the fully reversed cases reported in Line 10, how many are RAC related?

Line 10.2.1 Number of RAC Claims Involved – Show the number of claims involved in Line 10.2.

Line 11. Dismissals/Withdrawals - Report, under the appropriate column, the number of cases from Line 6 that were withdrawn by the appellant or dismissed (before determination) by you. In order for a case to be recorded in Line 11, all claims in the case must be dismissed or withdrawn.

NOTE: Do not count cases that were dismissed because they were determined to be incomplete in Line 11. Cases that were dismissed because they were determined to be incomplete should only be counted in Line 12.

Line 11.1. Number of Claims Dismissed or Withdrawn – Show the number of claims involved in Line 6.1 which were dismissed or withdrawn.

Line 11.1a – Report the number of SNF claims included in Line 11.1. Line 11.1b – Report the number of Home Health claims included in Line 11.1. Line 11.1c – Report the number of Inpatient Hospital claims included in Line 11.1. Line 11.1d – Report the number of Outpatient claims included in Line 11.1. Line 11.1e – Report the number of Lab claims included in Line 11.1. Line 11.1f – Report the number of Ambulance claims included in Line 11.1. Line 11.1g – Report the number of DME claims included in Line 11.1. Line 11.1h – Report the number of Physician claims reported in Line 11.1. Line 11.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 11.1.

Notes:

Misrouted correspondence and duplicate requests are not dismissals.

Line 11.2. RAC Redeterminations Dismissed or Withdrawn - Of the dismissed or withdrawn cases reported in Line 11, how many are RAC related?

Line 11.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 11.2.

Line 12. Number of Incomplete Redetermination Requests Dismissed - Enter the number of cases that were dismissed because the request was incomplete. Report incomplete cases in Line 12 only if ALL the claims from the case are incomplete. For information on what constitutes an incomplete request, refer to the Medicare Claims Processing Manual, Publication 100-04; Chapter 29; Section 310.1

NOTE: If one redetermination request contains multiple claims and or line items and is split, report the case according to the overall disposition of the individual claims and/or line items. (In many instances, split cases will be reported as partially reversed).

Example: A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request contains a name and signature of the appellant/supplier, and the supporting documentation identifies individual claims of the beneficiaries, pertinent *Medicare beneficiary identifier* and the dates of service. However, for some of the claims, the supplier does not identify the specific services (among the several line items on the claim) that are disputed. The contractor should not dismiss the entire redetermination request. Rather, in this situation, the contractor issues dismissals (incomplete requests) with respect to the individual claims for which the requisite information is incomplete, and issues favorable and/or unfavorable decisions for the remaining claims, as appropriate. For the purposes of reporting, the case is reported according to the overall disposition of the individual claims and/or line items. If the case contains some affirmations, reversals and dismissals, count the case as partially reversed in Line 9.

Example: A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request is missing the signature of the appellant/supplier, but identifies the individual claims of the beneficiaries, pertinent names and *Medicare beneficiary identifiers*, dates of service and the items or services disputed. Since the signature is missing, the entire request would be dismissed as incomplete, and counted in Line 12 of the CMS-2592.

Do not count cases that were dismissed for reasons other than being incomplete on Line 12. Only count those instances for which the entire request is dismissed on Line 12.

Line 13. Medicare Approved Amount (Not Applicable) - For cases included in Lines 9 and 10, show the Medicare Approved Amount for services where the initial determination was reversed at the redetermination level, either fully (Line 10) or partially (Line 9). Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Processing and Pending Times -This deals with processing and pending times for Part A and Part B appeals.

Computing Time to Process Redeterminations for (Lines 6 through 25)

For Lines 6-25, use the matrix below to determine the number of days from receipt to completion of redeterminations. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. In order to ensure that cases are processed timely, cases should also be date stamped or controlled in some way in the mailroom.

Situation	Date Completed
o The appellant withdraws the request.	The date the dismissal letter is mailed to the party.
o The contractor dismisses the request	The date the dismissal letter is mailed to the party.
o The contractor reverses the initial determination.	For both full and partial reversals, when the contractor completes the action that sets in motion correct payment of the claim and the contractor mails the decision letter to the party.
o The contractor affirms the initial determination	The date the decision letter is mailed to the party.

REDETERMINATIONS

PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED TIMELY (Lines 14-16)

Line 14. Redetermination Processing Time – Average – Report, under the appropriate columns, the average number of days from receipt of the redetermination in the corporate mailroom to the date of completion. Do not include redeterminations where documentation is submitted after the request (i.e., a redetermination cannot be counted in both Line 14 and Line 17).

To compute the average number of days from request to completion, divide the total days elapsed for all requests (where the documentation was submitted timely) cleared in the month by the number of requests cleared. Round results to the nearest day. The days elapsed for an individual request are calculated using the number of days from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number). If a case is cleared the same day it is received, consider it to require one day. For example, a case that is received and processed on January 7 is considered to require one day to clear. A case received on January 7 and cleared on January 8 is considered to require 2 days to clear.

Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

Line 15. Redeterminations Completed in 1-60 Days - Show the number of redeterminations that required 1-60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

Line 15a. RAC Redeterminations Completed in 1-60 Days – Of the total number of appeals reported in Line 15, show the number that are RAC related.

Line 16. Redeterminations Completed in over 60 Days - Show the number of redeterminations that required more than 60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

Line 16a. RAC Redeterminations Completed in Over 60 Days – Of the number of appeals reported in Line 16, show the number that are RAC related.

PROCESSING TIME: Redeterminations with DOCUMENTATION SUBMITTED AFTER REQUEST WAS RECEIVED (Lines 17-20)

NOTE: This section captures information in instances where the party submits additional documentation at the redetermination level (including those instances when the contractor requests the additional documentation) after the initial request for redetermination is received. The contractor must receive the documentation before the 60 day timeframe is up in order for data to be entered into Lines 17-20.

Line 17. **Redeterminations Processing Time - Average (Documentation Submitted Later)** – For redeterminations where documentation/evidence is submitted after the request is received, report under the appropriate columns, the average number of days from receipt of the redetermination to the date of completion. Using redeterminations where documentation was submitted later as the basis, follow instructions in Line 14 to calculate the average processing time.

Line 18. Redeterminations Completed in 1-60 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 1-60 calendar days were required to complete the case.

Line 18a. RAC Redeterminations Completed in 1-60 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 18, show the number that are RAC related.

Line 19. Redeterminations Completed in 61-74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 61-74 calendar days were required to complete the case.

Line 19a. RAC Redeterminations Completed in 61-74 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 19, show the number that are RAC related.

Line 20. Redeterminations Completed in over 74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and more than 74 calendar days were required to complete the case.

Line 20a. RAC Redeterminations Completed in over 74 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 20, show the number that are RAC related.

Pending Time Frames

Line 21. Closing Pending Redeterminations - Show, under the appropriate columns, the total number of redeterminations that have not been completed by the end of the reporting month. Note: Do not include pending effectuations in this line.

Line 22. Redeterminations Pending 1-30 Days – Show the number of redeterminations included in Line 21 that have been pending for 1-30 days, inclusive, at the end of the reporting month.

Line 23. Redeterminations Pending 31-60 Days - Show the number of redeterminations included in Line 21 that have been pending 31-60 days, inclusive, at the end of the reporting month.

Line 24. Redeterminations Pending 61-74 Days - Show the number of redeterminations included in Line 21 which have been pending 61-74 days, inclusive at the end of the reporting month.

Line 25. Redeterminations Pending Over 74 Days - Show the number of redeterminations included in Line 21 which have been pending more than 74 days at the end of the reporting month.

EFFECTUATION OF REDETERMINATION DECISIONS

Line 26. Total Effectuations - Show the number of redetermination cases for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

Notes: Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed" and "When to Consider a Case Effectuated").

Line 26a. Number of Claims Involved – Show the number of claims involved in Line 26.

Line 27. Number Effectuated 1-30 Days - Show the number of claims from Line 26a where you effectuated the decision within 30 calendar days of the date of the decision.

Line 28. Number Effectuated 31-60 Days - Show the number of claims from Line 26a where you effectuated the decision within 31- 60 calendar days of the date of the decision.

Line 29. Number Effectuated Over 60 Days - Show the number of claims from Line 26a where you effectuated the decision in more than 60 calendar days of the date of the decision.

Medicare Financial Management Manual
Chapter 12 – Instructions for Medicare Credit Balance Report Activities

10.1.3 - Processing CMS-838 Claims Adjustments
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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 *Medicare beneficiary identifier*, 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.

20.2 - Completing the CMS-838
(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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 *beneficiary identifier* 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.

20.9 - Exhibit II: Medicare Credit Balance Report Detail Page

(Rev.315, Issued: 05-17-19, Effective: 06-18- 19, Implementation: 06-18-19)

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Department of Health & Human Services
Form Approved
Centers for Medicare & Medicaid Services
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) *Medicare beneficiary identifier*	(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)

Form CMS-838 (10/03) INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT – PROVIDER INSTRUCTIONS, FORM CMS-8