CMS Medicare Manual System
Pub. 100-6 Financial Management

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

Transmittal 4 **Date: AUGUST 30, 2002**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
4		Entire Chapter	

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Medicare contractors only: these instructions should be implemented within your current operating budget.

This transmittal includes chapter 4 of the restructured Medicare Financial Management Manual.

The completed manual includes ten chapters containing all CMS instructions to carriers and intermediaries about CMS requirements described in the table below. This material was derived from the source material as shown in the last column.

While this revision updates and reorganizes text from current manuals, it includes no new procedures. It is a reorganization and compilation of these instructions into a single financial management manual for intermediaries and carriers. Where there are differences in carrier and intermediary requirements, we distinguish to which contractor the instructions apply. Contractors should send any questions or suggestions for improvement to their ROs.

This manual is designed primarily for display on the Internet. The following changes from past paper manual protocols are used as a result of the Internet environment.

- Redline - It is not possible to place a vertical bar in the left margin on Internet documents. Therefore changed text is identified by red, italic font. Note that redline is not used on this initial transmittal because all the text is new.

- Displaying change dates - The date and revision number for the last change in the section or subsection is shown after each section/subsection heading instead of at the bottom of the page.

- Page numbers - are not applicable for Internet documents.

- Distribution of printed copies is discontinued.

Also for the initial issuance a cross-reference is placed after each section heading to identify the source from where the material originated. This will be eliminated as subsequent transmittals replacing the same sections are released.

As the ten chapters are distributed the current financial instructions in PMs and the Carrier and Intermediary Manuals will be deleted.

Chapter	**Chapter Title**	**Source**
1	Budget Preparation	MIM-1, Chapters 1, 2, & 6 MCM-1, Chapters 1, 2, & 6
2	Budget Execution	MIM-1, Chapter 3 and 5 MCM-1, Chapter 3 and 5
3	Overpayments	MIM-2, Chapter 3, MIM-3, Chapter 8 MCM-3, Chapter 7
4	Debt Collection	MIM-2, Chapter 3 MCM-3, Chapter 7
5	Financial Reporting	MIM-1, Chapters 4 & 9 MCM-1, Chapters 4 & 9
6	Workload Reporting	MIM-3, Chapter 9 MCM-3, Chapter 13
7	Internal Control Requirements	New Material Issued With This Manual (CR 2231)
8	General Audit Guidelines	MIM-2, Chapter 1, MIM-4, Chapter 1
9	Intermediary Procedures for Provider Audits	MIM-4, Chapter 2
10	Provider Statistical & Reimbursement Report	MIM-2, Chapter 3

MIM = Medicare Intermediary Manual, CMS Pub 13, e.g., MIM-1 is Part 1 of CMS Pub 13

MCM = Medicare Carrier Manual, CMS Pub 14, e.g., MCM-2 is Part 2 of CMS Pub 14

Medicare Financial Management
Chapter 4 – Debt Collection

Table of Contents

NOTE: Revision 4, the initial release of this chapter, includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - Overpayment Demand Letters - FI

(Rev. 4, 08-30-02)

A2-2222

The purpose of an overpayment demand letter is to notify the provider of the existence and amount of an overpayment, and to request repayment. Every demand letter, regardless of the cause of the overpayment or the status of the provider must meet certain requirements as to form and content. Each demand letter is:

- Sent to the provider. (For institutional providers, the FI will not address the letter to the facility only, but to the person(s) it identified as responsible for any debts incurred by the provider. (See Chapter 3, Overpayments, §50A2.)

- Sent by certified mail, return receipt requested (FIRST REQUEST ONLY);

- Labeled either - FIRST REQUEST, SECOND REQUEST, or THIRD REQUEST;

- For a first request, mailed immediately after discovery or determination of the overpayment (FIs only - for an overdue cost report, the first day after the due date or extended due date. In overdue cost report cases, the next two items do not apply). In the case of the second or third request, mailed 30 days after the most recent demand letter (with an exception as noted on Exhibit 2);

- Each demand letter is an explanation of the nature of the overpayment, how it was established, and the amount determined.

- The demand letter provides an explanation of extended repayment schedules to the effect that approval will be granted only upon the showing of financial hardship and that any such schedule would run from the date of the FIRST REQUEST overpayment demand letter. The FI shall state that provider requests for extended repayments of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request

for the amount of the overpayment. This requirement in no way diminishes the need for the submission of financial data to support the provider request in accordance with §§20 and 30.

- The demand letter constitutes a request to the provider to refund the overpaid amount. The FI provides a brief description of the methods of repayment (or, where applicable, it requests the provider to submit the overdue cost report).

- The demand letter informs providers that continue to participate and have filed the cost report, that the FI will adjust (reduce or suspend) interim payments if it does not receive repayment or a repayment plan within 15 days. The FI shall not suspend interim payments before the 16th day after the date of notification.

The demand letter also points out that, where a cost report has not been filed timely and the provider continues to participate, interim payments were adjusted (reduced or suspended) on the first day following the due date of the cost report.

NOTE: The cost report reminder letter (see Chapter 3, Overpayments, §80.1A) serves as sufficient notice to the provider that interim payments will be suspended if the overpayment is not received on or before its due date.

A - Number of Requests

As a rule, the FI will send **three** overpayment demand letters to a provider. They constitute documentation of recovery efforts and must be in file if the case is referred to the DJ or results in litigation. The FI keeps copies of all demand letters. Where one or two letters have been sent and it believes that further requests would be futile, it will discontinue sending them. However, in such cases, it must consult the RO before taking such action and document the reasons why the full series of letters were not sent.

Similarly, if the demand letters cannot be delivered to the debtors because the FI has been unable to locate them, further demands need not be made. It refers such cases to the RO under Chapter 3, Overpayments, §40 as a potentially uncollectible overpayment. When referring the case, it documents all attempts made to locate the responsible debtor(s).

Where a repayment schedule has been established (either through refund or setoff against interim payments) after the first or second demand letters have been sent **and** the provider defaults on the repayment schedule, the FI counts the demand letters sent prior to the acceptance of the schedule toward the total of three letters normally sent to an overpaid provider.

B - Content of Demand Letters - FI Serviced Providers

Exhibits l, 2, and 3 contain detailed analysis of the requirements (these Exhibits are not all inclusive) for each of the three basic demand letters for use in various overpayment situations. Special requirements for each letter are discussed in the sections on particular types of aggregate overpayments. (See Chapter 3, Overpayments, §§10-30.) Certain items may be combined; for example, the Notice of Program Reimbursement may be

attached to the first demand letter. Since some cases may become very complex, some sample letters have been included. (See Exhibit 4 and Exhibit 5.)

Exhibit 1: Overpayment Demand Letter - First Request

Exhibit 2: Overpayment Demand Letter - Second Request

Exhibit 3: Overpayment Demand Letter - Third Request

Exhibit 4: Sample Overpayment Demand Letter - Cost Report Filed-Participating Provider

Exhibit 5: Sample Overpayment Demand Letter - Cost Report is Overdue--Terminated Provider Active in Title XIX

Exhibit 1 - Overpayment Demand Letter - First Request

KEY: Overpayment Situations

A. An overpayment due to pattern of excessive or noncovered services

B. Cost report overdue, participating provider

C. Cost report filed, participating provider (See Exhibit 4)

D. Cost report overdue, terminated provider

E. Cost report filed, terminated provider

F. Cost report overdue, terminated provider active in title XIX (See Exhibit 5)

G. Cost report filed, terminated provider active in title XIX

H. Interim rate adjustments

	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Send letter by certified mail	X	X	X	X	X	X	X	X
Mail letter to provider immediately after establishment of the overpayment	X		X		X		X	X
Mail letter to provider on the first day after the due date or extended due date of the cost report, if not received by then or on the first day after the 45 day period following program termination as applicable		X		X		X		
Include explanation of overpayment determination or Notice of Amount of Program Reimbursement	X		X		X		X	X
As applicable, request provider to submit cost report, make a refund, or arrange repayment	X	X	X	X	X	X	X	X
NOTIFY PROVIDER THAT FURTHER ACTION WILL BE APPLIED IF REQUESTED STEPS ARE NOT TAKEN:								
An adjustment (reduction or suspension) of interim payments has been imposed				X		X		
Notify provider it has 15 days to work out a repayment schedule before adjustment (reduction or suspension) of			X					

	A	B	C	D	E	F	G	H
schedule before adjustment (reduction or suspension) of interim payments is begun)								
If payment in full is not received within 30 days, interest will be charged			X		X		X	
A suspension of interim payment will be imposed in 15 days	X							X
Notify provider it has 15 days to submit a statement of explanation before suspension of interim payments is begun	X							X
Further suspension/reduction of interim payments will be imposed in 30 days if cost report is not received		X						
Explain the applicability of the §1870 waiver of liability provision and the appeal rights under it when the overpayment is due to a pattern of services which the provider neither knew nor could have been expected to know were not reasonable and necessary, or for custodial care. State that the provider may appeal an overpayment determination when the ultimate liability for its repayment rests with the provider. Advise the provider that if a determination is made that beneficiaries are liable for any such overpayment, the beneficiaries will be advised of their appeal rights under §1879 and that the provider could be made a party to beneficiaries appeals	X							
Pursuant to §1866(b)(2)(A) and (C) of title XVIII, continued failure to respond may result in termination of the agreement (if the overpayment is $l,000 or more)	X	X	X					
Termination does not abrogate the responsibility of the provider; therefore, a deemed overpayment exists				X		X		
If it becomes necessary to sue in a court of law to collect the overpayment, interest will be assessed and collected as part of any judgment rendered by the court				X		X		
Action to withhold the Federal share of title XIX payments will be initiated in 15 days						X	X	
The overpayment, if no action is taken, will result in referral of the	X			X	X	X	X	

	A	B	C	D	E	F	G	H
of the overpayment to the RO for collection								
The case will be turned over to the Department of Justice	X			X	X	X	X	

Exhibit 2 - Overpayment Demand Letter - Second Request

	A	B	C	D	E	F	G	H
Mail letter to provider 30 days after the first demand letter	X[1/]	X	X	X	X	X	X	X
As applicable, request provider to submit cost report, make a refund, or arrange repayment	X	X	X	X	X	X	X	X
NOTIFY PROVIDER THAT FURTHER ACTION IS IN EFFECT:								
(As applicable) All interim payments are suspended under 42 CFR §405.371	X		X					
(As applicable) Interim payments are further reduced by ___% under 42 CFR §405.371		X	X					X
NOTIFY FURTHER THAT:								
Pursuant to §1866(b)(2)(A) and (C) of title XVIII, continuing failure to respond may result in termination of the agreement (if the overpayment is $l,000 or more)	X	X	X					
Termination does not abrogate the responsibility of the provider; therefore, a deemed overpayment exists				X		X		
If it becomes necessary to sue in a court of law to collect the overpayment, interest will be assessed and collected as part of any judgment rendered by the court	X		X	X	X	X	X	
Action to withhold the Federal share of title XIX payments will be initiated in 15/30 days or has been initiated (as applicable)	X	X	X		X	X		
The overpayment, if no action is taken, will be referred to the RO for collection	X	X	X	X	X	X	X	X
The case will be turned over to the Department of Justice	X	X	X	X	X	X	X	X

	A	B	C	D	E	F	G	H
[1] In this case, the FI mails the letter to the provider **15** days after the first demand letter.								

Exhibit 3 - Overpayment Demand Letter - Third Request

	A	B	C	D	E	F	G	H
Mail letter to provider 30 days after demand letter 2	X	X	X	X	X	X	X	X
Send copy of letter to RO	X/	X	X	X	X	X	X	X
As applicable, request the provider to submit cost report, make a refund, or arrange for repayment	X	X	X	X	X	X	X	X
NOTIFY PROVIDER THAT FURTHER ACTION IS IN EFFECT:								
All interim payments are suspended under 42 CFR §405.371	X	X	X					X
NOTIFY FURTHER THAT:								
Pursuant to §1866(b)(2)(A) and (C) of title XVIII, continued failure to respond may result in termination of the agreement (if the overpayment is $l,000 or more)	X	X						
Termination does not abrogate the responsibility of the provider, therefore, a deemed overpayment exists				X		X		
If it becomes necessary to sue in a court of law to collect the overpayment, interest at the legal rate will be assessed and collected as part of any judgment rendered by the court	X/	X	X	X	X	X	X	X
The overpayment, if no action is taken, will result in referral of the overpayment to the RO for collection	X	X	X	X	X	X	X	X
Following, the case will be turned over to the Department of Justice	X	X	X	X	X	X	X	X

Exhibit 4 - Cost Report Filed - Participating Provider

FI NAME AND ADDRESS

Mr. Joe Smith, President
Valley Convalescent Center
Anytown, State ZIP Code

August 24, YYYY

Dear Mr. Smith:

On July 26, YYYY, we received your cost report for the fiscal year ending June 30. We have fully reviewed this report, and the results of our review have been incorporated in the enclosed copy of your "Notice of Amount of Program Reimbursement" (dated August 21, YYYY). As explained in the Notice, we find that the Valley Convalescent Center has been overpaid $1,100.00 for the past fiscal year.

If payment in full is not received by, (specify a date 30 days from the date of the notification), simple interest at the rate of - will be charged on the unpaid balance. For periods of less than 30 days the full monthly interest charge will be applied. Thus, if payment is received 31 days from the date of final determination, two 30-day periods of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will accrue on the remaining principal balance at the prevailing annual rate in effect on the date of final determination.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment schedule. Any repayment schedule (where one is approved) would run from the date of this letter. If we do not hear from you, your interim payments will be reduced/suspended starting on the 16th day from the date of this letter, and set off against the amount owing.

If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.

Sincerely,

(name and title)

Enclosure

FIRST REQUEST

This example pertains to a case where a cost report is filed, an overpayment is subsequently found, an NPR is issued, and the provider is still participating in the Medicare program. (See Chapter 3, Overpayments, §60.1.)

Exhibit 5 - Cost Report Is Overdue - Terminated Provider Active In Title XIX

FI NAME AND ADDRESS

Mr. Tom Brown, President
Hope Memorial Hospital
Anytown, State ZIP Code

October 28, YYYY

Dear Mr. Brown:

This letter is in regard to your failure to submit a cost report for the period beginning April 1, YYYY and ending with July 15, YYYY, the date Hope Memorial Hospital terminated its participation in the Medicare program. Until we receive an acceptably completed cost report from your facility, all interim payments made during the above period are deemed overpayments. Also, where a cost report is not filed on time and when filed, indicates an amount is due CMS, or if it is subsequently determined that an additional overpayment exists, such as when a Notice of Program Reimbursement is issued, interest will be assessed on the overpayment from the date the cost report was due to the date the cost report was filed. This interest assessment is made regardless of whether the overpayment is liquidated within 30 days.

Termination of the facility's Medicare participation in no way abrogated the responsibility of the hospital to comply with the Medicare law, regulations, and instructions applicable to the period when the hospital was participating. As we previously informed you, the overpayment is $2,765.50, the total amount of the interim payments during your last cost report period.

Further inaction on your part will result in referral of this case to the Centers for Medicare & Medicaid Services Regional Office. Following this, if you still fail to submit the required cost report, the file will be turned over to the Department of Justice for collection.

Since no response was received to our prior request, on August 29, YYYY, we initiated a request that your Federal share of payments in title XIX (Medicaid) be withheld. The withholding, once it is effective, will not be removed until you are in compliance with the Medicare law, regulations, and instructions.

Sincerely,

(name and title)

THIRD REQUEST

This example pertains to a case where the cost report is overdue, and the provider has terminated from Medicare but is active in title XIX, Medicaid - (See Chapter 3, Overpayments, §60.3.)

20 - Establishing Extended Repayment

(Rev. 4, 08-30-02)

A2-2223, B3-7160

Where the debtor does not comply with the first demand letter requesting that full reimbursement of the overpayment be made, but acknowledges the existence of an overpayment, it may contact the FI or carrier to arrange for a repayment schedule.

A debtor is expected to repay any overpayment as quickly as possible. If it cannot refund the total overpayment within 30 days after receiving the first demand letter, it should request an extended repayment schedule immediately. It must explain and document its need for an extended (beyond 30 days) repayment schedule. (See §30.l.) If, following desk review, an FI's audit uncovers a larger overpayment, the provider must submit further documentation (see §30.l) if it wishes to request an extended repayment schedule for the additional amount. Generally, no extended period of recovery should exceed 12 months from the date of the first demand letter request for repayment. The proposed repayment schedule must include specified times and amounts of repayments and submitted in writing for approval. The FI shall send a written notification of the approved repayment schedule to the provider.

The carrier shall apply the following guidelines when considering extended repayment (whether by offset of future benefit payments or direct payment):

- Recoup all overpayments of $5,000, or less, within 2 months;
- Recoup overpayments between $5,000 and $25,000 within 3 months;
- Recoup overpayments between $25,000 and $100,000 within 4 months; and
- Recoup overpayments over $100,000 within 6 months.

A repayment schedule may be established to recover all or part of an overpayment. The FI or carrier shall offset any money owed to the debtor prior to establishing a repayment plan. When a repayment schedule is used to recover part of an overpayment, the FI or carrier recovers the remainder of the overpayment by suspension of interim payments (FIs - see §40), setoff of monies due the debtor, or from a lump-sum payment by the debtor.

30 - Repayment Extended Longer Than 12 Months.

(Rev. 4, 08-30-02)

A2-2224, B3-7160.1, B3-7160.2

If a provider or physician demonstrates that repayment within a 12-month period would create extraordinary financial hardship, it may request a longer period of repayment.

Where it requests a schedule that would run longer than 12 months from the date of the first demand letter, the FI or carrier refers the request, **with its recommendations**, to the RO for disposition. The documentation listed in §30.1 is required (as it is for extended repayment periods of 12 months or less) for the RO to make its determination. The period for recoupment will not be extended unless the provider or physician demonstrates (with supporting documentation) that repayment within a 12-month period would create extraordinary financial hardship.

The RO ordinarily will not establish a repayment schedule for more than 36 months from the date of the first demand letter. The repayment schedule may be effective with the date the repayment schedule is proposed (or submitted by the provider or physician). The RO will approve only when it determines that such an action would benefit the program.

30.1 - Documentation Supporting a Request for Extended Repayment - Debtor is a Sole Proprietor - Carrier Only

(Rev. 4, 08-30-02)

B3-7160.1A

The carrier shall request the debtor (physician) to complete and return a Form CMS-379, Financial Statement of Debtor.

30.2 - Documentation Supporting a Request for Extended Repayment - Debtor is an Entity Other Than a Sole Proprietor

(Rev. 4, 08-30-02)

A2-2224.1, B3-7160.1B, B3-7160.5

The FI or carrier shall request the provider to furnish, in addition to its proposed repayment schedule, the following:

- **Balance sheets** - the most current balance sheet and the one for the last complete Medicare reporting period (preferably prepared by the provider's accountant).

  NOTE: If the time period between the two balance sheets is less than 6 months (or the debtor cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last two complete Medicare reporting periods.

- **Income statements** - related to the balance sheets (preferably prepared by the debtor's accountant).

CMS suggests that both the balance sheets and income statements include the following statements:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OF ADMINISTRATOR OF PROVIDER(S)

(For physicians/suppliers, "CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by _____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed

Officer or Administrator of

Provider(s)

Title

Date

For physicians/suppliers:

Signed

Officer or Owner of

Debtor(s)

Title)

- **Statement of Sources and Application of Funds** - for the periods covered by the income statements (see Exhibit 2 for recommended format).

- **Cash flow statements** - for the periods covered by the balance sheets (see Exhibit 3 for recommended format). If the date of the request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than 3 months after that of the most recent balance sheet, a projected cash flow statement should be included for the 6 months following the date of the request.

- **Projected cash flow statement** - covering the remainder of the current fiscal year. If fewer than 6 months remain, a projected cash flow statement for the following year should be included. (See Exhibit 3 for recommended format.)

- **FIs Only - Amount of outstanding** - accelerated payments.

- **List of restricted cash funds** - by amount as of the date of request and the purpose for which each fund is to be used.

- **List of investments** - by type (stock, bond, etc.), amount, and current market value as of the date of the report.

- **List of notes and mortgages payable** - by amounts as of the date of the report, and their due dates.

- **Schedule showing amounts** - due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet - such as Accounts Receivable, Notes Receivable, etc. (See §§1000ff. of the Provider Reimbursement Manual, Part I for definition of related organizations.)

This information may provide a lead to possible setoffs between underpayments and overpayments of related participating providers.

- **Schedule showing types** - and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

- **FIs Only - The percentage of occupancy** - by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods covered by the income statements; and

- **Requests for extended repayment** - of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request for the amount of the overpayment.

If a debtor is unable to furnish some of the documentation, it should fully explain why it is unable to. Where the debtor's explanation is reasonable and the documentation is otherwise acceptable, the FI shall forward the request for extended repayment to the RO with its recommendation. It shall continue recoupment of the overpayments pending receipt of the documentation and a decision on the extended repayment request.

An extended repayment schedule protocol assists the FI in evaluating extended repayment requests. (See Exhibit 1). It shall complete the protocol for all extended repayment requests, and forward a completed copy to the RO on those requests that exceed 12 months.

Exhibit 1 - Protocol for Reviewing Extended Repayment Schedule (ERS) - Provider/Physician Medicare Overpayments

Protocol for Reviewing Extended Repayment Schedule (ERS)

Provider/Physician _____

Provider/Physician Number _____

(FIs Only) Cost Report FYE _____ Overpayment Amount$ _____

(Carriers Only) FYE _____ Overpayment Amount$ _____

Date of Demand Letter _____

No. of Months Requested for ERS_____

Date ERS Approved/Not Approved (12 mos. or less _____

No. of Mos. Approved _____

Date Referred to RO for Consideration _____

Name of FI/Carrier

Reviewed By _____Date _____

FI/Carrier Analyst

Supervisor Review_____Date_____

FI/Carrier Official

1. FI or carrier summarizes the major reasons why the overpayment occurred.

2. FI or carrier reviews the documentation sent by the debtor for completeness. (Refer to §30.2 for recommended documentation.) It analyzes the financial data submitted to determine the availability of cash, marketable securities, accounts receivable, restricted and unrestricted endowment funds, or special funds. It considers whether these funds could be used for partial or full payment of the overpayment. Also, requests for ERS of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request for the amount of the overpayment. The debtor shall include a copy of the loan application with the denial letters from the bank.

3. FI or carrier performs the following calculations by using the most current financial data submitted by the provider to determine if it qualifies for an ERS.

a. Current Ratio

The current ratio relates the dollar value of current assets to the dollar value of current liabilities in order to evaluate an organization's ability to pay its current debt. Derived as:

$$\frac{\text{CURRENT ASSETS}}{\text{CURRENT LIABILITIES}} =$$

This ratio defines the number of dollars held in current assets per dollar of current liabilities (e.g., it relates current assets to current liabilities). Multiple coverage of liabilities is desirable. Generally, high values for the current ratio imply a good ability to pay short-term obligations and thus a low probability of technical insolvency.

Normally, the FI or carrier considers a current ratio of 2 to 1 adequate to meet current liabilities. However, a debtor with a current ratio (2 to 1 or greater) may have short-term payment problems if its current assets are not expected to be in liquid form (cash or short-term investments) in time to meet the expected payment dates of the current liabilities.

b. Quick Ratio

A liquidity ratio which measures the number of dollars of liquid assets (cash plus marketable securities plus accounts receivable) that are available per dollar of current liabilities. Derived as:

$$\begin{aligned} & \text{CASH} \\ + \quad & \text{MARKETABLE SECURITIES} \\ + \quad & \text{ACCOUNTS RECEIVABLE} \\ = \quad & \underline{\qquad} \text{ CURRENT LIABILITIES} \end{aligned}$$

This is a more stringent measure of liquidity than the current ratio. The FI/Carrier uses it to determine the adequacy of cash, accounts receivable, and marketable securities to pay current liabilities.

Normally, the FI/Carrier considers a quick ratio of 1.5 to 1 adequate to meet current liabilities. However, a debtor with a high quick ratio may have short-term payment problems if there are excessive amounts of slow-paying or doubtful accounts receivable which may not be turned into cash soon enough to meet maturing current liabilities. Conversely, a low quick ratio may not imply a future liquidity crisis if current liabilities include terms that will not require payment from existing current assets.

4. The FI, for institutional debtors, determines if there are any settlements (interim rate adjustments or cost report) in process which could be used to offset the outstanding overpayment.

5. Based upon the previous steps, the FI or carrier summarizes whether or not a repayment schedule should be approved or denied. If approval is recommended, it indicates the number of months, how it calculated the monthly payment and the reason(s) for the approval. If denial is recommended, it indicates the reason(s).

Exhibit 2 - Statement of Source and Application of Funds Period Covered

(Rev. 4, 08-30-02)

A2-2224.1 - Exhibit 7, B3-7160

STATEMENT OF SOURCE AND APPLICATION OF FUNDS

FOR THE PERIOD _____

Funds Provided by:

Operations - Net income for the period		$XXXX
Add: Charges not affecting working capital (depreciation, amortization, etc.)		XXXX
Less: Operating revenues not affecting working capital		XXXX
Total fund provided by Operation		$XXXX
Long term loans	XXXX	
Unrestricted cash donations		XXXX
Other (identify)		XXXX
Total Funds Provided		$XXXX

STATEMENT OF SOURCE AND APPLICATION OF FUNDS

FOR THE PERIOD _____

Funds Applied to:

Retirement of long-term obligations (mortgages, notes, bonds, etc.)		$XXXX
Purchase of equipment		XXXX
Purchase of land	XXXX	
Dividends to stockholders		XXXX
Other (identify)		XXXX
Total Funds Applied		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	
Working Capital* (end of period) (date)		XXXX
Less: Working Capital* (beginning of period) (date)		-XXXX
Net Increase (Decrease) in Working Capital	*$XXXX	

*Current Assets less Current Liabilities

Exhibit 3 - Cash Flow Statement Period Covered

(Rev. 4, 08-30-02)

A2-2224.1 - Exhibit 7, B3-7160.7

CASH FLOW STATEMENT FOR THE PERIOD _____

Cash provided by:

Operations (Schedule A) (See Exhibit 4)		$XXXX
Cash donations (unrestricted)		XXXX
Long-term borrowing		XXXX
Investment earnings (cash dividends, interest)		XXXX
Sale of long-term investments		XXXX
Sale of equipment		XXXX
Issuance of bonds		XXXX
Decrease in current assets - other than Accounts Receivable, Prepaid Expenses, and Inventory		XXXX
Increase in current liabilities - other than Accounts Receivable, Prepaid Expense, and Inventory		XXXX
Others		XXXX
Total Cash Provided	$XXXX	

CASH FLOW STATEMENT FOR THE PERIOD _____

Cash applied to:		
Purchase of equipment	$XXXX	
Payment of long-term debt	XXXX	
Payment of bond redemption fund	XXXX	
Purchase of long-term investments	XXXX	
Payment of dividends	XXXX	
Purchase of land and/or building (purchase price less mortgage, capital stock and non-cash assets given toward purchase)	XXXX	
Increases in current assets - other than Accounts Receivable, Prepaid Expenses, and Inventory		XXXX
Decreases in current liabilities - other than Accounts Payable and Prepaid Income		XXXX
Other		XXXX
Total Cash Applied		XXXX
Increase (Decrease) in Cash		$XXXX
Cash at end of period (date)		$XXXX
Less: Cash at beginning of period (date)		XXXX
Increase (Decrease) in Cash		XXXX

Exhibit 4 - Projected Cash Flow Statement Cash From Operations (Schedule A) Period Covered

(Rev. 4, 08-30-02)

A2-2224.1 - Exhibit 8, B3-7160.8 - Exhibit 4

PROJECTED CASH FLOW

CASH FROM OPERATIONS (SCHEDULE A)

Net Income (or Net Loss)		$XXXX
Increases:		
Depreciation expense	$XXXX	
Loss from sale of equipment	XXXX	
Decrease in net Accounts Receivable	XXXX	
Decrease in Prepaid Expense	XXXX	
Decrease in Inventory	XXXX	
Increase in Accounts Payable	XXXX	
Increase in Prepaid Income	XXXX	
Others	XXXX	XXXX
Gross Cash from Operations	$XXXX	
Decreases:		
Gain from sale of equipment	$XXXX	
Increase in net Accounts Receivable	XXXX	
Increase in Prepaid Expense	XXXX	
Increase in Inventory	XXXX	
Decrease in Accounts Payable	XXXX	
Decrease in Prepaid Income	XXXX	

Others	XXXX	XXXX
Net Cash from Operations		$XXXX

30.3 - Documentation for an Extended Repayment Schedule

(Rev. 4, 08-30-02)

A2-2224.2

After the FI/Carrier has reviewed the documentation submitted in support of the extended repayment schedule request, it sends its recommendation to the RO for approval. It submits the following:

- All information submitted by the provider. (See §30.l.);
- The date of the initial contact between the FI/Carrier and the provider concerning the overpayment;
- Copies of all correspondence (including demand letters) about the overpayment and the request for the extended repayment schedule;
- The amount of the overpayment; cost report year in which it occurred; dates and amounts of any repayments; dates and amounts of payments (interim or retroactive) held in account.
- The cost reports in which the overpayments appeared or were found. The FI furnishes any information it has on the financial status of related organizations, as determined through audits and other sources such as mercantile reports;
- The provider's proposed repayment schedule and rationale;
- The FI/Carrier's recommendation and supporting rationale including a completed extended repayment schedule protocol (see Exhibit 1); and
- The FI/Carrier's opinion, based on experience, as to the reliability of the financial data.

30.4 - Monitoring An Approved Extended Repayment Schedule

(Rev. 4, 08-30-02)

A2-2224.3, B3-7160.4

After an extended repayment schedule has been approved, the FI/Carrier shall continue to monitor the case to ascertain whether recoupment is being effectuated as contemplated. If it becomes apparent that the repayment schedule will not result in a liquidation of the indebtedness within the time period contemplated, it shall take further action, preferably the renegotiation of the amount of installment payments so that the overpayment will be recouped within the time period originally agreed upon. The FI/Carrier reports to the RO any significant changes in the debtor's financial condition or any indication that the debtor misstated or failed to disclose pertinent facts that may raise a question of its ability

to refund the overpayment. The FI/Carrier shall notify the RO immediately by telephone and send a detailed written statement of the problem.

40 - Procedure For Suspending Interim Payments - FI

(Rev. 4, 08-30-02)

A2-2225

A - General

In accordance with regulations (42 CFR §§405.370ff.), the FI shall suspend payments which would otherwise be authorized to providers when **needed to protect the program against financial loss** and;

- It has determined that the provider has been overpaid under title XVIII of the Act; **or**

- It has reliable evidence, although additional evidence may be needed for a determination, that an overpayment exists or, for FIs payments to institutional providers, that the interim payments to be made may not be correct.

Suspension of interim payments is undertaken as a supplemental recovery procedure to an approved extended repayment schedule. (See §§20 and 30.) The suspension of interim payments may be partial (for example, a percentage of payments suspended) or complete. The FI shall notify the provider of its intent to suspend and of the projected date for suspension by means of demand letters. (See §10, Exhibits l-5.)

B - Requirements for Suspension

For cases other than those listed in the exceptions, the FI shall comply with the following conditions to suspend interim payments:

- It shall notify the provider in writing of its intention to suspend payments, in whole or in part; and

- It shall give the provider an opportunity to submit a statement (including any evidence) as to why the suspension should not be put into effect. It shall inform the provider it has 15 days following the date of the notification to submit such a statement.

NOTE: The regulations (42 CFR 405.371(a)) provide that a shorter period may be imposed for good cause; however, the FI may not do this without the prior knowledge and concurrence of the RO. The FI will extend the time period within which evidence must be submitted if the provider can show good cause for doing so. If the provider expresses dissatisfaction with the impending suspension and there is reason to believe there may be a basis for the provider to challenge the finding of overpayment, the FI will give the provider an opportunity to make its argument.

EXCEPTIONS:

The requirements need **not** be met prior to the imposition of a suspension of interim payments where:

- The FI has reliable evidence that the circumstances giving rise to the need for suspension involve fraud or willful misrepresentation;

- The FI, after furnishing a provider a Notice of Amount of Program Reimbursement, suspends payment to recover, or aid in the recovery of, any overpayment identified in the determination to have been made to the provider; or

- The provider has failed to submit evidence requested which is needed to determine the amounts due the provider.

C - Amount to be Suspended

In determining the exact percentage of reduction of interim payments, the FI evaluates each case individually. (For hospitals and SNFs that furnish both Part A and Part B services, the FI may find it advisable to reduce the Part A payment without changing the Part B inpatient and outpatient payment.) The minimum reduction is 20 percent, but CMS considers the amount of overpayment and any other factors that might indicate that a higher percentage would be appropriate.

D - Submission of Evidence

When the provider protests a proposed suspension, the FI shall evaluate it together with any other relevant materials, and determine whether or not the facts justify a suspension.

It will give the provider written notice of this determination. Where suspension is to go into effect, it includes specific findings on the conditions upon which the suspension is based and an explanation of the decision. (See §10.) Where applicable, the notice may be included within one of the demand letters.

Where the suspension is put into effect on the basis of reliable evidence of overpayment but without an overpayment determination having been made, the FI shall obtain the additional evidence needed to determine whether an overpayment exists or whether full interim payments may be resumed. It shall inform the provider immediately of the determination and adjust or rescind the suspension, as appropriate. It forwards a copy of the determination to the RO.

E - Effective Date of Suspension Where Aggregate Overpayments Are Involved

Where aggregate overpayments (see Chapter 3, Overpayments, §20) form the basis for suspension, the effective date of the suspension is specified in Chapter 3, Overpayments, §§60 - 70 for each type of case.

F - Notification to the RO

Where the FI expects to suspend payment without notice to the provider, it shall notify the RO in advance of the suspension. It must always consult the RO prior to a suspension when it is uncertain whether suspension should be applied. If fraud is suspected, the FI will refer to The Program Integrity Manual (PIM), which can be found at the following Internet address: www.cms.hhs.gov/pubforms/83_pim/pimtoc.htm.

G - Duration of Suspension

The suspension remains in effect until:

- The overpayment is liquidated;
- The FI enters into an agreement with the provider for liquidation of the overpayment; or
- On the basis of subsequently acquired evidence, or otherwise, the FI determines that there is no overpayment.

EXCEPTION: Where the FI determines that continuation of the suspension would cause irreparable harm to the provider, it may, after obtaining financial documentation from the provider in support of its allegations of hardship and with the concurrence of the RO, adjust the suspension. This adjustment can be achieved by reducing the percentage of the payment suspended, or by lifting it for a predetermined amount of time. The arrangement to be worked out with the provider is at the FI's discretion. Many factors may affect the exercise of this discretion: the financial status, willingness to cooperate, past record in repayment of overpayments and rate of utilization by beneficiaries.

However, these provisions do not apply where the FI has evidence that the circumstances giving rise to the suspension involve fraud or serious misrepresentation.

40.1 - Disposition of Funds Withheld During Suspension

(Rev. 4, 08-30-02)

A2-2225.1

If, after the FI reduces or suspends interim payments for late cost report filing, the cost report is filed reflecting monies owed the program, the FI offsets the amount withheld against the amount of the overpayment reflected on the cost report. If the delinquent cost report reflects an underpayment, it offsets this amount, as well as the amount withheld for late filing, against any overpayment balances, including prior cost reporting years. If a repayment plan has been established for recovery of a prior year's overpayment, withholdings are offset against the outstanding balance, reducing the number of months for recovery.

40.2 - Failure to Timely File a Form CMS-91

(Rev. 4, 08-30-02)

A2-2225.2

Form CMS-91 (Hospital Interim Rate Change Report) collects hospital data that serves in computing interim rates. Hospitals receiving reimbursement under the PIP method must complete this form for each fiscal quarter.

The FI should receive Form CMS-91 from the hospital 30 days after the ending date of the fiscal quarter. Hospitals receiving interim payments under the percentage of charges, or the per diem method submit this form to the FI whenever they request a change (increase, decrease, or different method of reimbursement) in their interim rate.

- The information to enter on Form CMS-91 is the minimum information needed to perform the quarterly evaluation of PIP payments required by 42 CFR §413.64(h)(6) and to determine whether an increase in interim rate is appropriate under 42 CFR §413.64(c)(4). The information to be entered on the CMS-91 is the minimum information needed to review requests for changes in interim rates or for quarterly PIP reviews. Unless the information is supplied, the FI will deny requested interim rate increases because of the lack of appropriate information. It will convert PIP reimbursement to conventional interim payments for providers that do not furnish the information.

- Where a provider files a delinquent Form CMS-91 subsequent to being removed from PIP, the FI shall not reinstate PIP. Regulations 42 CFR §413.64(h)(2) specifically direct it to begin the PIP method only after it finds it administratively feasible. The FI is not bound to reimburse a provider under PIP when the provider makes it administratively difficult. In addition, 42 CFR §413.64(h)(4) provides that the FI's approval of a provider's request for reimbursement under PIP is conditioned upon the FI's judgment.

- Form CMS-92 (Computation of Interim Rates) is available for calculating the interim rates of hospital reimbursement. However, its use is not mandatory.

50 - Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments - General

(Rev. 4, 08-30-02)

A2-2226, B3-7170

Institutions and persons furnish health care services under both the Medicare and Medicaid programs, and are reimbursed according to the rules applicable to each program. Overpayments may occur in either program; at times resulting in a situation where an institution or person that provides services owes a repayment to one program while being reimbursed from the other.

50.1 - Withholding the Federal Share of Medicaid Payments to Recover Medicare Overpayments

(Rev. 4, 08-30-02)

A2-2226.1, B3-7170.1

Section 1914 of title XIX and 42 CFR §447.30 provide for CMS to withhold the Federal share of Medicaid payments with respect to Medicaid providers that have, or previously had, a Medicare provider agreement under §1866, and for physicians when:

- They have received an overpayment of title XVIII funds, and efforts to collect it have been unsuccessful; or

- Efforts to secure from the provider or physician, the necessary data and information to determine the amount, if any, of the overpayment have been unsuccessful (i.e., a deemed overpayment because the provider failed to file a cost report); and

- For physicians or suppliers, they have previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act, and during the 12 month period preceding the quarter in which CMS proposes to withhold the Federal share of Medicaid payments for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of the overpayment.

CMS may order the State to withhold the Federal share of Medicaid payments of a provider to recover Medicare overpayments plus accrued interest.

The FI or carrier shall establish whether or not a provider or physician is subject to these procedures. (See Chapter 3, Overpayments, §§60 - 70.3) for specific cases where withholding of title XIX payments may be undertaken.) The FI or carrier must be sure the provider or physician is participating in title XIX program prior to referring the case to the RO for withholding. It shall refer only those cases that it is unable to collect through established procedures. The RO resolves questions with respect to the provider's, physician's, or supplier's status in the Medicaid program.

Section 1914(a) of the Act permits, rather than requires, the Secretary to withhold the Federal share of Medicaid payments to recover Medicare overpayments. To allow flexibility in the administration of this provision, the ROs routinely determine whether it would be cost effective to withhold the Federal share. If they determine that it is not feasible, they notify the FI or carrier, citing the reason for not processing the collection request.

The provider or physician may appeal the FI's or carrier's overpayment determination. The appeal procedures, however, do not delay the withholding of the Federal share of payments due the Medicaid provider or physician.

If a provider or physician is subject to the procedures for withholding the Federal share of Medicaid payments to recover the Medicare overpayment and it has not met the conditions in the third demand letter, the FI or carrier shall send copies of all pertinent material to the RO with a recommendation to initiate withholding action.

Specifically, it includes in the case referral request to withhold the Federal share of Medicaid payments:

- Copies of the cost report - if applicable;
- The Notice of Program Reimbursement (if available);
- Invoices or other documentation of the amount(s) due;
- Cost reporting period(s) involved;
- Complete identification of the responsible officials and owners of the provider institution for each cost reporting period for which there is an outstanding overpayment;
- All correspondence concerning the overpayment; and
- A summary of the FI's/Carrier's contacts with the provider.

To implement the withholding action, the RO notifies the provider and the State Agency (SA) responsible for the State's title XIX expenditures. Withholding payment becomes effective no fewer than 60 days after the day on which the agency and the provider receive notice of withholding. The withholding of Federal payments under title XIX remains in effect until notice is received by the title XIX SA through the RO that:

- The overpayment has been refunded,
- Satisfactory arrangements have been made for repayment, or
- There is no overpayment based upon new evidence or a subsequent audit.

When the withholding of Federal payments under title XIX is no longer necessary, it will be lifted and the provider again receives Federal title XIX payments for Medicaid services rendered.

The FI shall notify the RO immediately if the provider submits an acceptable cost report or makes satisfactory arrangements for the repayment of the overpayment. It includes the date the delinquent cost report was filed or satisfactory arrangements for the repayment were made. Because the withholding process is a lengthy one, the RO can revoke a withholding before its effective date if the provider submits a satisfactory cost report or if it makes satisfactory arrangements for repayment.

The RO monitors the collection and advises the FI when the overpayment is recovered. If an excess amount is withheld, it advises the FI to restore any excess.

50.2 - Withholding Medicare Payments to Recover Medicaid Overpayments

(Rev. 4, 08-30-02)

A2-2226.2, B3-7170.2

Section 1885 of title XVIII of the Act and 42 CFR §405.375 provide for CMS to withhold Medicare payments under both Part A and B to recover Medicaid overpayments that a Medicaid agency has been unable to collect.

The RO determines if withholding the Medicare payments due the overpaid Medicaid institution is appropriate. Where it determines that withholding the Medicare payments is proper, it advises the FI to.

Withhold the Medicare payments to the institution by the lesser of:

- The amount of the Medicare payments to which the institution would otherwise be entitled;

- The total Medicaid overpayment.

The FI shall terminate the withholding action if the Medicaid overpayment is recovered or the RO advises it to do so.

It shall submit to the RO, at least monthly until the overpayment is recovered, the amount of Medicare payments withheld. If no claims are received in any month, it informs the RO that no payments were withheld.

The Medicaid agency established procedures to assure the return to the institution or person amounts withheld that are ultimately determined to be in excess of the Medicaid overpayments. The FI or carrier shall establish internal procedures to account for the Medicare amounts withheld under this section.

60 - Recovery From The Physician - Overpayment Demand Letters - Carrier

(Rev. 4, 08-30-02)

B3-7130

When a physician/supplier is liable for an overpayment of $10 or more, the carrier shall attempt recovery through the following procedures.

It shall recover an overpayment made to a physician/supplier as an individual or to a professional corporation (following the procedures described below) only from the party

to whom the overpayment was made. It shall make no attempt to recover an overpayment made to an individual physician/supplier from a professional corporation with which they may be associated as an employee or stockholder. Conversely, it shall not attempt recovery from an individual physician/supplier where the overpayment was made to a professional corporation with which they are, or were, associated.

A - Overpayment Amount Is At Least $10

For physicians/suppliers who are taking assignment, the carrier shall issue a demand letter that requests the physician/supplier to pay the debt in full within 30 days, or the amount owed and any assessed interest will be collected by offset.

For nonparticipating physicians/suppliers who periodically accept assignment, the carrier shall issue a demand letter that requests the physician/supplier to pay the debt in full within 30 days, or the amount owed will be collected from future claims submitted on assignment related basis. Also, it shall advise the physician/supplier that interest will accrue until the debt is paid in full.

The carrier shall retain uncollectible debts as Medicare receivables in its financial system. It shall search its files when claims from a nonparticipating physician are received. If there has been no collection activity for one year, it shall submit the uncollected overpayment to the RO for suspension of collection activities. If a claim for payment is received before the statute of limitations expires, the prior debt is to be offset. The applicable statute of limitations for the recovery of a Medicare overpayment is six years after the right of action accrues. The right of action accrues when Medicare makes a final determination that an overpayment occurred. If the overpayment is less than $50.00, the carrier shall issue only one demand letter. When overpayments less than $10.00 are aggregated to $10.00 or more, but less than $50.00, it shall issue one demand letter.

B - Overpayment Demand Letter

The purpose of an overpayment demand letter is to notify the physician/supplier of the existence and amount of an overpayment, and to request repayment. The demand letter must be written in such a manner as to fully explain the nature of the overpayment and the amount determined. Each demand letter must be:

- Sent to the physician/supplier by first class mail; and
- Mailed immediately after discovery or determination of the overpayment. In the case of the second request, the letter must be mailed 45 days after the date of the first demand letter.

C - Content of Demand Letters

The carrier shall refer to Exhibits I through VI for the standard formats for each demand and voluntary refund letters to be used in various overpayment situations.

The demand letter must advise the physician/supplier that overpayments are to be recovered through offset of current payments due or from future assigned claims submitted to the carrier. This action occurs unless the carrier receives repayment or the physician provides a statement within 15 days of the date of the letter of why this action should not take place. Refund of the overpayment and any accrued interest is to be made within 30 days. (See §60H. The carrier shall include a statement of current interest rates in the letter. The demand letter must also explain the availability of an extended repayment schedule if the overpayment is $1000 or more or if it would be a financial hardship to refund it in a lump sum. (See §§20ff.) The carrier shall advise the physician/supplier in the letter that they have the right to request a review or hearing, as appropriate, if they believe the determination is not correct. (See Medicare Claims Processing, Chapter 30, Beneficiary Correspondence and Appeals. A review is available for disputed overpayments of any amount, and a carrier fair hearing is available once the review has been conducted if the amount in dispute is at least $100.

D - Recovery by Offset

If, within 15 days of the date of the initial demand letter, the physician/supplier submits a statement and/or evidence as to why offset should not be effectuated, the carrier shall promptly evaluate the material. This is different from a request for appeal (see subparagraph F) in that the physician/supplier is protesting only the proposed offset, not the basis for the overpayment. If the carrier determines that offset should begin, it shall notify the physician/supplier in writing of its determination. It shall give specific reasons for its decision.

If no such statement is received, the carrier shall initiate recovery by offset 40 days after the date of the initial request for refund, unless the physician/supplier refunds the overpaid amount in full. The carrier shall apply any amounts payable to the physician/supplier by reason of assignment on behalf of **any** beneficiary to offset the overpayment. It shall apply any amount offset first to the accrued interest and then to the principal. If the overpayment was due to payment in excess of the reasonable charge, it shall advise the physician/supplier of the reduced coinsurance amount (and deductible amount if any) that the physician is permitted to charge the beneficiary based on the reduced reasonable charge and that if the physician has collected more, the excess must be refunded.

If it is not possible to make an immediate offset, the carrier shall annotate the physician's account so that the overpayment can be recouped from future Medicare benefits payable. When offset is used, the carrier sends the regular Explanation of Medicare Benefits (EOMB) to the beneficiary. However, it includes with the physician's/supplier's EOMB an explanation that benefit (or a specified amount of the benefit) are being applied to the overpayment and that the physician may not request the beneficiary to pay the amount applied to the overpayment.

The carrier shall discontinue offset only when the overpayment, plus all accrued interest, is recovered or it is determined on appeal that the physician/supplier was not overpaid.

After a favorable appeal decision, the carrier shall refund any excess amount withheld through offset. Also, it shall refund interest that was collected.

E - Follow-up Request

If the initial request for refund of an overpayment of $50 or more brings no response within 30 days, the carrier shall send a follow-up letter (enclose a copy of the initial letter to the physician/supplier) within 45 days. If any portion of the overpayment has been recovered, it shall include a statement of that amount.

F - Physician Appeals Within 30 Days of Notification of the Intent to Offset

If, within 30 days after the date of the initial request for refund informing the physician/supplier of the intention to offset, the physician/supplier submits a request for a review or hearing or otherwise protests the recovery, the carrier shall make every effort to conclude the appeal procedure before the deadline for effectuation of offset, i.e., the 40th day after the date of the initial notice. However, it shall begin offset 40 days after the initial request for refund, if refund has not been made, regardless of the status of any appeal request. (See subparagraph D.)

G - Refund Letter to Physician Returned as Undeliverable

Where a refund letter is returned as undeliverable, the carrier shall attempt to locate the physician/supplier using such sources as telephone directories, city directories, postmasters, driver's license records, automobile title records, State and local medical societies, or its own Medicare beneficiary records. If still unsuccessful in locating the physician, it shall contact:

American Medical Association
515 N. State St.
Chicago, IL 60610.

However, it shall not undertake this development if the overpayment is less than $600 or it appears that the cost of locating the physician and collecting the overpayment is likely to exceed the amount of recovery.

Below is a sample letter that can be used or adapted when writing to State or local medical societies, the American Medical Association, other professional organizations or other sources.

To Whom It May Concern:

This office desires to contact _____, in connection with official Medicare program business that is pending in this office. The last known address for this physician/individual/entity was _____. Correspondence that we sent to _____ at that address has been returned.

In order that we may continue our efforts, we would appreciate it if you would provide us with the latest address that you have for _____.

Your cooperation and early reply in this matter is appreciated.

Sincerely yours,

H - Interest

Section 1833(j) of the Act and 42 CFR 405.378 require that interest be charged on Medicare overpayments.

The interest rate on overpayments is determined in accordance with regulations promulgated by the Secretary of the Treasury and is the higher of the private consumer rate or the current value of funds rate prevailing on the date of final determination. Interest accrues from the date of the initial request for refund and is assessed for each 30 day period, or portion thereof, that payment is delayed after the initial refund request.

Waive interest charges if the overpayment is completely liquidated within 30 days from the date of the initial request for refund, or if you or the RO determine that the administrative costs of collection would exceed the amount of interest. Compute interest for both late payments and installment payments as simple interest using a 360-day year. Do not prorate interest on a daily basis for overdue payments received during the month (e.g., 10, 15, or 20 days late). Assess interest for a full 30-day period. Use U.S. Postal Service postmark date or a dated shipping label from a commercial carrier to determine timely receipt of payment.

Calculate interest for a 30-day period as follows:

Principal times Prevailing Interest Rate = Interest for Year

Interest for Year divided by 12 = 30-day interest

Thus, if a payment is made 31 days from date of determination, charge two 30-day periods of interest. Apply any payment to accrued interest first and then to principal. For example, an overpayment was determined on June 15, 1993, and no refund was received within 40 days. Offset was put into effect on July 25, 1993, and was applied first to 60 days of interest and the remainder applied to the principal. On or after August 15, 1993, (the 61st day after determination) any offset amount is applied to an additional 30 days of interest.

I - Direct Contact with Physician

If attempted offset of the overpayment is unsuccessful for 30 days, the carrier shall contact the physician/supplier either in person or by telephone. Generally, it shall make a personal visit only when the amount of the overpayment is $600 or more. The length of

the trip is a factor in deciding whether to contact the physician/supplier in person or by telephone.

J - Contact with Professional Organizations

The carrier shall contact State or local medical societies (or other professional organizations) for assistance in obtaining refund of Medicare overpayments if it believes such a contact would be productive.

K - Physician/Supplier Does Not Refund

If the physician/supplier does not refund and no portion of the overpayment is recovered by offset within 75 days after the date that the follow-up letter was sent, or within 75 days after the date of the notice of an unfavorable appeal determination, the carrier shall refer the case to the RO, in accordance with §140.5, as uncollected. It shall not refer any case to the RO for which an appeal is pending. If, based on the physician's normal rate of assignment, the overpayment can be recovered by offset within one year; the carrier shall not refer the case to the RO. (See §20.) If, after one year on offset, less than 50 percent of the overpayment is recouped, it shall refer the case to the RO.

In any case, the carrier shall maintain the "stop" on its records to insure continuing offset against future Medicare benefits. If the overpayment is recouped after referral to the RO, it shall notify CMS promptly. This notification is important since it may forestall a CMS referral to another agency to recover money that has been refunded.

Where the overpayment is $600 or more, CMS may refer the case to the Department of Justice for action. These overpayment cases must contain evidence indicating the physician/supplier has the means to refund the debt or satisfy a judgment, and evidence that the physician/supplier has been informed of their right to a review. (See §60A.) Therefore, the carrier shall include with the referral letter any available information about the physician's/supplier's financial status and professional standing. This information may be available from carrier medical consultants or other members of the carrier’s staff, or may be contained in professional publications or directories, or other easily accessible sources.

Such information should include, where possible, the nature of the physician's/supplier's practice and the amount paid to the physician during the previous year in Medicare benefits. In addition, the referral should include the information specified in Chapter 3, §50.2.

L - Exhibits - Sample Demand Letters

Exhibits I through VI include: the initial demand letter with optional opening paragraphs and the follow-up letter.It also includes a limited set of optional paragraphs to be used in specific situations, e.g., medical necessity denials, and installment payments. The carrier shall follow these formats, with the optional paragraphs, when preparing demand letters.

This section also includes standard letters to be used when the physician/supplier voluntarily submits a check to the carrier. These letters are optional if the carrier uses the remittance advice to inform physicians/suppliers of receipt of their refund checks.

Exhibit 1 - Initial Demand Letter to Physicians/Suppliers

Dear (Name of Physician):

Choose one of the following three paragraphs.

"This is to let you know that you have received Medicare payment in error which has resulted in an overpayment to you of $_____ for services dated _____ . The following explains how this happened."

or

"We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention."

or

"We have received your check in the amount of $_____. We thank you for bringing this overpayment to our attention. While we appreciate you submitting payment to us, our review found that the overpaid amount was $_____. Please remit the additional $_____."

How this overpayment was determined:

NOTE: This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.

Why you are responsible:

NOTE: For medical necessity determinations, the carrier shall insert appropriate paragraphs. It shall be sure to give an 1879 determination for each claim as well as the regulatory and statutory references for the 1879 determination.

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation, you **(fill in the specific 1870(b) determination for each claim.)** Therefore, you are not without fault and are responsible for repaying the overpayment amount.

(Applicable Authorities: Section 1870(b) of the Social Security Act; §§ 405.350 - 405.359 of Title 42, §§ 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations.)

What you should do:

Please return the overpaid amount to us by _____(date) and no interest charge will be assessed. Make the check payable to Medicare Part B and send it with a copy of this letter to:

Carrier Address

If you wish to appeal this decision:

You may request a carrier review. If you are not satisfied with the review decision, and the amount in dispute is at least $100, you may then request a carrier fair hearing. Please understand that interest will continue to accrue on the overpayment, regardless of any appeal. If you wish to appeal, you can submit a written request, within six months, to:

Address of Hearings Department

If you do not refund within 30 days:

If you do not repay the amount within 30 days, interest will accrue from the date of this letter at the rate of_____ percent for each 30-day period. Periods of less than 30 days will be counted as 30-day periods. Medicare has the authority to charge interest on its outstanding Part B debts in accordance with §1833(j) of the Social Security Act and 42 CFR 405.378.

On (Date) _____ we will automatically begin to offset the overpayment amount against any pending or future assigned claims. Offset payments will be applied to the accrued interest first and then to the principal. If you believe that offset should not be put into effect, submit a statement within 15 days of the date of this letter to the above address, giving the reason(s) why you feel this action should not be taken.

NOTE: If the overpayment is $1000 or more, the carrier shall include optional paragraph B2 of Exhibit IV.

For copies of the applicable laws and regulations, please contact us at the address shown in our letterhead, to the attention of the _____ Department.

If you have any questions regarding this matter, please contact us at _____.

Thank you in advance for your prompt attention to this matter.

Sincerely,

(Name of individual)

Exhibit 2 - Follow Up Demand Letter to Physicians/Suppliers

SECOND REQUEST

Dear (Name of Physician/Supplier):

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the initial letter sent to you which explains how the overpayment was determined and why you are responsible. As of today, we have not heard from you, either to request an overpayment appeal or to make payment.

As stated in our initial letter, offset of the overpayment amount, plus interest, will be made against any pending and future assigned Medicare claims.

If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact us.

Sincerely,

(Name of individual)

Enclosure

Exhibit 3 - Overpayment Report - Deleted

Deleted

Exhibit 4 - Optional Overpayment Customizing Paragraphs

A1 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials. It shall place it as the first paragraph under the heading "Why you are responsible."

Based on available information, we have determined that you had or should have had knowledge that the service(s) were not medically necessary and reasonable because...(i.e., pertinent information was available from the law and regulations [provide a cite, if possible], from [cite name/issue number of your newsletter], from a meeting you attended on [date], and from your peers in the medical community).

(Applicable Authorities: Section 1879 of the Social Security Act; §§411.404 and 411.406 of Title 42 of the United States Code of Federal Regulations.)

NOTE: The carrier shall be sure to include the applicable authorities at the end of the §1879 language as it appears here.

A2 - The carrier shall include this language in all overpayment letters that involve §1879 medical necessity denials where payment was collected from the beneficiary.

This overpayment is for services that are not medically reasonable and necessary per Medicare standards. If you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

B1 - The carrier shall include the following paragraph in all overpayment letters that involve payment in excess of the allowed charge.

The overpayment resulted from payment made to you in excess of the allowed charge for services. If you have collected a coinsurance and/or deductible from the beneficiary based on the incorrect amount, please be sure to refund the excess amount to the beneficiary.

B2 - If the overpayment is $1000 or more, the carrier shall include the following paragraph in the overpayment letter.

If payment in full or the offset of claims payment would cause you financial hardship, you may request to pay in installments by writing to us within 15 days from the date of this letter to the above address. Once again, please understand that interest accrues beginning from the date of this letter at the rate of _____ percent, for each 30-day period. Periods of less than 30 days are treated as 30-day periods.

B3 - The carrier shall include one of the appropriate paragraphs below in all overpayment letters that involve duplicate payments.

- The overpayment resulted from excess payments caused by multiple processing of the same charge.

- The overpayment resulted from Medicare payment on an assigned claim for which the beneficiary also received payment on an itemized bill and turned his payment over to you. Therefore, you are liable for $_____ which represents that portion of the total amount paid in excess of the fee schedule amount.

- You have mistakenly received duplicate primary payment from both Medicare and another entity (Specific payer). (Specific payer) is the appropriate payer. As such, you are liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer.

- This overpayment resulted from duplicate Medicare payments to you for services you provided to (**named beneficiary**).

NOTE: The above paragraphs are not all-inclusive. The carrier shall refer to Chapter 3, Overpayments, §130.6 ff. for other situations where a physician is liable.

Exhibit 5 - Sample Letter - Check Included for Correct Amount

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. We thank you for bringing this overpayment to our attention, thereby protecting the integrity and resources of the Medicare program.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check in the amount of $_____ and applied it to the overpayment.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

Exhibit 6 - Sample Letter - Check Included But Wrong Amount (Too Much)

Dear (Name of Physician/Supplier):

We appreciate your recent inquiry regarding Medicare payment that you believe was paid in error. We thank you for bringing this overpayment to our attention.

A review of our records confirms that you have been overpaid. (This paragraph should include a clear explanation of how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.)

We have received your check for $_____. You will notice that the amount of your check exceeds the overpayment amount. We will send you a check shortly for the excess amount.

Thank you once again for bringing this matter to our attention.

Sincerely,

(Name of individual)

Enclosure