Form Approved
OMB No. 0938-0600

MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of sections 1815(a), 1833(e),1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by:

Provider Name	Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

Signature of Officer or Administrator of Provider

Name and Title

Date *(mm/dd/yyyy)*

CHECK ONE:

☐ Qualify as a Low Utilization Provider

☐ The Credit Balance Report Detail Page(s) is attached.

☐ There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached)

Contact Person	Telephone Number *(including area code)*

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MEDICARE CREDIT BALANCE REPORT
DETAIL PAGE

Provider Name: _____

Provider Number: _____

Quarter Ending: _____

Medicare Part: _____ (Indicate "A" or "B")

Page _____ of _____

Contact Person: _____

Phone Number *(including area code):* _____

1 Beneficiary Name (Last Name, First Initial)	2 Medicare Beneficiary Identifier (MBI)	3 ICN Number	4 Type of Bill	5 Admission Date (mm/dd/yyyy)	6 Discharge Date (mm/dd/yyyy)	7 Paid Date (mm/dd/yyyy)	8 Cost Report (Open/ Closed)	9 Amount of Medicare Credit Balance	10 Amount of Medicare Credit Balance Repaid	11 Method of Payment	12 Amount of Medicare Credit Balance Outstanding	13 Reason for Medicare Credit Balance	14 Value Code	15 Primary Payer (Name & Billing Address)

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MEDICARE CREDIT BALANCE REPORT
PROVIDER INSTRUCTIONS

General

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses the information. In accordance with sections 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, all providers participating in the Medicare program are to complete a Medicare Credit Balance Report (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit." However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period; e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Only Medicare credit balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the manual [each provider manual will have the appropriate cite for that manual] that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

Submitting the CMS-838

Submit a completed CMS-838 to your fiscal intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

Completing the CMS-838

The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. This page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you have reported. An electronic file (or hard copy) of the detail page is available from your FI.

You may submit the detail page(s) on a diskette furnished by your contractor or by a secure electronic transmission as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE: Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;
- The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- The month, day and year of the reporting quarter; e.g., 12/31/02;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column 1:
The last name and first initial of the Medicare Beneficiary, (e.g., Doe, J.).

Column 2:
The Medicare Beneficiary Identifier (MBI) of the Medicare Beneficiary.

Column 3:
The multiple-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

Column 4:
The 3-digit number explaining the type of bill; e.g., 111 – inpatient, 131 – outpatient, 831 – same day surgery. (See the Uniform Billing instructions, [each provider manual has the appropriate cite for the manual].)

Columns 5/6:
The month, day and year the beneficiary was admitted and discharged, if an inpatient claim; or "From" and "Through" dates (date service(s) were rendered), if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 01/01/2002).

Column 7:
The month, day and year (e.g., 01/01/2002) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure the paid date and ICN number correspond to the most recent payment.

Column 8:
An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)

Column 9:
The amount of the Medicare credit balance that was determined from your patient/ accounting records.

Column 10:
The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the CMS-838 to your FI.)

Column 11:
A "C" when you submit a check with the CMS-838 to repay the credit balance amount shown in column 9, an "A" if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the CMS-838, and a "Z" if payment is being made by a combination of check and adjustment bill with the CMS-838. Use an "X" if an adjustment bill has already been submitted electronically or by hard copy.

Column 12:
The amount of the Medicare credit balance that remains outstanding (column 9 minus column 10). Show a zero ("0") if you made full payment with the CMS-838 or a claim adjustment had been submitted previously, including electronically.

Column 13:
The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons." Provide an explanation on the detail page for each credit balance with a "3."

Column 14:
The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter the code applicable to the payer with the largest liability. For code description, see [each provider manual has the appropriate cite for that manual].)

12 – Working Aged

13 – End Stage Renal Disease

14 – Auto/No Fault

15 – Workers' Compensation

16 – Other Government Program

41 – Black Lung

42 – Department of Veterans Affairs (VA)

43 – Disability

44 – Conditional Payment

47 – Liability

Column 15:
The name and billing address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report.

Payment of Amounts Owed Medicare

Providers must pay all amounts owed (column 9 of the report) at the time the credit balance report is submit- ted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a **separate** adjustment bill, electronic or hard copy, for all individual credit balances that pertain to open cost reporting periods. The FI will ensure that the monies are not collected twice.
- Submission of the detail information on the CMS-838 will not be accepted by the FI as an adjustment bill.
- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).

- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that "if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare…" the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.
- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, you may contact your FI regarding an extended repayment schedule.

Records Supporting CMS-838 Data

Develop and maintain documentation that shows that **each patient record with a credit balance** (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether the patient is an eligible Medicare beneficiary;
- Identify other liable insurers and the primary payer;
- Adhere to applicable Medicare payment rules; and
- Ensure that the credit balance is due and refundable to Medicare.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

Provider Based Home Health Agencies (HHAs)

Provider-based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it may be different from the FI servicing the parent facility.

Exception for Low Utilization Providers

Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, section 2414.4.B, or files less than 25 Medicare claims per year.

Compliance with MSP Regulations

MSP regulations at 42 CFR 489.20(h) require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of the CMS-838 and adherence to CMS' instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it on the CMS-838; i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.
