CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13183	**Date: April 24, 2025**
	Change Request 14044

SUBJECT: 100-06 Internet Only Manual (IOM) Updates - Chapter 3 - Beneficiary Liability

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the beneficiary liability section of the IOM to remove old language, such as Health Insurance Claim Number (HICN), Fiscal Intermediary (FI), and Carrier, that are no longer used.

EFFECTIVE DATE: May 27, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 27, 2025

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/100/Beneficiary Liability
R	3/110/Recovery Where the Beneficiary Is Liable for the Overpayment
R	3/110.1/Recovery Where the Beneficiary Is Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental
R	3/110.2/Recovery From the Beneficiary
R	3/110.3/When to Suspend Efforts to Recover from the Beneficiary Following the Initial Demand Letter
R	3/110.4/Content of Demand Letter to Beneficiary
R	3/110.5/Sample Demand Letter to Beneficiary
R	3/110.6/Optional Paragraphs for Inclusion in Demand Letters
R	3/110.7/Recovery Where Beneficiary Is Deceased
R	3/110.8/Beneficiary Wishes to Refund in Installments
R	3/110.9/Beneficiary Protests
R	3/110.10/When the Contractor Does Not Take Recovery Action in Beneficiary Cases but Considers Whether Waiver of Recovery is Applicable
R	3/110.11/Recording Overpayment Cases in Which the Provider is Not Liable—Part 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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 13183	Date: April 24, 2025	Change Request: 14044

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II. GENERAL INFORMATION

A. Background: CMS periodically reviews the IOM to ensure that all policy is interpreted as intended. This CR updates policy to remove old language that is no longer used by CMS.

B. Policy: This CR clarifies and updates to chapter 3, section 100 to 110 of the IOM publication 100-06.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14044.1	The contractors shall be aware of the updates to IOM Pub. 100-06, Chapter 3, which modernize the terminology to current standards.	X	X	X	X					NCH

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

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

ATTACHMENTS: 0

Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents
(Rev. 13183; Issued: 04-24-25)

Transmittals for Chapter 3

100 - Beneficiary Liability
(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

A beneficiary is liable for:

- Overpayments made to a provider that was without fault *except for* overpayments for medically unnecessary services or custodial care where the beneficiary, as well as the provider, was without fault. (See Medicare Claims Processing, Chapter 30, Limitation on Liability.)
- Situations in which Medicare pays a provider, and a Workers' Compensation (WC) carrier, automobile medical, or no-fault insurer or any liability insurer; or EGHP pays primary benefits to the beneficiary for the same services. (See Medicare Secondary Payer Manual)
- Overpayments made to the beneficiary.

110 - Recovery Where the Beneficiary Is Liable for the Overpayment
(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

When the *contractor* has determined the beneficiary to be liable for the overpayment, it shall initiate recovery efforts in accordance with the following sections, as appropriate. The chart below is meant to be a guide. The actual sections shall be reviewed for additional guidance.

MEDICARE BENEFICIARY NON-MSP OVERPAYMENTS

O/P Amount	Overpayment Notice	Level of Pursuit	Waiver Requests
$0-$49.99	No- refer to Ch. 3 §110.2	None	N/A
$50-$999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. If case is in offset status for one year with no collection activity, refer case to RO with a recommendation to terminate collection action.	Review all waiver requests and *decide* to approve or deny the waiver based on Ch. 3 §70.
$1000-$19999.99	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and *decide* to approve or deny the waiver based on Ch. 3 §70.
$20000 and over	Yes, See Ch. 3 §110	Attempt collection following Ch. 3 §110.2. Attempt to refer the case to SSA if applicable.	Review all waiver requests and *recommend* approving or denying the waiver based on Ch. 3 §70. If the recommendation is for approval, refer the waiver request to the Regional Office for concurrence.

110.1 - Recovery Where the Beneficiary Is Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

When the *contractor* determines the beneficiary is liable, and the beneficiary carries supplemental health insurance or is covered by another Government health benefits program such as Medicaid, TRICARE, CHAMPVA, or the Federal Employees Health Benefits Program, it may be possible to recover the overpayment from the other plan or program. Payments of deductible or coinsurance amounts and payment for services rendered persons who are not entitled to Medicare are the payments most likely to be recoverable.

If, based on the circumstances of the overpayment *the contractor has* knowledge of the other plan or program *and* the *contractor* believes there is a possibility that the other plan or program will refund the overpayment, it shall attempt to recover from the other plan or program. In this connection, it may be necessary to ask the beneficiary for their policy number or other information concerning their non-Medicare coverage. (See Medicare Claims Processing, Chapter 28, Coordination with Medigap, Medicaid, and Other Complementary Insurers, for procedures to follow where the overpayment is for services that should have been paid for by a WC carrier.)

To facilitate recovery of the Medicare overpayments to the extent possible, where another plan or program is involved, the *contractor* shall attempt to work out mutually satisfactory arrangements with the other

carrier(s). In negotiations with Medicaid agencies or carriers, it may be helpful for the *contractor* to point out that Medicare will refund directly to Medicaid agencies overpayments for services reimbursed on a charge basis.

The methods listed below have been used successfully. The *contractor* shall use any one or a combination, as it finds appropriate. The most desirable method in each situation depends upon the individual circumstances and the provisions of the other plan or program.

- The *contractor* shall arrange with the other plan or program for direct refund of overpayments. If the *contractor* is also the carrier under the other plan or program, a transfer of funds is the most convenient method of recovering. If another insurance carrier is involved, the *contractor* shall send the other insurance carrier a letter requesting refund of the overpayment. The letter should explain how the overpayment occurred and how it was calculated. The *contractor* shall follow up in 30 days with another letter or a phone call if payment or a letter of explanation has not been received. If this does not bring a meaningful response, it shall write to the President or Chief Administrative Officer of the other carrier.

- If the *contractor* does not use the above method for provider overpayments, it shall arrange with the other plan or program to make payment to overpaid provider upon the *contractor's* request, (even though the provider has not billed the other plan or program) and to notify the *contractor* of the payment. Upon receiving such a notice, the *contractor* shall recover the Medicare overpayment from the provider.

- Where neither of the above methods is possible, the *contractor* shall ask the provider if it would be willing to refund the overpayment and to bill the other plan or program, with the understanding that if it is unable to obtain payment, the *contractor* will refund the amount recovered to the provider. If the provider does not agree to refund the overpayment before collecting from the other plan or program, the *contractor* shall ask it to bill the other plan or program and to use the payment to refund the overpayment. If the *contractor* receives notice that a provider (or a beneficiary) plans to file a claim with another plan or program, it shall suspend recovery efforts for a reasonable period.

If the *contractor* has questions concerning the proper approach in recovering from a welfare agency, or another insurance plan, it should contact its RO.

If efforts to recover the overpayment are not successful, or if the *contractor* is certain that the other plan or program will not refund a particular overpayment, it shall seek recovery from the beneficiary in accordance with §110.2 *of this chapter*. It shall explain in the notice to the beneficiary that the other plan or program will not make payment directly to it. However, if the beneficiary is a Medicaid recipient, the *contractor* shall not attempt recovery from the beneficiary.

110.2 - Recovery From the Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The term Medicare Beneficiary Identifier (*MBI*) is a general term describing a beneficiary's Medicare identification number.

To recover a non-MSP overpayment from a beneficiary, follow the recovery procedure below. If the beneficiary protests following the receipt of a notification of overpayment, handle the protest in accordance with §110.9 *of this chapter*.

A. Non-MSP Overpayment Is Less Than $50

Take no further recovery action. Do not send a recovery letter, or attempt recoupment. Also do not refer case to CMS for further collection efforts. See §160.2 *of this chapter* for termination of collection procedures.

B. Non-MSP Overpayment Amount Is $50 or More

Upon discovering an overpayment of $50 or more, send the beneficiary a recovery letter containing the information in §110.4 *of this chapter*.

If there is no response within 30 days after sending the initial recovery letter and none of the conditions in §110.3 *of this chapter* are present:

1. Send a follow-up letter to the beneficiary, and

2. Arrange to begin *offset* of the overpayment against any Medicare payments that become due the beneficiary on day 60.

C. Referral to SSA

To be considered for SSA referral the overpayment amount must be $1000 or more and the beneficiary must be in current pay status. If, within 90 days of sending the initial demand letter, the overpayment has not been recovered and the individual has not requested a reconsideration, hearing or waiver (see §110.9 *of this chapter*) Prepare the case for referral to SSA for possible recovery from the individual's social security benefits.

However, if the beneficiary *is not entitled to monthly social security benefits,* do not refer the case to SSA. Offset should be continued in the case of beneficiaries who *is not entitled to monthly social security benefits*. If appropriate, the instructions for termination of collection action should be followed (See 110.3D *of this chapter* for additional instructions.).

The *contractor* should not refer an overpayment to SSA if it has knowledge that the beneficiary is deceased.

When preparing the case for referral to SSA the following must be included in the case file:

- Referral Form- contains the address of the referring agency (The Centers for Medicare and Medicaid Services (CMS) Central Office, CMS Regional Office, or the Medicare Contractor and information pertaining to the case; and

- Return Notice- for SSA use in recording information for crediting the CMS Trust Fund; and

- Waiver Determination- if the Medicare Contractor or CMS RO determines the beneficiary was at fault for the overpayment.

NOTE: The contractor's file must contain all overpayment notification letters and correspondence from the beneficiary and/or representative. Contractors may retrieve copies of the relevant forms from the servicing regional office or by accessing SSA's Program Operations Manual System at http://policy.ssa.gov/poms.nsf/poms. Access the HI section for Health Insurance and then the section number HI 022 titled Medicare Overpayments. Then access HI 02201 - Methods of Recovery for Title XVIII Overpayments and finally HI 02201.015 titled Appeal Requests and Refunds. The Beneficiary Overpayment Referral Notice is Exhibit A.

When an individual or his/her authorized representative receives notice from SSA that a Medicare overpayment will be withheld from title II benefits and protests the withholding, the protest applies only to the deduction from his/her title II benefits. It does not apply to the Medicare overpayment because the Medicare contractor has determined that the overpayment must be recovered.

If SSA receives an appeal and/or waiver request, they must stop the process of recovery. If the Medicare Contractor, CMS RO, or the Administrative Law Judge has previously denied a waiver request, SSA will then process the overpayment in accordance with current operating procedures. If the individual has not requested *a* waiver with the contractor but files a waiver request with SSA, then SSA must return the overpayment package to the appropriate contractor for processing.

When an individual or his/her representative goes to SSA to request a waiver and/or an appeal of the Medicare Overpayment withholding, SSA must complete the following forms, depending on the request:

- Waiver- Form 632-BK (Request for Waiver of Overpayment and Recovery of Change in Repayment Rate)

- Appeal of Withholding – SSA-795 (Statement or Claimant or Other Person) since the rate of the withholding is not an initial determination, does not use the SSA-561 (Request for Reconsideration) or HA-501 (Request for Hearing).

NOTE: The referral of a non-MSP beneficiary debt to SSA occurs regardless of the classification of the debt for financial reporting. Thus, a referral to SSA should occur even if the debt has been reclassified to Currently Not Collectible (CNC).

D. Beneficiary "Write-Off" between $50- $999.99

If there has been "No Activity" (i.e. no recoupment) within a 12-month period of a beneficiary non-MSP overpayment that is between $50-$999.99, verify that no collections are being made on any other older debts for the same beneficiary before you make a recommendation for write-off to the Regional Office. At the end of each Quarter compile a list of all beneficiary non-MSP overpayments between $50-$999.99 to the Regional Office for Write-Off.

Submit this information, including the status of probate, if applicable, with an explanation for the beneficiary non-MSP overpayment Write-off.

Example:

Region # xx	*Contractor #* xxxxx	*Medicare beneficiary identifier#* xxxxxxxxxx	Claim # xxxxxxxxxxxx
Claim paid date xxxxxxxx	Demand letter date xxxxxxxx	Det. date. xxxxxxxx	$ amt. xxxx

The RO will be responsible for approval or denial of all recommendations for "write-off", based on the information submitted by *contractor*.

NOTE: The write-off of a non-MSP beneficiary debt between $50-$999.99 occurs regardless of the classification of the debt for financial reporting. Thus, a request to write off non-MSP beneficiary debt between $50-$999.99 should occur even if the debt has been reclassified to Currently Not Collectible (CNC).

NOTE: Beneficiary overpayments that are greater than $1000 may be recommended for write-off following the above instructions if the Medicare contractor has verified from SSA that the beneficiary is not in a current pay status.

110.3 - When to Suspend Efforts to Recover from the Beneficiary Following the Initial Demand Letter

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Efforts to recover from the beneficiary should be suspended if any of the following conditions exist:

A. The Beneficiary Requests Administrative Appeal, or Questions the Overpayment Decision

The *contractor* shall make no further recovery efforts until it disposes of the appeal request. (See §110.9 *of this chapter*)

B. The Beneficiary Requests That Recovery be Waived or States Conditions that Might Qualify the Beneficiary for Waiver of Recovery

The contractor shall refer beneficiary waiver requests over $20,000 to their RO for waiver eligibility.

C. The Beneficiary Is Receiving Welfare Benefits

If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, the *contractor* shall ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. (See §110.1 *of this chapter*.) If the welfare agency does not refund the overpayment in full, the *contractor* shall not attempt recovery from the beneficiary, unless it is apparent that the beneficiary knew or should have known that the payment was incorrect.

NOTE: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

110.4 - Content of Demand Letter to Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment which is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the *contractor's* determination. Clarity is also important because the letter may eventually be used by CMS for further recovery attempts.

The following is the minimum information which shall be included in all overpayment refund letters sent to a beneficiary:

A. Name and address of physician, date and type of service, charges, date of check, amount of check, and name of payee.

B. A clear explanation of why the payment was not correct.

C. The amount of the overpayment and how it was calculated.

D. The beneficiary is required to refund the overpayment.

E. The refund should be by check or money order, and how it should be made out (enclose a pre-addressed envelope).

F. The refund can be made by installments. (See §110.8. *of this chapter*)

G. Unless a refund is made, the overpayment may be withheld from other Medicare benefits payable to the beneficiary and may be referred to the Social Security Administration for further recovery action.

H. Possible recovery from other insurance (if applicable).

I. An explanation of the beneficiary's right to a review or hearing as appropriate.

J. An explanation of the CMS/SSA waiver of recovery provisions. (See §170.3 *of this chapter*)

110.5 - Sample Demand Letter to Beneficiary

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The *contractor* may use or adapt the following model letter for requesting refunds of overpayments from beneficiaries:

"Dear Mr. _____:

A. Opening Paragraph:

"In (month and year) we paid (provider's, physician's, supplier's name and location) (you) $_____ more than was due for services furnished by _____ on _____ (from _____ through _____) (on _____). We have reviewed the payment and determined that it was incorrect. The correct payment should have been $_____."

The *contractor* shall include a clear and complete explanation of how the overpayment arose and how it was calculated.)

It shall add if applicable: "We have recovered $_____ from (specify source). Thus, the total remaining overpayment is $_____.

B. Liability of Beneficiary When Payment Made to Physician or Supplier

If payment was made to the physician, add the following:

"Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's, physician's, supplier's name) was not at fault. Therefore, you are liable for the $_____ incorrectly paid for the services you received."

C. Request for Refund

"Please send us a check or money order for $_____, within 30 days. Make the check or money order payable to (*contractor* name), and mail it in the enclosed self-addressed envelope."

D. Possible Offset

"If other Medicare benefits become payable to you and you have not refunded the incorrect payment, we will withhold the amount you owe from those benefits." (In the initial letter the *contractor* shall add: "beginning 60 days from the date of this letter.")

E. Possible Referral to Social Security Administration

If the overpayment is over $1000, add the following:

"If you do not repay this amount, this overpayment may be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action that, among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled."

F. Installment Payments

"If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of $_____each month for ___ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often."

G. Possible Recovery from Other Insurance

(The *contractor* shall not use this paragraph where it has determined that the private insurer will not pay.)

"If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider or physician) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office."

H. Notification of Appeal Rights

The notification of appeal rights must be in accordance with the reopening rules in Medicare Claims Processing, Chapter 29 – Appeals of Claims Decisions.

NOTE: If the overpayment was for medically unnecessary services or for custodial care, The *contractor* shall begin the first sentence of the appeals paragraph:

"If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services."

I. Notification of Waiver of Recovery Provision

"The law requires that you must repay an overpayment of Medicare benefits unless you meet both of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, and
- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses or would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination."

110.6 - Optional Paragraphs for Inclusion in Demand Letters

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The *contractor* should use or adapt the following paragraphs in explaining how the overpayment occurred.

A. Inpatient Hospital Deductible or Coinsurance Not Properly Assessed – *Part A*

1. General – *Part A*

"Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first $_____ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of $_____ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is $_____ per day coinsurance for each lifetime reserve day used.

2. Deductible Overpayment

"Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for ____ days in full. However, since these were the first inpatient hospital services furnished in this benefit period you are responsible for the deductible and the $_____ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus (provider's name) was overpaid by $_____."

3. Coinsurance Overpayment

"Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for ____ full days (less the $____ deductible). However, since you had previously been hospitalized for ____ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as ___ full days and ____ coinsurance days (and/or lifetime reserve days). Therefore (provider's name) has been overpaid on your behalf for _____ coinsurance days at $_____ per day and/or lifetime reserve days at $_____ per day) (less $_____ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is $_____."

B. Deductible Not Properly Assessed -*Part B*

"Under Part B of Medicare, no reimbursement may be made for the first $100 of approved charges incurred by a beneficiary in each calendar year." (If pertinent, add: "This is true even if you were covered under Medicare for only part of the year.") In these cases, explain the computation of the overpayment.

C. Payment Made Under Workers' Compensation Law

We paid $_____ in benefits for services furnished you by (provider's, physician's or supplier's name and location) on (dates). However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services that are covered under workers' compensation. Since (provider's, physician's, supplier's name) was not at fault in causing this overpayment, you are required to refund the $_____ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions."

D. Beneficiary Not Entitled to Medicare Benefits

"The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your Medicare Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (*contractor* name). Therefore, if you disagree with this decision, or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you."

110.7 - Recovery Where Beneficiary Is Deceased

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

Where a beneficiary who is liable for an overpayment dies, the *contractor* shall attempt to recover from such sources as State welfare agencies, or private insurance plans (see §110.1 *of this chapter*), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative. (See 42 CFR 424.60)

If the entire overpayment cannot be recovered by the above methods, it shall send a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative if known, or to the last known address of the deceased. It shall include the basic information in §110.5 *of this chapter* but shall not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The *contractor* shall not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. It shall not recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

Model Refund Request to Estate of Deceased Beneficiary (*contractor* shall adapt to Fit the Situation)

Estate of (deceased beneficiary) (or, if known, "Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear M. _____ if estate representative's name is known).

On (date) we paid (provider's, physician's, or supplier's name and location) (deceased beneficiary, if applicable) $ _____ more than was due for services furnished by (_____) on _____ (from _____ through _____)."

(This paragraph should include a clear and complete explanation of how the overpayment

arose, the amount of the overpayment, how it was calculated, and why the payment was not correct.)

The *contractor* shall add if applicable:

"We have recovered $ _____ from (specify source). Thus, the total remaining overpayment is $_____.

"If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits.

If payment was made to the physician, add the following:

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the (provider, physician) was not at fault in causing the overpayment. In this case ((provider, physician) name) was not at fault. Therefore, the estate of (deceased beneficiary) is liable for the $_____ incorrectly paid to ((provider, physician) name) for the services it furnished (deceased beneficiary).

"Please send us a check or money order in the amount of $ _____ payable to (*contractor* name) in the enclosed, self-addressed envelope within 30 days.

NOTE: The *contractor* shall undertake notification of appeal rights in accordance with the reopening rules in Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.

"If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver."

110.8 - Beneficiary Wishes to Refund in Installments

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The term Medicare Beneficiary Identifier (*MBI*) is a general term describing a beneficiary's Medicare identification number.

A. General

If an overpaid beneficiary states that they are unable to refund the full amount of an overpayment at one time, regular monthly installment payments are acceptable. The amount and frequency of the installments should be in reasonable relationship to the amount of the overpayment.

Normally, the installments should be large enough to effectively recover within 3 years; however, the *contractor* shall allow a longer installment period if the beneficiary is willing to refund at least $50 per month. In notifying a beneficiary that they can refund an overpayment by installments, the *contractor* shall specify the amount (not less than $10) and the number of monthly installments necessary to recover the overpayment.

NOTE: These provisions for repayment in installments do not apply to overpayments for which providers are liable.

The *contractor* shall exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that they cannot afford an installment of at least $10 per month, or that they can afford installments of $10 to $50 per month but the overpayment is so large that recovery would take substantially more than 3 years, the *contractor* shall treat such statement as a request for waiver. (See §110.9 *of this chapter*)

B. Notification of Installment Schedule

When agreement is reached with a beneficiary for refund by installments, the *contractor* shall notify the beneficiary of the installment schedule. Request the beneficiary to sign an installment agreement such as the one in paragraph C below. It shall give one copy of the agreement to the beneficiary and retain the other.

C. Suggested Installment Agreement

_____ _____

Name of Overpaid Beneficiary Medicare Beneficiary Identifier

Beneficiary's Address

I hereby agree to repay my Medicare overpayment totaling $ _____ to (*contractor's* name), which will receive the payments on behalf of the Centers for Medicare and Medicaid Services. My payments will be made as follows:

DATE PAYMENT DUE (Month, Day, Year)	Amount of Payment
_____	_____
_____	_____
_____	_____

_____

Signature of Beneficiary

_____

Date

D. Beneficiary Fails to Remit Installments

If the beneficiary fails to remit two consecutive installments, or after remitting the overdue installments, fails to remit any subsequent installments, the *contractor* shall ask the beneficiary the reason for the lapse. If it does not receive a response within 30 days or is informed that the beneficiary is unable to continue paying any installments the statement should be treated as a waiver request. If the *contractor* learns that the beneficiary is deceased, see §110.7 *of this chapter*.

E. Beneficiary Can No Longer Afford Installment Amount but Can Afford a Lesser Amount

If the beneficiary notifies the *contractor* that they can no longer afford to pay the agreed-upon installments but can afford a lesser amount, the *contractor* shall set up a new agreement, provided the new installment is at least $10 per month, and large enough to effect recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement.

110.9 - Beneficiary Protests

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

A beneficiary's reply to a notification of overpayment or request for refund may constitute a request for waiver, or request for appeal, i.e., reconsideration, review, *contractor* fair hearing, or ALJ hearing as applicable, or a request for both waiver and appeal.

A. Protests To Treat as Requests Administrative Appeal

The *contractor* shall consider a beneficiary's reply *to* a request for administrative appeal (Part A reconsideration, Part B review, Part B fair hearing, or ALJ hearing (both A & B), as applicable) if the beneficiary protests the existence of an overpayment, the amount of the overpayment, or if the nature of the protest is unclear. (See B below for which protests the *contractor* shall consider requests for waiver.) It shall take no further recovery action in such cases until the administrative appeal process is completed. (See Pub. 100-4, Medicare Claims Processing, Chapter 29, Appeals of Claims Decisions.) The *contractor* shall tell the beneficiary that the request is being considered (or has been forwarded to the Office of Hearings and Appeals, if a hearing request) and that no action is necessary until further notice. If the overpayment case has been referred to SSA, the *contractor* shall inform SSA of the appeal so that recovery action by SSA may be suspended pending the results of the appeal.

If the appeal determination is that the beneficiary is liable for an overpayment, the *contractor* shall send the beneficiary another request for refund of the overpayment (including all information in §110.5 *of this chapter*), unless the beneficiary has also requested waiver. In that event, see B below.

B. Protests To Treat as Requests for Waiver

If an overpaid beneficiary protests on the grounds of hardship, or that recovery would be inequitable, the *contractor* shall treat the protest as a request for waiver even if it is filed on a form ordinarily used for requesting administrative appeal. Discontinue collection efforts and make a waiver determination if necessary. If the beneficiary offers evidence of financial condition, the *contractor* shall include it but shall not solicit such evidence. It shall tell the beneficiary that the overpayment case will be forwarded to the Social Security Administration and that no action is necessary until further notice.

NOTE: If the beneficiary has also requested appeal, the *contractor* shall conduct the appeal prior to the waiver determination.

110.10 - When the *Contractor* Does Not Take Recovery Action in Beneficiary Cases but Considers Whether Waiver of Recovery is Applicable

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

The *contractor* shall consider whether waiver of recovery from the beneficiary is applicable. If the beneficiary is liable and the criteria for waiver of recovery from the beneficiary are likely to be met, i.e., it appears from the circumstances that the beneficiary was without fault and that recovery is against equity and good conscience or defeats the purpose of the Medicare program (i.e., would cause the individual financial hardship), the *contractor* makes a waiver determination.

The *contractor* shall first determine if the beneficiary was without fault see §70.3. If it appears that the beneficiary was without fault the *contractor* shall then determine if recovery would be against equity and good conscience or if recovery would defeat the purpose of title II or title XVIII of the Social Security Act.

- For recovery to be against equity and good conscience an individual must have changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that a payment would be made or because of the overpayment itself. (See 20 CFR §404.509)

- For recovery to defeat the purpose of title II or title XVIII of the Social Security Act the beneficiary must need all his or her current income to meet ordinary and necessary living expenses. (See 20 CFR §405.508)

The *contractor* shall make waiver of recovery determinations for individual non-MSP overpayments up to $20,000. If an individual non-MSP overpayment is greater than $20,000, and the *contractor* believes that the waiver of recovery is appropriate the *contractor* shall make a recommendation to the regional office for approval to waive the recovery. If there is a situation that involves several beneficiaries where the aggregate total of all waiver determinations exceeds $40,000, the regional office shall be notified. The regional office shall provide guidance as to who shall approve the waiver of recovery determinations.

If the *contractor* decides that the information available does not justify waiver, it proceeds with normal recovery efforts from the beneficiary.

NOTE: If a beneficiary requests an appeal or a waiver after the overpayment has been referred to the SSA for collection from Title II benefits, the SSA processing center will return the overpayment to the Medicare contractor to review the waiver and/or appeal.

110.11 – Recording Overpayment Cases in Which the Provider is Not Liable—*Part A*

(Rev. 13183; Issued: 04-24-25; Effective: 05-27-25; Implementation: 05-27-25)

If a provider is relieved of liability for refunding an overpayment, and an adjustment bill is required in accordance with Medicare Bill Processing, Chapter 1, General Billing Requirements, the *contractor* shall treat the charges involved in the year-end cost report as though they were covered; i.e., make provision to assure that the overpaid amount is not recovered from the provider at the time of final cost settlement.

If the *contractor* has a system capable of preventing year-end recovery from the provider, where it was relieved of liability for refunding an overpayment, it need not maintain an additional record of the case.