CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12946	**Date: November 8, 2024**
	Change Request 13753

SUBJECT: Medicare Financial Management Manual Chapter 3 - Overpayments 10-90 Updates 2024

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide updates to the Medicare Financial Management Manual, Chapter 3, sections 10-90.

EFFECTIVE DATE: December 10, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 10, 2024

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/ table of contents
R	3/10/Overpayments Determined by the Medicare Contractor
R	3/10/1/Aggregate Overpayments
R	3/10/2/Individual Overpayments
R	3/20/Recovery of Cost Report Overpayments- Cost Report Filed
R	3/20/1/Part A Provider is Participating in Medicare and Medicaid
R	3/20/2/Provider is No Longer Participating in Medicare and Not Participating in Medicaid
R	3/20/3/Provider is No Longer Participating in Medicare But is Participating in Medicaid
R	3/30/Recovery of Cost Report Overpayments- Overdue Cost Report
R	3/30/1/Part A Provider is Participating in Medicare and Medicaid
R	3/30/2/Provider is No Longer Participating in Medicare and Not Participating in Medicaid
R	3/30/3/Provider is No Longer Participating in Medicare But is Participating in Medicaid: One or More Cost Reports Not Filed
R	3/40/Recovery of Claims Accounts Receivables from the Provider- Part A Only
R	3/40/1/Demand Letter Contents
R	3/40/2/Sample Demand Letter for Claims Accounts Receivables
R	3/50/Recovery of Overpayments When a Provider Changes Its Contractor
R	3/50/1/Provider is Participating in Medicare and Medicaid
R	3/50/2/Action by Incoming Contractor
R	3/60/Interim Rate Adjustments and Periodic Interim Payment Adjustments – Part A Only
R	3/70/Determining Liability and Waiver of Recovery for Overpayments
R	3/70/1/1879 Determination – Limitation of Liability
R	3/70/2/1842(l) Determination
R	3/70/3/1870 Determination-Waiver of Recovery of an Overpayment
R	3/80/Individual Overpayments Discovered Subsequent to the Fifth Year
R	3/80/1/How to Determine the Fifth Calendar Year After the Year the Payment was Approved
R	3/80/2/Recovery of Overpayment Due to Overdue Cost Report
R	3/90/Provider, Physician, or Other Supplier Liability

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/90/1/Examples of Situations in Which Provider, Physician, or Other Supplier Is Liable
R	3/90/2/Provider, Physician, or Other Supplier Protests Its Liability

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 12946	Date: November 8, 2024	Change Request: 13753

SUBJECT: Medicare Financial Management Manual Chapter 3 - Overpayments 10-90 Updates 2024

EFFECTIVE DATE: 30 days from issuance
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: 30 days from issuance

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide updates to the Medicare Financial Management Manual, Chapter 3, sections 10-90.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide updated language to the existing instructions in Chapter 3 Overpayment sections 10-90.

B. Policy:

Overpayments are Medicare payments to a provider, or beneficiary who received the amounts that are due and payable under the statute and regulations. Once a determination of an overpayment is made, the overpayment amount is a debt that the provider or beneficiary owes to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must try to collect Federal Government claims that arise out of the agency's activities.

The Contractor will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part. However, once a contractor determines an overpayment has been made, it shall attempt to recover the overpayments in accordance with the Medicare regulations, in accordance with 42 CFR 405.371.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13753.1	Contractors shall review the Manual updates for the change from the term FI and/or Carrier to Contractor.	X	X	X	X					
13753.2	Contractors, in all cases, shall ensure that the Intent to Refer Letter (ITR) is sent in enough time to allow the debtor 60 days' notice prior to referral to	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Treasury. In accordance with provisions of the Debt Collection Improvement Act of 1996 (DCIA), eligible delinquent debts must be referred to Treasury by the 120th day of delinquency. (Refer to IOM Pub.100-06, chapter 4, §70 for further detail.)									
13753.3	Contractors shall send the ITR letter 60 days from the date of the initial demand letter if the provider has not responded, even though procedures for withholding the Federal share of the payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury.	X	X	X	X					
13753.4	Contractors shall follow the instructions in Chapter 4, Section 10 on the telephone contacts to the provider.	X	X	X	X					
13753.5	When the provider has not responded, even though the procedures for withholding the Federal share of Medicaid payments have been initiated, the Contractor shall send the Initial demand letter by the 30th calendar day, followed by the ITR letter by the 60th calendar day from the date of the Initial demand letter.	X	X	X	X					

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

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

ATTACHMENTS: 0

Medicare Financial Management Manual

Chapter 3 - Overpayments

Table of Contents
(Rev.12946, Issued:11-08-24)

Transmittals for Chapter 3

10 – Overpayments Determined by the Medicare Contractor

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Overpayments are Medicare payments *to* a *provider, or* beneficiary *who* received *the* amounts *that are* due and payable under the statute and regulations. Once *a determination of an overpayment is made,* the *overpayment* amount is a debt *that the provider or beneficiary owes* to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must *try to* collect *Federal Government* claims *that arise* out of the *agency's* activities.

The *Contractor* will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part. However once a c*ontractor* determines an overpayment has been made, it *shall* attempt *to recover the* overpayments in accordance with *the Medicare* regulations, *in accordance with 42 CFR 405.371.*

The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments.

These include:

.1) Requesting an Extended Repayment *Schedule (ERS).*

2) Establish*ing the ERS* repayment schedules.

3) Suspen*ding* interim payments to institutional providers.

4) Effecting recoupment or setoff, where appropriate.

5) *A*ttempting to locate the debtor, where necessary.

6) In addition, The Debt Collection Improvement Act of 1996 (31 USC 3711) requires Federal agencies to refer eligible delinquent debt to a Treasury-designated Debt Collection Center (DCC) for cross servicing and offset.

In all cases, the Contractor ensures that the Intent to Refer Letter (ITR) is sent in enough time to allow the debtor 60 days' notice prior to referral to Treasury. In accordance with provisions of the Debt Collection Improvement Act of 1996 (DCIA), eligible delinquent debts must be referred to Treasury by the 120th day of delinquency. (Refer to IOM Pub.100-06, chapter 4, §70 for further detail.)

** The Healthcare Integrated General Ledger Accounting System (HIGLAS) adds an additional 5 days after generating the intent to refer letter (ITR) to allow for interest accruals to appear on the ITR; therefore, the ITR will be generated on day 66.*

General*ly there are* two types of Overpayments:

A. Aggregate overpayments involve a group or all of provider's claims, e.g.:

1) Overpayments determined when the *Contractor* settles the cost report.

2) Overpayments resulting from a pattern of improper application of Medicare coverage provisions;

3) Overpayments with a threshold of less than $25 to equal $25 or higher.

4) Overpayments resulting from adjusting periodic interim payment*s*.

5) The provider failing to timely file a cost report.

6) Fraud, *ID Theft,* or program abuse.

7) Overpayments resulting from aggregated open uncollected balances for un-demanded claims overpayments (Part A Only).

8) Overpayments resulting from extrapolations of a sampled claim review applied to a claim universe.

9) Aggregate overpayments are described in §10.1, §20 and §30 of this chapter and Chapter 4, Debt Collection.

B. Individual overpayments refer to incorrect claims payment for services.

1) Individual overpayments are described in §10.2, §80 and Chapter 4, Debt Collection.

2) Medicare Secondary Payer (MSP) instructions can be found in the Medicare Secondary Payer Manual, CMS Publication 100-5.

10.1 - Aggregate Overpayments

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

A. *Institutional (Part A) Providers Serviced By the Contractor*

Aggregate overpayments to providers (overpayments arising in other than individual cases) may occur when:

- *The Contractor* determine*s the* amounts due when the provider files a cost report, or during desk review, final settlement or reopening of the cost report.
- *The Contractor* made excess interim payments to the provider.
- The provider includes non-allowable or excessive costs in its cost report.
- The provider fails to file a cost report (Chapter 3, §30).
- The provider fails to repay an accelerated payment; or
- The provider has a pattern of furnishing and billing for excessive or noncovered services. *Refer to the improper payment and not in compliance in the* Program Integrity Manual *Publication 100-08, Chapter 1).*
- *The Contractor* ma*d*e adjustments in the claim processing systems (Claims Accounts Receivables or carryover adjustment) (Refer to Chapter 4, §70.7.3).

1. The Provider initiates (Part A) the claim adjustment and after 60 days the amounts are aggregated to reach the $25 threshold.

10.2 - Individual Overpayments

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

An individual overpayment is an incorrect payment the *Contractor* makes to a provider, *or a beneficiary for* services under title XVIII.

Examples of individual overpayment cases are when the *Contractor*:

- Pays the provider, or *beneficiary for* services rendered after the beneficiary's benefits have been exhausted, or where the individual was not an eligible beneficiary.
- Incorrectly applies the deductible or coinsurance.
- Pays for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.
- Pays based on a charge that exceeds the reasonable charge.

- Processes duplicate charges/claims.
- Pays a physician on a non-assigned claim, or pays a beneficiary on an assigned claim, (Payment made to wrong payee).
- Makes primary payment/s for items or services for which another entity is the primary payer.
- Pays for items or services rendered during a period when the beneficiary was not an eligible Medicare beneficiary.

20.1 - Part A Provider is Participating in Medicare and Medicaid

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

When the provider files a cost report indicating an overpayment, a final determination is deemed to have occurred if the cost report is not accompanied by payment in full. Where the provider does not remit the overpayment in full, the *Contractor* sends the *initial* demand letter notifying the provider that it will reduce or suspend interim payments in 15 days if the provider does not make repayment arrangements.

If an overpayment is determined as a result of a tentative settlement, final settlement, interim rate adjustment, or reopening the *Contractor* sends the *Initial* demand letter within 7 calendar days. (See Chapter 4, §20)

When the Notice of *Program* Reimbursement (NPR), which is sent at the conclusion of an audit, results in an overpayment, *the initial* demand letter must also be sent.

- The NPR and the *initial* demand letter may be sent simultaneously, *or*
- The *Initial* demand letter may be sent as a separate document, or
- *The Initial demand letter can* be incorporated into the NPR.

If the issuance of the NPR changes the facts as stated in prior demand letters, the *Contractor* shall include in the NPR an explanation of the revised overpayment amount.

See Chapter 4, §40 to determine if the overpayment requires a withhold of payments.

If the provider does not respond within *60* days after the date of the *Initial* demand letter, the *Contractor* sends a *ITR* letter notifying the provider of the *Contractor*s intent to recoup the overpayment from interim payments. (If the current percentage of withhold is less than 100%, the demand letter shall state that interim payments will be withhold at 100% in 30 days if repayment arrangements are not made.)

- *The ITR letter* shall include notification of the intent to refer the entire debt to the Department of Treasury for additional collection action. (See Chapter 4, §20)

20.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

If the *Contractor* becomes aware that there is an imminent likelihood that a provider will be terminating from the Medicare program it shall contact the RO with regard to future collection efforts.

If the *Contractor* discovers an overpayment upon the filing of a cost report, or on determination of program reimbursement, with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund in a lump-sum, if it has not been made.

The *Initial* demand letter shall be sent, and all subsequent collection activities performed as specified in §20.1 and Chapter 4, §10-20.

If the terminated provider has sold the entity to a participating provider refer to Chapter 3, §130 for change of ownership instructions.

20.3 - Provider is No Longer Participating in Medicare But Is Participating in Medicaid

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

If the *Contractor* discovers an overpayment upon the filing of a cost report, or on determination of the amount of program reimbursement for a former Medicare provider that is still participating in Medicaid, it shall immediately contact the provider to obtain a refund in a lump sum, if it has not been made.

The *Initial* demand letter shall be sent and all subsequent collection activities performed as specified in §20.1 and Chapter 4, §10-20.

The *Initial* demand letter must provide notice (See Chapter 4, §10-20 and §60) that action to withhold its Federal share of Medicaid payments will be requested if repayment arrangements are not made within 15 days of the date of this notice. The *Contractor* shall send the *ITR* letter *60* days *from the date of the Initial demand letter if* the provider has not responded, even though procedures for withholding the Federal share of payments in title XIX have been initiated, so that if recoupment efforts and withholding of Medicaid funds are not effective, the case will be ready for referral to the Department of Treasury. If the terminated provider has sold the entity to a participating provider refer to Chapter 3, §130 for change of ownership instructions.

30 - Recovery of Cost Report Overpayments - Overdue Cost Report

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

When a provider fails to submit a cost report by the due date the *Contractor* shall take recovery action to notify the provider that submission of the cost report is required and that additional collection action will continue until an acceptable cost report is submitted.

30.1 - Provider is Participating in Medicare and Medicaid

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

A. General

For a participating provider, the cost report required for each cost report period is due on or before the last day of the fifth month following the end of that particular cost report period. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

If no cost report has been received by the seventh day after the due date (including extensions), the *Contractor* must send the *Initial* demand letter in Chapter 4, §20. (The seven-day timeframe allows for processing and mail time.) In addition, the *Contractor* must initiate 100% suspension of all Medicare payments on day seven if the cost report has not been received, an extension request has not been received and approved or a reduction in the rate of suspension has not been approved.

If the provider does not respond within *60 calendar* days *from* the *date of the Initial* demand letter, the *Contractor* shall send the *ITR* letter. (See Chapter 4, §20)

Note: *Contractors shall follow the instructions in Chapter 4, §10 on telephone contacts to the provider.*

30.3 – Provider is No Longer Participating in Medicare But is Participating in Medicaid: One or More Cost Reports Not Filed

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Where a provider's agreement under title XVIII has terminated and one or more cost reports have not been submitted the *Contractor* shall send the *Initial* demand letter. Requirements for this letter are in Chapter 4, §20. Since this situation involves not only a terminated provider but a provider that has failed to meet the basic obligation (submission of a cost report) for the period when it did participate, the *Initial* demand letter provides notice that initiation of the procedure for withholding the Federal share of Medicaid payments will begin in 15 *calendar* days if the C*ontractor* does not receive the cost report.

When the provider has not responded, even though the procedures for withholding the Federal share of Medicaid payments have been initiated, the Contractor shall send the *Initial* demand letter *by the 30th calendar* day, *followed by the ITR letter by the 60th calendar day from the date of the Initial demand letter.* This must be done so that if recoupment efforts and the withholding of Medicaid payments are not effective, the case will be ready for referral to the Department of Treasury.

40 – Recovery of Part A Claims Accounts Receivables from the Provider -

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24) Part A claims A/R arises from adjustments in the *Contractor's* claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). Some of the reasons these adjustments occur include the duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, a determination by the C*ontractor* that an adjustment was required, or an adjustment created from a credit balance report, CMS-838 *in accordance to Chapter 12, Credit Balance Reporting.* These adjustments are normally recovered through the recoupment of future claims and the recovered amounts are included in the remittance advices to the providers. For additional information see Chapter 4, §70.15.2.

40.1 – Part A Demand Letter Contents

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

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

The demand letter *shall* include the following information:

- That an overpayment was made;
- That interest will begin to accrue if the overpayment is not paid in full within 30 days;
- The name and *Patient Control Number (PCN)* of the beneficiary involved will be included in the spreadsheet attachment;
- The dates and types of services for which the overpayment was made to include sufficient information for the provider to identify the overpayment;
- How the overpayment was calculated;
- Why it is liable for recovery of overpayment (i.e., the reasons for finding the provider at fault);
- That recoupment of the overpayment from all available payments will occur on day 16 from the date of the Demand Letter;
- Rebuttal language shall be included;
- A reference to the Appeals rights in the remittance advice.

40.2- Sample Demand Letter for Claims Accounts Receivables

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Refer to Publication 100.06, Chapter 4, § 20.2, Sample Demand Letters for all Providers or Suppliers

50 - Recovery of Overpayments When a Provider Changes Its *Contractor*

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Where CMS approves a change of *Contractor* the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Medicare Claims Processing, Chapter 1,General Billing Requirements.)

50.1 Action By Outgoing *Contractor*

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

The outgoing C*ontractor* is responsible for effectuating final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter to ensure the timely receipt of the cost report as well as any NPRs and demand letters. The outgoing C*ontractor* is also responsible for assuring that the incoming C*ontractor* is aware of the outstanding overpayment and that recoupment is initiated by the withholding of interim payments, if necessary.

If the overpayment remains uncollected, the outgoing C*ontractor* is responsible for initiating the withholding of Title XIX payments (Medicaid) and for referring the overpayment to the Department of Treasury. The outgoing C*ontractor* must copy the incoming C*ontractor* on all correspondence with the provider to ensure a timely collection process.

A. Notification to Incoming *Contractor*

When the outgoing C*ontractor* is notified by the RO that the provider's request for a change of C*ontractor* has been approved, it shall notify the incoming C*ontractor* in writing of all outstanding program overpayments.

It shall include:

- The cost reporting period,
- The date the overpayment was determined.
- Explanation of the type of overpayment, e.g., cost report overpayment - desk review, cost report overpayment - audit.
- The current status of collection action, including any withhold that is currently in place to recoup the overpayment,
- The original balance of the overpayment and the current principal and interest balance of the overpayment.
- The outgoing C*ontractor* should also notify the incoming C*ontractor* of future settlements that *will* be occurring and of any unfiled cost reports.

B. Notice of Intent to Suspend Interim Payments

If at the time of the change of C*ontractor*, the outgoing C*ontractor* is recouping an overpayment by the withholding of interim payments the incoming C*ontractor* will continue the withhold. The outgoing C*ontractor* must notify the provider that the withhold will be continued by the incoming *Contractor* until the overpayment is liquidated or an acceptable ERS is approved. In addition, the outgoing C*ontractor* must notify the incoming C*ontractor* of the details of the withhold.

If after the change of C*ontractor* occurs the outgoing C*ontractor* determines that an overpayment exists, the outgoing C*ontractor* must notify the provider in accordance with normal procedures. The current C*ontractor* should receive a copy of all NPRs and demand letters. The outgoing C*ontractor* must contact the current Contractor to make sure that recoupment begins when necessary.

50.2 – Action by Incoming *Contractor*

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

The incoming *Contractor* is responsible for effectuating final settlements for the cost report periods after the change of *Contractor* becomes effective. If the *Contractor* receives a cost report from a prior period it should forward it to the outgoing *Contractor* to make the final settlement. If the outgoing *Contractor* is no longer participating in the Medicare program, the incoming *Contractor* shall contact the RO for further instructions. After the outgoing *Contractor* has completed its review of the cost report, it notifies the incoming *Contractor* whether the cost report is acceptable, and the final settlement. The incoming *Contractor* in accordance with Ch. 4, §40, disposes of funds withheld during the suspension of interim

payments (for an unfiled cost report) and initiates recoupment by the withhold of interim payments if necessary. While overpayments are outstanding at the outgoing *Contractor,* the incoming *Contractor* must keep the outgoing *Contractor* up to date regarding the provider's location and participation in the Medicare program. If the incoming *Contractor* learns of a provider's termination from the Medicare program it must notify the outgoing *Contractor* so that it may act accordingly.

60 - Interim Rate Adjustments and Periodic Interim Payment Adjustments – *Part A only*

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

The interest provisions of Chapter 4, §30 do not apply to Part A overpayments or underpayments determined as a result of interim rate and periodic interim payment (PIP) adjustments or utilization reviews. If necessary, an interim rate or periodic interim payment adjustment shall occur prior to the end of the cost reporting year. When this occurs, the interim rate or periodic interim rate is adjusted for the remainder of the cost reporting year in order to have aggregate payments approximate total allowable costs. This adjustment is based on any overpayment or underpayment determined as a result of the interim review. Since payments are adjusted, this overpayment or underpayment should not exist at the end of the cost reporting year.

If the review is completed after the end of the cost reporting year or after the cost report is filed, adjustments to the interim or periodic rate are not possible. In this case any determined overpayment or underpayment shall be considered in conjunction with the final settlement. By taking the overpayment or underpayment into consideration with the tentative or final settlement the *Contractor* will issue a tentative settlement payment, tentative settlement demand letter, or Notice of Program Reimbursement. When a demand letter is issued, interest will be assessed if necessary. The Notice of Program Reimbursement will begin the recoupment process in accordance to Chapter 4, *§ 10.*

70 – Determining Liability and Waiver of Recovery for Overpayments

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

The Medicare law contains three provisions (§1870, §1879 and §1842(l)) dealing with liability for, and recovery of, individual overpayments. These provisions do not cover cost report overpayments. These provisions are reflected below and, for a more extensive treatment, in Medicare Claims Processing Manual, Publication 100-04, Chapter 31, Financial Liability Protections.

The *Contractor* shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most *Contractor* payments for provider services are made to providers on behalf of the beneficiaries who received the services. If payment is made directly to the beneficiary, liability always lies with the beneficiary unless recovery is waived under the limitation of liability provision. Where the provider or physician has been overpaid, it is liable for the overpayment unless the *Contractor* determines that it was without fault with respect to the overpayment. If the *Contractor* determines that an overpaid provider or physician was without fault and therefore not liable for the overpayment, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault. However, recovery from the beneficiary may be waived if you determine the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

70.1- 1879 Determination – Limitation of Liability

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

§ 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, practitioners, and other suppliers who acted in good faith in accepting or providing services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision applies to all Part A/Part B claims decisions where claims are denied or reduced (pre-pay or post-pay) under §1862(a)(9) and §1879 (e) and (g) of the Act.

Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary. (See Medicare Program Integrity Manual (PIM), Publication 100-08, Exhibits, §14.1)

A. Limitation on Liability – Indemnification Procedures for Claims Filed under Part B

§ 1879(b) of the Act provides that, when a physician/supplier is held liable for the payment of expenses incurred by a beneficiary for items or services determined to be excluded and such physician/supplier requests and received payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program will indemnify the beneficiary or other person(s) for any payments made to the liable physician/s supplier (including deductible and coinsurance payments). Further, any such indemnification payments are considered overpayments to the physician/supplier. (See PIM Exhibits, §14.1.)

B. Limitation on Liability Where Physician and Beneficiary Did Not Have Prior Knowledge With Respect to Services Found *t*o *b*e *n*ot Reasonable *a*nd Necessary Services (§1879 of Act)

When both the physician and the beneficiary did not have prior knowledge with respect to services found to be not reasonable and necessary, permit Medicare payment to be made under under the limitation on liability provision. (See Medicare Program Integrity Manual (PIM), Publication 100-08, Exhibits, §14.1) An overpayment does not exist if a determination is made that the limitation of liability provision applies. The claim decision must incorporate a limitation of liability determination.

70.2 - 1842(l) Determination

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

For denials of non-assigned claims based on §1862(a)(1) involving physician services, the *Contractor* must make a determination under §1842(l) of the Act regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for post-payment denials. (See Medicare Program Integrity Manual (PIM), Publication 100-08, Exhibits, §14.3)

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24) Once the *Contractor* has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a §1870(b) determination regarding whether the provider/beneficiary was without fault with respect to the overpayment. Once this determination has been made, then waiver of recovery of the overpayment from the provider/beneficiary *should* be considered per §1870(c). The *Contractor* makes a §1870 determination for all assigned *and* non- assigned claims, however, §1870 (b) or (c) of the Act, does not apply to the provider on non- assigned post-payment §1862(a)(1) denied claims. However, it can apply to the beneficiary meaning that the beneficiary was not at fault in causing he overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program, §1870 is not limited to claims denied under §1862(a)(1) of the Act for not being reasonable and necessary. §1870 is the framework for determining who is liable for the overpayment and whether the overpayment recovery can be waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived per 1870(c), the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. §1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim, and this is the basis for the overpayment.

Examples of §1870 determinations:

A. Overpaid Provider or Physician Not Liable Because It Was Without Fault 1870(b) of the Act.)

If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the fifth calendar year after the year of payment) it is not liable for the overpayment: therefore, it is not responsible for refunding the amount involved. The *Contractor* makes these determinations.

A. **Beneficiary Liable for Overpayments to Provider That Was Without Fault With Respect to the Overpayment (§§1870(a) and (b) of the Act)**

- If an overpaid provider was without fault or is deemed without fault and therefore not Liable for refund, liability shifts to the beneficiary.

- If the overpayment involves services that are not reasonable and necessary, you should have made a §1879 determination regarding the beneficiary's liability for the overpayment.

- If the overpayment does not involve medically necessary services, then limitation on liability does not apply.

B. ***Contractor*** **Waiver of Recovery from Beneficiary (§1870(c) of the Act)**

- If a beneficiary is liable for an incorrect payment, recovery may be waived if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where an overpayment is discovered subsequent to the fifth calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.)

- If §1879 of the Act is applicable, then §1879 determination is made first since an *overpayment* does not exist if payment can be made under §1879 because there was lack of knowledge by both the beneficiary and the provider.

80 – Individual Overpayments Discovered Subsequent to the Fifth Year

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

There are special rules that apply when an overpayment is discovered subsequent to the fifth year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary.

In the absence of evidence to the contrary, the Contractor will not demand and recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See Medicare Program Integrity Manual, Publication (PIM) 100-08, Chapter 3.)

> **EXAMPLE 1:** On May 9, 2016, Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On January 6, 2022, the Contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The *Contractor*-will not recover this overpayment *if* there is no evidence to the contrary because it was determined subsequent to the fifth year after notification of payment. (Any determination date on or after Jan. 1, 2022, will not be recovered.) (If evidence to the contrary existed, recoupment may be initiated. The PIM should be referenced and if necessary, the appropriate Benefits Integrity unit at the *Contractor* for guidance.)
>
> **EXAMPLE 2:** On May 9, 2016, Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On September 20, 2019, the *Contractor* determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The *Contractor* will attempt recovery of the overpayment. (Any determination dates up to and including Dec. 31, 2021, will be recovered.)

80.1 – How to Determine the Fifth Calendar Year after the Year the Payment

Was Approved

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Only the year of the payment and the year it was found to be an overpayment **enter into the determination of the *fifth*-calendar year period. The day and the month** are irrelevant. With respect to payments made in 2016, the fifth calendar year thereafter is 2021. For payments made in 2017, the fifth calendar year thereafter is 2022, etc. Thus, the rules apply to payments made in 2016 and discovered to be overpayments after 2021, to payments made in 2017 and discovered to be overpayments after 2022, etc.

Where an overpayment to a provider, or a physician assignee for medically unnecessary services or custodial care is discovered (i.e., demanded) subsequent to the fifth calendar year after the year in which the payment was approved, the provider or physician assignee is prohibited from charging the beneficiary or any other person for the services notwithstanding the fact that the provider or physician assignee has refunded the overpayment if:

- The provider or physician assignee was at fault with respect to the overpayment;

- The beneficiary was without fault with respect to the overpayment. (where the overpayment is discovered in, or before, the fifth calendar year, an "at fault" provider or physician assignee is not prohibited from charging the beneficiary for the overpayment if it has refunded it. However, a without fault beneficiary who pays an at fault provider's or physician assignee's bill for medically unnecessary services or custodial care, can be indemnified in accordance with Medicare Claims Processing Manual, Publication 100-04, Chapter 30, Financial Liability Protections.

- Reopening's (See Medicare Claims Processing Manual, Publication 100-04, Chapter 29 Appeals of Claims Decisions for additional information)

- Your initial, or review determination or a decision by a Hearing Officer may be reopened under the following conditions:

- Within 12 months after the date of the determination or decision it may be reopened for any reason;

- After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or

At any time, if:

- Such initial or review determination was procured by fraud or similar fault of the beneficiary or some other person.

- If an overpayment is determined based on a reopening outside of the above parameters, the *Contractor* will not recover the overpayment.

80.2 - Recovery of Overpayment Due to Overdue Cost Report

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

Where CMS approves a change of *the Contractor*, the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Pub 100-04, Medicare Claims Processing Manual, Publication 100-04, Chapter 1, General Billing Requirements.)

A. Reminder Letter

The outgoing *Contractor* is responsible for effecting final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter required under §30.1 to ensure the timely receipt of the cost report.

B. *Initial* Demand Letter

If no cost report has been filed by the first day after the due date of the cost report (including extensions), the outgoing Contractor sends the first demand letter. (See Medicare Financial Management Manual, Publication 100-06, Chapter 4, Debt Collection, §20.2, Exhibit l, Column B.) It sends copies of the reminder letter and the first demand letter to the RO and incoming *Contractor*. Upon receipt of its copy of the letter, the incoming *Contractor* suspends the interim payment.

C. *Intent to Refer Letter*

The *Contractor* shall issue a "modified Intent to Refer (ITR) Letter for Unfiled Cost Reports," if the provider has not filed the cost report and the overpayment balance has not been paid. (See Medicare Financial Management Manual, Publication 100-06, Chapter 4, §20.2 Exhibit 7 for a sample intent letter)

D. Receipt of Delinquent Cost Report

If the delinquent cost report is sent to the incoming *Contractor*, it sends the cost report to the outgoing *Contractor* to make the final settlement.

After the outgoing *Contractor* has completed its review of the delinquent cost report, it notifies the incoming *Contractor* whether the cost report is acceptable, and the final settlement. The incoming *Contractor*, in accordance with Medicare Financial Management Manual, Publication 100-06, Chapter 4, §40.1, disposes of funds withheld during the suspension of interim payments.

90 - Provider, Physician, or Other Supplier Liability

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

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

- The *Contractor* considers a provider, physician, or other supplier without fault, if it exercised reasonable care in billing, and accepting the payment, i.e., it made full disclosure of all material facts; and
- *Based on* the information available, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the *Contractor's* attention.

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

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

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

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

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

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

Providers, physicians, or other suppliers are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help the *Contractor* identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan. (See Medicare Claims Processing, Chapter 28, Coordination With Medigap, Medicaid and Other Complementary Insurers).

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

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

This includes the following situations:

- Provider, physician, or other supplier is overpaid when the *Contractor* processed the claim more than once. If an overpayment to a provider, physician, or other supplier is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the provider, physician, or other supplier does not have a reasonable basis for assuming that the total payment received was correct and thus should have questioned it. The provider, physician, or other supplier is, therefore, at fault and liable for the overpayment.

- Provider, physician, or other supplier received payment from Medicare based on an assignment and the beneficiary received payment on an itemized bill and turned the payment over to the provider, physician, or other supplier.

- The provider, physician, or other supplier is liable for only the portion of the total amount paid in excess of the provider's, physicians, or other supplier's portion of the allowable amount.

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

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

Mr. B is liable for the remaining $75 of the duplicate payment. If Mr. B had previously paid Dr. A the $75 coinsurance, Dr. A is liable for the entire $300 overpayment.

- Provider, physician, or other supplier receives duplicate payments from Medicare and another insurer or plan (directly or through the beneficiary) which is the primary payer, i.e., an automobile medical or no-fault insurer, a liability insurer, a WC insurer, or, under certain circumstances, an EGHP. (See Medicare Claims Processing Manual, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers).

- The provider, physician, or other supplier is liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer. (See Medicare Claims Processing Manual, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers and/or Medicare Secondary Payer Manual). However, if the provider, physician, or other supplier turns the other insurance payment over to the beneficiary, the beneficiary is liable.

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

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

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

EXAMPLE: John Doe entered University Hospital on January 10, 2024. After using all of his benefit days, including lifetime reserve days, he returned home, but reentered the same hospital in fewer than 60 days and stayed an additional 30 days. University Hospital neglected to check its records and billed the *Contractor* for 30 days of inpatient hospital care. The *Contractor* made payment. Subsequently, the overpayment was discovered. Since the hospital should have known from its own records that Mr. Doe had exhausted his benefit days, the *Contractor* shall seek recovery from the hospital.

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

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

Examples:

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

Mathematical error does not include a failure to properly assess the coinsurance and/or deductible. The Contractor would determine the liability for coinsurance and deductible overpayments in accordance with D. above. Where payment to a provider, physician, or other supplier was based on a deductible amount, the provider, physician, or other supplier is without fault. Seek recovery from the beneficiary.

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

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

(See the Program Integrity Manual, which can be found at the following Internet address: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html if fraud is suspected.)

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

For example, the Medicare Office verified to the the hospital that the individual was not entitled to hospital insurance benefits.

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

1. Services that were not Medically Unnecessary or Custodial Services, e.g., skilled physical therapy services furnished by a nonqualified physical therapist, or services rendered pursuant to an authorization from the VA. (See the Medicare Benefit Policy, Chapter 16, Exclusions
In general, the provider, physician, or other supplier should have known about a policy or rule, if:

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

Generally, a provider, physician, or other suppliers' allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met.

However, there may be other circumstances that justify a finding that the provider, physician, or other supplier was not at fault. The *Contractor s*hall consider all the circumstances, including such factors as whether and to

what extent a coverage rule is spelled out in regulations, instructions, or in a CMS notice, and whether a *Contractor* misinformed the provider, physician, or other supplier about the rule; in deciding whether a provider, physician, or other supplier acted reasonably in billing for and accepting payment for noncovered services.

2. Medically Unnecessary or Custodial Services.

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

I. *For Part A,* the overpayment resulted from *payment for* services rendered in a nonparticipating portion of the facility *that is not certified for Medicare or for services to a beneficiary* in a bed *that Medicare* certified for a type of care other than *what the provider* furnished.

J. For Part B, the overpayment resulted with a payment to a physician on claim/s which did not accept the assignment. Since, the physician was paid but did not accept assignment, the physician is liable whether the beneficiary had also been paid.

K. Overpayment was for rental of durable medical equipment and the supplier billed under the one-time authorization procedure.

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

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

Two examples of such services are:

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

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

(Rev.12946, Issued:11-08-24); Effective: 12-10-24; Implementation:12-10-24)

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

a. There was an overpayment.
b. Was the amount of the overpayment calculated correctly; and whether,
c. The provider, physician, or other supplier is liable for repayment.