CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 41 **Date: APRIL 30, 2004**

CHANGE REQUEST 3163

I. SUMMARY OF CHANGES: Relevant provisions of the manual have been altered to conform to a regulatory change in how interest is calculated on Medicare overpayments and underpayments to providers, suppliers and other health care entities. The change also applies to Medicare Secondary Payer (MSP) recoveries. (Publication 100-05, Chapter 7, Section 30.1.5 is revised to address how interest is calculated for MSP debt.) Under the new instructions, interest for new debts will now be assessed only for full 30-day periods when payment is not made on time. Appropriate revisions (in some instances through deletions) have been made to the text of the demand letters and in Sections 30.3-30.6.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/40.2/ Sample Demand Letter for Claims Accounts Receivables
R	4/20.2/ Exhibit 2/ Overpayment Demand Letter – Cost Report Filed – First Request
R	4/20.2/ Exhibit 3/ Overpayment Demand Letter – Cost Report Filed – Second Request
R	4/20.2/ Exhibit 4/Overpayment Demand Letter – Cost Report Filed – Third Request
R	4/20.2/ Exhibit 5/ Overpayment Demand Letter – Unfiled Cost Report – First Request
R	4/20.2/ Exhibit 6/ Overpayment Demand Letter – Unfiled Cost Report – Second Request
R	4/20.2/ Exhibit 7/ Overpayment Demand Letter – Unfiled Cost Report – Third Request
R	4/30.3/ Interest Accruals
R	4/30.4/ Procedures for Applying Interest During Overpayment Recoupment
R	4/30.5/ Notification to Providers Regarding Interest Assessment
R	4/30.6/ Waiver and Adjustment of Interest Charges

R	4/90/ Exhibit 1/ Initial Demand Letter to Physicians/Suppliers

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-06	Transmittal: 41	Date: April 30, 2004	Change Request 3163

SUBJECT: Change in Interest Calculation for Medicare Overpayments and Underpayments and Medicare Secondary Payer (MSP) Recoveries

I. GENERAL INFORMATION

A. Background: Sections 1815(d) and 1833(j) of the Social Security Act (the Act) require that, whenever a payment to a provider, supplier, or other entity is more than (overpayment) or less than (underpayment) the amount that was due to the provider, supplier (including a physician), or other entity, we assess interest on the amount of the overpayment that the provider, supplier, or other entity owes to us or the underpayment that we owe to the provider, supplier, or other entity. Interest becomes due if the overpayment amount owed to us or the underpayment amount owed by us is not paid within 30 days of the date of the final determination of the overpayment or underpayment. The regulations implementing these authorities are at 42 CFR 405.378. Section 1862(b)(2)(B)(i) of the Act provides express authority to assess interest on Medicare Secondary Payer (MSP) debts. Interest is calculated on MSP debt using the method applicable to Non-MSP Medicare overpayments and underpayments as set forth in Section 405.378. For both Medicare overpayments and underpayments and MSP debts, interest is calculated in 30-day periods, and a period that is less than 30 days is considered to be a full 30-day period.

B. Policy: On July 25, 2003, a proposed rule was published in the Federal Register (68 FR 43995) to change how interest is calculated on Non-MSP Medicare overpayments and underpayments to providers, suppliers (including physicians), health maintenance organizations, competitive medical plans, and health care prepayment plans to be more reflective of standard business practices. This change would also apply to MSP debts. Under the rule, periods of less than 30 days will no longer be treated as a full 30-day period. Interest will be assessed only for full 30-day periods when payment is not made on time. This change would take effect for non-MSP overpayments and under-payments determined and MSP debts established on or after the effective date of the final rule.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3163.1	Interest on Non-MSP Medicare overpayments and underpayments and on MSP recovery demands shall be assessed for each full 30-day	All contractors and system maintainers

	period that payment is not made on time.	

I. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3163.2	This change in the method of calculation applies only to: (a) non-MSP Medicare overpayments and underpayments whose date of final determination occurs on or after the effective date of the final rule; and (b) those MSP debts where the debt is established by a recovery demand issued on or after the effective date of the final rule.
3163.3	For all debts determined or established prior to the effective date of the final rule, a 30-day interest charge shall continue to accrue on any principal balance outstanding at the beginning of each 30-day period until the debt is liquidated.
3163.4	Because the effective date for the change in the regulation will be 10/1/04, and the implementation date for this CR is not until 10/4/04, contractors shall not issue demand letters or MSP recovery letters on October 1-3, 2004. This will prevent the issuance of erroneous letters during the window between the effective date of the regulation, and the implementation date of these instructions.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3163.5	Medicare contractors shall continue to have the capability of calculating interest using the existing method (a period of less than 30 days is considered to be a full 30-day period) for debts determined or established prior to the effective date of the final rule.

C. Interfaces: N/A

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

E. Dependencies: This requirement and its effective date are dependent upon the content and timing of the publication of the final regulation amending 42 CFR 405.378. It is anticipated that the final regulation will be published in July 2004 with an effective date of October 1, 2004.

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Eugenia Mattison, 410-786-2564; Nancy Braymer, 410-786-4323 **Post-Implementation Contact(s):** Nancy Braymer, 410-786-4323	**These instructions shall be implemented within your FY 2005 operating budget.**

Medicare Financial Management Manual
Chapter 5 - Financial Reporting

Table of Contents

(Rev. 42, 04-30-04)

410.1 - General Information

(Rev. 42, 04-30-04)

All Medicare contractors receive unsolicited/voluntary refunds (i.e. monies received not related to an open accounts receivable). Following are detailed instructions on how to identify, process, track and report unsolicited/voluntary refund checks received from providers/physicians/suppliers, and other entities (*e.g.*, beneficiaries, insurers, employers, third party administrators (TPAs), etc.). These instructions shall not supersede other CMS guidance provided regarding the recovery and collection action on "demanded" debt, where an accounts receivable has already been established. If monies are received and the results of a contractor's investigation identify the existence of an established receivable, then the refund shall not be considered an "unsolicited/voluntary refund" within the context of the following instructions, and would not be reported on Exhibit 2 of these instructions (see section 410.9).

Intermediaries generally receive unsolicited/voluntary refunds from providers in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds from providers and third party payers as checks. Carriers generally receive checks from physicians, suppliers and third party payers. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

Acceptance/deposit of the voluntary refund check in no way limits the rights of the Federal Government or any of its agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

410.2 - Office of the Inspector General (OIG) Initiatives

(Rev. 42, 04-30-04)

The OIG, working with the Department of Justice and CMS, has initiatives to help combat health care fraud and abuse and to encourage health care providers/physicians/suppliers, and other entities to comply with the rules and regulations of Federal health care programs. Some of these initiatives include guidance, corporate integrity agreements (CIAs), and the OIG Self-Disclosure Protocol. The OIG Self-Disclosure Protocol is voluntary while the CIAs are mandatory. These initiatives are designed to ensure that the providers/physicians/suppliers, and other entities refund inappropriately received Medicare monies back to the trust funds.

CIAs are entered into between a health care provider/physician/supplier/other entity and OIG as part of a global settlement of a fraud investigation. Under the CIA (which can be for a period ranging from 3 to 5 years), the provider/physician/supplier or other entity is required to undertake specific compliance obligations, such as designating a compliance officer, undergoing training, and auditing. The provider/physician/supplier or other entity must report regarding their compliance activities on an annual basis to the OIG, which is responsible for monitoring the agreements.

The OIG Self-Disclosure Protocol was produced by the OIG to provide guidance to health care providers/physicians/suppliers and other entities that decide to voluntarily disclose irregularities in their dealings with the Federal health care programs. The decision to follow the OIG Self-Disclosure Protocol rests exclusively with the provider/physician/supplier and other entity. The OIG Self-Disclosure Protocol is intended to facilitate the resolution of only matters that, in the provider/physician/supplier and other entity's reasonable assessment, potentially violates Federal, criminal, civil, or administrative laws. It should be noted that providers/physicians/suppliers and other entities who self-disclose to the OIG sign an agreement stating that any refunds submitted as part of the self-disclosure process are not subject to appeal.

410.3 - Unsolicited/Voluntary Refund Accounts

(Rev. 42, 04-30-04)

All Medicare systems shall be able to separately distinguish and track unsolicited/voluntary refund checks which result from a 1) provider/physician/supplier and other entity under a CIA; 2) Provider/physician/supplier and other entity under the OIG Self-Disclosure Protocol; and 3) Straight Refund (a straight refund is a refund from a provider/physician/supplier, or other entity who is not under a CIA nor the OIG Self-Disclosure Protocol). All Medicare systems shall have the ability to identify and produce a report that distinguishes a refund as a CIA, OIG Self-Disclosure Protocol, or straight refund at the point of disposition (i.e., after investigation of the origin of the refund).

To assist in identifying providers/physicians/suppliers under a CIA, Medicare contractors *should* access the OIG Web site (http://www.oig.hhs.gov/fraud/cias.html) for a list of all providers/physicians/suppliers, and other entities under a CIA. *The OIG Web site will also give the effective date of the CIA. To obtain the termination date of the CIA, click on the CIA agreement. The time period of the CIA is contained within the agreement. If the Web site does not provide enough information to determine whether a CIA agreement is in existence, the contractor shall contact the provider as part of their investigation/resolution of the unsolicited/voluntary refund.* Because OIG Self-Disclosure Protocol agreements are voluntary, contractors may not be aware of this agreement unless a provider/physician/suppliers or other entity specifically notifies them.

Providers/physicians/suppliers under an OIG Self-Disclosure Protocol agreement are not given on the OIG Web site. The OIG will send a letter directing the provider/physician/supplier to refund money back to the Medicare contractor when the OIG has completed the Self-Disclosure matter and determined that an unsolicited/voluntary refund should be collected rather than a civil settlement pursued. *A copy of the letter is included as Exhibit 3.* The OIG will also send a copy of the letter to the attention of the Chief Financial Officer for Medicare Operations at the Medicare contractor. The OIG will direct the provider/physician/supplier to identify that the refund check is the result of an OIG Self-Disclosure Protocol agreement. *The provider/physician/supplier will have 30 days to refund the contractor.* If the contractor

does not receive the refund within 30 days, the contractor shall notify the Office of Counsel to the Inspector General (OCIG) attorney assigned to the OIG Self-Disclosure Protocol matter, as identified in the letter.

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

(Rev. 42, 04-30-04)

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/Health Insurance Claim (HIC)/Claim Number 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/HIC/Claim Number 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 P*hysician* S*upplier* O*verpayment* R*eporting 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.)

410.5 - Handling Checks or Associated Correspondence with Conditional Endorsements

(Rev. 42, 04-30-04)

Conditional endorsements are statements on the face of the check or associated correspondence, which might suggest that the payer has discharged its obligation by writing "paid in full" or like phrases that the payer intends as satisfaction/ extinguishment of the debt. Guidelines from the General Accounting Office (GAO) state that agencies must be extremely careful to avoid an unintended accord and satisfaction (i.e., an agreement to accept a payment in full for an amount less than the amount claimed).

The following instruction shall be applied to checks or associated correspondence with a conditional endorsement:

1) Medicare contractors shall deposit such a check within 24 hours of receipt in accordance with CMS's Medicare Financial Management Manual, Chapter 5 Financial Reporting, 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.

2) If any checks are not deposited within a 24-hour period, contractors shall record those 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.

3) Contractors shall immediately notify the debtor and/or the entity on whose account the check is drawn, if not the debtor, by certified mail. The following statement is suggested: **This is to acknowledge the receipt of the repayment in the amount of $XX, check number XX. The matter is being researched; however, the amount of the repayment may be insufficient to discharge the obligation and the debt may not be fully extinguished.**

4) The check(s) shall than be processed as outlined under section 410.4 or 410.6 as applicable.

The infrequent receipt of checks with conditional endorsements should not negatively impact your production process. The standard letter needed to meet this requirement shall be added to your automated letter processing or generated from a personal computer.

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

(Rev. 42, 04-30-04)

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/Health Insurance Claim (HIC)/Claim Number 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/HIC/Claim # 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 the*y 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.

410.7 - CMS Reporting Requirements

(Rev. 42, 04-30-04)

CMS shall require that all intermediaries and carriers report, in the provided Exhibit 2 format, the receipt of all unsolicited/voluntary refund checks from providers/physicians/suppliers, and other entities. The reports shall be due quarterly and shall be sent to the regional office (RO), BI Coordinator, by the 15th day of the following month (January 15, April 15, July 15, and October 15). All intermediaries and carriers shall be required to submit a "negative" report even if they have $0 dollar reporting. The RO will compile a list of all intermediaries and carriers that are required to submit a quarterly report and identify those that are not in compliance. The RO will contact those not in compliance and request the submission of the reports. On the last day of *the month* (i.e., January 31, April 30, July 31 and October 31), the RO will send the compiled list of intermediaries and carriers, with copies of all submitted reports to CMS Central office,

Director, Division of Benefit Integrity and Law Enforcement Liaison, Mail Stop C3-02-16, 7500 Security Boulevard, Baltimore, Maryland 21244.

410.8 - Overpayment Refund Form
(Rev. 42, 04-30-04)

Exhibit 1 displays the required information needed to research and document unsolicited/voluntary refunds received. Medicare contractors shall maintain files that include copies of all unsolicited/voluntary refunds received and the completed report, Exhibit 1. These documents shall serve as a tracking mechanism for audit trail purposes. *Contractors are not required to use Exhibit 1 verbatim; however, the alternative documents used shall contain, at a minimum, all of the elements outlined in Exhibit 1.*

410.9 - Unsolicited/Voluntary Refund Checks – Summary Report
(Rev. 42, 04-30-04)

Exhibit 2 displays reporting requirements for all CMS unsolicited/voluntary refund checks. The contractor shall report all unsolicited/voluntary refunds from providers/physicians/suppliers, and other entities identified on the OIG Web site, in addition to those that identify themselves as having a CIA, OIG Self-Disclosure Protocol, and/or straight refund. The following data shall be captured: the provider/physician/supplier, or other entity's name(s), provider number(s) Tax ID(s), reason code for refund, number of refund checks, and the total dollar amount of refund checks. Reason code #16 shall be used to identify that no reason was provided for the refund.

The contractor is not required to list each check received for the quarter individually, but may total all the checks on one line for the same provider/physician/supplier. Therefore, multiple checks for the same provider/physician/supplier when totaled shall be grouped by like categories for the following:

1. *Same Provider/Physician/Supplier*
2. *Same Reason Code*
3. *CIA category*
4. *Self-Disclosure category*
5. *Straight Refund category*

Example 1: Ten checks totaling $100.00 are received from Dr. X for Reason Code 02, but 5 checks are under a CIA and 5 checks are a straight refund.

Exhibit Columns:
Column 1, Provider/Physician/Supplier or Other Entity Name(s): Dr. X
Column 2, Provider/Physician/Supplier Number(s): 99999
Column 3, Tax ID Numbers: 9999999999
Column 4, Reason Codes: 02
Column 5, Line 1 CIA, SDP, Straight Refund: CIA

Column 5, Line 2 CIA, SDP, Straight Refund: Straight Refund
Column 6, Line 1 Total Number of Refund Checks: 5
Column 6, Line 2 Total Number of Refund Checks: 5
Column 7, Line 1 Total Amount of Refunds: $50.00
Column 7, Line 2 Total Amount of Refunds: $50.00

Example 2: Ten checks totaling $100.00 are received from Dr. Y, 8 checks are for Reason Code 02 and 5 of these checks are a CIA and 3 are a straight refund, 2 checks are for Reason Code 03 and 1 check is a CIA and 1 check is a straight refund.

Exhibit Columns:
Column 1, Provider/Physician/Supplier or Other Entity Name(s): Dr. Y
Column 2, Provider/Physician Supplier Number9s): 99999
Column 3, Tax ID Numbers: 9999999999
Column 4, Line 1 Reason Codes: 02
Column 4, Line 2 Reason Codes: 02
Column 4, Line 3 Reason Codes: 03
Column 4, Line 4 Reason Codes: 03
Column 5, Line 1 CIA, SDP, Straight Refund: CIA
Column 5, Line 2 CIA, SDP, Straight Refund: Straight Refund
Column 5, Line 3 CIA, SDP, Straight Refund: CIA
Column 5, Line 4 CIA, SDP, Straight Refund: Straight Refund
Column 6, Line 1 Total Number of Refund Checks: 5
Column 6, Line 2 Total Number of Refund Checks: 3
Column 6, Line 3 Total Number of Refund Checks: 1
Column 6, Line 4 Total Number of Refund Checks: 1
Column 7, Line 1 Total Amount of Refunds: $40.00
Column 7, Line 2 Total Amount of Refunds: $20.00
Column 7, Line 3 Total Amount of Refunds: $20.00
Column 7, Line 4 Total Amount of Refunds: $20.00

410.10 – Education

(Rev. 42, 04-30-04)

On an annual basis, the contractor shall include in the newsletter/bulletin the following information: "The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters *shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of*

the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

411 – Exhibits
(Rev. 42, 04-30-04)

411.1 - Exhibit 1 – Overpayment Refund Form
(Rev. 42, 04-30-04)

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: _____ HIC #: _____
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/HIC/Claim #/Claim 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/HIC/Claim # 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	_____

411.2 - Exhibit 2 - Unsolicited/Voluntary Refund Checks Summary Report
(Rev. 42, 04-30-04)

CONTRACTOR'S NAME _____
CONTRACTOR'S NUMBER (S): _____

REPORTING PERIOD FROM _____ TO _____
DATE OF REPORT _____

(1) PROVIDER/ PHYSICIAN/ SUPPLIER, OR OTHER ENTITY NAME (S)	(2) PROVIDER/ PHYSICIAN/ SUPPLIER NUMBER(S)	(3) TAX ID NUMBER (S)	(4) REASON CODES*	(5) PROVIDERS/PHYSICIANS/SUPPLIERS, AND OTHER ENTITIES UNDER A CIA, OIG SELF-DISCLOSURE OR STRAIGHT REFUNDS (Choose either A, B, or C from description below	(6) TOTAL NUMBER OF REFUND CHECKS	(7) TOTAL AMOUNT OF REFUNDS
Example 1:						
Dr. X	*99999*	*9999999999*	*02*	*CIA*	*5*	*$50*
			02	*Straight Refund*	*5*	*$50*
Example 2:						
Dr. Y	*99999*	*9999999999*	*02*	*CIA*	*5*	*$40*
			02	*Straight Refund*	*3*	*$20*
			03	*CIA*	*1*	*$20*
			03	*Straight Refund*	*1*	*$20*
						TOTAL $

*These codes are found on Exhibit 1

A – Providers/Physicians/Suppliers and Other Entities under a **CIA**
B – Providers/Physicians/Suppliers and Other Entities under **OIG Self-Disclosure Protocol**
C – **Straight Refunds**

THIS REPORT SHALL BE USED TO REPORT ALL UNSOLICITED/VOLUNTARY REFUND CHECKS RECEIVED DURING THIS PERIOD. INCLUDE THOSE REPORTED ON EXHIBIT 1 FOR CIA AND OIG SELF-DISCLOSURE PROTOCOL PROVIDERS/PHYSICIANS/SUPPLIERS, AND OTHER ENTITIES.

411.3 - Exhibit 3 – OIG Law Enforcement Demand Letter
(Rev. 42, 04-30-04)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Office of Investigations

[Date]

[Provider]

Re: Provider Self-Disclosure
[Provider]
OIG Case Number [CIMS#]

Dear [---------]:

We are writing to follow up on your [date of initial submission] disclosure to the Office of Inspector General ("OIG") pursuant to the OIG's Provider Self-Disclosure Protocol. Based upon our review of the materials and information you furnished to us, it appears that [Provider] should refund [$-----] in connection with claims it submitted to [Medicare/Medicaid] from [-------] to [--------]. Please refund this amount to [contractor or state payor] within 30 days. In addition to [Provider]'s refund check, please provide [contractor or state payor] with the following information: (i) why the voluntary refund is being made (i.e., Self-Disclosure Protocol submission); (ii) how it was identified; (iii) what steps were taken to ensure that the issues leading to the Self-Disclosure Protocol submission were corrected; (iv) the dates the corrective actions were in place; (v) the time period and provider numbers involved in the voluntary refund; and (vi) the fact that a full assessment was performed to determine the entire time frame.

To the extent that [Provider] seeks to receive reimbursement for underpayments identified in connection with its investigation of the claims described above, it is our understanding of CMS policy that [Provider] must resubmit those claims in accordance with CMS's [or state payor's] policies and procedures. Medicare Part A claims may only be reopened within the time limits prescribed by 42 C.F.R. § 405.750. See also 42 C.F.R. § 405.1885. Part B claims may only be reopened within the time limits prescribed by 42 C.F.R. § 405.841. See generally 42 C.F.R. §§ 405.701-.1889. In the event that the applicable time limit for resubmission of [Provider]'s [Part A/Part B] claims has already expired, the fact that [Provider] is making the refund described in the first paragraph above does not extend those time limits.

Please provide [Special Agent Assigned] and [OCIG Attorney Assigned] with written confirmation of [Provider's] repayment of the overpayment described above so that we may close our file. Thank you for bringing this matter to our attention.

Sincerely,

[Name of RIGI]
Regional Inspector General
for Investigations

cc: *[OCIG Attorney Assigned]*
[CMS Regional Office Contact Person]
[Contractor Benefit Integrity Manager or Coordinator]