

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 275	Date: November 18, 2016
	Change Request 9708

SUBJECT: Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision

I. SUMMARY OF CHANGES: This Change Request will provide additional criteria for determining when a contractor shall assume a provider, physician, or other supplier should have known about a policy or rule.

EFFECTIVE DATE: February 21, 2017

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

IMPLEMENTATION DATE: February 21, 2017

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/Table of Contents
R	3/90/Provider, Physician, or Other Supplier Liability
R	3/90.1/Examples of Situations in Which Provider, Physician, or Other Supplier Is Liable
R	3/90.2/Provider, Physician, or Other Supplier Protests Its Liability

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**

Number	Requirement	Responsibility							
		A/B MAC		D M E	Shared- System Maintainers				Other
		A	B		H H H	M I S S	V C S	C M W F	
	<p>particular provider/physician/supplier;</p> <ul style="list-style-type: none"> The provider, physician, or other supplier was previously investigated or audited as a result of not following the policy or rule; The provider, physician, or other supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule; The provider, physician, or other supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or The provider, physician, or other supplier previously received documented individual training/outreach from CMS or one of its contractors related to the same policy or rule. 								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E	C M E D I	
		A	B	H H H			
9708.2	<p>MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X	X	X	X		

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): Jay Blake, 410-786-9371 or jay.blake@cms.hhs.gov, Donna Sanders, 410-786-0289 or donna.sanders@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

Table of Contents

(Rev.275, Issued: 11-18-16)

90 – Provider, *Physician, or Other Supplier* Liability

90.1 - Examples of Situations in Which Provider, *Physician, or Other Supplier* Is Liable

90.2 - Provider, *Physician, or Other Supplier* Protests Its Liability

90 - Provider, *Physician, or Other Supplier* Liability

(Rev. 275, Issued: 11-18-16, Effective: 02-21-17, Implementation: 02-21-17)

A provider, *physician, or other supplier* is liable for overpayments it received unless it is found to be without fault. The *contractor*, as applicable, makes this determination.

The *contractor* considers a provider, *physician, or other supplier* without fault, if it exercised reasonable care in billing for, and accepting, the payment; i.e.,

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

Normally, it will be clear from the circumstances whether the provider, *physician, or other supplier* was without fault in causing the overpayment. Where it is not clear, the *contractor* shall develop the issue.

90.1 - Examples of Situations in Which Provider, *Physician, or Other Supplier* Is Liable

(Rev. 275, Issued: 11-18-16, Effective: 02-21-17, Implementation: 02-21-17)

In accordance with §90 the following are examples of situations in which the provider, *physician, or other supplier* is liable for an overpayment it received.

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

This includes, among others, situations in which a provider, *physician, or other supplier* failed to report any additional payments he may have received from the beneficiary and situations in which a provider, *physician, or other supplier* failed to request applicable information from the beneficiary including, but not limited to, information needed by the *contractor* to identify cases in which Medicare may be secondary payer, or if it did request such information, it failed to annotate the billing form.

(Providers, *Physician, or Other Supplier* are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help the *contractor* identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan.) (See Medicare Claims Processing, chapter 29, Coordination With Medigap Insurers.)

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

B. Provider, *Physician, or Other Supplier* Receives Duplicate Payments.

This includes the following situations:

- Provider, *physician, or other supplier* is overpaid because the *contractor* processed the provider's, *physician's, or other supplier's* claim more than once. If an overpayment to a provider, *physician, or other supplier* is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the provider, *physician, or other supplier* does not have a reasonable basis for assuming that the total payment the provider, *physician, or other supplier* received was correct and thus should have questioned it. The provider, *physician, or other supplier* is, therefore, at fault and liable for the overpayment.
- Provider, *physician, or other supplier* received payment from Medicare on the basis of an assignment and a beneficiary received payment on an itemized bill and turned the beneficiary payment over to the provider, *physician, or other supplier*. The provider, *physician, or other supplier* is liable for only the portion of the total

amount paid in excess of the provider's, *physician's, or other supplier's* portion of the allowable amount. The beneficiary is liable for the balance of the overpayment. However, if the beneficiary paid any portion of the coinsurance to the provider, *physician, or other supplier*, the provider, *physician, or other supplier* is liable for that amount also. If the provider, *physician, or other supplier* protests recovery of the overpayment on the grounds that the provider, *physician, or other supplier* applied all or part of the check received from the beneficiary to amounts the beneficiary owed the provider, *physician, or other supplier* for other services, the beneficiary, rather than the provider, *physician, or other supplier*, is liable for refunding such amounts.

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

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

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

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

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

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

If the previous stay had been in a different hospital, or if more than 60 days had elapsed between the end of the first stay and the start of the second stay but the benefit period had remained unbroken because John had been in an SNF or a different hospital, the *contractor* would consider University Hospital "without fault." In this latter situation, the hospital would not have been able to ascertain from its own records that benefit days had been exhausted. The *contractor* would seek recovery from the beneficiary.

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

Examples:

- Error in calculation by the *contractor* in calculating reimbursement;
- Error by the provider, *physician, or other supplier* in calculating charges, or
- Overlapping or duplicate bills.

Mathematical error does not include a failure to properly assess the coinsurance and/or deductible. The *contractor* would determine the liability for coinsurance and deductible overpayments in accordance with D.

above. Where payment to a provider, *physician, or other supplier* was based on a deductible amount, the provider, physician, or other supplier is without fault. Seek recovery from the beneficiary.

E. The Provider, *Physician, or Other Supplier* Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

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

(See the Program Integrity Manual, which can be found at the following Internet address:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>, if fraud is suspected.)

G. The Beneficiary Was Not Entitled to Part A Benefits and the Provider, *Physician, or Other Supplier* Had Reason to Believe That the Beneficiary Was Not Entitled to Such Benefits.

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

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

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

In general, the provider, *physician, or other supplier* should have known about a policy or rule, if:

- The policy or rule is in the provider, *physician, or other supplier* manual or in Federal regulations;
- *CMS or a CMS contractor* provided general notice to the medical community concerning the policy or rule;
- *CMS, a CMS contractor, or the OIG* gave written notice of the policy or rule to the particular provider, *physician, or other supplier*;
- *The provider, physician, or other supplier was previously investigated or audited as a result of not following the policy or rule;*
- *The provider, physician, or other supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;*
- *The provider, physician, or other supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements, which are related to the policy or rule; or*
- *The provider, physician, or other supplier previously received documented training/outreach from CMS or one its contractors related to the same policy or rule.*

Generally, a provider's, *physician's, or other supplier's* allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met. However, there may be other circumstances that justify a finding that the provider, *physician, or other supplier* was not at fault. The *contractor* shall consider all of the circumstances, including such factors as whether and to what extent a coverage rule is spelled out in regulations, instructions, or in a CMS notice, and whether a *contractor* misinformed the provider, *physician, or other supplier* about the rule; in deciding whether a provider, *physician, or other supplier* acted reasonably in billing for and accepting payment for noncovered services.

2. Medically Unnecessary or Custodial Services.

The *contractor* shall apply the criteria in Medicare Claims Processing, Chapter 30, *Financial Liability Protection* in determining whether the provider, *physician, or other supplier* should have known that the services were not covered.

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

J. The Physician Was Paid but Did Not Accept Assignment.

The physician is liable whether or not the beneficiary had also been paid.

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

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

L. Items or Services Were Furnished by Practitioner or Supplier not Qualified for Medicare Reimbursement

Two examples of such services are:

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

90.2 – Provider, *Physician, or Other Supplier* Protests Its Liability

(Rev. 275, Issued: 11-18-16, Effective: 02-21-17, Implementation: 02-21-17)

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

- a. There was an overpayment;
- b. The amount of the overpayment was correctly calculated; and whether,

The provider, *physician, or other supplier* is liable for repayment.