CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1998	**Date: January 4, 2018**
	Change Request 10166

Transmittal 1912, dated September 1, 2017, is being rescinded and replaced by Transmittal 1998, January 4, 2018, to revise business requirements 10166.3, 10166.5 and 10166.7, and to remove requirements 10166.4 and 10166.6. All other information remains the same.

SUBJECT: HIGLAS Enhancement Required for Implementation of Overpayment based Denials

I. SUMMARY OF CHANGES: This Change Request (CR) lays out the requirements that are specific to HIGLAS for implementation of Overpayment based Denials.

EFFECTIVE DATE: April 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

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
N/A	N/A

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

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	**Transmittal: 1998**	**Date: January 4, 2018**	**Change Request: 10166**

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SUBJECT: HIGLAS Enhancement Required for Implementation of Overpayment based Denials

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IMPLEMENTATION DATE: April 2, 2018

I. GENERAL INFORMATION

A. Background: Under Code of Federal Regulation (CFR) § 424.530(a)(6)(i), an enrollment application may be denied if the enrolling provider, supplier or owner thereof has an existing Medicare overpayment. (As defined in 42 CFR § 424.502, *Owner* means any individual or entity that has any partnership interest in, or that has five percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Social Security Act). Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States (US) Government or US Treasury.

For purposes of this Change Request (CR), the term “supplier” includes physicians, non-physician practitioners, physician groups, and non-physician practitioner groups.

Per 42 CFR § 424.530(a)(6)(iii), a denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier, or owner thereof does either of the following:

- Satisfies the criteria set forth in § 401.607 and agrees to a Centers for Medicare & Medicaid Services (CMS) approved extended repayment schedule; or
- Repays the debt in full. Consistent with §424.530(a)(6)(i) and (iii) and the instructions in this CR, when processing a Form CMS-855A, CMS-855B, or CMS-855S initial or change of ownership application, the contractor shall determine whether the provider, supplier, or any of the owners listed in Section 5 or 6 of the application has a delinquent Medicare overpayment that: (i) Is at least $1,500 in aggregate; (ii) Has not been repaid in full at the time the application was filed; (iii) Is not currently being appealed or offset; (iv) Is not part of a CMS/Treasury approved extended repayment schedule; and (v) Is not for a bankrupt provider.

B. Policy: Consistent with 42 CFR §424.530(a)(6)(i) and (iii).

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility			
		A/B MAC	DME	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10166.1	The Healthcare Integrated General Ledger Accounting System (HIGLAS) shall create a new **CMS Delinquent Overpayment Extract** with a tilde delimited format per Attachment A.									HIGLAS, PECOS
10166.2	HIGLAS shall make the necessary changes to stop the transmission of the RBD Extract to PECOS and the MAC Data Centers.	X	X							HIGLAS, HP VDC, PECOS, VDC, VDCs
10166.3	HIGLAS shall, every business day, generate (via AutoSys) and deliver, using the Network Data Mover, the new extract of ARs (excluding beneficiary transactions and interest debit memos) to PECOS.									HIGLAS, PECOS
10166.4	This requirement has been deleted									HIGLAS
10166.5	HIGLAS shall create a new extract that identifies all Institution/individual providers within a Jurisdiction with an aggregate delinquent Medicare overpayment greater than or equal to $1,500. The overpayment criteria of greater than or equal to $1500 is determined by including the following amounts: • principal overpayment balance amount (Open ARs), • accrued interest balance amount (Open ARs) • write-off amount using all the 1099-C eligible receivable activities (Open and Closed ARs)The Extract consists of the following information: • Contractor code • Contractor Name • Provider name • Corporation/Individual Identifier • Taxpayer Identification Number (TIN) • National Provider Identifier (NPI) • Cumulative remaining principal overpayment amount • Cumulative remaining accrued interest amount • Total Overpayment Amount • Cumulative principal write-Off amount • Cumulative Interest write-Off amount									HIGLAS
10166.6	This requirement has been deleted.									HIGLAS
10166.7	HIGLAS shall exclude the following from the Overpayment extract:									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

	• Overpayments that are on a Medicare-approved plan of repayment
	  • Exclude Original Overpayments that are converted into Loans from the Extract. When the original overpayment is closed using the 1099C eligible write off activities, then these write off amounts will be included in the extract
	  • Exclude all Open Loan Transactions and the corresponding Debit Memos from the Extract. 1099C write offs on Loan Transactions, and the corresponding Debit Memos is included in the Extract
	• Overpayments that are currently being appealed or in litigation for open transactions
	• Provider is bankrupt - exclude all overpayments with bankruptcy AR status
	• Non-Demanded overpayments (provider initiated/voluntary refund/return checks/prepayment) will be excluded from the extract
	
	Open Overpayments that are less than or equal to 60 days old from the first demand letter date to the reporting date or receivables currently being offset (AR/AP Netting Offsets) in the last 60 days from the reporting date will be excluded from the Extract.									

10166.8	HIGLAS shall provide a standard message of "No data found" if there is no overpayment information to display.									HIGLAS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Joseph Schultz, 410-786-2656 or joseph.schultz@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 1

Contractor CD	Contractor Name	Provider Name	Corporation/Individual Identifier

TIN	NPI	Cumulative remaining principal overpayment amount	Cumulative remaining accrued interest amount	Total Overpayment Amount	Cumulative principal write Off amount

Cumulative Interest write Off amount