CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1186	**Date: FEBRUARY 23, 2007**
	Change Request 5348

SUBJECT: Changes to Chapter 30 - Updates to Amount in Controversy Requirement and Correction of Appeals Terminology

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Chapter 30 language concerning the amount in controversy requirement and correct appeals terminology to reflect the new process.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***January 1, 2006
IMPLEMENTATION DATE: May 23, 2007

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	30/Table of Contents
R	30/20.1.1/ Statutory Basis
R	30/30/Determining Liability for Disallowed Claims Under §1879
R	30/30.2.1/General
R	30/30.2.2/Provider/Practitioner/Supplier is Determined to Be Liable – Right to Appeal
R	30/40.1/Determining Whether Provider, Practitioner, or Supplier Had Knowledge of Noncoverage of Services
R	30/40.3.2/Qualified Notifiers
R	30/100.2/Conditions for Indemnification
R	30/100.3/Development and Documentation of Indemnification Requests
R	30/100.9/Limitation on Liability Determination Does Not Affect Medicare Exclusion
R	30/100.10 Exhibits/Exhibit 4 – Letter to Practitioner or Supplier

	(Noninstitutional Services)
R	30/100.10 Exhibits/Exhibit 5 – Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)
R	30/100.10 Exhibits/Exhibit 6 – Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services
R	30/110.2/When to Make Limitation on Liability Decisions
R	30/110.3/ Preparation of Denial Notices
R	30/110.5.3/Other Reasons for Contractor Request for Copies of ABNs
R	30/120/Contractor Specific Instructions for Application of Limitation on Liability
R	30/120.1/Documentation of Notices Regarding Coverage
R	30/120.2/Availability of Coverage Notices to Operating Personnel
R	30/120.3/Applicability of Limitation on Liability Provision to Claims for Outpatient Physical Therapy Services Furnished by Clinics
R	30/120.4/Limitation on Liability Notices to Beneficiaries From Contractors
R	30/120.5/Contractor Redeterminations or Reconsiderations in Assignment Cases Conducted at the Request of Either the Beneficiary or the Assignee
R	30/120.5.1/Guide Paragraphs for Contractors to Use Where Section 1879 is Applicable at the Redetermination Level
R	30/130/Intermediary Specific Instructions for Application of Limitation on Liability
R	30/140/Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for Contractors and Physicians
R	30/140.2/Services Furnished Beginning October 1, 1987
R	30/140.3/Time Limits for Making Refunds
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R	30/140.9/Guide Paragraphs for Inclusion in Appeal Determination

R	30/140.10/Physician Fails to Make Refund
R	30/140.11/OIG Referral Procedures
R	30/150/DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) - Instructions for Contractors and Suppliers
R	30/150.4/Time Limits for Making Refunds
R	30/150.5.2.2/When a Request for an Advance Determination of Coverage Is Mandatory
R	30/150.7/Appeal Rights
R	30/150.8/Processing Initial Denials
R	30/150.9/Processing Beneficiary Requests for Appeal
R	30/150.10/Processing Supplier Requests for Appeal
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R	30/150.12/Supplier Fails to Make Refund

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1186	Date: February 23, 2007	Change Request: 5348

SUBJECT: Changes to Chapter 30 – Updates to Amount in Controversy Requirement and Correction of Appeals Terminology

Effective Date: January 1, 2006

Implementation Date: May 23, 2007

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration.

B. Policy: The purpose of this change request (CR) is to update language concerning the amount in controversy requirement and correct appeals terminology to reflect the new process.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5348.1	Contractors shall enact language changes included in Chapter 30.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

There are no changes in workload as a result of this CR.

V. CONTACTS

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Post-Implementation Contact(s): Aaron Pleines Aaron.Pleines@cms.hhs.gov 410-786-2137

VI. FUNDING

A. ***For TITLE XVIII Contractors*:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

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(Rev. 1186, 2-23-07)

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20.1.1 - Statutory Basis

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A coverage determination for an item or service must be made before there can be a decision with respect to whether Medicare payment may be made under the limitation on liability provision. Medical review entities, acting for the Secretary, are authorized to make the coverage determinations. These entities include *F*iscal *I*ntermediaries (FIs),

*Carrier*s, *Qualified Independent Contractors (QICs)* and Quality Improvement Organizations (QIOs). In CMS Ruling 95-1 and hereafter in these instructions, these entities are referred to collectively as Medicare contractors. These entities must act in accordance with the Medicare statutes, regulations, national coverage instructions, accepted standards of medical practice, and CMS Rulings when making coverage determinations.

The claims payment and beneficiary indemnification provisions (§§1879(a) and (b)) of the limitation on liability provision are applicable only to claims for beneficiary items or services submitted by providers, or by suppliers (which includes physicians or other practitioners, or an entity other than a provider that furnishes health care services under Medicare) that have taken assignment, and only to claims for services, not otherwise statutorily excluded, that are denied on the basis of §§1862(a)(1), 1862(a)(9) , 1879(e), or 1879(g) of the Act, which, under current law, include the following:

- Services and items 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 (§1862(a)(1)(A) of the Act);
- Pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration, furnished to an individual at high or intermediate risk of contracting hepatitis B, that are not reasonable and necessary for the prevention of illness (§1862(a)(1)(B) of the Act);
- Services and items that, in the case of hospice care, are not reasonable and necessary for the palliation or management of terminal illness (§1862(a)(1)(C) of the Act);
- Clinical care services and items furnished with the concurrence of the Secretary and, with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, that are not reasonable and necessary to carry out the purposes of §1886(e)(6) of the Act

(which concerns identification of medically appropriate patterns of health resources use) (§1862(a)(1)(D) of the Act);

- Services and items that, in the case of research conducted pursuant to §1142 of the Act, are not reasonable and necessary to carry out the purposes of that section (which concerns research on outcomes of health care services and procedures) (§1862(a)(1)(E) of the Act);
- Screening mammography that is performed more frequently than is covered under §1834(c)(2) of the Act or that is not conducted by a facility described in §1834(c)(1)(B) of the Act and screening pap smears and screening pelvic exams performed more frequently than is provided for under §1861(nn) of the Act (§1862(a)(1)(F) of the Act);
- Screening for glaucoma, which is performed more frequently than is provided under §1861(uu);
- Prostate cancer screening tests (as defined in §1861(oo)), which are performed more frequently than is covered under such section;

- Colorectal cancer screening tests, which are performed more frequently than is covered under §1834(d) ;
- The frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;
- Custodial care (§1862(a)(9) of the Act);
- Inpatient hospital services or extended care services if payment is denied solely because of an unintentional, inadvertent, or erroneous action that resulted in the beneficiary's transfer from a certified bed (one that does not meet the requirements of §1861(e) or (j) of the Act) in a skilled nursing facility (SNF) or hospital (§1879(e) of the Act);
- Home health services determined to be noncovered because the beneficiary was not "homebound" or did not require "intermittent" skilled nursing care (as required by §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act) on or after July 1, 1987, and before December 31, 1995 (§1879(g)(1) of the Act); and.
- Hospice care determined to be noncovered because the beneficiary was not "terminally ill" (as required by §1861(dd)(3)(A) of the Act), as referenced by §1879(g)(2) of the Act since BBA 1997.

30 - Determining Liability for Disallowed Claims Under §1879

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

See §20 for the criteria that must be met before the *contractor* considers limitation on liability as discussed in the following subsections.

Ordinarily a finding is made that the beneficiary did not know nor could reasonably have been expected to know that the items or services were not covered by Medicare, unless there is evidence as discussed in §40.2 . The procedures for determining whether the provider knew or could reasonably have been expected to know of the noncoverage of services are discussed in §40.1 .

30.2.1 - General

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor holds the provider, practitioner, or supplier liable for noncovered services if it is determined that the provider:

- Had actual knowledge of the noncoverage of services in a particular case, or
- Could reasonably have been expected to have such knowledge.

However, it does not hold a provider, practitioner, or supplier liable under §1879 where the provider, practitioner, or supplier indicates on the claim (via Occurrence Code 32 *or* the HCPCS code modifier "GA" on *contractor* claims) that they have given the beneficiary, before furnishing the items or services, an ABN. In such a case, the

contractor holds the beneficiary, not the provider, practitioner, or supplier, liable for the denied charges.

30.2.2 - Provider/Practitioner/Supplier is Determined to Be Liable - Right to Appeal

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A provider, practitioner, or supplier that is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by the contractor. (See Chapter 29, "Appeals of Claims Decisions.")

NOTE: Under §1879(b) of the Act and 42 CFR 411.402 et seq., if the provider, practitioner, or other supplier is considered to be liable and requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of the beneficiary's expenses, the Medicare program indemnifies the beneficiary or other person(s) for any amounts paid by the beneficiary. This includes any deductible or coinsurance charges paid by or on behalf of the beneficiary. Further, these indemnification payments are considered an overpayment to the provider, practitioner, or other supplier. The limitation on liability provision applies to third party payers, including liability insurers. Therefore, a provider, practitioner, or supplier that the contractor determines liable may not seek payment from a third party payer without being subject to recovery action that could occur if it sought payment from the beneficiary.

40.1 - Determining Whether Provider, Practitioner, or Supplier Had Knowledge of Noncoverage of Services

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The Medicare contractors determine, based on the information they maintain and/or disseminate to a particular provider, practitioner or other supplier, whether the provider, practitioner or other supplier actually had prior knowledge that services or items would likely be denied or whether knowledge reasonably could have been expected. The determination of actual or expected knowledge is based on all the relevant facts pertaining to each particular denial. In accordance with regulations at 42 CFR 411.406 , evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

- A Medicare contractor's prior written notice to the provider, practitioner, or other supplier of Medicare denial of payment for similar or reasonably comparable services or items;
- Medicare's general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, *contractor*s' written guides, and directives); and
- Provision of the services and items was inconsistent with acceptable standards of practice in the local medical community (refer to §40.1.3 and §40.1.4).

If any of the circumstances described above exists, a provider, practitioner or other supplier is held to have knowledge.

40.3.2 – Qualified Notifiers

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

An ABN must be delivered to the beneficiary (or authorized representative) by a qualified notifier such that the beneficiary (or authorized representative) may have confidence in and rely upon the accuracy and credibility of the notice. A QIO, *contractor*, group or committee responsible for utilization review for the provider that furnished the services, or provider, practitioner, or supplier that furnished or ordered the items and/or services (including their staff and employees) is a qualified notifier for delivery of ABNs for the purposes of the limitation on liability provision and the refund requirements provisions. In this section, when explaining the "notifier's" liability risks, etc., it is generally the provider, practitioner, or supplier that furnished or ordered the items and/or services to which reference is made.

100.2 - Conditions for Indemnification

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A beneficiary or any person(s) who assumed financial responsibility for payment is indemnified for claims filed if all of the following conditions are met:

- The contractor has determined that the beneficiary is without liability under authority of §1879 of the Act for items and services furnished by a provider, practitioner, or supplier;

- The contractor or the QIO has determined that the provider, practitioner, or supplier is liable under §1879 for the items and services furnished to the beneficiary. A provider, practitioner, or supplier is considered to have knowledge that payment will not be made under Medicare for items or services in a particular claim where the following evidence is established regarding the provider, practitioner, or supplier;

  (1) Evidence that a provider, practitioner, or supplier knew, or could reasonably be expected to have known, of exclusion of items or services

  o General notice to the medical community regarding exclusion of certain items or services: e.g., colonic irrigation, acupuncture.

  o General notice to the medical community that services exceeding certain frequencies would be denied or subject to additional review, e.g., vitamin B12 injections, or nursing home visits more frequent than once a month.

  o Written notice to the particular provider, practitioner, or supplier that a type of service or item would be noncovered in all or certain circumstances.

A distinction must be maintained between coverage rules that specify that a type of service or item would be not reasonable or necessary in all or certain circumstances, and utilization guidelines the contractor established to identify excessive services. Any written policies or other internal edits that are disclosed to a provider, practitioner, or supplier would not be considered as a “notice” of exclusion, since they are used for referring claims for further development rather than as rules to make a contractor coverage decision.

In addition to instances when the Medicare program has given notice, the allegation of a provider, practitioner, or supplier is not accepted without further verification in situations of potential program abuse involving a pattern of unnecessary services by a provider, practitioner, or supplier to a number of beneficiaries. When a provider, practitioner, or supplier frequently renders unnecessary services, i.e., services that significantly exceed the frequency with which the general medical community renders them, it is reasonable to expect the provider, practitioner, or supplier to know that such a pattern deviates from the standard practice.

(2) Evidence that provider, practitioner, or supplier did not have knowledge of exclusion of services.

In contrast to subsection 1, there may be situations where an assumption can be made that neither the beneficiary nor the provider, practitioner, or supplier had knowledge of exclusion, and liability can be limited by the reviewer without a statement by either party. In the following situations, further development would not be necessary:

a. The service is for a type of treatment that can be rendered only by a physician, but the contractor has not previously denied payment for the treatment, and it is not unreasonable that a particular physician might consider the treatment appropriate. In order to determine whether the services are reasonable and necessary, the contractor requests its physician consultant or CMS to advise whether the services are covered. This is a case for which there are no general coverage guidelines for the services; the contractor has not advised either the physician or the medical community regarding the coverage of the services; and the contractor is uncertain without expert consultation. In such a case, it may be presumed that neither the beneficiary nor the physician could have known that the services would be noncovered.

b. The item or service is ordinarily covered, but a question is raised as to whether it is reasonable and necessary in treatment of a particular diagnosis. Neither the provider, practitioner, or supplier nor the medical community has been advised that the item or service is not covered for that diagnosis. The case requires a determination by the contractor’s medical consultant or is referred to CMS for guidance. As in example (a), the liability of both parties should be limited.

c. The provider, practitioner, or supplier is newly arrived in the contractor service area, and the contractor has not yet communicated to the provider, practitioner, or supplier information in an existing general notice that the item or service is not covered, always or under certain circumstances.

NOTE: If any provider, practitioner, or supplier could reasonably be expected, by virtue of normal medical knowledge, to know that the service was unneeded, the presumption suggested in the above examples would not apply.

- The requester for indemnification has paid the provider, /practitioner or supplier all or some of the charges for items and services for which the beneficiary's liability has been waived under §1879 of the Act; and
- The requester seeks indemnification by filing a written statement prior to the end of the sixth month following:

  o The month in which payment was made to the provider, practitioner or supplier; or

  o The month in which the contractor advised the beneficiary that the beneficiary was not liable for the noncovered items or services, whichever is later.

The contractor extends the six month time limit if good cause is shown. *The contractor* uses the principles *for determining good cause* outlined in Chapter 29, "Appeals of Claim Decisions."

100.3 - Development and Documentation of Indemnification Requests

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

When the contractor receives a request or inquiry concerning indemnification directly from the beneficiary or the beneficiary's authorized representative, it must obtain the following information and documentation:

- Identifying information sufficient for the contractor to locate the claim(s) for noncovered items or services for which payment has been made to the provider, practitioner, or supplier by the beneficiary or other person and for which the liability of the beneficiary was limited. Ordinarily, the initial MSN or *appeal* determination suffices.
- A statement on Form SSA-795, "Statement of Claimant or Other Person," (see §100.10, Exhibit 4) to the effect that the requester paid the provider, practitioner, or supplier all or some of the charges for the noncovered items or services for which the beneficiary's liability was limited. The statement must specify the amount the requester has paid the provider, practitioner, or supplier. If the requester submits this information in a letter, the letter serves as the signed statement.

100.9 - Limitation on Liability Determination Does Not Affect Medicare Exclusion

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A determination to limit the liability of the beneficiary, as well as a finding that the physician's or supplier's liability may be limited and program payment made, does not change noncovered items or services into covered items or services. This means that the coverage question can still be raised as an issue *at a level* subsequent to a*n appeal* determination that authorized program payment under §1879 . It also means that, for purposes of determining *an* amount in controversy for a*n appeal*, payment made under §1879 should be disregarded because coverage is still at issue and the amount charged is still in controversy.

Exhibit 4 - Letter to Practitioner or Supplier (Noninstitutional Services)

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear _____:

Under §1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain categories of noncovered items or services submitted as assigned claims if the beneficiary did not know and could not reasonably be expected to know that the items or services would not be covered. Further, the law provides that the practitioner or supplier will be liable for the charges if it is found that he/she knew or could reasonably be expected to know that Medicare would not cover the items or services.

On (date of limitation on liability notification), you were notified that the following items or services provided to (name of beneficiary) were not covered and that you were liable for the charges for these items or services:

Description of Services	Date Provided

(Beneficiary or other person on behalf of beneficiary) has submitted evidence which establishes that he/she paid you $_____ for the items or services described above. Since it has been determined that you are liable for the items or services, §1879(b) of the Act requires that the Medicare program make payment (indemnification) to him/her for this amount. The amount of this payment will be treated as an overpayment to you and appropriate collection action will be taken unless you advise this office that refund has been made to (name of requester).

If you do not agree with the amount that (name of requester(s)) has established he/she paid you, please notify this office.

If we do not hear from you regarding the amount of the payment or that you will make refund directly by_____ (15 days after date of this notice) payment will be made to (name of requester(s)) and action will be taken to collect the overpayment from you.

If you disagree with this determination, you may request a *redetermination*. The bases for such a *request* are: (1) that the services you provided were reasonable and necessary; (2) that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (3) that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. The request for *redetermination* must be in writing, and it must be filed within 120 days of the date *you received* the initial determination. If you have already received an adverse redetermination, you may request a *reconsideration* within *180 days* of the date *you received* the redetermination. Our office will assist you if you need help in requesting a *redetermination* or a *reconsideration*. You need not file another request for a *redetermination* or a *reconsideration* if you already have taken such action.

Exhibit 5 - Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear (Beneficiary's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (the limitation on liability provision) for the noncovered services provided you by (physician's/supplier's name) on (date) has been received.

The evidence submitted establishes that you paid (physician/supplier) (amount paid) for the noncovered services. It was determined upon *redetermination* that you were not liable for these charges. Your refund for these payments to (physician/supplier) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid.

If your (physician/supplier) requests *an appeal* of this claim, it is possible that Medicare might find that your (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay your (physician/supplier) for this service. Also, you would be responsible for any deductible and coinsurance amounts. If this happens, you will receive a copy of the notice to your (physician/supplier).

Any future items or services of this type provided to you will be your responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning this matter, please call this office. If you prefer to visit your social security office, please take this letter with you.

Exhibit 6 - Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear (Person's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (limitation on liability provision) for the noncovered services provided (beneficiary's name) by (name of physician/supplier) on (date) has been received.

It was determined upon *redetermination* that (beneficiary's name) was not liable for the charges.

The evidence establishes that you paid (physician/supplier) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment for the expenses incurred by (beneficiary's name).

If his/her (physician/supplier) requests a*n appeal* of this claim, it is possible that Medicare might find that the (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay the (physician/supplier) for this service. Also, (beneficiary's name) would be responsible for any deductible and coinsurance amounts. If this happens, (beneficiary's name) will receive a copy of the notice to his/her (physician/supplier).

Any future items or services of this type provided to (beneficiary's name) will be his/her responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit the social security office, please take this letter with you.

110.2 - When to Make Limitation on Liability Decisions

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A - Initial Claims

In implementing the limitation on liability provision, the contractor makes a coverage decision before making a limitation on liability decision. Section 1879 of the Act provides that limitation on liability can be allowed only in cases:

> Where - (1) a determination is made that, by reason of §1862(a)(l) or (9) or by reason of a coverage denial described in subsection (g) of the Act, payment may not be made under Part A or Part B of this title for any expenses incurred for items or services furnished an individual by a provider of services... (Section 1879(a)(1) of the Social Security Act.)

NOTE: Subsection (g) refers to home health service denials under §§1814(a)(2)(C) and 1835(a)(2)(A) , i.e., the patient is or was not confined to home; or the patient does or did not need skilled nursing care on an intermittent basis; and to hospice denials under §1861(dd)(3)(A) for services determined to be noncovered because the beneficiary was not "terminally ill".

Only after the contractor makes a decision that care is not reasonable or necessary, is custodial, is not reasonable and necessary for the palliation or management of terminal illness in hospice denials, or does not meet the homebound or intermittent nursing care

requirements in home health service denials, or does not meet the “terminally ill” condition for hospice care, should a determination be made regarding limitation on liability. In every such case there will be two parts to the limitation on liability determination:

1. Whether and when the beneficiary knew or should have known that the services were noncovered, and
2. Whether and when the provider knew or should have known that the services were noncovered.

In any case where the provider gave the beneficiary notice that the services would be noncovered, the contractor will find that the provider knew that the services were noncovered.

B - *Redetermination*

At the *redetermination* level, again the contractor first makes a determination on the coverage issue. It considers the question of limitation on liability, if applicable, only if the initial adverse coverage decision is wholly or partially affirmed. (See Chapter 29, “Appeals of Claim Decisions,” for discussion of the appeals process.)

110.3 - Preparation of Denial Notices

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The provider and beneficiary notification procedures discussed in §§30 and 40 for determining liability do not change the instructions for the preparation and issuance of denial notices in Medicare Claims Processing Manual, Chapter 21, “Medicare Summary Notices.”

Accordingly, in cases where the services are found to be custodial care or not reasonable and necessary, or in the case of HHA services, are denied for technical reasons under §1814(a)(2)(C) or §1835(a)(2)(A) , or in the case of hospice services, are denied for technical reasons under §1861(dd)(3)(A) :

An MSN denying the service(s) is sent to the beneficiary in cases where only the beneficiary is entitled to limitation on liability for any part of the noncovered stay. The notice advises the beneficiary of the beneficiary’s entitlement to indemnification (see §§100 .) in the event the provider seeks payment from the beneficiary for the noncovered services. It uses MSN messages 50.36.2:

> It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider’s bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

All denial notices explain any decision regarding limitation on liability for either the provider, practitioner, or supplier or the beneficiary. (See Chapter 21, “Medicare Summary Notices.”)

All denial notices, where either the beneficiary or provider, practitioner, or supplier has been found liable, must state that the provider has a right to a *redetermination* .

Providers, practitioners, and suppliers do not receive a separate written notification or copy of the MSN. Providers, practitioners, and suppliers must utilize the coding information (e.g., ANSI X12N Reason Codes) conveyed via the financial remittance advice (RA) to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

110.5.3 - Other Reasons for Contractor Request for Copies of ABNs

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Other good reasons for contractors to request submission of copies of ABNs include, but are not limited to, the following:

A - Any need that arises from the appeals processes for documentation.

B - Any practical need to identify the particular items and/or services, dates of service, reasons for predicting Medicare denial of payment, or other pertinent facts about the beneficiary notification.

C - Any plausible allegation or dispute as to the form, content, or delivery of a particular ABN or a particular group of ABNs, e.g., all ABNs furnished by a particular notifier, all ABNs for a particular item, *etc.*

D - For the purposes of a data analysis, utilization study, or other investigation or study.

120 - *Contractor* Specific Instructions for Application of Limitation on Liability

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

120.1 - Documentation of Notices Regarding Coverage

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A critical step in the implementation of the limitation on liability provision is the distribution by *contractor*s of notices regarding coverage issues to the medical community, or to specific segments of it, such as laboratories or certain physician specialty groups. An ongoing program of communication by *contractor*s is essential. Timely communication of existing general notices to physicians and suppliers new to a *contractor’*s service area is essential. The existence of written general notices will often determine the extent of program liability. As a minimum, the *contractor* should have a program for dissemination of the coverage guidelines published in the National Coverage Determinations Manual and the Medicare Benefit Policy Manual, as well as other

guidelines contained in this manual for determining medical necessity and others issued from time to time in other CMS issuances.

120.2 - Availability of Coverage Notices to Operating Personnel

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

All review personnel should have ready access to a file of general notices regarding coverage for processing review cases involving the issue of limitation on liability.

In addition to general notices, the *contractor* must have a mechanism for identifying and locating correspondence with individual physician/suppliers regarding coverage of particular services or items. This mechanism should meet at least the following minimum requirements:

- The *contractor* must be able to determine if a practitioner or supplier has been sent an explanation, in lieu of, or in addition, to, a routine MSN denial notice, that a type of service or item is not reasonable and necessary. Such explanation may consist of a general notice or may be individual correspondence with the physician/supplier such as is usually found in *contractor* correspondence units or comparable units. Claims history files can also be checked, but these are generally useful only when the identical item or service in question has been previously denied as not meeting the requirements of §1862(a)(1) ;
- A copy of such an explanation must be readily available to *appeal* personnel; and
- Procedures must be established requiring that a check of all files be made to determine if such an explanation was ever sent before the physician/supplier's liability is limited.

Once a physician/supplier receives an explanation of denial for an item or service after an *appeal* determination, that determination would be considered a notice that should be readily accessible for future use for a similar claim(s).

120.3 - Applicability of Limitation on Liability Provision to Claims for Outpatient Physical Therapy Services Furnished by Clinics

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A - General

The limitation on liability provision is applicable to claims for items or services furnished by a physician-directed outpatient physical therapy (OPT) clinic that are denied on the basis of §1862(a)(1) .

The limitation on liability determination for OPT clinic claims will be made by *contractor*s at the initial determination level, in accordance with §120.4. The procedures discussed in §120.2, second bullet , for determining a physician's/supplier's liability will be followed when processing this category of claims.

120.4 - Limitation on Liability Notices to Beneficiaries From *Contractors*

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The *contractor* adds MSN Limitation of Liability Message 50.36.2 to the MSN sent to the beneficiary (who is presumed not to have knowledge of nonpayment by Medicare) at the time of the initial determination.

To message 50.36.2, it also adds the following language:

> Do not apply if your (doctor/supplier) told you in writing, before furnishing the service, that Medicare would not pay.

The *contractor* adds MSN Limitation of Liability Message 50.36.1 to the MSN sent to the beneficiary (who is held to have had knowledge of nonpayment by Medicare) at the time of the initial determination.

The *contractor* adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M25 to the RA sent to the physician/supplier (who is presumed to have knowledge of nonpayment by Medicare) at the time of the initial determination.

The *contractor* adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M38 to the RA sent to the physician/supplier who is held to be not liable because the beneficiary is held liable at the time of the initial determination.

In addition to the above, as appropriate, the *contractor* notifies both the beneficiary and the physician/supplier at the time of the initial determination of their appeal rights (this is contained on the back of the MSN and the RA).

120.5 - *Contractor Redeterminations* in Assignment Cases Conducted at the Request of Either the Beneficiary or the Assignee

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In every *appeal* where the limitation on liability provision is applicable, the *re*determination consists of two stages. The first stage is a new, independent and critical reexamination of the facts regarding the coverage issue. If the original decision regarding coverage was appropriate, the second stage is the decision whether to limit the liability of the beneficiary and, if so, whether to also limit the liability of the provider, practitioner, or supplier.

Redeterminations in assignment cases are conducted at the request of either the beneficiary or the assignee. Frequently, the *redetermination* request is received from only one of the parties, either the provider/physician/supplier or the beneficiary, and the only notice to the other party that a *redetermination* has been requested is a copy of the determination, i.e., after the fact. In a limitation on liability case, the parties may have adverse interests in the limitation on liability decision, since a provider, practitioner, or supplier may seek to show reason why the beneficiary's liability should not be limited in order to be able to collect his/her fee from the beneficiary. Therefore, when the *contractor* receives a request for a *redetermination,* it sends a notice that a request has been filed to the other party to the *redetermination* indicating that that party may submit additional evidence. This is necessary to satisfy the statutory requirement that both parties be informed of their rights and privileges in the *appeal* process.

120.5.1 - Guide Paragraphs for *Contractors* to Use Where §1879 Is Applicable at the *Redetermination* Level

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The *contractor* uses the following paragraphs (in addition to other required *appeal* decision paragraphs) where the limitation on liability provision applies at the *appeal* level in the various situations shown below:

Situation I - To the provider, practitioner, or supplier when neither the provider, practitioner, or supplier nor the beneficiary is determined liable (program payment made under §1879 of the Act)

Paragraph(s):

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a physician/supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare, if neither the beneficiary nor the physician/supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have *concluded* that these services are excluded under Medicare. However, since we find that neither (beneficiary's name) nor you knew, or could reasonably have been expected to know, that the services were excluded from coverage, the Medicare program will reimburse you under this provision of the law for the reasonable charge for the services, less any deductible and coinsurance. (Beneficiary's name) is responsible for any deductible and coinsurance amounts. Upon receipt of this notice, it will be considered that you now have knowledge of the exclusion of (description of service) for similar conditions, and this limitation of liability will not apply to future claims for the same or substantially similar services.

cc: Beneficiary

Situation II - To provider, practitioner, or supplier when the provider or practitioner orsupplier is held liable

Paragraph(s);

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a provider or practitioner or supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare. *Medicare may make payment under this situation* if neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have determined that (beneficiary's name) did not know and could not have been expected to know, that these services were excluded from coverage. However, we find that (select applicable phraseology from the following): (l) based upon the claim of (date) which was a similar claim in which

payment was denied; (2) (our notification to you of (date) that such services are excluded); (3) (or any other basis used to determine the provider, practitioner, or supplier to be liable)), you knew, or could have been expected to know, that these services were excluded. We also find that you did not notify the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. Because of this, you are held liable for the full charges for the services.

We have also reviewed the claim with regard to the issue of whether the services were not reasonable and necessary. We found that the services were not reasonable and necessary.

If you disagree with this determination regarding your liability, on the basis that the services were necessary, or on the basis that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services, or on the basis that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services, *you may request a reconsideration within 180 days of receipt of this notice*, at which time you may present any new evidence that would have a material effect on this determination. Our office, or your social security office, will assist you if you need help in requesting a *reconsideration*.

cc: Beneficiary

Situation III - To the beneficiary when the beneficiary is held liable

Paragraph(s):

We have reviewed your claim for (description of the services). When we reviewed your claim, we considered two things. First, we considered whether the service you received was *reasonable and* necessary. Medicare will only pay for reasonable and necessary services. We found that the service was not *reasonable and* necessary.

Second, we considered whether you knew, or were told, that Medicare would not pay. Medicare would not hold you liable if you did not know and your (doctor/supplier) did not tell you in advance, in writing, that Medicare would not pay. In that case, we would pay you any amount you pay or paid your (doctor/supplier) for the service. Our review shows that (choose one of the following to complete the sentence: (the (doctor/ supplier) told you in writing, before giving the service, that Medicare would not pay); (this service had been denied on other claims for you); OR (we told you in a letter dated (DATE) that Medicare would not pay for this service)). Since we believe you knew Medicare would not pay for this service, Medicare cannot pay. You are liable for the charges.

If you do not agree with our decision, ask for a *reconsideration from a Qualified Independent Contractor (QIC)*. The *QIC* will decide whether the service was *reasonable and* necessary. Th*e QIC* will also decide whether you knew, or were told, Medicare would not pay. You must ask for a *reconsideration* within *180 days* of the date *you receive* this notice. At the *reconsideration*, you may present any new evidence which would affect our decision. If you need help, your social security office will help you request a *reconsideration*.

cc: Physician/Supplier

Situation IV - Rider paragraph to be included in the copy of the notice to the beneficiary when the physician/supplier is held liable

If you paid any amounts to (physician's/supplier's name) for this service, Medicare will pay you back the amount you paid. To get this payment, bring or send to this office three things. (1) A copy of this notice. (2) Your (doctor's/supplier's) bill. (3) A receipt or other proof you have paid the bill.

(See §§120.4 for handling requests for indemnification where payment has been made to a liable practitioner or supplier.)

130 - Intermediary Specific Instructions for Application of Limitation on Liability

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

See § 120.5.1 for guide language.

140 - Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for *Contractor*s and Physicians

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Following are the procedures for implementing §1842(l) of the Act. Under §9332(c) of OBRA 1986 (P.L. 99-509), which added §1842(l) to the Act, new liability protections for Medicare beneficiaries affect nonparticipating physicians.

140.2 - Services Furnished Beginning October 1, 1987

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Under §1842(l) of the Act, effective for services furnished on or after October 1, 1987, nonparticipating physicians who

1. Do not accept assignment,
2. Do not claim payment after the death of the beneficiary, and
3. Do not bill under the indirect payment procedure must refund to beneficiaries any amounts collected for physicians' services which are denied because they are not reasonable and necessary under §1862(a)(1) .

This provision is applicable in any case in which the *contractor* denies payment or reduces the level of payment on the basis of §1862(a)(1). In the latter situation, there is, in effect, a denial of the more extensive service or procedure on the basis that it is not reasonable and necessary under §1862(a)(1), even though Medicare payment is made for the less extensive service or procedure (e.g., an intermediate office visit is allowed as a brief office visit). Where a reduction in the level of payment occurs, the physician must refund to the beneficiary any amounts he/she collects which exceed his/her maximum allowable actual charge (MAAC) for the less extensive procedure. Of course, in the

unusual case where the physician's MAAC for the less extensive service equals or exceeds his/her actual charge for the more extensive service, no refund is required.

Section 1842(l) of the Act applies only to physicians' services subject to the Medicare Economic Index (MEI). Certain services, such as those involving injections that can be given by a paramedical person other than a physician (e.g., pneumococcal and hepatitis vaccine injections) which may be denied under §1862(a)(1) are not physicians' services for purposes of the MEI. Therefore, denials of payment on the basis of §1862(a)(1)(B) of the Act for those services are not subject to §1842(l) refund requirements. Additionally, services of physician extenders (e.g., physician's assistants, nurse practitioners, MEDEXes, etc.) are not physicians' services and are not subject to §1842(l) refund requirements. The application of §1842(1) refund requirements on the correct statutory basis, i.e., only on the basis of §1862(a)(1), and only to physicians' services subject to the MEI, is essential. Incorrect application improperly takes away physicians' rights to bill beneficiaries for denied services and incurs unnecessary expenses for review, development, and appeals.

140.3 - Time Limits for Making Refunds

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A required refund must be made within specified time limits. Physicians who knowingly and willfully fail to make refund within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program. Under §1842(1) , a refund of any amounts collected must be made to the beneficiary within the following time limits:

- If the physician does not request an *appeal* of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the physician receives notice of the initial determination. (See §140.6 for notice requirements.); or
- If the physician requests an *appeal* within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the physician receives the notice of the *appeal* determination.

140.5 - Appeal Rights

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Nonparticipating physicians have the same rights to appeal the *contractor's re*determination in an unassigned claim for physicians' services if the *contractor* denies or reduces payment on the basis of §1862 (a)(1) as they or participating physicians have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the physician knew or should have known that Medicare would not pay for the service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the service or, if so informed, did not sign a statement agreeing to pay. In addition to the beneficiary's right to appeal the *contractor's* decision to deny or reduce payment on the basis of §1862

(a)(1), the beneficiary becomes a party to any request for *appeal* filed by the physician. Since the beneficiary and the physician may have adverse interests in a decision regarding refund, it is essential to notify the beneficiary in any case in which the physician requests an *appeal* of the denial or reduction in payment or asserts that a refund is not required because one of the conditions in §140.4 is met. (See Chapter 29, "Appeals for detailed appeals instructions.")

140.6 - Processing Initial Denials

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In any unassigned claim for physician's services furnished on or after October 1, 1987, in which the *contractor* denies or reduces payment on the basis of §1862(a)(1) , the *contractor* will send separate notices to both the beneficiary and the physician. In some cases, the beneficiary (or physician) may submit a copy of an ABN which satisfies the requirements in §140.4 . The *contractor* should not make an automatic finding that the service is not reasonable and necessary merely because the beneficiary has submitted an ABN. The fact that there is an acceptable ABN must in no way prejudice the *contractor*'s determination as to whether there is or is not sufficient evidence to justify a denial under §1862(a)(1). In the case where there is an acceptable ABN, the *contractor* will mail a standard denial MSN notice to the beneficiary. In the absence of an acceptable ABN, and depending on whether there is a full denial or a partial reduction in payment, the *contractor* will include, in addition to one of the "medical necessity" denial notices, one of the following notices in the MSN sent to the beneficiary.

140.6.1 - Initial Beneficiary Notices

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Notice 1 - Full Denial

> If the doctor should have known that Medicare would not pay for the denied services and did not tell you in writing before providing the services, you may be entitled to a refund of any amounts you paid. However, if the doctor requests a*n appeal* of this claim within 30 days, a refund is not required until we complete our *appeal*. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

Notice 2 - Reduction in Payment

> If the doctor should have known that Medicare would not pay for the more extensive service and did not tell you this in writing before providing the service, you may be entitled to a refund of any amount you paid which is more than the doctor is allowed by law to charge under Medicare for the less extensive service. However, if the doctor requests a*n appeal* of this claim within 30 days, a refund is not required until we complete our *appeal*. If you paid for the more extensive service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

In addition, add the following paragraph:

> You could have avoided paying $_____, the difference between the maximum amount the doctor or supplier is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

140.6.2 - Initial Physician Notices

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Include in the notice to the physician the following:

- The patient's name and health insurance claim number;
- A description of the service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN; and
- Depending on whether the beneficiary submitted a copy of an acceptable ABN with his/her claim, include in the notice to the physician one of the following:

Notice 1 - Advance Beneficiary Notice Received Prior to Initial Determination

> (The service identified above has been denied because/although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service. Since you informed the beneficiary in writing prior to furnishing the service that Medicare was likely to deny payment for the (more extensive) service and the beneficiary signed a statement agreeing to pay, the beneficiary is liable for (this/the more extensive) service.

or

Notice 2 - Advance Beneficiary Notice Not Submitted

> (The service identified above has been denied because/Although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service).
>
> If you have collected (any amount from the patient/any amount that exceeds your maximum allowable actual charge (MAAC) for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases:
>
> - If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service; or
> - If you notified the beneficiary in writing before providing the service that you believed that Medicare was likely to

deny the service, and the beneficiary signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the *contractor* was wrong in its determination that Medicare does not pay for this service, you should request *an appeal* of this determination by the *contractor* within 30 days of receiving this notice. Your request for *appeal* should include any additional information necessary to support your position.

If you request *an appeal* within this 30 day period, you may delay refunding the amount to the beneficiary until you receive the results of the *appeal.* If the *appeal* determination is favorable to you, you do not have to make any refund. If, however, the *appeal* is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable *appeal* decision.

The law also permits you to request *an appeal* of the determination at any time within six months of receiving this notice. A*n appeal* requested after the 30 day period does not permit you to delay making the refund. Regardless of when a*n appeal* is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(1) of the Social Security Act. Section 1842(1) specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program.

If you have any questions about this notice, please contact (*Contractor* contact, telephone number).

The *contractor* will ensure that the telephone number puts the physician in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply to claims the *contractor* automatically denies under the A/B link procedures. In those cases, the QIO is responsible for notifying the beneficiary and physician of the refund requirements of §1842(1) and making the refund determination where appropriate.

140.7 - Processing Beneficiary Requests for *Appeal*

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a beneficiary requests a*n appeal* of the initial denial or reduction in payment, the *contractor* will process the *appeal* in the normal fashion except that, where the *appeal*

results in a reversal to full or partial payment, the *contractor* will include the following special paragraph in the *appeal* notice sent to the beneficiary:

> The doctor who furnished this service has been informed of this decision and advised that he/she may collect (his/her full charge for the service/up to the maximum amount he/she is allowed by law to charge under Medicare for the less extensive service for which payment has been made).

If the reversal is for the less extensive service, the *contractor* will incorporate in the notice the following:

> You could have avoided paying $_____, the difference between the maximum amount the doctor is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

The *contractor* will send the physician who furnished the service a separate notice which clearly identifies the service for which full or partial payment is being made (i.e., includes the patient's name, health insurance claim number, a description of the service billed by procedure code, date and place of service, and amount of the charge. Where only partial payment is being made, the *contractor* will clearly indicate the less extensive service for which payment has been made). The *contractor* will include the following language:

> You were previously advised that Medicare payment could not be made for this service. However, after reviewing this claim, we have determined that payment may be made (for a less extensive service). Therefore, if you have already refunded the amounts you collected from the beneficiary for this service, you may recollect (these amounts/any amounts which do not exceed your maximum allowable actual charge (MAAC) for the less extensive service for which payment has been made).

140.8 - Processing Physician Requests for *Appeal*

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a physician requests a*n appeal*, the *contractor* will notify the beneficiary as discussed in §140.5 . The *appeal* process consists of three stages, even though the physician may be contesting only one issue (e.g., the physician may assert that he/she did not know, and could not have reasonably have been expected to know, that Medicare would not pay for the services).

140.8.1 - *Appeal* of the Denial or Reduction in Payment

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The first part of the *appeal* is a new, independent, and critical reexamination of the facts regarding the denial or reduction in payment. If the *contractor* finds that the initial denial or reduction in payment was appropriate, the *contractor* will go on to §140.8.2 .

140.8.2 - Beneficiary Given ABN and Agreed to Pay

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A physician who has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the physician claims to have given an ABN to the beneficiary, the *contractor* will ask the physician to furnish a copy of the signed ABN. The *contractor* will examine the ABN to determine whether it meets the guidelines in §140.4 . In the absence of acceptable evidence of advance notice, the *contractor* will go on to §140.8.3 .

140.8.3 - Physician Knowledge

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In determining whether the physician knew, or could reasonably have been expected to know, that Medicare would not pay for the services, the *contractor* will apply the same rules that are applicable in determining physician liability under §1879 of the Act. (See §30.2 .)

140.9 - Guide Paragraphs for Inclusion in *Appeal* Determination

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The *contractor*, upon completion of its *appeal*, will send the physician a*n appeal* notice and send a copy to the beneficiary. If the initial payment determination is reversed to full or partial payment, the *contractor* will include in the *appeal* notice the physician notice language required in §140.7 . Otherwise, the *contractor* will include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

Under §1842(l) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the services, the physician notified the beneficiary in writing that Medicare would not pay for the services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Physician Did Not Know That Medicare Would Not Pay For the Services

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the physician did not

know, and could not reasonably have been expected to know, that Medicare does not pay for the services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of services) for similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) the physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (2) the physician notified the beneficiary in writing before furnishing the services that Medicare would not pay for the services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these services within 15 days from the date you receive this notice. *A* refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. If we paid for a less extensive procedure, you need refund only the amount which exceeds your maximum allowable actual charge (MAAC) for the less extensive procedure. The beneficiary has been sent a copy of this notice. Physicians who knowingly and willfully fail to make appropriate refunds may be subject to assessments of double the violative charges, civil money penalties (up to $2000 per violation), and/or exclusion from the Medicare program for a period of up to 5 years.

140.10 - Physician Fails to Make Refund

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Under §1842(1) of the Act, a physician who knowingly and willfully fails to make refund within the time limits in §140.3 may be subject to sanctions (i.e., civil money penalties and/or exclusion from the Medicare program). Generally, the failure of a physician to make a refund comes to the *contractor*'s attention as a result of a beneficiary complaint to the *contractor*, Social Security Administration (SSA), or CMS. If necessary, the *contractor* will contact the beneficiary to clarify the information in the complaint and to determine the amount the beneficiary paid the physician for the denied services. If the *contractor* determines that a physician failed to make a refund, it will contact the physician in person or by telephone to discuss the facts of the case. The *contractor* will attempt to determine why the amounts collected have not been refunded and will explain that the law requires that the physician make refund to the beneficiary and that if he/she fails to do so, the OIG may impose civil money penalties and assessments, and sanctions. The *contractor* will make a dated report of contact and include the information relayed to the physician and the physician's response. The *contractor* will recontact the beneficiary in 15 days to determine whether the refund has been made. When the amount in question is $300 or more or where there are at least three outstanding violations by the physician, the *contractor* will contact the Sanctions Coordinator in the appropriate field office of the

OIG by telephone to discuss whether referral to OIG is appropriate. If the case should be referred, the *contractor* will make the referral to the regional OIG Sanctions Coordinator in accordance with the procedures following. The *contractor* should not make a referral until the

physician's appeal rights have been exhausted, or until the time limit for an appeal has passed.

140.11 - OIG Referral Procedures

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The *contractor* will include in the sanction recommendation to the OIG/FO (to the extent appropriate) the following:

- Identification of the Subject - The subject's name, address and a brief description of the subject's special field of medicine.
- Origin of the Case - A brief description of how the violations were discovered.
- Statement of Facts - A statement of facts in chronological order describing each failure to comply with the refund requirements in §1842(1).
- Documentation - Copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the physician regarding the physician's failure to make refund.
- Other Significant Issues - Any information that may be of value in the event of a hearing to bar a physician from receiving Medicare payment.

150 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) - Instructions for *Contractors* and Suppliers

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Following are the procedures for implementing §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Under §132 of SSAA-1994 (Social Security Act Amendments of 1994, P.L. 103-432) which adds §1834(a)(18) to the Act, and under §133 of SSAA-1994 which adds §1834(j)(4) and §1879(h) to the Act, new liability protections for Medicare beneficiaries affect suppliers of medical equipment and supplies. All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Beneficiaries' liability for payment for certain items and services, that is, for otherwise covered medical equipment and supplies as defined in §150.10 , which are furnished on or after January 1, 1995, and for which Medicare payment is denied for one of several reasons specified below, may be limited as follows. For both assigned and unassigned claims, for which the supplier knew or should have known of the likelihood that payment would be denied (that is, the supplier is held to be liable) and for which the beneficiary did not know, the beneficiary has no financial responsibility and the refund provisions of the Act apply in virtually all cases. The single

exception to this rule of applicability is that, with respect to medical equipment and supplies for which the supplier accepted assignment and for which payment is denied because the item or service is not medically reasonable and necessary under §1862(a)(1) of the Act, the §1879 Limitation on Liability provisions which applied to such denials prior to January 1, 1995, still apply. The refund provisions do not apply to these denials.

In claims for medical equipment and supplies, payment reductions may be based on partial denials of coverage for additional expenses not attributable to medical necessity. A medical necessity "partial denial" is the denial of coverage for the unnecessary component of a covered item or service, when that component is in excess of the beneficiary's medical needs. Any such excess component is not medically reasonable and necessary and therefore, under §1862(a)(1) of the Act, it is not covered. A partial denial may be used to base payment on the least costly, medically appropriate, alternative. The beneficiary liability protections of §1879 and of §1834(j)(4) of the Act apply to any payment reductions due to partial denials of coverage for medical equipment or supplies on the basis of medical necessity under §1862(a)(1) of the Act. (See §140 for its similar provision for the applicability of the refund requirements under §1842(l) of the Act to partial denials of coverage for physicians' services.)

When the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act apply and the supplier is held to be liable, a required refund must be made on a timely basis. Suppliers which knowingly and willfully fail to make refund within specified time limits may be subject to civil money penalties and/or exclusion from the Medicare program.

Refund is not required if the supplier is held not to be liable, that is, if it is held that the supplier did not know and could not reasonably have been expected to know that Medicare would not pay on the basis of §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, or if it is held that, before the item or service was furnished, the beneficiary was informed by the supplier that Medicare would not pay and the beneficiary agreed to pay for the item or service. In any case where the supplier is held not to be liable, the beneficiary is liable for payment.

150.4 - Time Limits for Making Refunds

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A refund of any amounts collected must be made to the beneficiary on a timely basis. Refund is considered to be on a timely basis only if made within the following time limits:

- If the supplier does not request *an appeal* of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the supplier receives the remittance advice (RA).
- If the supplier requests *an appeal* within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the supplier receives the notice of the contractor's determination of the supplier's appeal.

150.5.2.2 - When a Request for an Advance Determination of Coverage Is Mandatory

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A request for an advance determination of coverage of medical equipment and supplies is mandatory under §1834(a)(15)(C)(i) & (ii) of the Act, respectively, when:

- The item is on the list developed by the Secretary under §1834(a)(15)(A) of items which are frequently subject to unnecessary utilization in your *contractor* service area; or
- The supplier is on the list developed by the Secretary under §1834(a)(15)(B) of the Act of suppliers for which a substantial number of claims have been denied as not medically reasonable and necessary under §1862(a)(1) of the Act or the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

150.7 - Appeal Rights

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Nonparticipating suppliers have the same rights to appeal the DMERC's determination in an unassigned claim for medical equipment and supplies if the DMERC denies payment on the basis of §1862(a)(1) , §1834(a)(17)(B) , §1834(j)(1) , or §1834(a)(15) of the Act as they or participating suppliers have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the item or service. In addition to the beneficiary's right to appeal the DMERC's decision to deny payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, the beneficiary becomes a party to any appeal request filed by the supplier. Since the beneficiary and the supplier may have adverse interests in a decision regarding refund, it is essential to notify the beneficiary in any case in which the supplier requests an *appeal* of the denial or asserts that a refund is not required because one of the conditions in §150.5 is met. (See Chapter 29, "Appeals of this Claims Decision," for detailed appeals instructions.)

150.8 - Processing Initial Denials

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which the DMERC denies payment on the basis of §1862(a)(1) , §1834(a)(17)(B) , §1834(j)(1) , or §1834(a)(15) of the Act, send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

NOTE: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an ABN which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the Form CMS-1500 to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary will in no way prejudice the DMERC's determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the Form CMS-1500 to that effect, include, in addition to one of the denial notices in Chapter 21, "Medicare Summary Notices," the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice

(MSN 8.54)

If the supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the supplier requests an *appeal* of this claim within 30 days, a refund is not required until we complete our *appeal*. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your supplier.

(MSN 8.54) - In Spanish

Si el suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra

revisión. Si usted pagó por este servicio y no escucha nada sobre un reembolso en 30 días, comuníquese con su suplidor.

B. Initial Supplier Notice

Include in the notice to the supplier the following;

- The patient's name and health insurance claim number;
- A description of the item or service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN, (see Chapter 21, "Medicare Summary Notices"); and

• If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a "-GZ" modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(Remark Code N124)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(Remark Code N125)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: if you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

If an exception applies to you, or you believe the *contractor* was wrong in denying payment, you should request an *appeal* of this determination by the *contractor* within 30 days of receiving this notice. Your request for *appeal* should include any additional information necessary to support your position. If you request an *appeal* within 30-days, you may delay refunding to the beneficiary until you receive the results of the *appeal.* If the *appeal* determination is favorable to you, you do not have to make any refund. If the *appeal* is unfavorable, you must make the refund within 15 days of receiving the unfavorable *appeal* decision.

You may request an *appeal* of the determination at any time within 120 days of receiving this notice. An *appeal* requested after the 30-day period does not permit you to delay making the refund. Regardless of when a*n appeal* is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

> The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.
>
> The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (*contractor* contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply where the *contractor* automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.

150.9 - Processing Beneficiary Requests for *Appeal*

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a beneficiary requests *an appeal* of the initial denial, process the *appeal* in the normal fashion except that, where the *appeal* results in a reversal, include the following special paragraph in the *appeal* notice sent to the beneficiary:

> The supplier which furnished this item or service has been informed of this decision and advised that it may collect its full charge for the item or service.

Send the supplier which furnished the item or service a separate notice which clearly identifies the item or service for which payment is being made (i.e., include the patient's name, health insurance claim number, a description of the item or service billed by procedure code, date and place of service, and amount of the charge. Include the following language:

> You were previously advised that Medicare payment could not be made for this item or service. However, after reviewing this claim, we have determined that payment may be made. Therefore, if you have already refunded the amounts you collected from the beneficiary for this item or service, you may recollect these amounts.

150.10 - Processing Supplier Requests for *Appeal*

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a supplier requests a*n appeal*, notify the beneficiary as discussed in §150.7 . The *appeal* process consists of three stages, even though the supplier may be contesting only one issue (e.g., the supplier may assert that it did not know, and could not have reasonably have been expected to know, that Medicare would not pay for the items or services).

150.10.1 - *Appeal* of the Denial of Payment

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The first stage of the *appeal* is a new, independent, and critical reexamination of the facts regarding the denial of payment. If the DMERC finds that the initial denial of payment was appropriate, go on to §150.10.2 .

150.11 - Guide Paragraphs for Inclusion in *Appeal* Determination

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Upon completion of the *appeal,* the DMERC will send the supplier a*n appeal* notice. Send a copy to the beneficiary. If the initial payment determination is reversed to payment, include in the *appeal* notice the supplier notice language required in §150.9 . Otherwise, include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

> Under §1834(a)(18) and under §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the items or services, the supplier notified the beneficiary in writing that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above items or services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Supplier Did Not Know That Medicare Would Not Pay For the Services

> Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which

Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the supplier did not know, and could not reasonably have been expected to know, that Medicare does not pay for the items or services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above items or services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of item or service) similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) The supplier did not know, and could not reasonably have been expected to know, that Medicare would not pay for the items or services; or (2) The supplier notified the beneficiary in writing before furnishing the items or services that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these items or services within 15 days from the date you receive this notice. *A* refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. The beneficiary has been sent a copy of this notice.

Suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program.

NOTE: For claims presented to the *contractor* prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

150.12 - Supplier Fails to Make Refund

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Under §1834(a)(18)(B) of the Act, a supplier which knowingly and willfully fails to make refund within the time limits in §150.4 may be subject to sanctions under §1128A the Act (i.e., civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program).

NOTE: For claims presented to the *contractor* prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

Generally, the failure of a supplier to make a refund to a beneficiary comes to the DMERC's attention as a result of a beneficiary complaint or a referral from the Social Security Administration (SSA) or the CMS. Document beneficiary complaints and, if necessary, contact the beneficiary to clarify the information in the complaint and determine the amount the beneficiary paid the supplier for the denied items or services. If the DMERC determines that a supplier failed to make a refund, the DMERC will contact the supplier in person or by telephone (if that is not feasible, contact the supplier by letter) to discuss the facts of the case. The DMERC will attempt to determine why the amounts collected have not been refunded. Explain that the law requires that the supplier make a refund to the beneficiary and that if it fails to do so, the Secretary may impose civil money penalties, assessments, and exclusion from the Medicare program. Make a dated report of contact. Include the information relayed to the supplier and the supplier's response. Re-contact the beneficiary in 15 days to determine whether the refund has been made. Do not make any referral to the CMS regional office until the supplier has been formally notified to refund the money and the supplier's appeal rights have been exhausted, or until the time limit for an appeal has passed.