Supporting Statement
Medicare Credit Balance Reporting Requirements
and Supporting Regulations in 42 CFR 405.371, 405.378, and 413.20

A. BACKGROUND

Through the submission of this information collection request, CMS is seeking to reinstate the information collection requirements previously approved under OMB control number 0938-0600. The OMB Control Number lapsed due to administrative issues. Section 1866(a)(1)(C) of the Social Security Act (Act) requires health care providers participating in the Medicare program to make adequate provisions to refund any monies incorrectly paid. Studies performed by the Centers for Medicare & Medicaid Services (CMS), the Government Accountability Office (GAO), and the HHS Office of the Inspector General (OIG) during the early 1990's showed that providers were not complying with this requirement.

Improper payments are made to providers through the Medicare claims processing system. Whenever a provider receives an improper payment for a claim it has submitted, this payment is usually recorded in its accounting system. Such payments are identified as Medicare credit balances.
According to both GAO and OIG, providers have no incentive to refund credit balances due to the Medicare program or to refund them on a timely basis. Generally, this is because no penalties can be assessed against them until the credit balances are identified. GAO and OIG concluded that CMS needed to strengthen its controls over Medicare credit balances and recovery procedures employed by its Medicare contractor (Medicare Administrative Contractor), and establish penalties to enforce timely reporting and repayment by providers. In 1991, GAO specifically recommended that CMS initiate a provider credit balance reporting system.

On April 8, 1991, CMS issued instructions requiring providers to report all Medicare credit balances to their contractor on a quarterly basis. These requirements were suspended because the Paperwork Reduction Act requires that the Office of Management and Budget (OMB) approve national data collections of this type.

On April 21, 1992, OMB approved the use of Form CMS-838 (838), Medicare Credit Balance Report. Following this approval, CMS reinstated its mandatory credit balance reporting requirements on June 8, 1992, furnishing providers with instructions for completing the 838 on a quarterly basis. At that time, contractors were instructed to designate a component to monitor and control all credit balance transactions, assure that all providers submit a completed report, accept checks as repayment of credit balances, and timely process adjustment bills. On September 10, 1992, CMS issued clarifying instructions advising providers that failure to file the required reports may lead to the suspension of Medicare payments; however, CMS' intention is to achieve compliance by the provider community in reporting credit balances and not to impose sanctions. At this time, we are requesting for reinstatement of the previous OMB approval for the use of Form CMS-838.

B. JUSTIFICATION

1. Need and Legal Basis

Section 1815(a) of the Act authorizes the Secretary to request information from providers which is necessary to properly administer the Medicare program. Quarterly credit balance reporting is needed to monitor and control the identification and timely collection of improper payments.

Credit balances are mainly attributable to provider billing practices and cannot be eliminated by program functions; they will continue to occur. In December 1992, the OIG issued a Management Advisory Report (MAR) on their extended review of credit balances (See Attachment). They state that approximately 90 percent of credit balances result from providers: (1) billing Medicare and a private insurer for the same service, (2) submitting duplicate billings for services in a manner which cannot be detected by system edits, and (3) billing for services not performed. The 1992 MAR recommends that CMS continue its plan of recovery by requiring hospitals to report Medicare credit balances to contractors on a quarterly basis.

The reporting requirements provide CMS with the authority to impose sanctions such as the suspension of program payments in accordance with 42 CFR 413.20(e) and 405.371 if providers do not report credit balances on a timely basis. Furthermore, once a credit balance has been identified on an 838 and demand for payment is made, CMS has the authority to charge interest if the amount is not repaid within 30 days in accordance with 42 CFR 405.378.

Providers that repay credit balances before the end of each calendar year quarter are not required to report such balances on the CMS-838. These providers only need to submit the certification statement indicating it has no Medicare credit balances to report for each applicable calendar year quarter.

2. Information Users

The information obtained from Medicare credit balance reports will be used by the contractors to identify and recover outstanding Medicare credit balances and by Federal enforcement agencies to protect Federal funds. The information will also be used to identify the causes of credit balances and to take corrective action.

All providers participating in the Medicare program will be required to submit a quarterly credit balance report (Form CMS-838) to their contractor. The report and its instructions require providers to report information which includes:

-Provider Name and Number
-Patient Name and Identification Number
-Dates of Service
-Credit Balance Amount
-Cause of Credit Balance

Contractors will collect overpayments related to identified credit balances, process adjustment bills, and maintain the credit balance reports. Contractors will issue a demand for payment and assess interest, if necessary, in accordance with established procedures for any amounts that remain outstanding.

The information collected from the providers will also be used to identify causes of credit balances so corrective action can be taken. The providers will report the cause of each credit balance they identify in their records. The contractors will analyze this information and determine what actions are needed to prevent further occurrences. For example, there may be a failure in a contractor's claims processing edits which allows duplicate claims to be processed without being detected. In addition, if the results of a contractor's review indicate that problems exist outside of their area of responsibility, the issue will be referred to CMS for action (e.g., change in billing instructions, regulations, provider manuals).

3. Improved Information Technology

The form is 100 percent electronic. The requested information is maintained by the majority of providers in computerized accounting systems. Computerized files for this form allow for proper input of the specific information required in the credit balance report. These files are available at a provider's request, and the necessary data is easily extracted from their accounts receivable records. Because the majority of providers have this electronic capability, the burden associated with hard copy reporting is greatly reduced.

4. Duplication/Similar Information

There is no duplication of this type of data being collected or reported elsewhere. The availability of credit balance information was discussed with GAO and the OIG. Providers are not preparing or forwarding credit balance data to any other governmental or non-governmental entity.

However, it's important to emphasize that the Medicare Credit Balance Report is just one option for Part A Medicare contractors who service providers to report self-identified overpayments. Any burden estimates contained in this information collection request are completely independent of those associated with the information collection request approved under OMB control number 0938-1323, Medicare Program; Reporting and Returning of Overpayments. The Medicare Credit Balance Report is for Medicare Part A providers that are serviced by Part A Medicare Administrative Contractors.

5. Small Business

These requirements do not significantly impact small businesses.

6. Less Frequent Collection

We are requesting that providers report credit balances on a quarterly basis. A less frequent collection would mean that millions of dollars in program funds may remain outstanding for an extended period of time.

7. Special Circumstances Affecting the Information Collection

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-Day Federal Register notice was published May 16, 2016. No public comments were received. The 30-day Federal Register notice published on July 19, 2016. No public comments were received.

9. Payment to Respondent

There is no payment or gift made to any respondent.

10. Confidentiality

This co1lection maintains confidentiality to the extent of the law. There is no associated SORN with this collection because the personally identifiable information that is collected (Provider Name/Number and Patient Name/Identification Number) are not maintained in a system of records as that term is defined in the Privacy Act of 1974.[1]

11. Sensitive Questions

There are no questions of a sensitive nature involved in the credit balance data collection.

12. Estimate of Burden

The burden associated with the information collection is based upon the amount of time needed by providers to prepare and submit the credit balance reports. In most instances, the reports will be prepared electronically creating little burden. However, in many instances, providers will need to review patient files to ensure that credit balance amounts are in fact due Medicare and not another insurer or patient.
Provider costs to verify credit balance amounts due Medicare and to prepare the requisite reports will cost $ 40.3 million per year, computed as follows:

Number of Providers Serviced by Part A MACs	52,582
Number of Hours per Quarter to Generate Report	X 3
Total Hours per Quarter	157,746

1 A “system of records” means a group of any records under the control of an agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other particular assigned to the individual (see 5 U.S.C. 522a(a)(5)).

Number of Quarters	X 4
Total Hours	630,984

Reporting is based on our policy and procedures outlined in the Financial Management Manual Publication 100.6, Chapter 12.

Cost Per Hour (63.82/hr. Financial Specialist 13-2099)	X $63.82

This information comes from the Bureau of Labor Statistics and includes 100% of salary overhead. BLS website http://www.bls.gov/oes/current/oes_md.htm

Total Costs	$40,269,399

13. Capital Costs

There are no capital and startup costs or operation and maintenance costs associated with this collection.

14. Cost to Federal Government

Federal Government costs for this initiative will be $ 1.2 million per year. This estimate is based upon the cost of 3/4 full-time equivalent (FTE) employee at each contractor to monitor the credit balance reports, the recovery of outstanding credit balances, the issuance of demand letters, and audit costs to verify the accuracy of provider credit balance reports.

Costs to the Government are calculated as follows:

Cost of 3/4 FTE Employee ($ 63.82/hr., Financial Specialist 13-2099)	$99,559
Number of Contractors	X 12
Costs	$1,194,708

No. of Audits of Credit Balance Reports	25
No. of Hours per Audit	X 4
Total Hours	100
Cost per Hour ($71.18/hr. Auditor 13-2011) X $71.18	
Costs	$7,118

BLS website http://www.bls.gov/oes/current/oes_md.htm

Total Costs	$1,201,826

15. Changes in Burden/Program

The burden per submission has not changed; however, the overall total annual burden has increased from $550,056 to $630,984 due to an increase in the number of providers that submit claims to Medicare and are subject to Medicare credit balance reporting. The burden has been adjusted accordingly. We have also revised the total cost burden to reflect the use of 100% of the hourly wage when calculating fringe and overhead.

16. Publication Data

There are no plans to publish the information collected under this submission.

17. Expiration Date

The Form CMS-838 will display the expiration date. The expiration date is located in the lower left hand corner of the certification page. It is also located in the lower left hand corner of the detail page. The expiration date is also located in the PRA disclosure statement located on the instructions page.

18. Exception to Certification Statement

There are no exceptions to the certification statement.

C. COLLECTION OF INFORMATION EMPLOYING STATISTICAL INFORMATION

This collection of information does not employ statistical methods.